Behavioral Health for Children, Youth and Families in the District of Columbia:

A REVIEW OF PREVALENCE, SERVICE UTILIZATION, BARRIERS, AND RECOMMENDATIONS

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District of Columbia
Department of Behavioral Health

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BEHAVIORAL HEALTH FOR CHILDREN, YOUTH, AND FAMILIES IN THE DISTRICT OF COLUMBIA: A REVIEW OF PREVALENCE, SERVICE UTILIZATION, BARRIERS, AND RECOMMENDATIONS

EXECUTIVE SUMMARY

BACKGROUND

The District of Columbia (DC) Department of Behavioral Health (DBH) has been proactively developing a comprehensive system of care to improve the emotional, social, and behavioral health and well-being of children, youth, and their families. As transformation of the District's children and youth behavioral health systems began to take shape, a sentinel event occurred that caused the District to pause and reconsider its overall mental and behavioral health system design. On March 30, 2010, an argument over a missing bracelet led to one of the deadliest mass shootings in the history of the District, leaving four young people dead and six others wounded. This tragedy underscored the strong link between school truancy, behavioral health issues, and potential violence. In response to this incident and urging by family members of the involved youth, the South Capitol Street Memorial Act (Act) was passed on April 10, 2012 by the DC City Council. The overarching goal of the Act is to transform how the District addresses youth behavioral health issues by identifying early signs of unmet behavioral health needs and promoting effective interventions, thus preventing future tragedies.

This report was prepared for DBH by the Georgetown University National Technical Assistance Center for Children's Mental Health as one of a series of reports and resource guides required by the legislation to enhance the District's ability to address youth behavioral health issues. It provides key information on:

1. the types and prevalence of behavioral health conditions among youth by age, sex, race/ethnicity, ward residence, and sexual orientation;
2. the level of utilization of behavioral health services by youth and the distribution/location of those services in the District; and
3. the barriers preventing youth from accessing behavioral health services and recommendations for improving accessibility of services.

The Act provides an opportunity for DBH to continue its efforts to address the mental and behavioral health needs of children, youth, and their families through in-depth analyses of the underlying factors that contribute to behavioral health conditions. In addition, it provides DBH with the ability to reassess its service system with the goals of improving access and the quality of care.

The full report[1] provides a framework for applying a public health approach to addressing the needs of children and youth with behavioral health conditions. It provides the following:

- a description of the objectives of the Act's required data analysis;
- a description of the social, economic, and environmental factors that influence the behavioral challenges faced by children, youth, and families in the District;
- a review of existing national and secondary data and other available resources used to determine prevalence of need, service utilization, and barriers to behavioral health care;

[1] Wotring, J.R., O'Grady, K.A., Anthony, B.J., Le, L.T., Rabinovitz, L.A., Yoon, I.S., Rotto, K. (2014). *Behavioral health for children, youth and families in the District of Columbia: A review of prevalence, service utilization, barriers, and recommendations.* Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

- data analysis including comparisons to national prevalence rates, types and prevalence of behavioral health conditions among children and youth in the District, and service utilization; and
- a framework for a strong public health system, consisting of seven consensus themes that emerged from key informant interviews, to address the behavioral health needs of children, youth, and their families with accompanying recommendations.

Access to Mental Health Services

Untreated or unresolved mental health issues in childhood can have serious enduring consequences. In fact, most mental health disorders in adults originate in childhood. Among adults reporting a mental health disorder during their lifetime, more than half report the onset as occurring in childhood or adolescence (IOM, 2009). In the United States, 13% to 20% of all children experience a mental disorder in a given year (Centers for Disease Control and Prevention [CDC], 2013; Merikangas et al., 2010; Stagman & Cooper, 2010). The National Survey of American Families estimates that 79% of children ages 6-17 years have an unmet need for mental health services (Katoaka, Zhang, & Wells, 2002).

Addressing lack of access to mental health services is a national and local concern. Generally agreed upon barriers include: difficulty in accessing providers; stigma regarding mental health treatment; workforce shortages; and logistical issues such as geography, transportation, and finances (American Academy of Pediatrics, 2009). These national barriers are reflected locally with particular emphasis on geography and workforce. The District, however, is working to address access to care issues through innovative programming in the public mental health system and coordination with community resources.

PROFILE OF THE DISTRICT

Population and Environment

Healthy People 2020 ranked social determinants of health as a top priority for the nation, which includes all factors in an individual's life that collectively affect health and functioning. Such factors include neighborhood, health care, education, and economics (US DHHS, 2013b). There are wide disparities in these factors across the District's wards for all residents and especially for children in areas such as educational achievement and poverty (DC Action for Children, 2012).

The inequitable distribution of mental health challenges in the District can be attributed to a range of factors including poverty, race/ethnicity, education level, and affiliation with other child-serving systems. The majority of children, youth, and young adults in the District are Black (53%), followed by White (28%) and Hispanic (12%). Analysis of data from the U.S. Census Bureau shows that consistently more children live in poverty in the District compared to the rest of the nation, particularly in Wards 7 and 8 (see Appendix 5A). Based on data from the 2000 Decennial Census and the 2006-2010 American Community Survey, Wards 7 and 8 also report the lowest rates of high school graduation (see Appendix 5C). As such, children and youth in Wards 7 and 8 experience the lowest levels of educational achievement and economic advancement.

Further, the proportion of children and youth ages 3-21 served under the Individuals with Disabilities Education Act (IDEA) is greater in the District compared to the rest of the nation. Data from the U.S. Office of Juvenile Justice and Delinquency Prevention show that the rate of youth placed in juvenile detention and correctional facilities is also consistently higher (see Appendix 5D). Lastly, although there has been a steady decline, the rate of children ages 0-17 in foster care for the District is nearly four times the national average (see Appendix 5D). Service delivery in the District to the most vulnerable children and youth is further complicated by these complex issues.

Prevalence of Behavioral Health Conditions Among Children and Youth

On average, children and youth in the District do not differ significantly from the rest of the nation on prevalence of Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, Conduct Disorders, Anxiety Disorders, or current depression. A lower proportion of youth in the District seriously considered suicide in the past 12 months compared to national estimates, however they are significantly more likely than the national average to have attempted suicide in the past 12 months (11.5% vs. 7.8%) and to require treatment by a doctor or nurse for their injuries (4.8% vs. 2.4%) (CDC, 2013). Therefore, although fewer youth in the District report feeling depressed or consider suicide than their national counterparts, when they do contemplate suicide they are more likely to follow through with an attempt.

Child-Serving Agencies and System Fragmentation in the District

Improving access to services is a daunting task since the children's mental health system in the District consists of a provider network comprised of 20 distinct agencies that provide the array of services and supports available to children, youth and their families. A key tenet of a public health approach to children's mental health is the integration of systems to promote unified interventions and services (Miles et al., 2010). While the behavioral health system in the District has made significant positive changes and is poised to make even more, service delivery and access remain confounded by many challenges. Fragmentation results in divided responsibilities and funding authorities, the complexities of a dual-payment system, lack of unified individualized service planning processes for individuals, and databases that cannot communicate.

Infrastructure and Financing

The majority of youth in the District (89,492 in FY 2012) ages 0-17 have public health insurance coverage through programs operated by the Department of Health Care Finance (DHCF), which is the agency responsible for Medicaid-funded mental health services through Medicaid Managed Care Organizations (MCO) and Medicaid Fee For Service (FFS) arrangements (see Figure 4 in the full report). DBH provides a range of mental health services and supports to children and youth in the District including school-based services through the School Mental Health Program (SMHP), early childhood services at the Howard Road Clinic, crisis services through the Children and Adolescent Mobile Psychiatric Services (ChAMPS) program, and specialized mental health services through the Mental Health Rehabilitation Services (MHRS) program (page 19, full report). The MHRS program specifically targets youth with significant mental health needs. Eligibility for MHRS services includes any child or youth with more intensive mental health needs with a severe emotional disturbance (SED) diagnosis. DHCF finances services through contracts with MCOs and directly through individual providers on a FFS basis, while DBH's provider network is comprised of community-based providers (page 16, full report).

SERVICE ARRAY

MHRS

Consumer Demographic data

From FY 2010 to FY 2012, MHRS services were accessed the most by Black children and youth, those living in Wards 6, 7, and 8, and those between the ages of 6-13 years; however the proportion of young adults ages 18-21 increased the most (3%) within this timeframe (see Table 2 in the full report).

Prevalence Estimates of Mental Health Diagnoses in Youth Receiving MHRS

In FY 2012, the most commonly diagnosed mental health conditions among children and youth in the District ages 0-17 years receiving MHRS were Bipolar Disorder and Manic, Depressive, and Other Episodic Mood Disorders. Furthermore, Manic, Depressive, and Other Episodic Mood Disorders diagnoses had the greatest proportionate increase, while Adjustment Disorders had the greatest proportionate decrease between FY 2011 and FY 2012 (page 13, full report).

Service Utilization
Since FY 2008, there has been a gradual increase in MHRS service utilization among children and youth ages 0-24. Between FY 2010 and FY 2012, the greatest utilization of MHRS services was found in Wards 6, 7, and 8 while expenditures were greatest for children and youth ages 0-17. In FY 2012, Community Support, Community-Based Interventions, Counseling, and Crisis Services were the most heavily utilized and costly services (page 27, full report).

Medicaid MCO/FFS

Consumer Demographic Data
From FY 2010 to FY 2012, a large majority of children, youth, and young adults ages 0-24 years who accessed Medicaid MCO and Medicaid FFS services were Black, paralleling Medicaid enrollment demographics, with Wards 2, 7, and 8 having the greatest proportion of consumers served. Specifically, the proportion of young adults ages 22-24 who accessed Medicaid MCO and Medicaid FFS services increased by 3% within the same timeframe (page 31, full report).

Prevalence Estimates of Mental Health Diagnosis in Youth Receiving MCO/FFS
Diagnosis data for children and youth accessing services through the MCO and FFS arrangements were requested, but are unavailable due to inaccuracies in DHCF's data collection system for this field.

Service Utilization
Between FY 2010 and FY 2012, there has been a steady increase in Medicaid MCO and FFS service utilization among children and youth ages 0-24 years with the highest utilization occurring in Wards 2, 7, and 8. Screenings, Individual Psychotherapy, and Behavioral Health Counseling and Therapy were found to be the most highly utilized services. There has been a nearly two-fold increase in the utilization of key community-based MHRS services between FY 2010 and FY 2012 and a steady increase in MCO and FFS service utilization within the same time period (page 34, full report). Using the FFS expenditure data as a proxy of total DHCF monies would grossly underestimate total expenditures and so claims expenditures were not reported or analyzed in this report.

UNMET NEED

Unmet need is defined as the identified behavioral health needs of a community that are not being met by the current service system. To approximate the level of unmet need and the gap in services for children and youth in the District, data reported by DBH and DHCF were analyzed (page 21, full report). The following formula was created to estimate the provisional level of need in the District. A fully accurate calculation could not be produced due to a duplicated consumer count:[2]

1. $\left(\begin{array}{c}\text{Total Number of}\\ \text{Children in the District}\end{array}\right) \times \left(\begin{array}{c}\text{National Prevalence of Children with a}\\ \text{Mental or Behavioral Health Problem}\end{array}\right) =$

   Estimated Number of Children in the District with a Mental or Behavioral Health Problem

2. $\left(\begin{array}{c}\text{Estimated Number of Children in the District}\\ \text{with a Mental or Behavioral Health Problem}\end{array}\right) \left(\begin{array}{c}\text{Total number of children and youth served through}\\ \text{MHRS, Medicaid MCO and Medicaid FFS Providers}\end{array}\right) =$

   Provisional Estimate of Unmet Need in the District

[2] Paid claims data were received from DBH and DHCF in 2013. The DHCF service data excluded MHRS, but did not exclude children who also accessed MHRS. If a child accessed services through both a MCO and MHRS, the child was counted in both systems. As a result, the total consumer counts for DHCF and DBH may include duplicated individuals. Although there was no available mechanism to crosswalk the data sets at the time of the data analysis, DBH and DHCF have since worked together to determine an unduplicated count. Further data analysis is recommended using an unduplicated count of children and youth to determine the true unmet need in the District.

With a total of 109,480 children and youth ages 0-17 in the District according to the 2012 Census annual estimate, and a total of 13%-20% of children in the nation experiencing a mental disorder in a given year, the behavioral health system should have served between 14,232 and 21,896 children and youth in FY 2012. A total of 12,058 children and youth ages 0-17 accessed services in FY 2012 from MHRS and Medicaid MCO and Medicaid FFS providers.

Therefore, the approximate gap could include between 2,174 and 9,838 children and youth with behavioral health needs who are not being served (15% to 45%). Since the DBH and DHCF consumer counts are duplicated, many children and youth are counted in both systems. Consequently, the unmet need is likely even greater than the provisional calculation. Understanding the true unmet need would require more detailed data analysis that allow for the elimination of duplication between system counts.

PUBLIC HEALTH APPROACH

Movement Towards a District-Wide Public Health Approach to Children's Mental Health

A public health approach encourages systems to concentrate the largest portion of their efforts on preventing and promoting mental health and then move up the pyramid to provide more individualized treatments and interventions (Miles et al., 2010). Historically, mental health services have focused on the top of the pyramid, that is, the treatment component of the public health framework, designed for and utilized by youth with severe mental illness. There are increasing efforts, however, in the District to care for these children with a system of care approach in an effort to provide coordinated and family-centered care. There is also an expanded focus on promotion and prevention; particularly early intervention, as integral to providing the full continuum of mental health services.

Leadership across the various children's systems has implemented numerous systemic changes including: (1) developing more robust community-based services; (2) adopting evidence-based practices (EBPs) within their disciplines: (3) accepting a data-driven decision-making methodology that shares information across systems; and (4) reducing duplication and extra costs.

Components of a Public Health Approach: Strengths, Barriers, and Recommendations

Based on the data context provided, the full report contains detailed organizational and programmatic recommendations, consistent with the public health approach, to further position DBH as a leader in reducing behavioral health disparities among the District's children, youth, and families. These recommendations include strengthened partnership and collaboration, less siloed and duplicative funding mechanisms, improved service array, expanded workforce, and more transparent data sharing (page 38, full report).

DBH sees these strategies as consistent with their public health approach to integrate service delivery for children and youth with behavioral health needs. The data analysis shows DBH is building a body of EBPs more broadly focused on the entire population, including services for young children, school-based interventions, and other initiatives focusing on the promotion of mental health and the prevention of mental health problems.

CONCLUSION

The children's behavioral health system in the District is developing an improved public health approach to address the gaps in services for children, youth, and their families, despite a complex payment system and an inability to serve all children in need. Review of the data suggests that social determinants of health, such as socioeconomic status, educational attainment, and residence, are closely linked to behavioral health inequities. There is a continued need to reaffirm a shared vision, strengthen a set of core values and principles, and further support the mission of all public agencies serving children, youth, and

their families. If implemented strategically in an integrated manner, the public health approach should begin to close the gaps in services. With a renewed focus on promoting healthy communities where children, youth, and their families can live and thrive, the DC South Capitol Street tragedy can be turned into a benchmark for change.

BACKGROUND

On March 30, 2010, an earlier argument over a missing bracelet led to one of the deadliest mass shootings in the history of the District of Columbia (DC, or the District), leaving four young people dead and six others wounded. This tragedy underscored the strong link between school truancy, behavioral health issues, and potential violence and once again put an underserving social services system under scrutiny.

In response to this incident and to urging by family members of the involved youth, the South Capitol Street Memorial Act (Act) was passed on April 10, 2012 by the DC City Council. The overarching goal of the Act is to transform how the District addresses youth behavioral health issues by identifying early signs of unmet behavioral health needs and promoting effective interventions, thus preventing future tragedies.

This Youth Behavioral Health Review is one of a series of reports and resource guides required by the Act to help the District better address youth behavioral health issues. As required, it provides key information on:

- the **types and prevalence** of behavioral health conditions among youth, broken down whenever possible by age, sex, race/ethnicity, ward residence, and sexual orientation;
- the **level of utilization** of behavioral health services by youth and the distribution/location of those services in the District; and
- an analysis of **barriers or obstacles** preventing youth from accessing behavioral health services and recommendations for improving accessibility of services.

This report was completed by the National Technical Assistance Center for Children's Mental Health (TA Center) at Georgetown University. Since 1984, the TA Center has been dedicated to improving behavioral health systems and services for children, youth, and their families. The TA Center benefits from being an integral part of the Georgetown University Center for Child and Human Development within the Department of Pediatrics in the Medical Center.

OVERVIEW

Overwhelming evidence suggests mental health and behavior problems in childhood impair educational and social development, which can affect later competence and productivity (Costello & Angold, 2000; Institute of Medicine [IOM], 2009). Children's mental health challenges create a burden, not only for the affected children, but also for their families and society. An IOM report estimates mental, emotional, and behavioral (MEB) disorders among children, youth, and young adults to age 25 in 2007 cost the United States roughly $247 billion (IOM, 2009).

Access to Mental Health Services

Untreated or unresolved mental health issues in childhood can have serious enduring consequences. In fact, most mental health disorders in adults originate in childhood. Among adults reporting a mental health disorder during their lifetime, more than half report the onset as occurring in childhood or adolescence (IOM, 2009).

In the United States, 13% to 20% of all children experience a mental disorder in a given year (Centers for Disease Control and Prevention [CDC], 2013; Merikangas et al., 2010; Stagman & Cooper, 2010). Despite concentrated efforts by those in various treatment settings, the vast majority of children with mental health disorders remain untreated (U.S. Department of Health and Human Services [US DHHS], 1999; Lehman & Steinwachs, 1998; Wang, Demler, & Kessler, 2002). The National Survey of American Families estimates that 79% of children ages 6-17 years have an unmet need for mental health services (Katoaka, Zhang, & Wells, 2002). Equally troubling is the difficulty to treat persistent and chronic mental health disorders when treatment is available.

Addressing lack of access to mental health services is a nationwide and local concern. Generally agreed upon barriers include: difficulty in accessing providers; stigma regarding mental health treatment; workforce shortages; and logistical issues such as geography, transportation, and finances (American Academy of Pediatrics, 2009). These national barriers are reflected in the District with particular emphasis on geography and workforce. The District, however, is working to address access to care issues through innovative programming in the public mental health system and coordination with community resources.

DC Child-Serving Agencies and System Fragmentation

Improving access to services is a daunting task since the children's mental health system in the District is spread across multiple agencies. A key tenet of a public health approach to children's mental health is the integration of systems (health, education, social services, child welfare, juvenile justice, and mental health) to promote unified interventions and services (Miles et al., 2010).

Figure 1 illustrates the comprehensive system designed to meet the behavioral health needs of all children through nine child-serving agencies in the District. Each agency has a unique role and function in aiding children and youth to live healthy and productive lives.

Figure 1. DC Child-Serving Agencies

Like any large child-serving system, the District is faced with challenges that at times work at cross purposes, preventing integration. These challenges include contending with multiple federal lawsuits, a dual-payment system, minimal care coordination, and lack of centralized data as noted by the following:

- Over the past 40 years, at some point each of the major child-serving systems—child welfare, juvenile justice, education, and mental health—have been involved in class action lawsuits alleging that appropriate care, protection, and services were not provided to the vulnerable populations these systems serve. Individual consent decrees and multiple court monitors have at times put the required reforms on different paths, instead of operating under one coordinating plan.
- There is divided responsibility and funding authority between the Department of Behavioral Health (DBH)[3] service system and the Medicaid Managed care Organizations (MCOs) and Medicaid Fee For Service (FFS) arrangement through the Department of Health Care Financing (DHCF). This dual-payment system can result in multiple payments for the same service, different standards for credentialing, administrative requirements that do not support a robust array of services, parallel and different provider networks, and reduced continuity of care when children move back and forth between the custody of the state and their families.
- The existence of multiple MCOs to manage Medicaid services leads to difficulties with care coordination (Rosenbach & Young, 2000). Providers are rarely credentialed with more than a few payers; thus, families must navigate multiple agencies and providers to obtain a full range of services.
- Although core components of a comprehensive system of care are available through DBH to MCO enrollees, they have not been uniformly accessed by children, youth, and families served by the MCOs. These components include intensive, individualized care planning and management processes, for example, High Fidelity Wraparound; as well as culturally responsive and trauma-informed evidence-based practices, such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Multi-Systemic Therapy (MST), and Parent Child Interaction Therapy (PCIT).
- There is no unified, individualized service planning process or pathway to care for every child, youth, and family with mental, emotional, or behavioral disorders across the education, child welfare, juvenile justice, health, substance abuse, and mental health systems. Children, youth, and families are challenged to implement multiple plans from multiple service systems, leading to

[3] At the time of analysis, the DBH was known as the Department of Mental Health (DMH). Since then, there has been organizational restructuring bringing the Addiction Prevention and Recovery Administration (APRA) and DMH under one administration, currently DBH.

failure to complete all expected actions, which leads to further sanctions and frustrations (DC Behavioral Health Association, 2009).

- Currently, all DC child-serving systems lack a centralized data reporting mechanism and rely on a fragmented system spread across multiple databases. The types of data collected and tracking sources are different depending on the system and its function.
- The various agency databases are unable to communicate, which makes data sharing difficult and inefficient. There is no common data language or central consumer identification system, creating difficulties in exchanging information. Only administrative data are consistently collected for programs and services, which hinders coordinated case management and service delivery.

Healthcare Coverage in the District

Behavioral health services are operated by a variety of public and private providers and most are financed through Medicaid. The District has very high rates of health insurance coverage. As of 2012, 98.7% of children and youth ages 0-17 had health insurance coverage as compared to 94.5% nationally (The Child and Adolescent Health Measurement Initiative, 2012). As a result, health care reform will have a marginal impact on children and youth in the District, as coverage levels are already among the highest in the country.

The District is one of six jurisdictions to implement Medicaid expansion prior to the mandate in 2014 (Sommers, Arnston, Kenney, & Epstein, 2013). Enrollment in Medicaid does not guarantee consistent services, since there is sometimes a dual-payment system for service delivery. Due to such high rates of Medicaid coverage, however, the District is well positioned to dramatically influence and improve behavioral health services to children, youth, and their families.

Movement Toward A Public Health Model

Although the District has struggled with providing behavioral health services to youth, progress is being made toward a comprehensive behavioral health infrastructure. A public health approach to children's mental health encourages systems to concentrate the largest portion of their efforts on preventing and promoting mental health and then move up the pyramid to provide more individualized treatments and interventions (Miles et al., 2010).

Mental health services in the District and across the nation historically have focused on the top of the pyramid, that is, the treatment component of the public health framework, designed for and utilized by

youth with severe mental illness. There are increasing efforts, however, to care for these children with a system of care approach in an effort to provide coordinated and family-centered care. There is also an expanded focus on promotion and prevention, particularly early intervention, as integral to providing the full continuum of mental health services to children, youth, and their families.

Progress is being made toward a more integrated public health approach. In 2007, the various child-serving agencies began coordinating their systems in a more uniform fashion as they worked through their respective consent decrees and court orders directing improvement. Another development resulting from the lawsuits are the yearly Consumer Service Reviews (CSRs), which assess compliance with the settlement agreements and measure performance and outcomes of the child behavioral system. The yearly CSRs are an effective way to measure the system and improve the quality of service delivery.

Around the same time that coordination was occurring around the consent decrees, new leadership in several of the child-serving agencies sought opportunities to collaborate across systems to better serve youth. While the lawsuits were requesting improved service delivery and outcomes, leadership realized it would take a systematic overhaul of their individual systems and then the entire human service system to improve the quality of care delivered to consumers, increase accessibility and capacity, and measure performance and outcomes.

As a result, leadership across the various children's systems has implemented numerous systemic changes including: (1) developing more robust community-based services; (2) adopting evidence-based practices within their disciplines: (3) accepting a data-driven decision-making methodology that shares information across systems; and (4) reducing duplication and extra costs. DBH, along with its system collaborators, is building a coordinated approach to service delivery that focuses on implementing best practices and EBPs at all levels of service delivery, creating accountability for those involved.

In this vein, DBH has merged with the Addiction Prevention and Recovery Administration (APRA) to form a single department to bring substance abuse and mental health together to better serve individuals with co-occurring disorders. It is expected that with this merger, even more innovative practices and programs will be on the horizon. Agencies have also engaged in cross training and DBH staff members are co-located at the Child and Family Services Agency (CFSA) to conduct mental health screenings for youth entering into the foster care system. More recently, all CFSA caseworkers will be trained in assessments and co-located staff will serve as mental health consultants. Other efforts to enhance service delivery include system-wide implementation of the Child and Adolescent Functional Assessment Scale

(CAFAS) as the common tool for assessing children and youth on their daily functioning, as well as monitoring their progress over time. Adoption of the CAFAS across all DC child-serving agencies will facilitate better data sharing across systems and create a more coordinated and systematic approach to service provision.

Importantly, DBH developed the Children's Plan in 2010 to serve as a blueprint for change with the overarching goal of implementing and expanding services and supports to children, youth, and their families in the District. This five-year plan identifies barriers to care, outlines ways to leverage the resources of each child-serving agency, and identifies community-based programs and services proven to be successful in increasing access and improving the quality and timeliness of care.

DBH utilizes the system of care (SOC) concept to inform service delivery and service systems. SOC provides a framework and philosophy to guide services, systems, and supports to improve the lives of children with mental health challenges and their families (Stroul, Blau, & Friedman, 2010). Recently, DBH received a one-year children's system of care expansion planning grant and a five-year implementation grant. This set the stage for the acceptance of a longer-term cooperative agreement with the Substance Abuse and Mental Health Services Administration (SAMHSA). The agreement assists in building and developing a system of care (SOC) by growing family support in agency policy and practice, increasing early intervention service delivery options, and focusing on mental wellness and prevention. The implementation grant outlines four broad goals: (1) develop an inclusive governance structure that has authority to oversee DC's SOC implementation; (2) develop and sustain a data-driven and comprehensive array of services; (3) develop a family driven and youth guided SOC; and (4) use strategic communication and social marketing activities to generate increased support.

DBH sees these strategies as key to supporting the overall integration of the service delivery system for children with mental, emotional, or behavioral disorders. In addition, DBH is building a body of evidence-based practices more broadly focused on the entire population, including services for young children, school-based interventions focusing on the promotion of mental health and the prevention of mental health problems, and a mental wellness platform to serve DC children and families well into the future. Although the DC behavioral health system is poised to make significant changes in service delivery and access, as noted, there are still numerous challenges recognized by those within the system and other stakeholders. This report consists of a systematic review of available sources to outline these challenges, define the system as it exists, provide information about those involved in the system or trying

to gain access, and makes recommendations for a more public health approach to children's mental health.

Four methods of data collection were used. Review of data sources and data analysis were completed in the spring and summer of 2013: (1) a review of the recent literature on children's mental health focusing on the factors associated with mental health problems and the national prevalence of mental health need; (2) an analysis of the available secondary data sources on children's behavioral health, including sources identified by DBH experts that are specific to the DC youth population; (3) an analysis of paid claims data describing utilization of behavioral health services in the District; and (4) in-depth key informant interviews with DC child-serving agencies and child advocacy groups. For a more detailed description of the methodologies used and limitations of each method, see Appendices 1 and 2.

DATA REPORTING

The following section presents the results and analyses of each data source used in the assessment of the DC youth behavioral health system. A total of 35 key sources were identified and incorporated throughout the report to inform the assessment. Appendix 3 provides detailed descriptions of each of the key sources. From the literature review, 15 papers were selected and are summarized in Appendix 4.

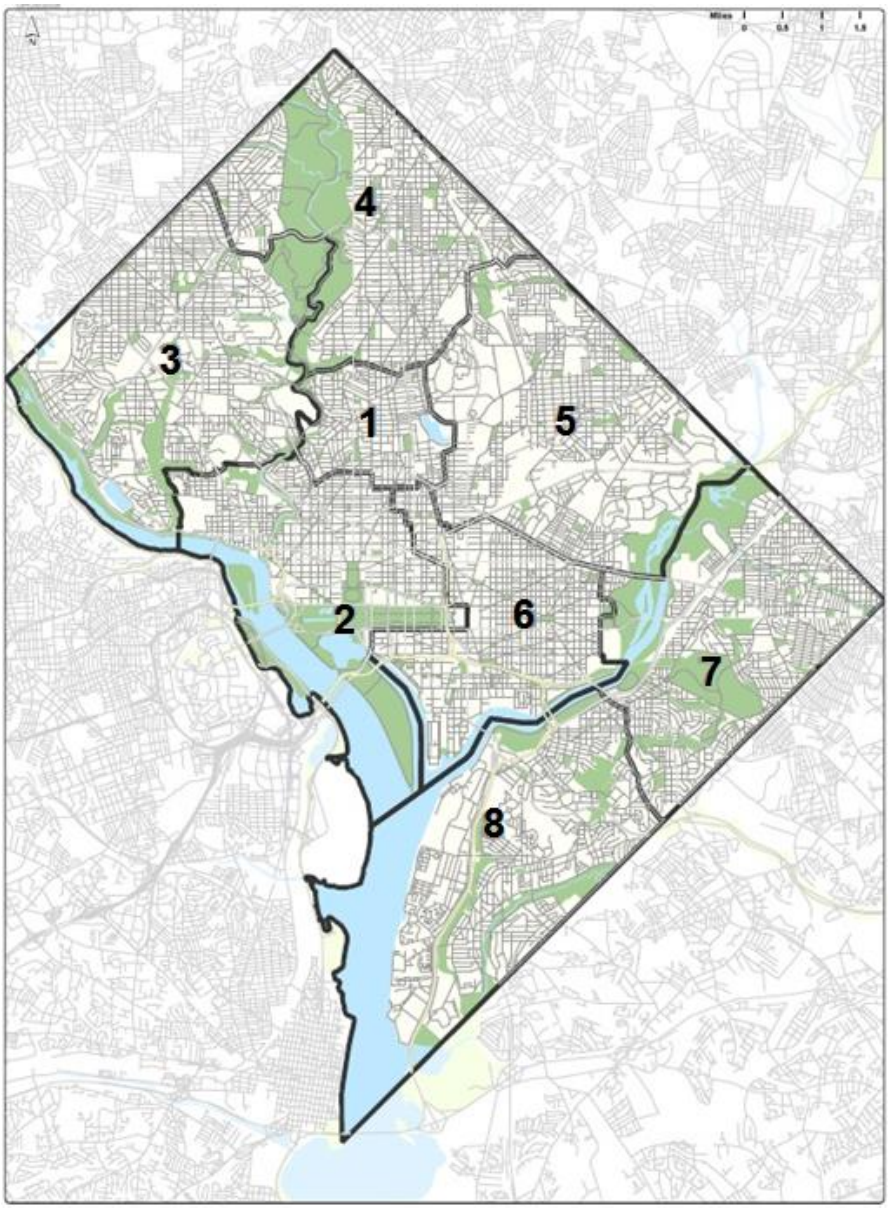
The first section describes social and environmental factors influencing behavioral health problems in the District. National- and District of Columbia-level prevalence data are then discussed followed by a description of the DC behavioral health system. To provide an estimate of the unmet need for behavioral health services, a detailed analysis of service utilization in the District is discussed in the last section with a provisional estimate of the level of unmet need for behavioral health services among DC children and youth.

The DC Population and Environment

Healthy People 2020 ranked social determinants of health as a top priority for the nation, which includes all factors in an individual's life that collectively affect health and functioning. Such factors include neighborhood, health care, education, and economics (US DHHS, 2013b). There are wide disparities in these factors across DC wards for all residents and especially for children in areas such as educational achievement and poverty (DC Action for Children, 2012).

The District is geographically divided into eight wards, which can be distinguished by culture, history, and demographic characteristics (see Figure 2). Importantly, much of the variation in poverty, race/ethnicity, and education in the District occurs along these geographic boundaries. Thus, it is important to examine more closely the impact of geographic location and external risk factors on the behavioral health needs of youth living in the various wards.

Figure 2. 2012 Ward Boundaries as Adopted by the DC Council



Data Source: DC Office of Planning, retrieved from: http://planning.dc.gov/DC/Planning.
NOTE: These boundaries reflect legislation adopted by the DC Council on June 21, 2011. At the time this map was created, this legislation had not yet been signed into law. The boundaries shown may be subject to technical correction by Council staff.

Relationship Between Environmental Factors and Mental Health

Behavioral health in children is a complex issue influenced by a range of factors. Genetic and biological influences play an important role in child and adolescent development (Kessler, Avenevoli & Merikangas, 2001; Kraemer et al., 2001; US DHHS, 1999). Social and environmental factors such as sex, sexual orientation, race/ethnicity, culture, and language are important contributors to behavioral health. The evidence further points to the substantial impact of community-level adversity, such as poverty, poor resources (e.g., school quality), stressors (e.g., high crime rates), and involvement with the child welfare and juvenile justice systems as significant risk factors for behavioral health problems. Studies show living in deprived neighborhoods is associated with greater risk for children's mental health problems, even after controlling for genetic factors (Caspi et al., 2000; Odgers et al., 2012; Xue, Leventhal, & Earls, 2005). Furthermore, the physical and social characteristics of neighborhood and community environments are thought to play an important role in the inequitable distribution of negative health outcomes, including mental health (Aneshensel & Sucoff, 1996). This cumulative impact of exposures further complicates behavioral health problems in the child and youth population.

The following provides supporting documentation for the inequitable distribution of mental health challenges in the District. Please refer to Appendix 5 and Table 1 below for more detail.

- **Poverty Distribution:**
    - More children live in poverty in the District compared to the rest of the nation and this difference has remained fairly consistent from 2007 through 2011.
    - Wards 7 and 8 have the largest number of children living in poverty and this rate is increasing. Wards 2 and 3 are the least populated and are home to children from the wealthiest households.
- **Racial/Ethnic Distribution:**
    - The majority of children, youth, and young adults in the District are Black (53%), with Whites comprising (28%) and Hispanics (12%).
    - Wards 7 and 8 have the largest number of Black children overall with Ward 3 being predominantly White. The greatest proportion of Hispanic children resides in Wards 1 and 4.
- **Sexual Orientation:**
    - DBH's eCura system does not collect data on sexual orientation and overall data for sexual orientation is not yet available across systems.

- **Education**
  - *High school graduation rates:*
    - Wards 7 and 8 report the lowest rates of high school graduation (72% and 69% respectively). The highest percentages of young adults with high school degrees or higher are in Wards 2 and 3 (98% and 97% respectively).
  - *Special Education:*
    - The proportion of children and youth ages 3-21 served under the Individuals with Disabilities Education Act (IDEA) is greater in the District compared to the rest of the nation (16.4% versus 13.1%). IDEA ensures early intervention, special education, and other related services to children with disabilities.
    - A vast majority of youth in the District with Emotional Disturbance (ED) is between 12-17 years of age and those with ED ages 18-21 are much higher in the District compared to the rest of the United States.
- **Connection to other child-serving systems:**
  - *Juvenile Justice:*
    - The rate of youth placed in juvenile detention and correctional facilities is consistently higher in the District compared to the rest of the nation. In 2010, the number of youth in residential placements was nearly twice as high in the District as in the rest of the United States (428 per 100,000 versus 225 per 100,000).
  - *Child Welfare:*
    - Although there has been a steady decline, the rate of children ages 0-17 in foster care[4] for the District is nearly four times the national average, with the trend remaining steady over the years.

[4] Foster care means 24-hour substitute care for children placed away from their parents or guardians through the child welfare system, including but not limited to placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and pre-adoptive homes. (45 CFR sec 1355.20)

Table 1. Selected Demographic Characteristics of the District of Columbia's Child, Youth, and Young Adult Population: Results from the U.S. Census Bureau's American Community Survey	
Demographic Characteristics	**n (%)**
Age Group*	
0-4	38,876 (20%)
5-13	49,377 (26%)
14-17	21,227 (11%)
TOTAL Under 18	**109,480 (57%)**
18-24	82,492 (43%)
TOTAL Under 24	**191,972**
Sex*	
Male	92,773 (48%)
Female	99,199 (52%)
TOTAL	**191,972**
Race/Ethnicity*	
White	54,703 (28%)
Black	102,175 (53%)
American Indian and Alaskan Native	375 (0%)
Asian	5,878 (3%)
Native Hawaiian and Other Pacific Islander	117 (0%)
Two or More Race Groups	5,712 (3%)
Hispanic or Latino	23,012 (12%)
TOTAL:	**191,972**
Ward Residence**	
Ward 1	9,034 (9%)
Ward 2	4,656 (5%)
Ward 3	10,108 (10%)
Ward 4	15,202 (15%)
Ward 5	12,732 (13%)
Ward 6	9,881 (10%)
Ward 7	17,825 (18%)
Ward 8	21,377 (21%)
TOTAL*:	**100,815**

*2012 estimates from the U.S. Census Bureau, Population Division. Annual Estimates of the Resident Population by Sex, Age, Race, and Hispanic Origin for the United States and States: April 1, 2010 to July 1, 2012
** Based on 2010 estimates from the U.S. Census Bureau, 2010 Decennial Census
*** Reported for under 18 only
Data Source: Population Division, U.S. Census Bureau
NOTE: Ward Residence reported for children under 18 only. Each year the U.S. Census Bureau revises its post-2010 estimates. Therefore, data presented here may differ from previously published estimates.

Prevalence of Behavioral Health Conditions Among Children and Youth

Prevalence Estimates from National Sources

Behavioral and mental health problems among children, youth, and young adults are common (CDC, 2013; Merikangas et al., 2010; US DHHS, 1999). Several sources report that nationally up to 20% of all children experience a mental disorder in a given year (CDC, 2013).

Several nationally representative surveys and surveillance systems were reviewed to determine the estimated prevalence of specific behavioral and mental health conditions in the District. Key points from national surveys include:

- On average, DC youth do not differ significantly from the rest of the nation on prevalence of Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder (6.8% vs. 7.9%), Conduct Disorders (4.9% vs. 3.2%), Anxiety Disorders (3.8% vs. 3.3 %), or current depression (2.3% vs. 2.2%).
- Youth ages 12-17 in the District are significantly less likely to experience a major depressive episode in the past 12 months compared to the rest of the United States (6.46% vs. 8.15%) or report feeling sad or hopeless every day for at least two consecutive weeks in the past 12 months compared to their national counterparts (24.9% vs. 28.5%).
- A lower proportion of youth in the District seriously considered suicide in the past 12 months (11.1%), compared to national estimates (15.8%) (CDC, 2013).
- Youth in the District are significantly more likely than the national average to have attempted suicide in the past 12 months (11.5% vs. 7.8%) and to require treatment by a doctor or nurse for their injuries (4.8% vs. 2.4%) (CDC, 2013).

Extrapolating from the CDC data, although fewer youth in the District report feeling depressed or consider suicide than their national counterparts, when they do contemplate suicide they are more likely to follow through with an attempt.

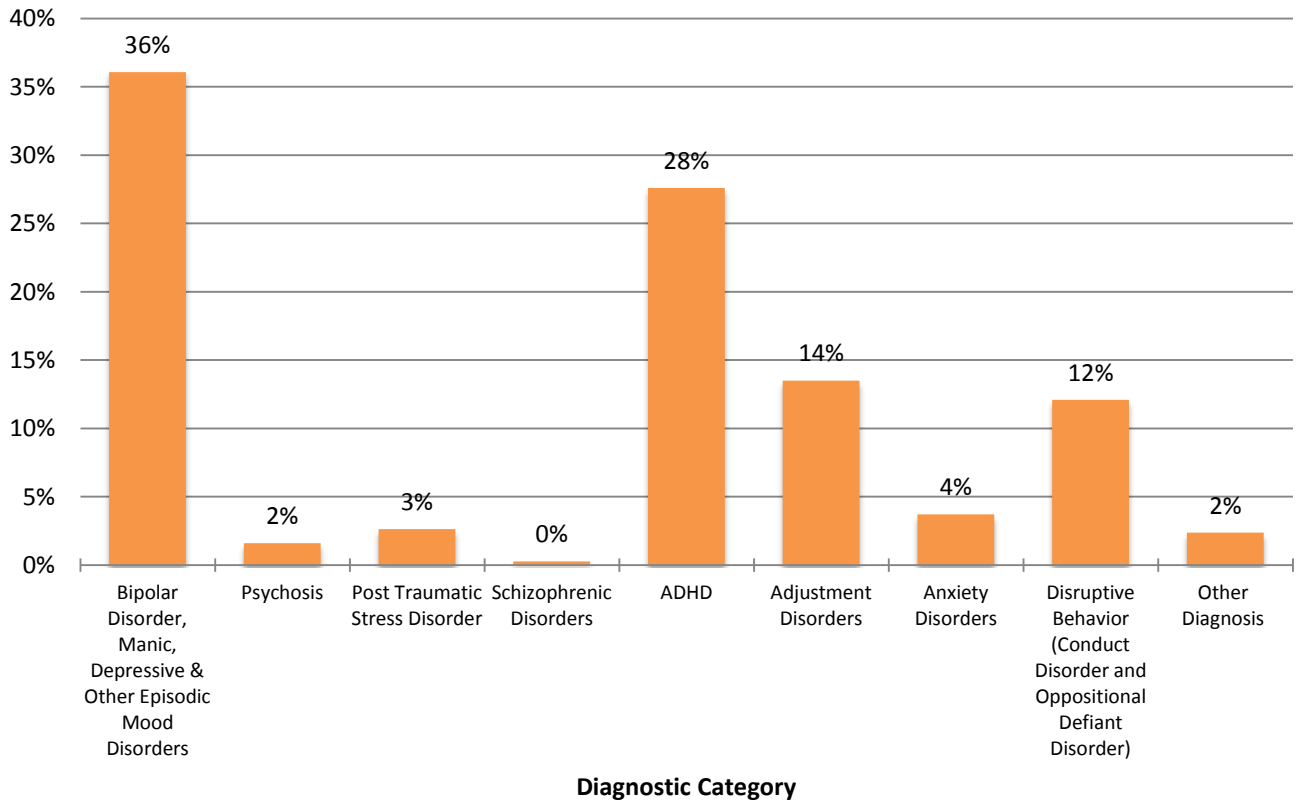
Prevalence Estimates of Mental Health Diagnoses in Youth Receiving Mental Health Rehabilitation Services

The following prevalence estimates of mental health diagnoses were found among children and youth in the District ages 0-17 years receiving Mental Health Rehabilitation Services (MHRS), which are provided

by DC DBH-certified community mental health providers to children and youth with severe emotional disturbance (DC Municipal Regulations and DC Register [DCR], 2012) (see Appendix 6 for details):

- Bipolar Disorder, Manic, Depressive and Other Episodic Mood Disorders; Attention Deficit Hyperactivity Disorder (ADHD); Adjustment Disorders; and Disruptive Behavior Disorders were the most commonly diagnosed conditions in FY 2012 (Figure 3).
- The proportion of Manic, Depressive and Other Episodic Mood Disorders diagnoses have increased the most at 4% between FY 2011 and FY 2012.
- Adjustment Disorders had the greatest proportionate decrease at 3% between FY 2011 and FY 2012.
- All other diagnostic categories have remained relatively stable across the years.

Figure 3. Diagnostic Prevalence of District of Columbia Children and Youth Receiving MHRS Services Ages 0-17 in FY 2012 (n=4,187)



Data Source: DBH eCura System and provided by DBH's ARE Unit
NOTE: Includes children and youth ages 0-17; diagnosis is through the last claim during the fiscal year.

Description of the Child and Youth Service Delivery System in the District of Columbia

The following section provides an overview of the mental health service delivery system in the District. Figure 4 provides a visual representation of how behavioral health services are financed in the District. Though the diagram is comprehensive, it is not possible to explain all the nuances of the system graphically. Thus, the following section elaborates on the coverage status, payment mechanisms, and associated services and providers. This overview is necessary to understand the service utilization data presented in the next section.

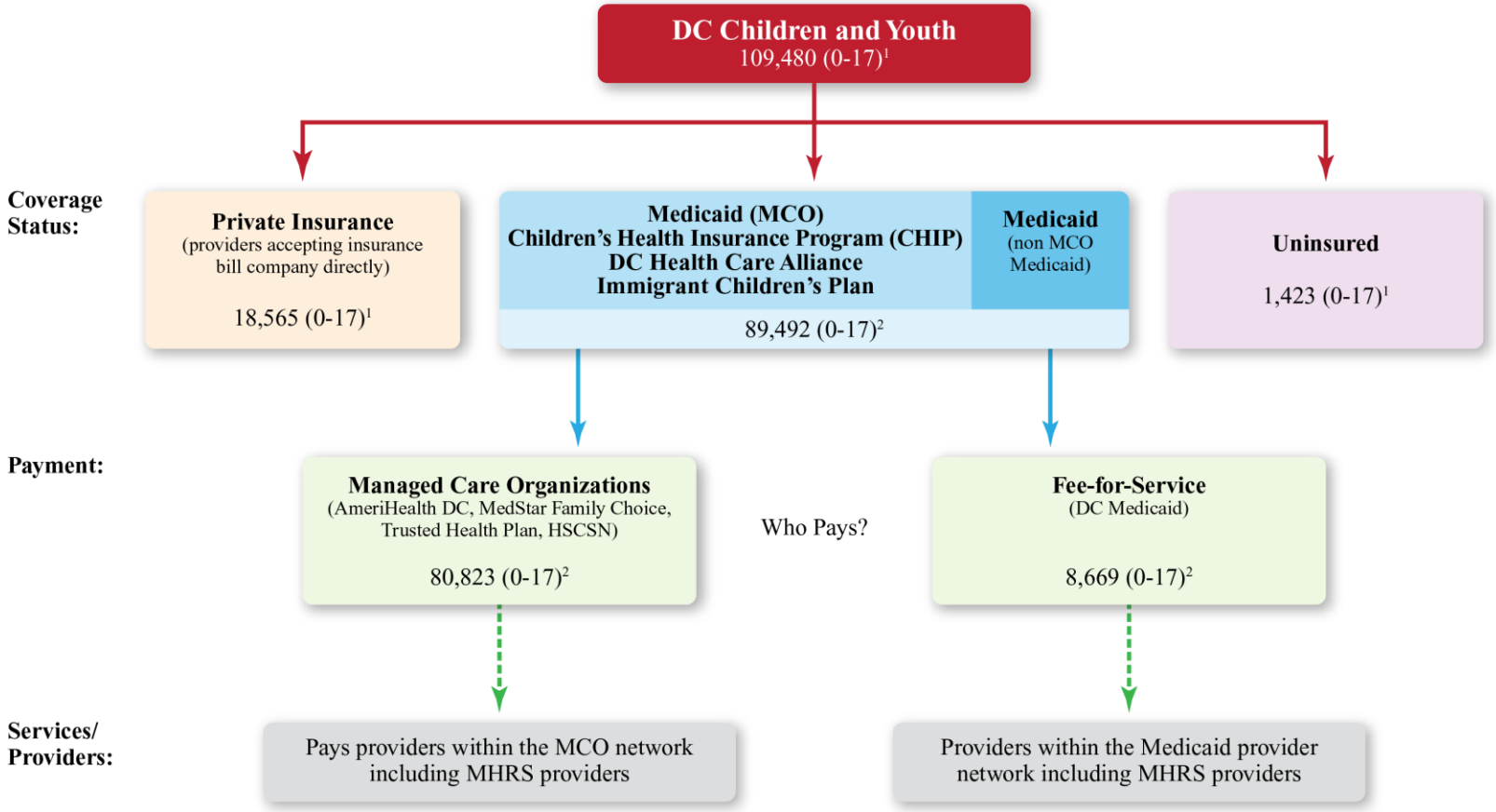
Public System Service Agencies

The majority of youth in the District (89,492 in FY 2012) ages 0-17 have public health insurance coverage through programs operated by DHCF (the agency responsible for Medicaid-funded mental health services). DBH provides specialized mental health services through MHRS to youth with significant mental health needs.

Payment and Financing

DHCF finances services through contracts with MCOs and directly through individual providers on a FFS basis, while DBH's provider network is comprised of community-based providers. DHCF pays capitation rates to contracted MCOs to finance the delivery of services accessed by MCO-enrolled beneficiaries within the managed care network. The MCO is responsible for paying for and credentialing a provider network that offers traditional mental health outpatient services (e.g., assessment, counseling, and psychiatric services). MHRS delivered through non-MCO arrangements are paid on a FFS basis, even when delivered to MCO-enrolled Medicaid beneficiaries. MCO enrollees are eligible to receive out of office MHRS, such as community support and community-based interventions (CBI), through the DBH network at no financial cost to the MCOs. DBH providers are reimbursed on a FFS basis by DBH for MHRS. All youth enrolled in Medicaid, whether their care is financed through an MCO or FFS arrangement, are eligible to receive MHRS through the DBH provider network.

Figure 4. Funding of Mental Health Services in the District of Columbia



- a provider can be credentialed by an MCO, DHCF, or DMH. These credentials are not mutually exclusive.
- youth with private insurance or those without insurance can also access MHRS services.

1 = Annual Estimates: April 1, 2010 to July 1, 2012. The estimates are based on the 2010 Census and reflect changes to the April 1, 2010 population due to the Count Question Resolution program and geographic program revisions. For population estimates methodology statements, see http://www.census.gov/popest/methodology/index.html. The total number of uninsured was calculated using the Kaiser Family Foundation estimates of uninsured youth ages 0-17. The total number of privately insured was calculated by subtracting Medicaid insured and uninsured from the total population.
2 = DHCF Division of Research and Rate Setting Analysis

Approximately 90% of children receiving Medicaid were automatically enrolled in an MCO as of FY 2012. Children eligible for Medicaid primarily on the basis of income are enrolled in a Medicaid MCO. Most Department of Youth Rehabilitative Services (DYRS) affiliated youth, with the exception of those committed to both CFSA and DYRS can also become enrolled in an MCO. Children and youth that qualify for Medicaid FFS include those in the custody of CFSA, as well as those committed to both CFSA and DYRS. Medicaid FFS eligibility also extends to children and youth who qualify for Supplemental Security Insurance (SSI), the federal income supplement program, based on a medically fragile health determination, such as children who are disabled or who have special health care needs. Finally, a child having 60 days of consecutive enrollment in a Psychiatric Residential Treatment Facility (PRTF) also qualifies for Medicaid FFS (Ferguson et al., 2009). Eligibility for MHRS services includes any child or youth with more intensive mental health needs with a severe emotional disturbance (SED) diagnosis.

Pathways to Behavioral Health Services

A youth can enter into the behavioral health service system through any of the following portals:

Medicaid MCO:

1. Direct mental health services from a physician or other provider within an MCO's behavioral health organization's provider network;
2. Follow-up referral from a primary care physician or specialist in an MCO after an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) appointment (or well-child visit); and
3. Referral from an MCO to DBH for MHRS (if the level of need requires services).

Medicaid FFS:

1. Mental health services furnished by a provider enrolled with FFS Medicaid;
2. Follow-up referral from a primary care physician or specialist after an EPSDT appointment (or well-child visit); and
3. Referral from a Medicaid FFS provider to DBH for MHRS (if the level of need requires services).

DBH Services:

1. Provider or self-referral to MHRS from Medicaid MCO or Medicaid FFS providers;
2. Access Helpline is the primary point of entry for MHRS;
3. Direct enrollment in MHRS at a Core Service Agency (CSA) that is a DBH-certified community-based MHRS provider;

4. Referral from hospital staff, DYRS, CFSA, or APRA to DBH or DBH-certified CSAs; and
5. Referral from parents, DCPS, or charter schools to the School Mental Health Program (SMHP).

Department of Health Care Finance Infrastructure and Services

DHCF is the single District agency responsible for the operation of DC's Medicaid program and Children's Health Insurance Program (CHIP), which operates as a Medicaid expansion to cover children from households with higher incomes than Medicaid eligibility levels. DHCF also operates locally financed health care programs, such as the DC Health Care Alliance and the Immigrant Children's Program. The Medicaid/CHIP program—which provides coverage to children, families, childless adults, and individuals, who are aged, blind or disabled—is jointly financed by the federal and District governments.

Services Offered

DHCF offers a comprehensive array of mental health care services including:

- psychiatric visits,
- inpatient hospital care,
- outpatient physician visits,
- pharmaceutical services,
- emergency services,
- partial hospitalization,
- medication,
- outpatient screening and rehabilitation, and
- case management.

In addition, the broad scope of the EPSDT benefit for all Medicaid-enrolled youth includes medically necessary behavioral health services and treatment. All services are financed through Medicaid or through programs designed to reach those without insurance.

Managed Care Organizations

DC Medicaid currently has contracts with 4 MCOs: AmeriHealth DC, MedStar Family Choice, Trusted Health Plan, and Health Services for Children with Special Needs (HSCSN). The first three MCOs serve individuals enrolled in Medicaid, CHIP, the Immigrant Children's Program, and the DC Alliance program. HSCSN serves children meeting SSI criteria up to age 26. Currently, approximately two-thirds of Medicaid enrollees participate in MCOs, although among children, this proportion is more than 90%. All youth enroll with an MCO with limited exceptions as discussed previously (DHCF, 2013).

Department of Behavioral Health Infrastructure and Services

The role of DBH is to develop, provide, deliver, and oversee a community-based, family-driven and youth-guided, high quality behavioral health system that is accessible to all children and youth in the District. DBH's target population is all children and youth eligible for MHRS and school-based services via the District's public mental health system (DBH, 2013). Children and youth enrolled in Medicaid MCOs who are in need of more intensive mental health services receive them through the MHRS program. CSAs, DBH-certified community-based MHRS providers, deliver these services.

Services Offered

DBH provides mental health services and supports to children and youth in the District. For a complete description of all DBH services, see Appendices 7-10.

- ***Access Helpline***
    - The Access Helpline is designed to serve as an easily accessible point of entry into the public mental health system in the District for all residents. The Access Helpline is housed in the Division of Care Coordination within DBH. There are a total of six lines (four crisis and two administrative) and 15 staff members. The line is open 24 hours a day, 7 days per week. A wide variety of calls are received and staff members are trained in how to address issues specific to the age of the caller and severity of the need. Each line has a specific purpose and target population. For descriptions of each crisis line, see Appendix 7.
- ***Mental Health Rehabilitation Program (MHRS)***
    - DBH provides outpatient treatment and support services primarily through its MHRS program (for detailed description see Appendix 8). MHRS core services include (1)

diagnostic/assessment, (2) medication/somatic treatment, (3) counseling, and (4) community support. Specialty services include (1) crisis/emergency, (2) rehabilitation/day services, (3) intensive day treatment, (4) CBI, and (5) Assertive Community Treatment (ACT) (DCR, 2012). For Medicaid to cover a service through MHRS, the child or youth must be Medicaid-eligible and have a diagnosis, or be at risk for having a mental, behavioral, or emotional health diagnosis. Eligibility excludes those with substance abuse disorders, intellectual disability, and other developmental disorders, unless disorders co-occur with a diagnosable SED.

- ***School Mental Health Program (SMHP)***
    - DBH's SMHP provides prevention, early intervention, direct treatment, and consultation services to students, teachers, and parents in DC public and charter schools. During the 2010-2011 school-year, 59 schools (50 DCPS and 9 Public Charter Schools) were served though SMHP (DBH, 2011). SMHP employs a two-tiered model. Tier 1 schools are characterized by high utilization and readiness for the program and a minimum student body of 200. Tier 1 schools offer a full-time clinician who provides prevention, early intervention, and treatment services for students. Tier 2 schools offer a part-time clinician who provides an array of specialized services.
- ***DC Choices High-Fidelity Wraparound Project***
    - The DBH Wraparound Initiative was developed in partnership with DYRS and CFSA. Wraparound is a community-based, family-driven, team-based process for planning and implementing services and supports for youth at risk for or returning from PRTFs or non-public school placements.
- ***Evidence-Informed, Evidence-Based and Promising Practices***
    - DBH has made significant progress over the last five years implementing and expanding a variety of evidence-informed, evidence-based and promising practices. Some of these include Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and more recently Transition to Independence Process (TIP) for youth of transition-age. The practices are implemented offsite in home-, school-, and community-based settings for children and youth ages 0-18. These practices aim to provide comprehensive, individualized care for children, youth, and families with an ultimate goal of reducing residential and institutional placements. (See Appendix 9 for full list of evidence-based practices and system capacity.)

- ***Crisis and Emergency Services***
    - Mental health crisis and emergency services for children and youth are provided by two major programs, the Children and Adolescent Mobile Psychiatric Services (ChAMPS) program, and the Crisis/Emergency Service at the Children's National Medical Center (CNMC). ChAMPS is a DBH-funded mobile crisis response program run by Catholic Charities. The ChAMPS program provides crisis services for children and youth ages 0-21 and their families. Services include rapid response mobile crisis and onsite stabilization services for those experiencing a crisis in the community, ChAMPS-assessed youth need for inpatient psychiatric hospitalization, and follow-up visits to stabilize families and link them to support services (Acosta, et al., 2010, CLC, n.d.; DBH, 2011). In FY 2012, ChAMPS served a total of 882 children, up from 414 in FY 2010 (see Appendix 10).
- ***Inpatient Services***
    - Children and youth can receive inpatient services at two locations in the District: Children's National Medical Center (CNMC) or the Psychiatric Institute of Washington (PIW). CNMC has two psychiatric units for children ages 0-13 and youth ages 13-18. PIW has an acute care unit for children ages 5-12 and another acute care unit for adolescents needing immediate care. A third sub-acute unit provides longer term care for children and youth in between crisis and recovery targeted to those transitioning from the juvenile justice system back into the community (Acosta, et al., 2010).

Unmet Need

Unmet need is defined as the behavioral health need of a community that is not being met by the current service system. In order to approximate the level of unmet behavioral health need and the gap in services for children, youth, and young adults in the District, data reported by DBH and DHCF are first summarized separately, then jointly to provide as comprehensive a view as possible of service provision in the District. A provisional calculation and discussion of unmet need follows the data summaries.

Accessibility and Utilization Data

To understand the level of utilization of behavioral health services by children, youth, and young adults and the distribution of those services in the District, customized reports derived from paid claims data

were created by the Applied Research and Evaluation (ARE) team at DBH and the Division of Research and Rate-Setting Analysis at DHCF. The analyses of demographic characteristics by age, sex, race/ethnicity, and ward residence, level/amount of utilization and/or total units of services, types of service use, and cost of services for children, youth, and young adults in the system were provided using the most current and accurate data available. The DBH data include MHRS provided to children, youth, and young adults with severe and complex behavioral needs, while the DHCF data include services delivered by the Medicaid MCO and Medicaid FFS providers for those ages 0-24 years. Importantly, more than one body can enroll providers; therefore, these provider groups are not mutually exclusive. The DHCF data also include services provided through the SMHP. Of note, although DHCF excluded MHRS in creating the reports, the consumer count may be duplicated and a child can be served by and counted in both systems.

MHRS

MHRS Consumer Demographic Data (Table 2)

- From FY 2010-2012, MHRS was accessed more by males compared to females.
- A large majority of children accessing MHRS each year is Black (93-95%).
- A majority of children and youth accessing MHRS were ages 6-13 years, however the proportion of young adults ages 18-21 has increased the most (3%) from FY 2010-2012.
- MHRS was accessed the most by residents of Wards 6 (27%), 7 (20%), and 8 (28%) in FY 2012.
- There has been a steady increase in the utilization of MHRS among children and youth ages 0-24 years between FY 2008-2012 (Appendix 11). Since 2009, DBH has expanded the array of intensive community-based services available, including a broad array of evidence-based and promising practices (DC DBH Child Dashboard, 2013), which has contributed to the increased number of consumers enrolled and served.
- In FY 2012, a small percentage (3%) of children using MHRS were ages 0-5 years. Though the types of intense, community-based services offered by MHRS may not be appropriate for young children, alternative services for this age group can be accessed at DBH's Howard Road clinic located in Anacostia. This facility offers community-based services to children, youth, and families, including early childhood services.

Table 2. Total Unduplicated Count of Consumers Ages 0-24, Served Through MHRS by Demographic Variables			
	FY 2010	FY 2011	FY 2012
Age Group	**n (%)**	**n (%)**	**n (%)**
0-5	223 (4%)	185 (3%)	170 (3%)
6-13	2,142 (39%)	2,354 (38%)	2,343 (37%)
14-17	1,444 (26%)	1,643 (26%)	1,672 (26%)
18-24	1,745 (31%)	2,044 (33%)	2,125 (34%)
TOTAL:	**5,554**	**6,226**	**6,310**
Race/Ethnicity	**FY 2010**	**FY 2011**	**FY 2012**
White	67 (1%)	83 (1%)	73 (0%)
Black	5,124 (92%)	5,783 (93%)	5,973 (95%)
American Indian or Alaskan Native	6 (0%)	7 (0%)	8 (0%)
Asian	7 (0%)	8 (0%)	5 (0%)
Native Hawaiian and Other Pacific Islander	0 (0%)	0 (0%)	0 (0%)
Two or More Race Groups	4 (0%)	3 (0%)	1 (0%)
Hispanic or Latino	244 (4%)	231 (4%)	172 (3%)
Unknown/Other	102 (2%)	111 (2%)	78 (1%)
TOTAL:	**5,554**	**6,226**	**6,310**
Sex	**FY 2010**	**FY 2011**	**FY 2012**
Female	2,421 (44%)	2,765 (44%)	2,763 (44%)
Male	3,123 (56%)	3,449 (55%)	3,536 (56%)
Unknown	10 (0%)	12 (0%)	11 (0%)
TOTAL:	**5,554**	**6,226**	**6,310**
Ward Residence*	**FY 2010**	**FY 2011**	**FY 2012**
Ward 1	296 (6%)	323 (6%)	276 (5%)
Ward 2	237 (5%)	271 (5%)	262 (4%)
Ward 3	23 (0%)	24 (0%)	25 (0%)
Ward 4	364 (7%)	392 (7%)	391 (7%)
Ward 5	505 (10%)	554 (9%)	582 (10%)
Ward 6	1,500 (29%)	1,629 (28%)	1,607 (27%)
Ward 7	948 (18%)	1,155 (20%)	1,160 (20%)
Ward 8	1,333 (26%)	1,492 (26%)	1,641 (28%)
TOTAL:	**5,206**	**5,840**	**5944**

***** Total consumers ages 0-24 by ward as represented in Table 2 totals 5,944 in FY 2012. Total consumers served ages 0-24 totals 6,310. The reason for this discrepancy in consumer counts is invalid addresses. This can apply to youth living in transitional situations without a consistent address. This issue is also applicable to the many youth committed to CFSA placed outside the District. Due to the Interstate Compact on the Placement of Children legislation, CFSA is able to place children in foster care outside of the District. Of the 1,400 youth in foster care in the District, 690 are placed in Maryland as of March 2013 (Maryland Department of Human Resources, 2013). Any of the 690 youth receiving MHRS would not be counted in the ward map, though they are technically residents of DC.

Data Source: DBH eCura system and provided by DBH's ARE Unit, customized KPI Report

NOTE: Based on claims submitted for dates of service within the specified timeframe.

MHRS Clusters

Services provided through the MHRS system fall into four service clusters:

1. **Initial and Ongoing Services** include:
    - Counseling
    - Community Support
    - Diagnostic Assessment
    - Medication Somatic
2. **Intensive Community-Based Services** include:
    - Assertive Community Treatment (ACT)
    - Community-Based Interventions (CBI)
        - Level I – Multi-Systemic Therapy (MST)
        - Levels II & III – 90 & 180 day authorization
        - Level IV –Functional Family Therapy (FFT);
3. **Specialty Services** include:
    - Day/Rehabilitation Services
    - Integrated Community Care Project (ICCP)
    - Supported Employment
    - Team Meeting
    - Jail Diversion
4. **Crisis Services** include:
    - Non-Authorized Crisis Beds
    - Psychiatric Beds
    - Emergency Services

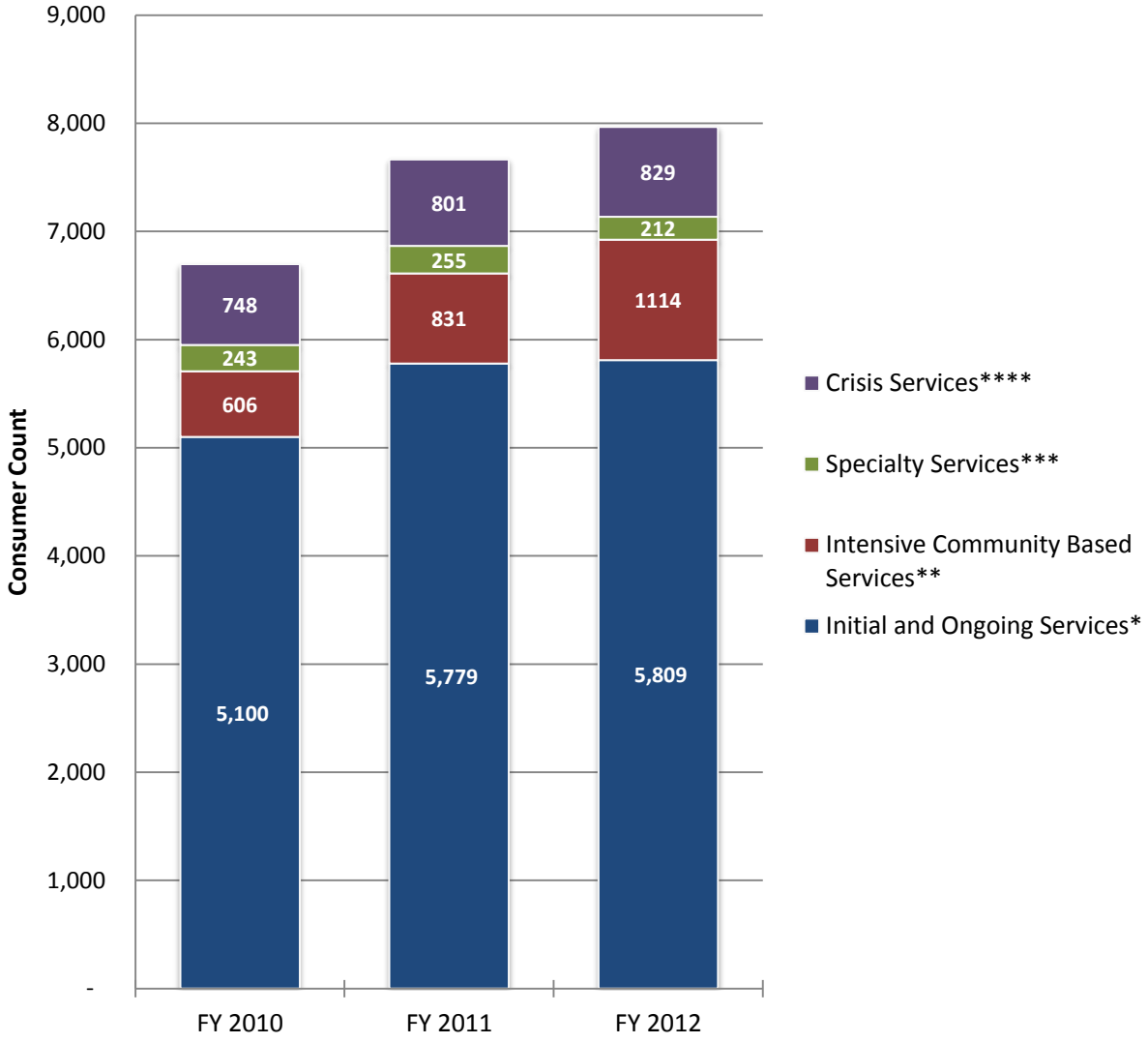
These clusters and the services that fall within them are DBH-designated categories used to describe the consumers served, units of service, total amount paid, and average paid per consumer. DHCF does not use the same clusters, which limits the capacity to make direct comparisons.

Figure 5 provides an overview of the number of children, youth, and young adults ages 0-24 years receiving MHRS in each of the four service clusters for years FY 2010-2012. Of note, consumers can be

counted in more than one category; therefore, the total number of children and youth receiving services across clusters does not equal the total number of unique consumers.

- Overall consumer counts increased annually from FY 2010-2012, from 6,697 to 7,964.
- Consumer counts increased from FY 2010-2012 for each cluster except Specialty Services, which decreased from 243 to 212.
- The vast majority of children and youth use Initial and Ongoing Services, which is to be expected since each child and youth must receive a diagnostic assessment to gain entry into the public mental health system.
- The largest percentage increase (3%) by children occurred in the Intensive Community-Based Services cluster. Over the last few years, DBH has worked to expand this cluster of services and supports to better serve children and youth with severe mental health disorders and co-occurring problems within the community.
- A small number of children and youth make use of Specialty Services.

Figure 5. MHRS Consumer Counts Among Individuals Ages 0-24 by Service Cluster and Fiscal Year



*Includes Counseling, Community Support, Diagnostic Assessment, and Medication Somatic
**Includes ACT, CBI II, III, MST & FFT
***Includes Day, ICCP, Supported Employment, Team Meeting, and Jail Diversion
****Includes Non-Authorized Crisis Beds, Psychiatric Beds, and Emergency Services
Data Source: DBH eCura System and provided by DBH's ARE Unit, Mental Health Expenditure and Service Utilization Report (MHEASURE) PACE Report - Page 6 (through 6/30/2013)
NOTE: Numbers are based on Claims Submitted for dates of service within the specified timeframe; the numbers will increase based on additional Claims and Encounters submitted.

MHRS Utilization

- **MHRS Units**
  - The units of services used through MHRS grew by more than 50% from FY 2010 to FY 2012, increasing from 891,830 to 1,350,750. This growth in service use occurred for all age groups, except those ages 0-5. Each year, children ages 6-13 utilized the most units of services, followed by the 14-17 year old age group and the early childhood age group.
- **MHRS Utilization by Service**
  - In FY 2012, Community Support, Community Based Intervention (CBI), Counseling, and Crisis Services were the most heavily utilized and costly services.
  - Total units of service nearly doubled between FY 2010 and FY 2012 for key community-based services including individual–face-to-face community support in the Initial and Ongoing Services cluster and CBI Levels II and III in the Intensive Community-Based Services cluster.
- **MHRS Claims Expenditures**
  - Expenditures for children and youth ages 0-17 were by far the highest every year compared to the 18-21 and 22-24 age groups. Expenditures for this age group have also increased the most substantially year to year. However, the broad range of children and youth included within the 0-17 year age category might explain some of the gap in claims expenditures.
  - For youth and young adults ages 18-21 and 22-24, expenditures were significantly lower compared to those ages 0-17 and have also remained relatively stable from FY 2010 to FY 2012.
  - While expenditures have generally increased annually in the past three years in all age groups with the exception of young adults ages 22-24 from FY 2011 to FY 2012, this finding parallels an increase in the overall number of consumers.

For detailed tables and graphs on MHRS service utilization, please refer to Appendix 12.

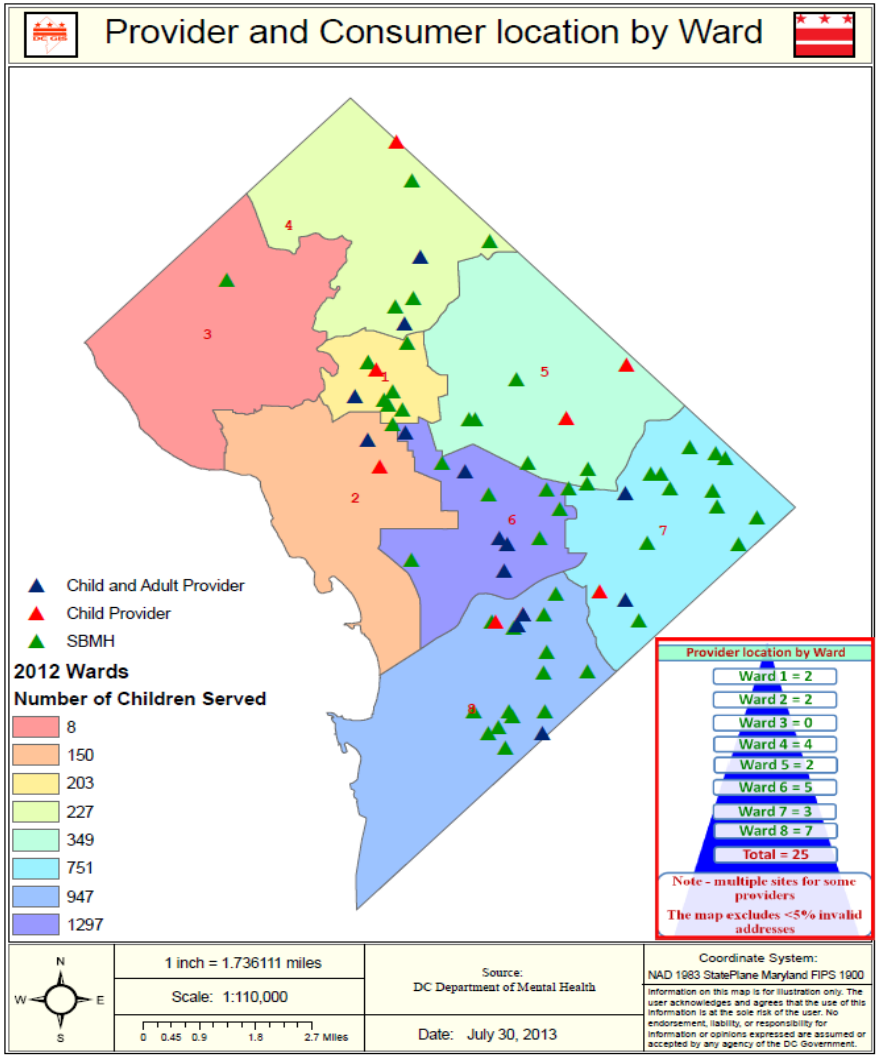
Mental Health Provider Distributions

The geographical distribution of nonmedical behavioral health providers is consistent with the number of children accessing their services.

- **MHRS and School Mental Health Provider Location** (Figure 6) presents the distribution of MHRS and SMHP providers in relation to the number of children, ages 0-18 years, served by ward.
    - There is a high concentration of providers in Wards, 1, 4, 6, 7, and 8, in which the greatest number of children and youth live and access these services.
    - Few providers are located in Wards 2 and 3.[5]
- **Pediatric Psychiatry Specialist, MHRS, and School Mental Health Provider Location** (Figure 7) includes the location of pediatric psychiatry specialists and indicates a significant discrepancy in the distribution of these providers across the city.
    - The majority of pediatric psychiatrists are located in the Northwest region of the District, primarily in Wards 1, 2, and 3, with a majority concentrated in Ward 3 despite nearly 40% of DC children residing in the Southeast region in Wards 7 and 8.
    - While the SMHP program provides an array of mental health services, children needing a pediatric psychiatrist have to travel far in order to receive those specialty services.
    - MHRS providers offer services to offset some provider shortages in the other wards; however the lack of pediatric psychiatrists in the Southeast region indicates important barriers to services.

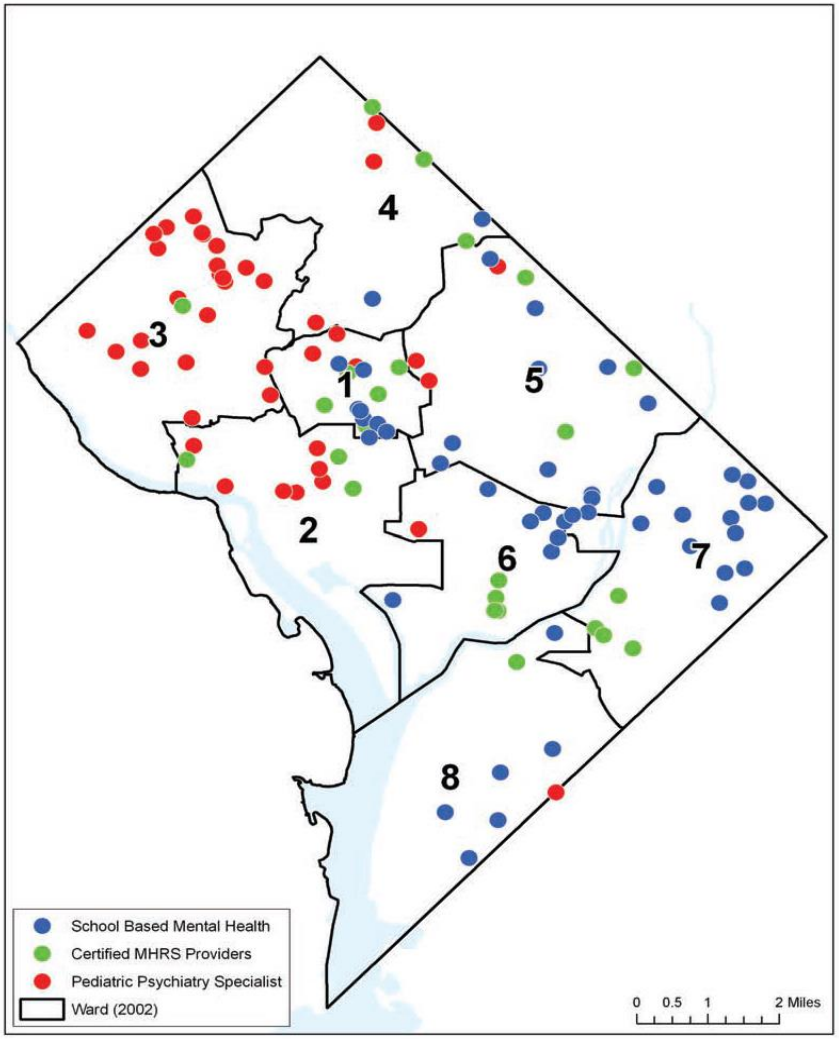
[5] Some providers are CSAs that participate in one or more Medicaid MCO or Medicaid FFS, or are a freestanding mental health clinic not serving exclusively MHRS.

Figure 6. MHRS and SMHP* Provider Location



* School-Based Mental Health (SBMH) in the map is the same as the School Mental Health Program (SMHP)
Data Source: DBH's Office of Accountability

Figure 7. Pediatric Psychiatry Specialist, MHRS, and SMHP* Provider Location



* School-Based Mental Health (SBMH) in the map is the same as the School Mental Health Program (SMHP)
Data Source: Chandra, et al., 2009

Medicaid MCO/FFS

It is important to note the data presented here include only services financed through the Medicaid MCOs and FFS and does not represent all mental health services or consumers who accessed mental health services through Medicaid. For example, inpatient services were not included in the analysis.

MCO/FFS Consumer Demographic Data (Table 3)

- The total number of children, youth, and young adults served by Medicaid MCOs or Medicaid FFS decreased from FY 2010 to FY 2011, but then increased in FY 2012.
- A large majority of children, youth, and young adults accessing mental health services were Black, paralleling Medicaid enrollment demographics.
- Males were consistently more likely than females to receive Medicaid MCO and Medicaid FFS services in FYs 2010, 2011, and 2012.
- Wards 2, 7, and 8 had the greatest proportion of consumers served from FY 2010 to FY 2012 with Ward 8 the highest.
- The proportion of young adults ages 22-24 that accessed Medicaid MCO and Medicaid FFS services increased by 3% from FY 2010 to FY 2012.

Table 3. Total Unduplicated Count of Consumers Ages 0-24 Served Through Medicaid MCOs and Medicaid FFS By DemographicVariables

	FY 2010	FY 2011	FY 2012
Age Group*	**n (%)**	**n (%)**	**n (%)**
0-17	8,098 (84%)	7,504 (85%)	7,873 (83%)
18-21	1,198 (12%)	934 (11%)	1,034 (11%)
22-24	325 (3%)	437 (5%)	542 (6%)
TOTAL :	**9,621**	**8,875**	**9,449**
Race/Ethnicity	**FY 2010**	**FY 2011**	**FY 2012**
White	42 (0%)	50 (1%)	61 (1%)
Black	8,763 (91%)	7,674 (86%)	8,239 (87%)
American Indian or Eskimo	#	#	#
Asian	#	#	26 (0%)
Hispanic or Latino	559 (6%)	847 (10%)	818 (9%)
Other	68 (1%)	94 (1%)	91 (1%)
Unknown	169 (2%)	185 (2%)	212 (2%)
TOTAL :	**9,621**	**8,875**	**9,449**
Sex	**FY 2010**	**FY 2011**	**FY 2012**
Female	3,996 (42%)	3,876 (44%)	4,044 (43%)
Male	5,624 (58%)	4,999 (56%)	5,405 (57%)
Unknown	#	#	#
TOTAL :	**9,621**	**8,875**	**9,449**
Ward Residence	**FY 2010**	**FY 2011**	**FY 2012**
Ward 1	604 (6%)	735 (8%)	716 (8%)
Ward 2	2,059 (21%)	1,840 (21%)	1,855 (20%)
Ward 3	33 (0%)	32 (0%)	35 (0%)
Ward 4	884 (9%)	1,070 (12%)	1,045 (11%)
Ward 5	936 (10%)	962 (11%)	1,050 (11%)
Ward 6	968 (10%)	825 (9%)	977 (10%)
Ward 7	1,925 (20%)	1,490 (17%)	1,641 (17%)
Ward 8	2,205 (23%)	1,919 (22%)	2,127 (23%)
Unknown	#	#	#
TOTAL :	**9,621**	**8,875**	**9,449**

*Age based on Date of Service.
- Cell sizes of 25 or fewer are not reported for privacy purposes
Data Source: DHCF MMIS System and provided by DHCF's Division of Research and Rate Setting Analysis
NOTE: Total number of unique beneficiaries, ages 0-24, with a paid Encounter and/or non-zero FFS claim with a First Date of Service in the given fiscal year. Excludes MHRS services (Provider type code T01). Only includes claims that had one of the DBH-identified procedure codes (see Appendix 13 for full list of procedure codes included in this analysis).

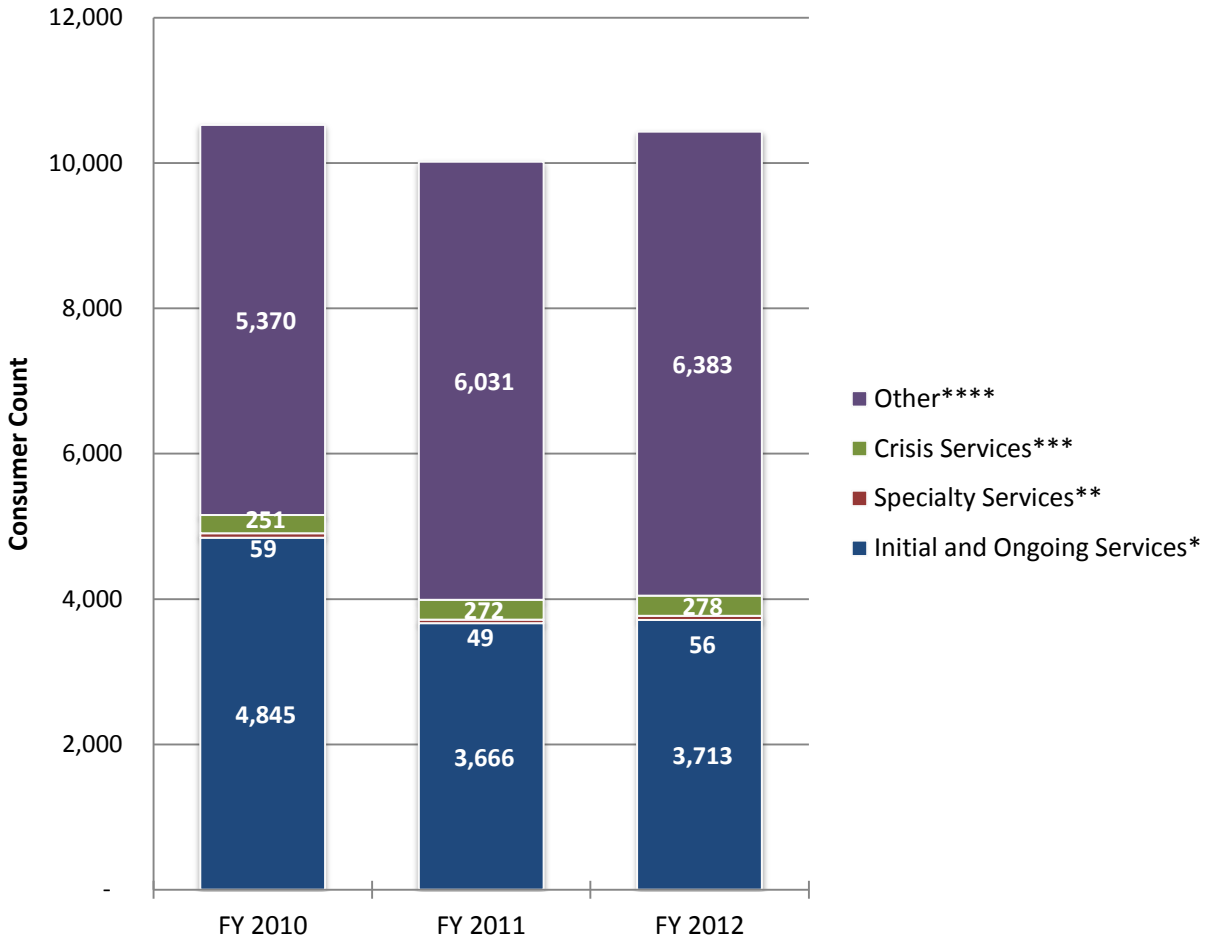
MCO and FFS Service Clusters

Figure 8 depicts the number of children, youth, and young adults ages 0-24 years receiving Medicaid MCO/FFS services in each of the four DBH service clusters for FYs 2010, 2011, and 2012. DHCF categorized services according to the four DBH-designated service clusters: (1) Initial and Ongoing Services, (2) Intensive Community-Based Services, (3) Specialty Services, and (3) Crisis Services in order to facilitate comparison. However, a majority of DHCF consumers accessed "Other" services falling outside of the four DBH clusters. The "Other" category includes some highly utilized services, such as individual psychotherapy, developmental screening and testing, and activity therapy (See Appendix 13).

Again, consumers can be counted in more than one category; therefore, the total across clusters does not equal the total number of unique consumers served through the MCO and FFS arrangements.

- Service utilization in the Intensive Community-Based Services cluster was extremely low for the Medicaid MCO and Medicaid FFS providers.
- The service cluster with the highest consumer counts each year was the "Other" category, indicating high use of developmental screening, individual psychotherapy, activity therapy (such as music, dance, art, or play therapies), and day services.
- A high proportion of children and youth also accessed services in the Initial and Ongoing Services cluster, reflecting the need for diagnostic assessments, screening, and support.
- The Initial and Ongoing Services cluster saw a decrease from FY 2010 to later years.
- The consumer counts in the other two clusters were substantially lower with Medicaid MCOs and Medicaid FFS providing little in the way of Crisis Services or Specialty Services, possibly due to those services being delivered through the MHRS program.

Figure 8. Medicaid MCO/FFS Consumer Counts Among Individuals Ages 0-24 by Service Cluster and Fiscal Year



*Includes Counseling, Community Support, Diagnostic Assessment, and Medication Somatic
**Includes Day, ICCP, Supported Employment, Team Meeting and Jail Diversion
***Includes Non-Authorized Crisis Beds, Psychiatric Beds, and Emergency Services
****Includes all other procedure codes listed in Appendix 13, not elsewhere classified here

Data Source: DHCF MMIS System and provided by DHCF's Division of Research and Rate-Setting Analysis

NOTE: Total number of unique beneficiaries, ages 0-24, with a paid Encounter and/or non-zero FFS claim with a First Date of Service in the given fiscal year. Excludes MHRS services (Provider type code T01). Only includes claims that had one of the DBH-identified procedure codes (see Appendix 14 for full list of procedure codes included in this analysis).

Medicaid MCO and Medicaid FFS Service Utilization

- **MCO/FFS Service Units**
    - Although accurate service utilization data by consumer were obtained, it was not possible to procure unbiased data, attributable to the data reporting system, on the total units of services used by children, youth, and young adults ages 0-24 years by year for this analysis.[6]
- **MCO/FFS Utilization by Service**
    - The most highly utilized services in the Medicaid MCO and FFS arrangements were focused on Screenings, Individual Psychotherapy and Behavioral Health Counseling and Therapy.
- **MCO/FFS Claims Expenditures**
    - Using the FFS expenditure data as a proxy of total DHCF monies would grossly underestimate total expenditures and so claims expenditures are not being reported or analyzed in this report.[7]

For a full description of MCO/FFS service utilization, please refer to Appendix 14.

ARE and DHCF Data

Total Consumers Served

Figure 9 highlights the total numbers of consumers served by DBH's MHRS providers and DHCF's Medicaid MCO and Medicaid FFS providers. As previously stated, a provider can be credentialed by more than one body; therefore the categories are not mutually exclusive. Although the DHCF service data excluded MHRS services, they did not exclude children who also accessed MHRS. Therefore, the counts in the figure may include duplicated individuals. It would be inappropriate to add the counts together to

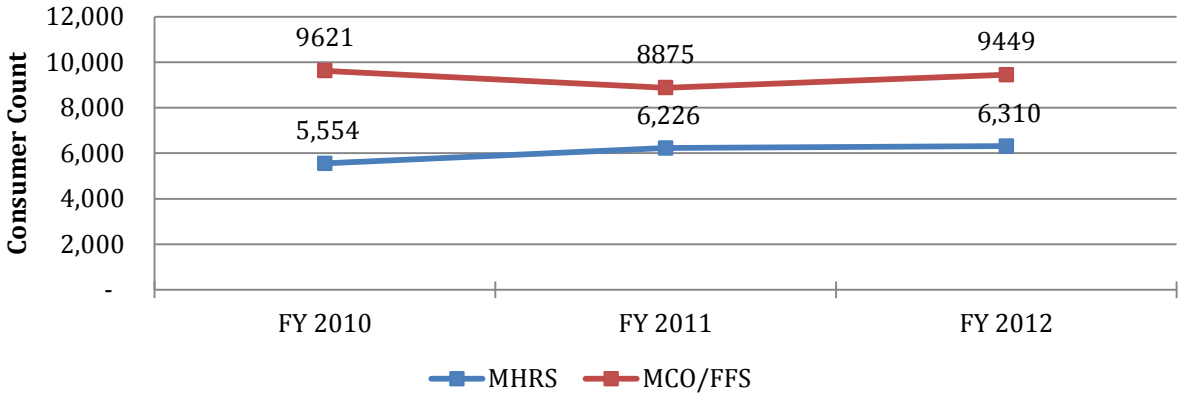
[6] As noted in Appendix 2C, the U.S. Government Accountability Office (GAO) and the U.S. Department of Health and Human Services Inspector General (US DHHS OIG) have described the limited usefulness of the Medicaid Managed Care encounter data in the Medicaid Statistical Information System (MSIS), the only national database of Medicaid claims and beneficiary eligibility information (US DHHS OIG, 2009; GAO, 2012). Although DHCF consistently collects and uses encounter data, the way these data are entered and managed by the District's MMIS limits what information can be extracted and analyzed regarding units of service and payment amounts.

[7] The District also has technical challenges with encounter data; therefore accurate expenditure data are not available for the services reported on in this study as provided by MCO providers. Specifically, for such granular data as are reported here, DHCF only has reliable data on claims paid through FFS mechanisms, which represent only a portion of the services described here.

determine the total number of consumers served across the system. However, the figure provides a close approximation of service use in the system.

The total number of consumers accessing the specified services via Medicaid MCO and Medicaid FFS providers is consistently higher than the MHRS providers for each reported year. The gap decreased in 2011, perhaps due to the increased number of services offered by DBH. MHRS provides specialty services for children, youth, and young adults in need of a higher level of care, so it is expected that the number of consumers accessing services through the MCOs and Medicaid FFS is greater.

Figure 9. Total Consumers Served Ages 0-24 in Fiscal Years 2010, 2011 and 2012: MHRS and MCO/FFS



Data Source: DBH eCura System and provided by DBH's ARE Unit, customized KPI Report; DHCF MMIS System and provided by DHCF's Division of Research and Rate-Setting Analysis
NOTE: Totals are an unduplicated consumer count for all services.

Calculation of Unmet Need

The following formula was created to estimate the provisional level of need in the District:

3. $\left(\begin{array}{c}\text{Total Number of}\\ \text{Children in the District}\end{array}\right) \times \left(\begin{array}{c}\text{National Prevalence of Children with a}\\ \text{Mental or Behavioral Health Problem}\end{array}\right) =$

Estimated Number of Children in the District with a Mental or Behavioral Health Problem

4. $\left(\begin{array}{c}\text{Estimated Number of Children in the District}\\ \text{with a Mental or Behavioral Health Problem}\end{array}\right) \left(\begin{array}{c}\text{Total number of children and youth served through}\\ \text{MHRS, Medicaid MCO and Medicaid FFS Providers}\end{array}\right) =$

Provisional Estimate of Unmet Need in the District

With a total of 109,480 children and youth ages 0-17 in the District according to the 2012 Census annual estimate, and a total of 13%-20% of children living in the United States experiencing a mental disorder in a given year (CDC, 2013), DC's behavioral health system should have served between 14,232 and 21,896 children and youth in FY 2012. A total of 12,058 children and youth ages 0-17 accessed services in FY 2012 from MHRS and Medicaid MCO and Medicaid FFS providers. Therefore, based on national averages, the approximate gap could include between 2,174 and 9,838 children and youth with behavioral health needs who are not being served. As such, the provisional unmet need in the District ranges from 15% to 45%.[8] Since the DBH and DHCF consumer counts are duplicated, many children and youth are counted in both systems[9]. Therefore, the total of 12,058 children accessing services in FY 2012 is an overestimation and the unmet need is likely even greater than the provisional calculation of 2,174 to 9,838 children and youth or 15% to 45%. Understanding the true unmet need would require more detailed data analysis that allow for the elimination of duplication between system counts. To diminish this gap and strengthen the behavioral health infrastructure for all children and youth in need in the District, strategic planning, collaboration, and data-driven decision making need to be at the forefront to improve service delivery and the continuum of care.

[8] Unmet need in the District was calculated by multiplying the 2012 Census annual estimate by the CDC prevalence rates to obtain the number of children who should have been served in FY 2012. The actual number of children and youth ages 0-17 served was calculated by adding the DMH and DHCF consumer counts. The number of children served was then subtracted from the estimated number of children who needed services to calculate the service gap. The unmet need was then calculated by dividing the number served by the number that should be served to obtain the percentage range for unmet need. With a duplicated data set, the unmet need calculation is provisional.

[9] Paid claims data were received from DBH and DHCF in 2013. The DHCF service data excluded MHRS, but did not exclude children who also accessed MHRS. If a child accessed services through both a MCO and MHRS, the child was counted in both systems. As a result, the total consumer counts for DHCF and DBH may include duplicated individuals. Although there was no available mechanism to crosswalk the data sets at the time of the data analysis, DBH and DHCF have since worked together to determine an unduplicated count. Further data analysis is recommended using an unduplicated count of children and youth to determine the unmet need in the District.

Data-Driven Decision Making to Implement Change

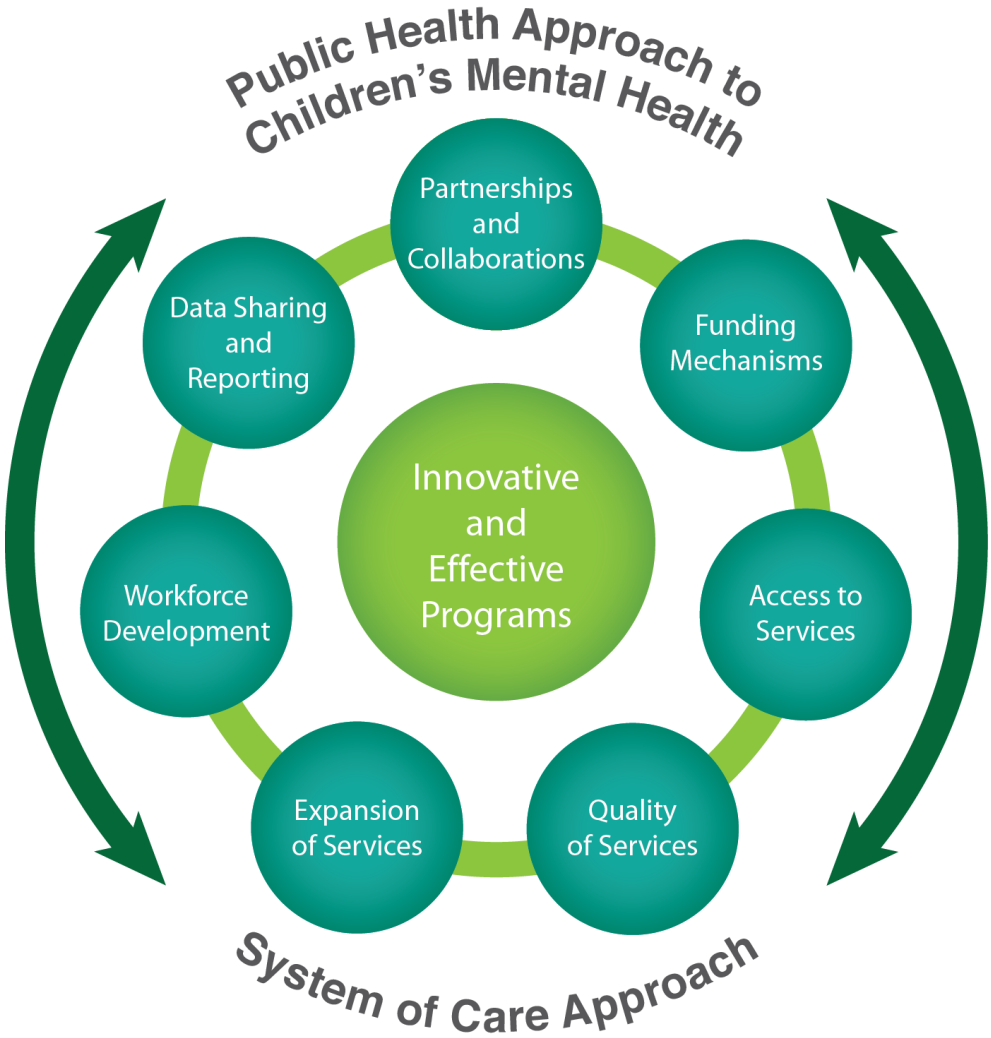
The preceding data demonstrate the strides that DBH has made over the last several years to implement a wide array of services and supports across the continuum of care to serve the behavioral health needs of children, youth, and their families. While DBH has been successful in expanding the array of evidence-based programs and interventions offered, systematic collection of key data indicators to monitor and assess the quality of these services is critical to track progress, strengthen existing programs, and further expand service capacity. Greater accessibility to care and improved care coordination will also alleviate the unmet need for behavioral health services, reflected in the data. Based on the data context previously provided, the following section outlines a framework to further strengthen the public behavioral health system in the District with a series of recommendations in key areas to strengthen the existing infrastructure and service delivery systems.

COMPONENTS OF A PUBLIC HEALTH APPROACH: STRENGTHS, BARRIERS, AND RECOMMENDATIONS

As noted earlier in this report, the District is working toward a public health model in delivering children's mental health services.

Figure 10 depicts the framework, components, and innovative services in the District. This section presents the strengths and barriers of the seven components of a public health framework for behavioral health and recommendations are offered to further strengthen the public behavioral health system in the District.

Figure 10. Framework, Components, and Services for a Strong Public Behavioral Health System for Children, Youth, and Their Families in the District of Columbia



Component 1: Partnerships and Collaborations

Children and youth, especially those identified as having mental or behavioral health issues, are touched by multiple systems—education, special education, child welfare, juvenile justice, mental health, and substance abuse to highlight a few. Collaboration across these systems is needed to ensure coordinated, integrated, and comprehensive care for children, youth, and their families. The District has acknowledged the importance of working collaboratively and has made great efforts adopting this principle as demonstrated by their building an integrated system of care that is family-driven and youth-guided to ensure comprehensive services and supports. Despite the movement towards a shared vision across agencies and family partners, systemic barriers are a challenge for strengthening these relationships. Importantly, partnerships with families and authentic family involvement continue to be a challenge for the entire system.

1. Recommendations Regarding Partnerships and Collaborations:

a. Continue to have DBH as the coordinating body for behavioral health services.
b. Standardize data reporting requirements and screening and assessment tools.
c. Improve coordination of mental health services for youth and young adults to facilitate their transition from child- to adult-serving systems.
d. Continue to enhance cross-agency collaboration through the Office of the Deputy Mayor for Health and Human Services to improve behavioral health services.
e. Use community and academic resources to the fullest extent by identifying and convening a group of research, policy, and clinical partners to provide ongoing support to enhance the behavioral health system for children and youth.
f. Partner with a community and engage in community-based participatory research efforts to address these complex public health issues.
g. Conduct a collaborative study examining the suspected relationship between unmet need and later delinquency, antisocial, and violent behavior.

Component 2: Funding Mechanisms

Children and youth in the District have high health insurance coverage with the vast majority of all children and youth having insurance. Despite the District's position as a national leader in Medicaid and CHIP coverage, data suggest children in the District are not accessing needed mental health services. The

District serves children and youth through Medicaid MCO, Medicaid FFS, and MHRS providers. The dual-service delivery system allows for broad access to care, but the same system has been consistently identified as a challenge for consumers and providers to navigate. Specifically, questions remain regarding quality and appropriateness of care among the systems, and the transition between Medicaid MCO and Medicaid FFS is often poorly coordinated. Both issues result in inappropriate and untimely services. Also, rates for the MCOs are often lower and reduce the willingness of private providers to accept DC Medicaid.

2. Recommendations Regarding Funding Mechanisms:

a. Provide technical assistance to help Medicaid MCO, Medicaid FFS, and MHRS providers implement health reform and ensure integrated care.
b. Incentivize quality care through regulations, rates, and funding structures. Specifically, examine provider quality incentive models to improve service delivery as well as enhance patient care and satisfaction with care (Bailit Health Purchasing, LLC, 2002).

Component 3: Access to Services

DBH has strategically worked to improve accessibility of the children's behavioral health system by expanding coverage and offering a wide array of services and supports to create a more comprehensive system. However, it recognizes the need for improvement in behavioral health promotion, prevention, and early intervention to avoid the need for more intense and expensive services. Accessibility barriers exist for children, youth, and their families with regard to entry into the system, navigation of the system, coordination of care, and service provision. Entry into the behavioral health system is not transparent; there are multiple points of entry and navigation of the system is difficult and complex. Access Helpline is poorly understood and is unable to follow up appropriately on referral appointments. The lack of qualified mental health providers and professionals, geographic discrepancies, language concerns, and enduring stigma affect access and compromise the achievement of mental health equity and successful outcomes. These issues have the most impact on those wards with areas of greatest need.

3. Recommendations Regarding Access to Services:

a. Increase social marketing and community outreach efforts to reduce stigma around behavioral health.

b. Develop a campaign to help the public and professionals understand the structure and purpose of the Access Helpline, the primary point of entry for MHRS.
c. Collect and share data on where providers are located, what services they offer, and which insurance plans they accept to promote better understanding of the provider landscape and more strategic contracting with providers.
d. Incentivize providers to participate in DC Medicaid.

Component 4: Quality of Care

The focus of DBH has shifted from only inpatient and outpatient services to accurately determining need and appropriate services, providing timely access, system coordination and continuity, and quality of care. This expansion has implicit challenges such as coordination of care within the dual system of services. The transfer of children and youth between the MCO and FFS systems can frequently exceed the 30-day requirement. A gap in services can occur for children and youth with moderate mental health concerns who do not have deep end needs. The increasing use of evidence-based practices, although aimed at improving quality, can be accompanied by challenging issues of capacity, workforce requirements, implementation, and funding. High provider turnover disrupts care. It is also difficult to create a climate where providers can focus on quality and best practices instead of primarily on compliance.

4. Recommendations Regarding Quality of Care:

a. Strengthen the yearly Consumer Service Reviews (CSRs) through the development of quality metrics to evaluate whether quality services are being delivered to children, youth, and their families.
b. Supplement CSR feedback with the collection of standardized consumer surveys.
c. Employ effective training materials, workshops, and technical assistance to maintain consistent reliability for system-wide implementation of the chosen method of functional assessment (Child and Adolescent Functional Assessment Scale [CAFAS]).
d. Implement and monitor measures of fidelity in conjunction with the expansion of evidence-based practices.

Component 5: Expansion of Services

DBH recognizes the importance of having a comprehensive array of services to meet the needs of children and youth living with a mental or behavioral health challenge. Services and supports have been expanded in multiple ways. Select examples include an improved Psychiatric Residential Treatment Facility placement process; expansion of wraparound and community-based services; expansion of SMHP to include 19 more schools; and making an extensive array of evidence-based practices available for children with intense needs including FFT, MST, and MST-PSB.

DBH has also expanded services for children and youth with more focused concerns such as evidence-based practices focused on disruptive problems (PCIT) and trauma (TF-CBT). DBH is reaching the early childhood population through the Healthy Futures and Primary Project, and community and clinical services are available at Howard Road (PCIT, CPP-FV). The system is still heavily focused, however, on youth with a severe mental illness. Youth with moderate behavioral problems are unable to access MHRS and do not enter the system until the concerns escalate. There are still insufficient resources for youth and young adults of transition age, although DBH has recently started implementing the Transition to Independence Process (TIP), which addresses the specific needs of this particular group.

5. Recommendations Regarding Expansion of Services:

a. Carefully expand the menu of evidence-based practices focusing on identified needs such as treatment foster care, family violence, and co-morbid mental health and substance abuse.
b. Continue to grow intensive, community-based services and collect information on how children and youth who are discharged or diverted from residential care are faring.
c. Reduce the lag time between referral to placement into residential treatment to avoid delays in appropriate care for those children and youth with the highest need. While the lag time between referral and placement is not unique to the District, streamlining this process can lead to timely access to services and appropriate care.
d. Increase transition services for youth and young adults entering the school system and the adult system.
e. Increase community identification, understanding, and response to signs of mental illness and substance use disorders through the Mental Health First Aid training.
f. Continue support for the integration of behavioral health prevention efforts into primary care.
g. Support further expansion of early childhood services, like Healthy Futures and the Early Childhood Mental Health Consultation project.

Component 6: Workforce Development

In the District, salaries are competitive and the city is supported by a number of federal grants. DBH provides extensive training, supervision, and support for its providers and is developing a community support worker certification process to ensure high-quality staff. There is cross-agency collaboration between DBH and the Department of Parks and Recreation to train and utilize natural supports. The DBH Training Institute is a source of support and expertise for providers. However, there is insufficient capacity to deliver needed services and supports, with many providers lacking the proper skill sets. While some specialized MHRS services are delivered by licensed staff, most services are provided by unlicensed personnel who are credentialed according to DC MHRS Provider Regulation (DCR, 2012). Regulation states that staff who are determined by the provider as capable of providing services are credentialed for direct service work. While regulation also requires that all services delivered by credentialed staff be supervised by a qualified practitioner, this does not happen consistently. DBH is currently in the process of creating a policy to make its oversight of supervision stricter. High turnover of clinical staff, partially due to high caseloads, creates a strain on the system. Of note, every school is not served by a school mental health clinician, leading to an overuse of and over reliance on community support workers. Low and unequal reimbursement rates contribute to a lack of clinicians, particularly child psychiatrists, to serve those in the public system.

6. Recommendations Regarding Workforce Development:

a. Incentivize qualified providers and mental health professionals to stay in the District through supervision, training, and peer-to-peer support and reimbursement rates that are linked to appropriate and effective care.
b. Monitor treatment plans to ensure that the most appropriate provider is delivering the service.
c. Train professionals in all child-serving agencies to identify the early signs of behavioral health concerns and refer appropriately for care.

Component 7: Data Sharing and Reporting

There is consensus in the District around the need to set standard data reporting requirements in order to monitor programs and interventions. Agencies are focusing on program evaluation and quality improvement, exemplified by the District-wide implementation of the CAFAS by DBH, CFSA, and DYRS as the standard assessment tool for measuring functional outcomes. Various Memoranda of

Understanding have been created to facilitate data sharing across systems. DBH will soon implement the Integrated Care Applications Management System (ICAMS), which will integrate electronic medical records, claims and billing, and reporting into one system. ICAMS will generate a unique identifier that will support consumer matching in other systems.

7. Recommendations Regarding Data Sharing and Reporting:

a. Promote adoption of the CAFAS by other agencies focused on child and youth behavioral health (e.g., DC Public Schools, charter system, and the Office of the State Superintendent of Education [OSSE]) to help standardize data collection on care quality and outcomes.
b. Analyze and synthesize individual client-level data.
c. Determine the service array that seems to work best for children and youth with complex behavioral health challenges based on diagnostic information and functional assessments at various points in time along with the type, frequency, and duration of services and supports.
d. Examine individual-level service utilization data by ward to begin addressing the possible link between unmet behavioral health needs and delinquency and violent behavior later in life.
e. Continue interagency strategizing around how to best codify and share information.
f. Closely monitor the Integrated Care Applications Management System (ICAMS) rollout to determine its effectiveness.
g. Partner with sister agencies to develop and adopt a universal identifier.
h. Estimate unmet need on a regular basis through an unduplicated count of consumers.

CONCLUSION

The children's behavioral health system in the District is developing an improved public health approach to address the gaps in services for children, youth, and their families, despite a complex payment system and an inability to serve all children in need. Review of the data show that social determinants of health, such as socioeconomic status, educational attainment, and residence, are closely linked to behavioral health inequities.

Given the complex behavioral health needs of children, youth and their families, the collective effort of both the public and private sectors is needed to properly address these issues. No one agency, entity, or individual has the depth of knowledge, skills, resources, and abilities necessary to resolve all of the challenges faced by the District's young people.

DBH has laid a foundation for addressing the behavioral issues of its children and youth, but there is a continued need to reaffirm a shared vision, strengthen a set of core values and principles, and further support the mission of all public agencies serving children, youth, and their families. If implemented strategically in an integrated manner, the public health approach coupled with the seven components for a strong public behavioral health system should begin to close the gaps in services. With a renewed focus on promoting healthy communities where children, youth, and their families can live and thrive, the DC South Capitol Street tragedy can be turned into a benchmark for change.

GLOSSARY OF TERMS

Addiction Prevention and Recovery Administration (**APRA**) – District of Columbia agency responsible for the regulation and policy around substance abuse prevention, treatment and recovery services (DC Department of Behavioral Health [DBH], 2011).
Affordable Care Act (**ACA**) – Health care reform law that aims to expand health insurance coverage and increase access to services (U.S. Department of Health & Human Services [HHS], n.d.a).
Assertive Community Treatment (**ACT**) – Intensive, integrated, crisis, treatment, and mental health rehabilitative community support provided by an interdisciplinary team to children and youth with serious emotional disturbance and to adults with serious and persistent mental illness by an interdisciplinary team. ACT is provided with dedicated staff time and specific staff to consumer ratios. Service coverage by the ACT team is required twenty-four (24) hours per day, seven (7) days per week. ACT is a specialty service (DC Municipal Regulations & DC Register [DCR], 2012).
Attention Deficit/Hyperactivity Disorder (**ADHD**) – Characterized by a pattern of behavior, present in multiple settings (e.g., school and home). Symptoms are divided into two categories of inattention and hyperactivity and impulsivity that include behaviors like failure to pay close attention to details, difficulty organizing tasks and activities, excessive talking, fidgeting, or an inability to remain seated in appropriate situations that can result in performance issues in social, educational or work settings (American Psychiatric Association, 2013a).
Behavioral Health – A person's overall social, emotional and psychological well-being and development (South Capitol Street Memorial Amendment Act of 2012 [The Act], 2012).
Child and Family Services Agency **(CFSA) –** District of Columbia agency responsible for the coordination of foster care, adoption, and child welfare services and services to protect children against abuse or neglect and assisting their families (DBH, 2011).
Community-Based Intervention (**CBI**) – Time-limited, intensive services for children and youth ages 6-21 years intended to reduce out-of-home placement. CBI is a specialty service (DCR, 2012).
Community Support – Rehabilitation and environmental support considered essential to assist a consumer in achieving rehabilitation and recovery goals. Community Support services focus on building and maintaining a therapeutic relationship with the consumer. Community Support is a core service (DCR, 2012).
Cognitive Behavioral Intervention for Trauma in Schools (**CBITS**) – School-based, group, and individual intervention. It is designed to reduce symptoms of post-traumatic stress disorder (PTSD), depression, and behavioral problems, and to improve functioning, grades and attendance, peer and parent support, and coping skills (Cognitive Behavioral Intervention for Trauma in Schools [CBITS], n.d.).
Conduct Disorder – Characterized by behavior that violates either the rights of others or major societal norms. These symptoms must be present for at least three months with one symptom having been present in the past six months. To be diagnosed with conduct disorder, the symptoms must cause significant impairment in social, academic, or occupational functioning. The disorder is typically diagnosed prior to adulthood (American Psychiatric Association, 2013b).
Core Services Agency (**CSA**) – A District of Columbia Department of Behavioral Health (DBH) certified community-based provider that has contracted with DBH to provide specified Mental Health Rehabilitation Services (MHRS). A CSA shall provide at least one core service directly and may provide up to three core services via a contract with a sub-provider or subcontractor. A CSA may provide specialty services directly if certified by DBH as a specialty provider. A CSA shall also offer specialty services via an affiliation agreement with all specialty providers (DCR, 2012).
Counseling – Individual, group or family face-to-face services for symptom and behavior management, development, restoration, or enhancement of adaptive behaviors and skills, and enhancement or maintenance of daily living skills. Counseling is a core service (DCR, 2012).
Crisis/Emergency Services – Mental health services that support the consumer through a crisis, such as meeting with the consumer in the community or an emergency department to help calm the consumer;

implementing the crisis plan developed for the consumer; assisting the consumer to reach an emergency department; and providing pertinent mental health information about a consumer to an emergency department to assist in addressing a crisis. Crisis/Emergency services are specialty services (DCR, 2012).
Day/Rehabilitation Services – A structured, clinical program intended to develop skills and foster social role integration through a range of social, psycho-educational, behavioral, and cognitive mental health interventions. Day/Rehabilitation services are curriculum-driven and psycho-educational and assist the consumer in the retention or restoration of community living, socialization, and adaptive skills. Rehabilitation/Day Services is a specialty service (DCR, 2012).
Department of Health Care Finance (**DHCF) –** District of Columbia's state Medicaid agency; administers the Medicaid Fee-for-Service (FFS) program, Medicaid Managed Care Organizations (MCOs), Alliance program, Immigrant Children's Program, and Children's Health Insurance Program (CHIP) (Department of Health Care Finance [DHCF], n.d.).
Department of Behavioral Health (**DBH**) – District of Columbia agency responsible for providing emergency care and comprehensive mental health services and support to District residents in need of the public mental health system (DBH, 2011).
Department of Youth Rehabilitation Services **(DYRS) –** District of Columbia agency responsible for providing security, supervision, and residential and community support services for committed and detained juvenile offenders and juvenile persons in need of supervision (DCR, 2012).
Diagnostic and Assessment – Intensive clinical and functional evaluation of a consumer's mental health condition that results in the issuance of a Diagnostic/Assessment report with recommendations for service delivery. A Diagnostic/Assessment shall determine whether the consumer is appropriate for and can benefit from MHRS, based upon the consumer's diagnosis, presenting problems and recovery goals. Diagnostic/Assessment is a core service (DCR, 2012).
District of Columbia **(DC, the District)**
District of Columbia Public Schools (**DCPS**)
Evidence-Based Practices (**EBPs**) – Integration of (a) clinical expertise, (b) best current evidence and (c) client values to provide high-quality services reflecting the interests, values, needs, and choices of individuals served (Robey et al., 2004).
Functional Family Therapy (**FFT**) – A short-term, research-based prevention and intervention program for at-risk adolescents and their families that can be provided in a variety of settings by a trained team of providers with FFT site certification (DCR, 2012).
Integrated Community Care Project (**ICCP**) – Project designed to discharge individuals with long-term episodes of care at St. Elizabeth's Hospital, and who need a creative approach to service delivery in the community to help them remain in their communities. ICCP is delivered by a community provider using mental health and non-mental health services and supports (DBH, 2010).
Jail Diversion – Programs that divert individuals with mental illness, and often co-occurring substance use disorders, away from jail and provide linkages to community-based treatment and support services. The individual may be allowed to enter a deferred prosecution agreement (misdemeanor) or a deferred sentencing agreement (felonies) for participating in treatment (both mental health and substance abuse treatment) during the process of the adjudication of the offense. Not the same as Juvenile Behavior Diversion Program (DBH Correspondence, 2013).
Major Depressive Episode **(MDE)** – The loss of interest or pleasure in daily activities for at least two weeks accompanied by depressive symptoms that impair day-to-day functioning (National Institute of Mental Health [NIMH], 2011).
Managed Care Organization (**MCO**) – A health care delivery system that provides care through a network of providers for a predetermined monthly fee (DBH, 2011).
Medication Somatic – Medical interventions, including physical examinations, prescription, supervision or administration of mental-health related medications, monitoring and interpreting the results of laboratory diagnostic procedures related to mental health-related medications, and medical interventions needed for effective mental health treatment provided as either an individual or group intervention. Medication/Somatic Treatment is a core service (DCR, 2012).

Mental Health Rehabilitation Services (**MHRS**) – Mental health rehabilitative or palliative services provided by a District of Columbia Department of Behavioral Health certified community mental health provider to children and youth with severe emotional disturbance (DCR, 2012).
Multi-systemic Therapy (**MST**) – An intensive model of treatment based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions; offered by the District of Columbia Department of Behavioral Health (DCR, 2012).
The Office of the State Superintendent of Education (**OSSE**) – The State Education Agency for the District of Columbia (DC) that sets proactive policies, exercises vigilant oversight and directs resources that guarantee residents educated in DC are among the highest performers in the nation (Office of the State Superintendent of Education [OSSE], n.d.).
Parent Child Interaction Therapy (**PCIT**) – An evidence-based practice that provides 12 weeks of parent child observational training (DBH, 2011).
Psychiatric Residential Treatment Facility (**PRTF**) – Any non-hospital facility with a provider agreement with a State Medicaid Agency to provide the in-patient services benefit to Medicaid-eligible individuals under 21 years of age (DCR, 2013).
School Mental Health Program (**SMHP**) – District of Columbia (DC) Department of Behavioral Health school-based program that provides prevention, early intervention and treatment services to children of all ages in DC schools (Department of Behavioral Health Children and Youth Services Division [CYSD], 2010).
Severe Emotional Disturbance (**SED**) – Term used to describe children experiencing emotional, behavioral or mental disorders; defined by the District of Columbia Department of Behavioral Health as having a primary diagnosis on either AXIS I or AXIS II of the DSM-IV Manual or equivalent ICD-9 codes, excluding substance abuse or developmental disorder unless co-occurring (DCR, 2012).
Social Determinants of Health (**SDH**) – Are the conditions in the environments in which people are born, grow, live, learn, work, play, worship, and age that affect much of the health inequities in health status within and between countries (World Health Organization [WHO], 2013).
Substance Abuse and Mental Health Services Administration (**SAMHSA**) – Federal agency responsible for improving health status by reducing the impact of mental and substance use disorders (DBH, 2011).
Supported Employment –An evidence-based supported employment program run by DBH that involves helping adult consumers find and maintain a job. Therapeutic activities include assessment, benefits, counseling, follow-along supports, and on-going individual job coaching (DCR, 2013).
Team Meeting – Includes services such as Youth Family Team Meetings (YFTMs) at DYRS detention facilities, hospital treatment team and discharge planning meetings, Family Team Conferences (FTCs), Team Conferences, discharge planning meetings between levels of care when there is a primary provider billing Medicaid (DBH Correspondence, 2013).
Transition to Independence Process (**TIP**) – Evidence-based practice for improving the outcomes of youth and young adults with emotional or behavioral difficulties (CYSD, 2010).
Trauma-Focused Cognitive Behavioral Therapy (**TF-CBT**) – Psychotherapeutic intervention designed to help children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school or community violence; or exposure to disasters, terrorist attacks, or war trauma (DBH, 2011).
Youth – Individuals under 18 years of age residing in the District of Columbia and those individuals classified as Youth in the custody of the Department of Youth Rehabilitation Services along with the Child and Family Services Agency who are 21 years of age or younger (DBH, 2013).

APPENDICES

APPENDIX 1: METHODOLOGY

Children's behavioral health is complex and in most instances children receive care through a variety of systems. Appropriately, the sources of data retrieved and used in this systematic review are diverse in order to adequately understand and assess the behavioral health needs of children and youth in the District and the services and supports in place to address them. The review draws on a variety of sources each playing a unique and complementary role at each stage of analysis. Sources discovered through the literature review primarily provided context for the writing of this report. The national reports also set the context and offered a tremendous amount of background information. The national surveys contained important information on the type of mental health conditions and prevalence estimates for children and youth nationally and in the District. Data retrieved from the U.S. Census Bureau provided contextual knowledge about children, youth, and young adults in the District. The DC-specific reports provided useful background information on the behavioral health system, including how children and youth differ from adults in how they are served. The paid claims data from DBH and DHCF provided critical demographic and service utilization data to better understand accessibility and allowed for a provisional calculation of unmet need. The key informant interviews allowed for a more robust description of the strengths of the system, gaps in services and possible barriers preventing access to needed services.

Four methods of data collection were used: (1) a review of recent literature on children's behavioral health focusing on the factors associated with behavioral health problems and the national prevalence of behavioral health need; (2) an analysis of available secondary data sources on children's behavioral health, including DBH expert identified sources specific to the DC youth population; (3) an analysis of paid claims data describing utilization of behavioral health services in the District; and (4) in-depth key informant interviews with the DC child-serving agencies and child advocacy groups.

Appendix 1A. Literature Review

A formal search of the peer-reviewed literature and unpublished "grey literature," such as government reports and editorials, was conducted using Google Scholar and other search engines to provide the most current information on child and youth behavioral health. The literature was explored for information on the following broad topics for the purposes of this report:

1. Prevalence of behavioral health conditions among children and youth in the nation. Such conditions included social, emotional, psychological, and developmental difficulties. The type and prevalence of behavioral health conditions stratified by demographic characteristics.
2. Utilization of behavioral health services. This involves patterns of behavioral health service use among populations of children and youth across the nation, including those involved in the child welfare and juvenile justice systems.

The search strategy combined key terms for child and adolescent behavioral health with prevalence, utilization, accessibility, or unmet need. Further, a set of demographic terms including sex, race/ethnicity, and sexual orientation were added to this search. This strategy produced four separate search results. In order to ascertain the most recent findings on the topic, the search was restricted to literature from 2005 to present. The search was also limited to those that (1) included only children and/or youth; (2) were available in English; and (3) were representative of the U.S. or Washington, DC population. Potential articles were identified, first based on review of the paper title and abstracts, and then by thorough examination. The search resulted in 63 articles and reports, which were reviewed in detail.

Appendix 1B. National Surveys and Reports

The second method draws on available secondary research and data sources to assess the prevalence of behavioral health conditions and patterns of behavioral health service utilization, and provided a general understanding of the behavioral health infrastructure in place for children and youth in the District. All nationally representative surveys that collected information on the topic of child and youth behavioral health were reviewed for DC-specific estimates. Additionally, experts from DBH on children's mental health in the District provided a preliminary list of secondary data sources, which were explored in great detail for this report. Reference lists of the initial expert identified sources were scanned for additional materials. The websites of all the major child-serving agencies in the District were examined for relevant publications to include in the review. Additionally, there was an analysis of U.S. Census Bureau data collected from the annual American Community Survey.

Appendix 1C. Paid Claims Data

The analyses of the level of utilization and types of services used by children and youth in the District's public behavioral health care system were carried out using the most current data available. Service utilization data came from two paid claims systems: (1) eCura – DBH's patient management and billing system used to account for all services provided to enrollees of its MHRS Program and (2) Medicaid Management Information System (MMIS) – DHCF's claims processing and information retrieval system used for enrollees in their Medicaid MCOs and Medicaid FFS arrangement. This also includes enrollees in the DBH-run School Mental Health Program (SMHP). A formal request for the creation of customized reports describing service utilization by child and youth consumers enrolled in the MHRS program and Medicaid MCOs and Medicaid FFS was made to the Applied Research and Evaluation (ARE) Unit at DBH and the Division of Research and Rate-Setting Analysis at DHCF, respectively.

The information requested from both departments included:

- total consumers enrolled;
- total consumers served by age, gender, race/ethnicity, ward residence, and sexual orientation;
- total consumers served by service type;
- total units of service received by service type;
- claims expenditures; and
- diagnosis information.

The reports were specific to children and youth ages 0-17 years and youth and young adults of transition age between 18-24 years for FYs 2010 to 2012. Though the Act called for a review of the DC population under age 18, transition age youth ages 18-24 were included in the analysis. The presence of behavioral health issues makes the already challenging transition into adulthood more complex and difficult for young people, thus it was important to look at this particular population and the services and supports available to them as they transition to the adult system.

Provider maps also created by the ARE team and staff in the DBH Office of Accountability were used to compare the distribution of MHRS providers across the wards in the District.

Importantly, two working group meetings with the ARE team and the Division of Research and Rate-Setting Analysis team and follow-up telephone and electronic communications took place to facilitate accurate interpretation of the customized reports and to gain a better understanding of the capabilities of both data management systems. The teams at DBH and DHCF are highly skilled and experts on their data

systems and the report relied heavily on their customized reports and assistance in understanding the results.

Appendix 1D. Key Informant Interviews

A range of key informants from the major child-serving agencies in the District was identified by members at DBH. Respondents included individuals in various positions from a variety of community organizations. In total, 22 key informant interviews were conducted.

List of Key Informants
District of Columbia Public Schools (DCPS)
Arthur Fields
Deitra Bryant-Mallory
Ramonia Rich
Pamela Downing-Hosten
Adele Fabrikant
Department of Behavioral Health (DBH)
Steve Baron
Serge King
Barbara Parks
Denise Dunbar
Lisa Bullock
Matt Caspari
Michael Neff
Nancy Ejuma
Patrina Anderson
Carol Zahm
Tricia Mills
Kendra Fitzgordon
Jana Berhow
Alexis Haynes
Chris Raczynski
Department of Health Care Finance (DHCF)
Claudia Schlosberg
Katherine Rogers
Colleen Sonosky
Department of Youth Rehabilitation Services (DYRS)
Stephen Luteran
Child and Family Services Agency (CFSA)
Deborah Porschia-Usher
Advocacy Organizations
Gail Avent
Shannon Hall
Hyesook Chung
Rebecca Brink
Joy Purcell
The Office of the Deputy Mayor for Health and Human Services
Abby Bonder

An interview guide was developed based on the literature review and secondary data analysis and then personalized for each interviewee depending on his or her area of expertise. The guide was further modified on the basis of prior interviews and emergence of new themes. The interview format was semi-structured and interviewees were allowed to deviate from the guiding questions to allow for diverse responses. All interviews were conducted by at least one and up to three members of the research team either by teleconference or face-to-face, depending on practicality and the availability of selected parties. Interviews typically lasted 60 minutes, but the timeframe was adjusted according to the number of interviewees participating at a time (minimum 30 minutes, maximum 120 minutes). Finally, notes were taken by at least one member of the research team and two members whenever possible.

Major Interview Topics and Guiding Questions

- Topic 1. History of youth behavioral health system in DC
- Topic 2. Behavioral health infrastructure
- Topic 3. Data Infrastructure
- Topic 4. Identification of unmet need among District youth
- Topic 5. Service delivery system
- Topic 6. Health Care Reform
- Topic 7. Workforce Development
- Topic 8. School-Based Mental Health Programs (SMHP)
- Topic 9. Behavioral Health Services in schools
- Topic 10. Charter Schools and DCPS
- Topic 11. Additional topic areas

Thematic Analysis

Shortly after each interview, notes were combined to strengthen the validity of responses and interviewees were asked to review, edit, and approve the final notes. Three members of the research team conducted thematic analysis and synthesis of major themes from the key informant interviews. Thematic analysis of the interviews with partners and stakeholders revealed seven major themes critical for understanding and strengthening the youth behavioral health infrastructure in the District. Theme identification and discovery emerged primarily from qualitative analysis or open coding of approved interview notes. Analysis of the textual data followed the method of Weiss (1994), which is a framework approach (Miles & Huberman, 1994) with categories emerging inductively. As is common in the analysis of key informant interviews, context for the major themes was buttressed by a review of the literature as well as the expertise and personal experiences of the research team with the subject matter (Bulmer, 1979; Maxwell 1996; Straus 1987). Although described in somewhat discrete ways, the major themes overlap, interconnect, and build upon one another.

APPENDIX 2: LIMITATIONS

This section describes the methodological concerns, data limitations, and analytic challenges associated with the review of the youth behavioral health service delivery system in the District. Every attempt was made to obtain the most accurate and recent data sources. When particular data or reports were unavailable, the challenges were specifically described in the appropriate section with text or a footnote. Each type of data source has varied strengths and weaknesses. It is important to note these critical limitations when reviewing the data summaries and to interpret the results accordingly. This study, although described as a Meta-Analysis and/or Epidemiological Report in the contract, does not utilize statistical methods to create effects size estimates, nor does it examine the patterns, causes, and effects of mental health conditions on children and youth. This study was also not an evaluation of the effectiveness of the service delivery system or any specific interventions or practices. It did not examine system-level or child-level outcomes for children, youth, and their families. It did not assess the impact of infrastructure development. The review is based on several different data sources each serving a distinct purpose. Together, these data sources created as comprehensive a view as possible of the behavioral health landscape in the District to inform future planning and drive decision making to strengthen infrastructure and service delivery.

Appendix 2A. Literature Review

The literature review was limited by the selection and exclusion criteria, specifically the geographical and timeframe restrictions. The initial query utilized the following search terms: child or youth mental health statistics combined with prevalence, utilization, accessibility, or unmet need. Articles prior to 2005 were omitted to focus on the most current information available. Much of the available literature did not contain recent DC-specific data. Therefore, the results were sparse.

Appendix 2B. National Surveys and Reports

The inherent limitations in using national survey data to estimate prevalence are well accepted (Centers for Disease Control MMWR, 2013). Differences in the design and implementation of surveys, for instance, whether parent-reported or youth-reported, telephone or face-to-face, can have an impact on estimates. Additionally, different surveys use a variety of proxy measures and instruments to determine the presence or absence of behavioral or emotional health issues. Given the inconsistency across studies in the way behavioral disorders are defined, measured, and reported in this population, variations in prevalence estimates exist, which limit the capacity to make direct comparisons. Moreover, while many

surveys screen for behavioral health issues, not all surveys measure the prevalence of specific behavioral health conditions. For example, depression or anxiety may be measured by suicide attempts and not by clinical diagnosis.

Additionally, certain at-risk populations were not captured in household or school-based surveys such as the homeless population, institutionalized populations, or children and youth not attending school. Lack of data on these groups underestimated the true prevalence of behavioral health problems. The stigma associated with behavioral and emotional problems may have also underestimated the true prevalence. Another drawback in ascertaining the prevalence of behavioral health conditions in DC children and youth is many nationally representative surveys lacked a sufficient sample size to make statistically accurate estimates. To supplement type and prevalence data obtained from these national surveys, diagnosis data were also obtained from DBH.

There are well-known challenges in using diagnosis data in estimating the prevalence of mental health conditions, particularly for the young population (Brauner & Stephens, 2006). Not all children in need of behavioral health services will access them and even after contact has been made with the system, there are issues with follow up, resulting in a lack of diagnosis and underestimation of the prevalence. Diagnosing young children can be especially challenging due to their developmental ability to express their feelings accurately. This in combination with multiple informants, such as the parent or teacher, contributes to misdiagnosis. Further, the Diagnostic and Statistical Manual of Mental Disorders (DSM) has limited diagnostic categories specific to children and so clinicians often are forced to apply adult diagnostic criteria to children and youth, which is inherently problematic. Other barriers leading to under diagnosis include lack of transportation and screening and assessments not being culturally appropriate. These issues created imprecision in the diagnosis data.

The age ranges for the data sources also tended to differ. Although an effort was made to report data on children, youth, and young adults ages 0-24, the majority of national surveys and reports focused on children and youth ages 0-17. Therefore, it is critical to take note of the age range when viewing different figures and tables. Additionally, it is important to note Census data could not be easily disaggregated by ward for youth and young adults of transition age in the District. Therefore, the DC ward residence demographics only included data for children and youth less than 18 years of age.
Although numerous national reports were reviewed, the reliability of some resources was questioned. Time constraints did not allow for an extensive review of the methodology used in each report. Therefore, study weaknesses may be present in some of the national reports described. The national reports reviewed

were not all-inclusive and there could be other sources that would have further informed the report content. With new reports being published and unpublished documents being sometimes difficult to obtain, this report represents the best resources available at the time of the review.

Appendix 2C. Paid Claims Data

Customized data reports, based on primary data sources and using procedure codes, were created by the ARE team at DBH and the Division of Research and Rate-Setting Analysis at DHCF. There are several important limitations in using paid claims data to analyze behavioral health service utilization among District youth. Although data were requested by sexual orientation, this information is not collected in the paid claims systems. Using data reports based on paid claims data specifically and not claims data more broadly may underestimate actual service use as not all claims are paid. Additionally, not all behavioral health services for children, youth, and young adults are captured between the two paid claims data systems, eCura and MMIS, resulting in data gaps. For example, consumer counts for DBH programs such as Primary Project, Healthy Futures, and the Juvenile Behavioral Diversion Program are not included in the data reports. As such, service utilization data are not comprehensive for all services and supports.

Additionally, there are no claims generated for uninsured or privately insured consumers in the public system. Some services also may have been billed incorrectly or may not have been billed for by the provider at all leading to an underreporting of actual service delivery. Further, there is a time lag between the delivery of care and the availability of the paid claims data pertaining to the service. The delay resulting from the time it takes for a provider to submit a claim and the payer to process the claim likely leads to an underestimation of service use. Further, since behavioral health providers can be enrolled in more than one body, the provider groups (MCO, FFS, and MHRS) are not mutually exclusive.

To supplement type and prevalence data obtained from national surveys, DBH also provided diagnosis data from their eCura system for children ages 0-17. At the time of this report, DBH was unable to disaggregate diagnosis data for transition age youth and young adults ages 18-24 from adults 25 and over. Diagnosis data for children and youth accessing services through the MCO and FFS arrangements were unavailable due to inaccuracies in DHCF's data collection system for this field. Since a majority of DC children and youth are enrolled in a Medicaid MCO, lack of diagnosis data on this population presents a major limitation in estimating the true prevalence of mental disorders.

With regard to DHCF's MMIS system, the limited usefulness of the Medicaid MCO encounter data and the inconsistent picture of expenditures have been well documented (US DHHS OIG, 2009; GAO, 2012). These cautions should be taken into account when reviewing the data summaries. Therefore, data could not be obtained on total units of service and claims expenditures. Any data reported in these categories would be inaccurate, biased, and/or present only a fraction of what the system actually handles. Heeding the advice of the DHCF team, these data points were not included in the report and the challenges are described in the respective sections. Further, it is important to note that the DHCF data presented in this report included only services financed through the Medicaid MCOs and Medicaid FFS and do not represent all mental health services or consumers who accessed mental health services through Medicaid. For example, inpatient services were not included in the analysis.

Service utilization data were received and analyzed in aggregate and not by the individual child. Without individual level data, it is not possible to determine which service array seems to work best for children and youth with complex behavioral health challenges based on diagnostic information and functional assessments at various points in time along with the type, frequency, and duration of services and supports. Additionally, without individual level service utilization data by ward, it is difficult to address the suspected relationship between unmet behavioral health needs and delinquency and violent behavior later in life.

In reporting on service utilization, the DBH and DHCF data were reported by consumers, who can utilize services in more than one service cluster. Therefore, the service use counts are duplicated. The four reported service clusters are used widely for DBH purposes, and while DHCF does not typically use these designations in reporting their Medicaid data, the same groupings were applied for comparison purposes. Since DBH is the provider for MHRS, it is to be expected that DBH would have delivered the bulk of services in these clusters. The majority of the DHCF service data fell into a category labeled "Other." It is important to understand the different purviews of DBH and DHCF when viewing their respective data.

Very importantly, the DHCF service data excluded MHRS, but it did not exclude children who also accessed MHRS. For example, if a child accessed services through their MCO and also accessed MHRS,

then the child would be counted in both systems[10]. Therefore, the total consumer counts for DHCF and DBH may include duplicated individuals. There is currently no mechanism directly available in the data systems to crosswalk the data sets and count a child once, for an unduplicated count of all consumers. Although an estimated calculation of unmet need was completed for this report, it is a provisional calculation overestimating the total number of children and youth served and thereby underestimating the unmet need. To understand the true unmet need in the District, more detailed data analyses that allow for de-duplication between system counts would need to occur.

The lack of a common identifier among consumers in the District is a critical limitation. A number of child-serving agencies work with DHCF to use the Medicaid identifier. However, no citywide unique identifier exists. To accurately link the DBH and DHCF data sets and provide a true unduplicated count of children and youth, a crosswalk would need to occur between the eCura and Medicaid identifiers. To ensure no duplication in data reporting, such a crosswalk would need to be completed for any future data requests. With the recognition by high-level leaders that a common identifier would lead to greater integration, planning should continue to occur to identify a way to implement a citywide identifier for service delivery and research and policy analysis purposes.

Appendix 2D. Key Informant Interviews

The Georgetown team worked collaboratively with DBH to generate a representative list of interviewees from each child-serving agency in the District. The majority of interviewees were DBH leaders and staff members. Local child advocacy organizations were also interviewed. DBH maintained responsibility for coordinating the interviews and the TA Center had responsibility for conducting the interviews, note taking and analyzing the approved notes. Limitations existed with regard to the data collection process and descriptive information captured. First, representatives from every child-serving agency were not available to be interviewed on the phone. Notably, DCPS elected to respond in writing, and so limited information was available from that agency. Additionally, due to scheduling conflicts, the interview with CFSA did not occur. A written response was also received from CFSA.

[10] Paid claims data were received from DBH and DHCF in 2013. The DHCF service data excluded MHRS, but did not exclude children who also accessed MHRS. If a child accessed services through both a MCO and MHRS, the child was counted in both systems. As a result, the total consumer counts for DHCF and DBH may include duplicated individuals. Although there was no available mechanism to crosswalk the data sets at the time of the data analysis, DBH and DHCF have since worked together to determine an unduplicated count. Further data analysis is recommended using an unduplicated count of children and youth to determine the unmet need in the District.

Further, due to the iterative nature of this process, information learned at select interviews informed future interviews. Though this is a natural part of the key informant interview process, it limits the consistency of each interview. For example, clarifying questions were added to the interview protocols during the process and follow-up questions were also emailed to interviewees. For the most part, interviewees did not qualify their statements with citations and resources. Therefore, information gleaned from the interviews is a product of the respondents' current knowledge and understanding and could be influenced by their individual perceptions. Last, time constraints prohibited the team from interviewing all necessary stakeholders. The majority of interviewees had suggestions of other important individuals to interview; however, follow up with all suggested individuals was not possible.

APPENDIX 3: SUMMARY TABLE OF NATIONAL SURVEYS AND REPORTS

Descriptions of National Surveys and Reports				
Court Monitor Reports				
Author(s)	**Name**	**Type**	**Dates**	**Description**
Center for the Study of Social Policy	Assessment of **the District** of Columbia's Child Welfare System	Assessment	As of January 31, 2009	The Center for the Study of Social Policy (CSSP) is the court-appointed Monitor for LaShawn A. v. Fenty and in charge with evaluating the provision of services and supports for children involved in **DC** foster care. This assessment provides results from the foster parent survey and case record review.
Center for the Study of Social Policy	LaShawn A. v Gray Progress Report	Court Monitors Report	January 1-June 30, 2012	Progress report on **the District's** child welfare system's performance during the specified time period. Provides a summary of outcomes to be achieved, maintained, and sustainability and exit criteria, from the LaShawn A. v. Fenty Implementation and Exit Plan.
	LaShawn A. v. Fenty Implementation and Exit Plan	Court Monitors Report	2010	Includes information on **the District's** plan includes outcomes to be achieved and maintained, and sustainability and exit criteria, and the 2010-2011 Strategy Plan of action steps to achieve outcomes in **the District**.
Jones, DR	William Dixon, et al., v. Adrian M. Fenty, et al., Court Monitor's Notice of Submission of Report	Report	October 1, 2010 - September 30, 2011	This report provides an update on **the District's** progress in meeting the Dixon performance standards with specific focus on five areas: implementation of exit criteria, budget issues, St. Elizabeth Hospital, Community System Redesign, and Management of PRTFs.
DC Specific Data				
Author(s)	**Name**	**Type**	**Dates**	**Description**
Gresenz CR, Blanchard JC, Timbie JW, Acosta J, Pollack CE, Ruder T, Saloner B, Benjamin-Johnson R, Weinick RM, Adamson DM, Hair B (RAND Corporation)	Behavioral Health in the **District of Columbia**: Assessing Need and Evaluating the Public System of Care	Report	2010	Provides estimates of mental health disorders based on the BRFSS, NSDUH, NSCH, and YRBS surveys. Describes utilization of behavioral health care services based on 1) eCura; 2) Medicaid managed care claims data from managed care organizations; and 3) DC Hospital Association data. Analyzes the level and type of service use using enrollee data in the District's Mental Health Rehabilitation Services programs (MHRS), Medicaid Managed Care, children with disabling mental health conditions enrolled in the Health Services for Children with Special Needs (HSCSN) program, and use of emergency department services for mental health conditions among all District residents.
Child and Family Services Agency, Office of Planning, Policy and Program Support	CFSA Annual Public Report FY 2011	Report	FY 2011	Presents information on CFSA's accomplishments, areas needing improvement, analyses of foster care cases and permanency, and recommendations for meeting the requirements of the **DC** Adoption and Safe Families Act. Permanency is reunification, adoption, guardianship or legal custody and is essential to a child's overall well-being.

DC Specific Data				
Author(s)	**Name**	**Type**	**Dates**	**Description**
Child and Family Services Agency	CFSA Mental Health Services Multi-Year Plan Development	Presentation	January through March 2008 (work group met to prioritize MH services) - not an actual study	Presentation summarizing a multi-year plan to enhance mental health services for children in foster care with CFSA. The document is based on a Mental Health Working Group, which met to prioritize mental health needs.
DC Action for Children	Children's Mental Health in **D.C.:** The Mismatch Between Need and Treatment	Data Snapshot	2012	Contains data from the National Comorbidity Survey (NCS) on U.S. adolescents having a mental disorder by type and prevalence. Report also contains data on why available services are insufficient to meet the needs of the population.
DC Action for Children	DC Kids Count	Custom Report		Data center on national and state-level indicators of child and family well-being.
Blake SM, Bingenheimer JB, Sami S, Bruce, D., Shore A, Cartwright S, DeSantis A.	DCPS: Youth Risk Behavior Surveillance System Trend Analysis Report, 1997-2007	Report	1997-2007	Summary of findings from trend analysis of suicide surveillance systems from 1997-2007 in **DC**.
Human Systems and Outcomes, Inc.	Dixon Annual Report	Report	2004-2012	This report concentrates on the 2012 CSRs. Community Service Reviews (CSRs) are completed to measure performance of child and adult systems in accordance with the terms of the settlement agreement which ended the Dixon lawsuit. 565 interviews were completed in May of 2012 including 89 youth receiving mental health services in **the District**.
Department of Youth Rehabilitation Services, Office of Research and Evaluation	DYRS Annual Performance Report	Report	FY 2012	Provides a description of programs and services DYRS offers to improve public safety and to give youth involved in the court system an opportunity to become productive community members. A lot of focus on **DC** YouthLink, the DYRS initiative to support community-based placements.
Ishizuka K, Ashton P (Justice Policy Institute)	Fostering Change: How investing in **D.C.'s** child welfare system can keep kids out of the prison pipeline	Brief	2013	Talks about how improving youth outcomes can lead to better public safety in **the District**. Shows the distribution of youth in foster care by Ward residence and other demographic factors.

DC Specific Data				
Author(s)	**Name**	**Type**	**Dates**	**Description**
Acosta J, Blanchard JC, Pollack CE, Benjamin-Johnson R, Adamson DM, Gresenz CR, Saloner B (Rand Health)	Guide to the Behavioral Health Care System in **the District of Columbia**	Working Paper	2010	Gives a detailed description of the organizational and systems structure of the behavioral health care system in **the District**. Also describes the funding and financing mechanisms. Contains the location and description of mental health rehabilitation services providers (MHRS), acute care hospitals, and school mental health programs (SMHP).
Chandra A, Gresenz CR, Blanchard JC, Cuellar AE, Ruder T, Chen AY, Gillen EM (RAND Corporation)	Health and Health Care Among **District of Columbia** Youth	Technical Report	2009	Describes the infrastructure of the health care delivery system for children and youth in **the District**, the health status of youth and changes over time in health status. Contains prevalence data on difference types of mental health conditions by demographic subgroups.
DC's Children's Law Center	Improving the Children's Mental Health System in **the District of Columbia**	Report	2012	Provides a blueprint for improving mental health treatment for youth in the juvenile justice system, drawing from previous research, reports, Children's Law Center's expertise, and allied organizations serving **District** families. The report includes specific recommendations for creating a functioning children's mental health system in **the District**.
	Juvenile Behavioral Diversion Program (JBDP)	Presentation	2008-2012	History of the creation of JBDP. Provides information on JBDP demographic data (e.g. gender, age, grade and race) on enrollment, results from a reliability and validity study, a recidivism study and ecological study.
Neal M (Justice Policy Institute)	Mindful of the Consequences: Improving Mental Health for **D.C.'s** Youth Benefits the District	Brief	2012	Looks at the intersection of child and youth mental health and the juvenile justice system in **DC**. Explores the role of mental health and public safety and how untreated mental health problems can directly or indirectly lead youth into the juvenile system.
National Center for Health Statistics, Centers for Disease Control and Prevention (CDC)	National Survey of Children's Health (NSCH)	Survey	2011-2012	National telephone survey that looks at the physical and emotional health of children 0-17 years.
Substance Abuse and Mental Health Services Administration (SAMHSA)	National Survey on Drug Use and Health (NSDUH)	Survey	2010-2011	In-person household survey that looks at national and state-level prevalence of drug and alcohol use and mental illness in the United States.
National Center for Health Statistics, Center for Disease Control and Prevention (CDC)	NS-CSHCN	Survey	2009-2010	National telephone survey that looks at the prevalence of children with special health care needs and their health and functional status.

DC Specific Data				
Author(s)	**Name**	**Type**	**Dates**	**Description**
Department of Behavioral Health, Children and Youth Services Division (CYSD)	The Children's System of Care Plan - A Comprehensive 3-5 Year Plan for Redesign	Report	FY 2011 (plan has been circulated for comment to stakeholders, plan is to finalize upon review and revision)	Outlines a 3-5 year mental health plan using a Systems of Care approach for addressing child/youth issues. Provides a blueprint for change in the form of an action plan that will expand evidence-based community services, reduce the number of youth in out-of-home residential placements, increase the range of services for children 5 years and younger, and encourage family programs. The plan identifies barriers to care and successfully scaled up community-based programs and services.
Centers for Disease Control and Prevention (CDC)	Youth Behavioral Risk Survey (YBRS)	Survey	2011	National school-based survey part of the larger Youth Risk Behavior Surveillance System (YRBSS) that provides information on health-risk behaviors that contribute to the leading causes of death and disability among youth and adults.
Grant Applications				
Author(s)	**Name**	**Type**	**Dates**	**Description**
Department of Behavioral Health	Community Block Grant	Grant Application	FY 2012	Provides an overview of the **DC** Behavioral Health Care System, including services for prevention, early identification, treatment and recovery systems. Lists definitions of Behavioral Health Services performance indicators and an estimate of the need for mental health services in the District. Estimates are based on the National Co-morbidity Survey (NCS) and related surveys and projected to the District based on data from U.S. Census data. Provides description of expenditures for treatment and recovery systems.
Department of Behavioral Health	Planning Grants for Expansion of the Comprehensive Community Mental Health Services for Children and their Families	Grant Application	2011	This is the grant application for the Expansion of the Comprehensive Community Mental Health Services for Children and Their Families in **the District**. Presents information on the target population and service gaps.
Department of Behavioral Health	System of Care Expansion Implementation Grant	Grant Application	Builds on a previous grant from 2011	This is the application for the **DC** System of Care Expansion Cooperative Agreement which builds on the 2011 System of Care Planning Grant. The goal of this agreement is to create a sustainable infrastructure which provides comprehensive mental health services.

National Data				
Author(s)	**Name**	**Type**	**Dates**	**Description**
Centers for Disease Control and Prevention (CDC)	CDC Mental Health Surveillance Among Children--United States	Report	2005-2011	Provides a summary of ongoing federal surveillance systems that include estimates of mental disorders among children living in the United States.
National Center for Health Statistics, Centers for Disease Control and Prevention (CDC)	National Survey of Children's Health (NSCH)	Survey	2011-2012	National telephone survey that looks at the physical and emotional health of children 0-17 years.
Substance Abuse and Mental Health Services Administration (SAMHSA)	National Survey on Drug Use and Health (NSDUH)	Survey	2010-2011	In-person household survey that looks at the national and state-level prevalence of drug and alcohol use and mental illness in the United States.
National Center for Health Statistics, Centers for Disease Control and Prevention (CDC)	NS-CSHCN	Survey	2009-2010	National telephone survey that looks that the prevalence of children with special health care needs and their health and functional status.
Centers for Disease Control and Prevention (CDC)	Youth Behavioral Risk Survey (YBRS)	Survey	2011	National school-based survey part of the larger Youth Risk Behavior Surveillance System (YRBSS) that provides information on health-risk behaviors that contribute to the leading causes of death and disability among youth and adults.

Peer-Reviewed				
Author(s)	**Title**	**Type**	**Year Published**	**Description/Findings**
Merikangas KR, He JP, Burstein M, Swendsen J, Avenevoli S, Case B, Georgiades K, Heaton L, Swanson S, Olfson M.	Service utilization for lifetime mental disorders in U.S. adolescents: results of the National Comorbidity Survey-Adolescent Supplement (NCS-A)	Article	2011 (study period: 2002-2004)	Looks at the National Comorbidity Survey-Adolescent Supplement (NCS-A). 36.2% of adolescents with a mental disorder received services. Authors found that severity of disorder was associated with increased likelihood of receiving treatment. Still, half of youth with severe disorders never received treatment. Those with ADHD had the highest level of service use (59.8%), followed by behavioral disorders (45.4%). Less than one in five adolescents needing treatment received services for anxiety, eating or substance use disorders. Hispanic and non-Hispanic Black adolescents were less likely to receive treatment than White adolescents for mood and anxiety disorders.
Reports				
Author(s)	**Title**	**Type**	**Year Published**	**Description/Findings**
Cooper JL, Banghart P, Aratani Y	Addressing the Mental Health Needs of Young Children in the Child Welfare System	Report	2010	Addresses why mental health in the child welfare system is important. Specifically focuses on the prevalence of young children in the child welfare system and how neglect and abuse impact on development. Also suggests direction for new policy and practice.
Shonkoff JP, Garner AS, The Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood Adoption, and Dependent Care, and Section on Developmental and Behavioral Pediatrics	The Lifelong Effects of Early Childhood Adversity and Toxic Stress	Technical Report	2011	Presents an ecobiodevelopmental approach for how early childhood experiences, environmental influences and toxic stress impact on genetic predispositions affecting development and later life health. This approach stresses the importance of early life experiences and how they influence physical and mental well-being later in life.
O'Connell ME, Boat T, Warner KE	Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities	Consensus Report	2009	Speaks to the impact of early intervention on preventing mental, emotional, and behavioral (MEB) disorders. Reviews promising new areas of research that support the prevention of mental health problems, substance abuse and other problem behaviors in children, youth and young adults up to age 25 years.

APPENDIX 4: RESULTS FROM THE LITERATURE REVIEW

Descriptions of Key Sources Identified in the Literature Search					
Peer-Reviewed					
Author(s)	**Title**	**Type**	**Year Published**	**Study Period**	**Description/Findings**
Bringewatt EH, Gershoff ET	Falling through the cracks: Gaps and barriers in the mental health system for America's disadvantaged children	Review	2010		21% of children in need of mental health services receive them. 79% of children not receiving services equal approximately 7.5 million children ages 6-17 years in need of mental health evaluation but not receiving it. Children from low-income settings have the greatest rate of mental health disorders but the greatest underutilization of services. Socio-economic status is a good predictor of behavioral health need.
Cummings JR, Druss BG	Racial/ethnic differences in mental health service use among adolescents with major depression	Article	2011	2004-2008	Authors examined racial/ethnic differences in service utilization using the National Survey on Drug Use and Health (NSDUH). Adjusted rates of blacks (32%), Hispanics (31%) and Asians (19%) who received any treatment were lower than those of non-Hispanic whites (40%). Black, Hispanic and Asian youth were also less likely to receive prescription medication, treatment from a mental health specialist or medical provider, and receive any mental health treatment in an outpatient setting compared to non-Hispanic white youth.
Farmer EMZ, Mustillo SA, Wagner HR, Burns BJ, Kolko DJ, Barth RP, Leslie LK	Service use and multi-sector use for mental health problems by youth in contact with child welfare	Article	2010	2002	At 18-month post-investigation for abuse and/or neglect, 23.8% of youth were receiving some service for a mental health problem, and among served youth, 33% received services from multiple sectors. Among served youth, 35% received help from specialty mental health, 23% from schools and 22% from both. The study found increased entry into services among youth in foster care and among youth with more severe behavioral problems. Consistent with other reports, the study showed decreased service use for ethnic/racial minorities.
Horwitz SM, Hurlburt MS, Goldhaber-Fiebert JD, Heneghan AM, Zhang J, Rolls-Reutz J, Fisher E, Landsverk J, Stein REK	Mental Health Services Use by Children Investigated by Child Welfare Agencies	Article	2012	Mar 2008-Sep 2008, Sep 2010-Mar 2011	At 18-month follow-up, 23.9% of children had a mental health problem. At baseline, 33.3% received some mental health service with younger children receiving fewer services. At follow-up, service use decreased to 30.9%. Among 2-10 year old children, service use by children from other race/ethnic groups was significantly lower compared to White children. Service use increased as young children entered school, had more contact with medical care providers, or had more involvement with child welfare.

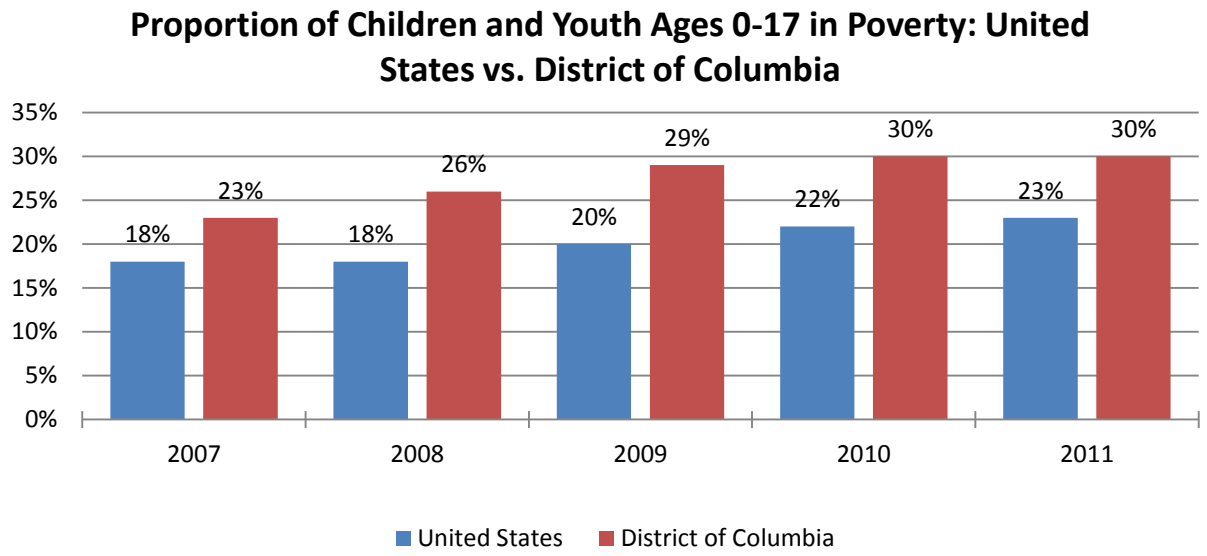
Peer-Reviewed					
Author(s)	**Title**	**Type**	**Year Published**	**Study Period**	**Description/Findings**
Knitzer J, Cooper J	Beyond Integration: Challenges For Children's Mental Health	Article	2006		National evaluations show reduced reliance on residential placements and hospitalization (43% reduction in length-of-stay), improved functioning for children enrolled (42% reduction in behavioral problems) and increased use of intensive community-based services. The number of children receiving specialty health services increased 69% from 1986 to 1996. Less than 1/3 of youth were served by hospitals and residential treatment centers while a majority were served in outpatient settings. Black and Latino children are more likely than white children to end up in the most intensive mental health care settings, to underuse services and achieve poor outcomes. Children with mental health problems do less well in school than children with other disabilities.
Merikangas KR, He J, Burstein M, Swanson SA, Avenevoli S, Cui L, Benjet C, Georgiades K, Swendsen J	Prevalence and Treatment of Mental Disorders Among US Children in the 2001-2004 NHANES	Article	2010	2010	Authors look at the 12-month prevalence of mental disorders using data from the National Health and Nutrition Examination Survey (NHANES). Anxiety disorders were most common (31.9%) followed by behavioral disorders (19.1%), mood disorder (14.3%), and substance use disorders (11.4%). Additionally, about 40% also met criteria for another class of lifetime disorder. Females were twice as likely to experience unipolar mood disorders compared to males. About 1 out of 4-5 adolescent meets the criteria for a mental disorder with severe impairment across their lifetime.
Price OA, Lear JG	School Mental Health Services for the 21st Century: Lessons from the District of Columbia School Mental Health Program	Report	2008		DCPS reports that about 18% of students in **the District** require special education services, 18% emotional disabilities and 13% mental retardation. 10.5% of children in **DC** have a behavioral health issue needing treatment (data on variation by Ward is available). 12.9% of children have a learning disability and 7.9% have serious emotional disturbance (2000). LGBTQ youth in DC schools were found to be in critical need for mental health programs. 31% vs. 14% of GLB youth considered attempting suicide in the past year compared to heterosexual youth (YRBS, 2007). 33% vs. 9% of GLB youth actually attempted suicide compared to heterosexual youth. The DC SMHP and the Center for Student Support Services (CSSS) fully subsidize 63 mental health professionals to provide services to school across the city.
Raghavan R, Leibowitz AA, Andersen RM, Zima BT, Schuster MA, Landsverk	Effects of Medicaid managed care policies on mental health service use among a national probability sample of children in the child welfare system	Article	2006	1999-2002	Investigators analyzed data from the National Survey of Child and Adolescent Well-Being (NSCAW), the first national survey of children involved with the child welfare system. Children in counties with behavioral carve-outs under Medicaid managed care had lower odds of inpatient mental health service use. In the sample, 16% of children received ambulatory mental health services and 2% received inpatient care.

Peer-Reviewed					
Author(s)	**Title**	**Type**	**Year Published**	**Study Period**	**Description/Findings**
Schwarz SW (National Center for Children in Poverty [NCCP])	Adolescent Mental Health in the United States	Report	2009		Approximately 20% of adolescents have a diagnosable mental health disorder. Existing mental health problems become more complex as children transition into adolescence. Mental health problems that are left untreated can lead to negative outcomes such as poor performance in school, strained family relationships or involvement with the child welfare or juvenile justice systems. 67-70% of youth in the juvenile justice system have a mental health disorder. 70% of adolescents that require mental health services do not receive care.
Simpson GA, Bloom B, Cohen RA, Blumberg S, Bourdon KH (CDC)	U.S. Children with Emotional and Behavioral Difficulties: Data from the 2001, 2002, and 2003 national Health Interview Surveys	Article	2005	2001-2003	The study analyzes data from the 2001, 2002 and 2003 National Health Interview Surveys (NHIS). According to the NHIS 2001-2003, about 5% of U.S. children had emotional or behavioral difficulties. Of those, 80% had impacted functioning due to their difficulties. 1 out of 10 of these children will require assistance paying for needed services.
Stein BD, Sorbero MJ, Daton E, Ayers AM, Farmer C, Kogan JN, Goswami U	Predictors of adequate depression treatment among Medicaid-enrolled youth	Article	2013	2006-2010	Authors analyze administrative claims data from a Medicaid-enrolled population of youth ages 6-24 years old who started treatment for a depressive disorder. 59% of depressed youth received minimally adequate psychotherapy, but 13% received minimally adequate pharmacotherapy. Those who began their treatment with inpatient stay for depression and racial/ethnic minorities were less likely to receive minimally adequate pharmacotherapy and more likely to receive inadequate services overall.
Tang MH, Hill KS, Boudreau AA, Yucel RM, Perrin JM, Kuhlthau KA	Medicaid Managed Care and the Unmet Need for Mental Health Care among Children with Special Health Care Needs	Article	2007	2000-2002	Using data from the National Survey of Children with Special Health Care Needs (CSHCN), authors examined the relationship between Medicaid MCO pediatric behavioral health programs and the unmet need among CSHCN. Medicaid served 25% of all CSHCN. State pediatric Medicaid mental health managed care programs (behavioral health carve-outs and integrated models) were associated with more unmet mental health care need than fee-for-service (FFS) programs among CSHCN with Medicaid.
Toomey SL, Chien AT, Elliott MN, Ratner J, Schuster MA	Disparities in Unmet Need for Care Coordination: The National Survey of Children's Health	Article	2013	2007	Study analyzed data from the National Survey for Children's Health (NSCH) to determine the parent-reported need for their child's care coordination. 41% of parents reported that their children needed care coordination, and of those 31% did not receive effective care coordination. 41% vs. 26% of CSHCN have unmet care coordination needs compared to children without special health care needs. Latino (40%) and Black (37%) children were more likely to have unmet care coordination needs compared to white children (27%).

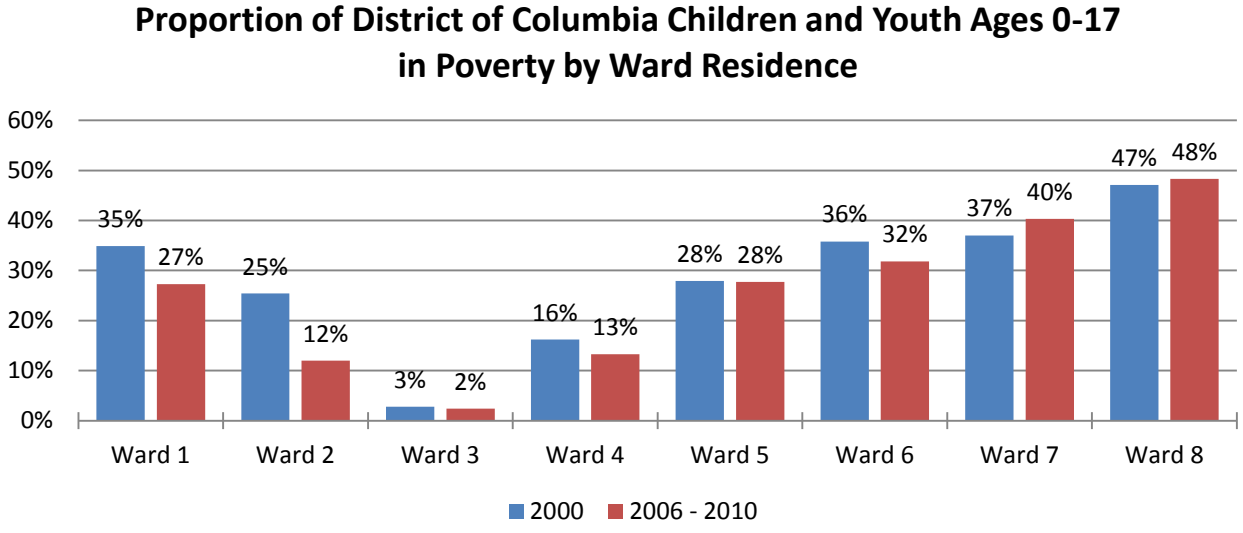
Reports					
Author(s)	**Title**	**Type**	**Year Published**	**Study Period**	**Description/Findings**
Cooper JL, Aratani Y, Knitzer J, Douglas-Hall A, Masi R, Banghart P, Dababnah A	Unclaimed Children Revisited: The Status of Children's Mental Health Policy in the United States	Report	2008		Prevalence estimates of children and youth mental health conditions range from 5-13%. 9.5-14% of young children ages 0-5 years have serious mental health problems that impair functioning. Despite this finding, young children are the least likely to receive the services they need. 85% of children in Head Start and children 3-5 years with identified health needs did not receive treatment. DC identified the following state and federal challenges: workforce, service capacity, sufficient funding, service delivery, and specific funding needs.
Cooper JL, Banghar PL, Aratani Y (National Center for Children in Poverty [NCCP])	Addressing the Mental Health Needs of Young Children in the Child Welfare System	Report	2010		Age of first episode of maltreatment is associated with mental health problems in adulthood. Approximately 80% of all youths involved with child welfare agencies have emotional/behavioral disorders, developmental delays, or other issues requiring mental health interventions. Between 32-42% of these children are 6 years or younger. Among young children ages 2-5 years, 32% were in need of mental health services but only 7% received services.

APPENDIX 5: Relationship Between Environmental Factors and Mental Health

Appendix 5A. Poverty Distribution

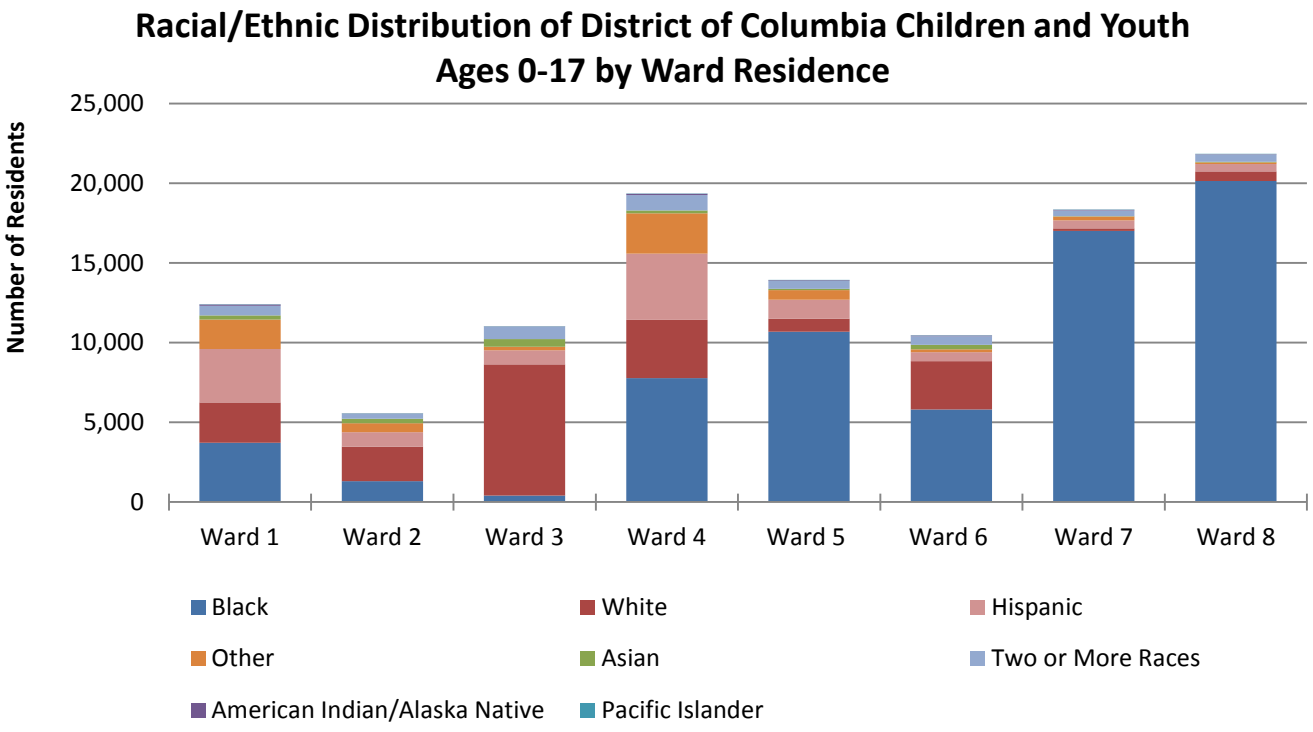


Data Source: The Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2011 American Community Survey.
NOTE: Data reported here reflects the share of children under age 18 who live in families with incomes below the federal poverty level. The federal poverty definition consists of a series of thresholds based on family size and composition. In calendar year 2011, a family of two adults and two children fell in the "poverty" category if their annual income fell below $22,811. Poverty status is not determined for people in military barracks, institutional quarters or for unrelated individuals under age 15 (such as foster children). The data are based on income received in the 12 months prior to the survey.



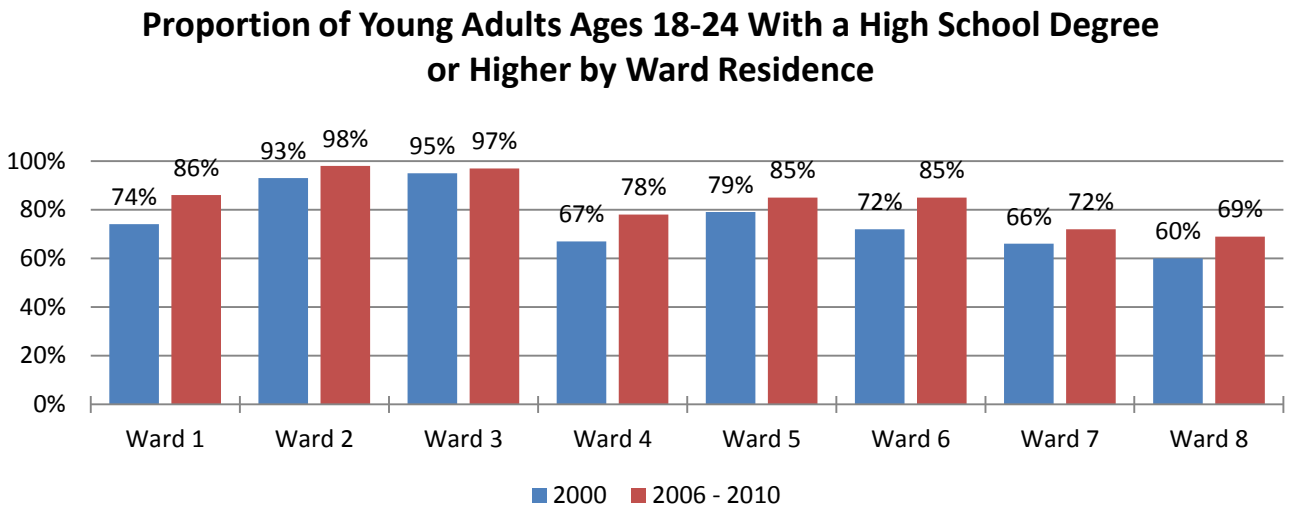
Data Source: From the U.S. Census Bureau. 2000 Decennial Census. 2006-10 data are five year estimates from the American Community Survey.
NOTE: Percent of children under 18 years living below 100 percent of the federal poverty level.

Appendix 5B. Racial/Ethnic Distribution



Data Source: U.S. Census Bureau. 2000 and 2010 Decennial Census.
NOTE: The Decennial Census considers race and Hispanic ethnicity as separate concepts, so a person who is Hispanic will also be represented in one of the race categories listed.

Appendix 5C. Education



Data Source: 2000 Decennial Census and 2006-2010 American Community Survey
NOTE: High school graduate includes people who have earned a high school diploma (or equivalency) and higher.

Number and Percentage of All Children with Disability* Served Under The Individuals with Disabilities Education Act, Part B, by Age Group and Year: United States vs. District of Columbia

	Ages 3-21								Ages 3-5					
	1990-91	2000-01	2005-06	2007-08	2008-09	2009-10	% of public school enrollment, 2009-10**	% change in number served, 2000-01 to 2009-10	1990-91	2000-01	2005-06	2007-08	2008-09	2009-10
United States	4,710,089	6,295,816	6,712,605	6,605,695	6,483,372	6,480,540	13.1	2.9%	389,751	592,087	698,608	699,841	699,966	716,175
District of Columbia	6,290	10,559	11,738	10,863	10,671	11,371	16.4	7.7%	411	374	507	567	543	683

*Includes all of the 13 disability categories: Autism, Deaf-Blindness, Deafness, Emotional Disturbance, Hearing Impairment, Intellectual Disability, Multiple Disabilities, Orthopedic Impairment, Other Health Impairment, Specific Learning Disability, Speech or Language Impairment, Traumatic Brain Injury and Visual Impairment

**Percentage of students with disabilities is based on the total enrollment in public schools, prekindergarten through 12th grade.

Data Source: U.S. Department of Education, Office of Special Education Programs, *Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act,* selected years, 1992 through 2006, and Individuals with Disabilities Education Act (IDEA) database, retrieved September 14, 2011, from http://www.ideadata.org/PartBdata.asp. National Center for Education Statistics, Common Core of Data (CCD), "State Non-fiscal Survey of Public Elementary/Secondary Education," 2009-10. (This table was prepared September 2011.)

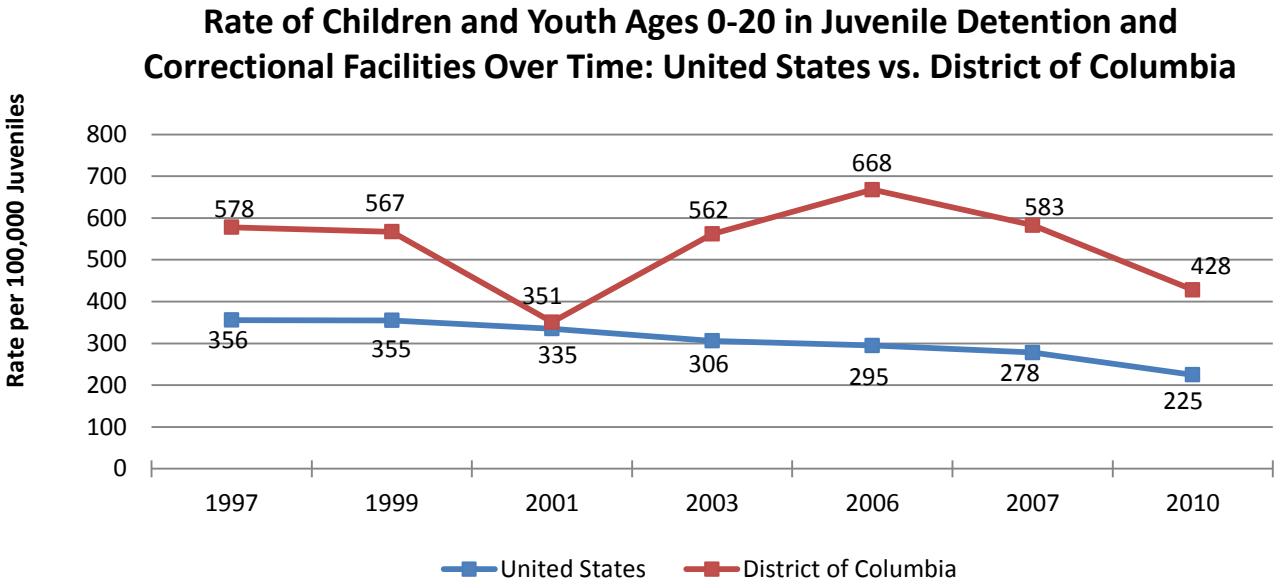
NOTE: Prior to October 1994, children and youth with disabilities were served under Chapter 1 of the Elementary and Secondary Education Act as well as under the Individuals with Disabilities Education Act (IDEA), Part B. Data reported in this table for 1990-91 include children ages 0-21 served under Chapter 1. U.S. totals for 2007-08 and 2008-09 do not include data for Vermont.

Emotional Disturbance Among Children and Youth Served Under the Individuals with Disabilities Education Act, Part B, by Age Group and Race/Ethnicity for 2011: United States vs. District of Columbia		
Demographic Characteristics	**U.S. n (%)**	**DC n (%)**
Age Group		
3-5	3,127 (1%)	5 (0%)
6-11	106,964 (29%)	317 (21%)
12-17	233,135 (62%)	887 (60%)
18-21	31,326 (8%)	271 (18%)
TOTAL ages 3-21:	**374,552**	**1,480**
Race/Ethnicity*		
White	198,032 (53%)	18 (1%)
Black	99,817 (27%)	1,409 (96%)
American Indian or Alaskan Native	5,356 (1%)	#
Asian	3,180 (1%)	0 (0%)
Native Hawaiian and Other Pacific Islander	971 (0%)	0 (0%)
Two or More Race Groups	11,395 (3%)	#
Hispanic or Latino	52,674 (14%)	45 (3%)
TOTAL:	**371,425**	**1,472**

Data not available
*Only includes children and youth ages 6-21
Data Source: Individuals with Disabilities Education Act (IDEA) Data, created 9/10/2012

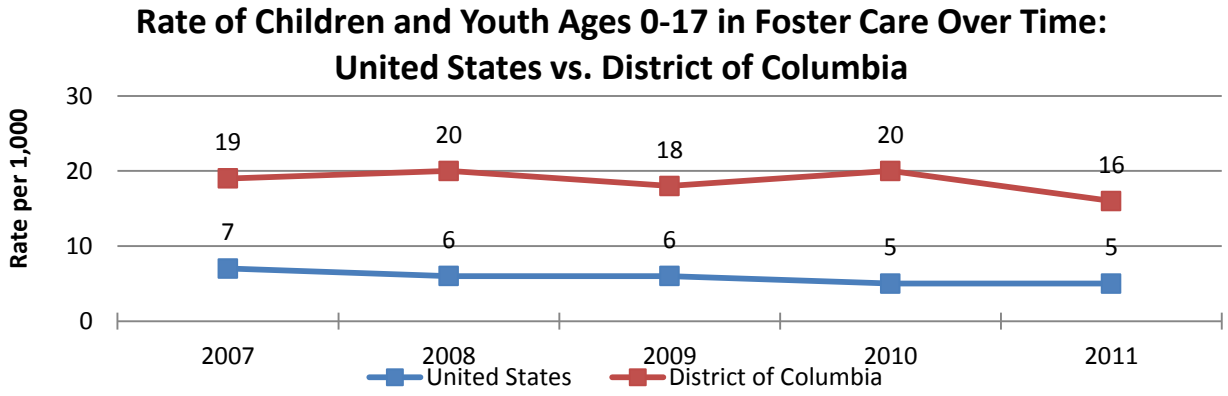
Appendix 5D. Connection to Other Child-Serving Systems

Juvenile Justice



Data Source: Data from Sickmund, Melissa, Sladky, T.J., and Kang, Wei. (2005) "Census of Juveniles in Residential Placement Databook." Online Author's analysis of OJJDP's Census of Juveniles in Residential Placement 1997, 1999, 2001, 2003, 2006, 2007, and 2010 [machine-readable data files].
NOTE: Persons under age 21 detained, incarcerated or placed in residential facilities. To preserve the privacy of the juvenile residents, cell counts have been rounded to the nearest multiple of three. "State of Offense" refers to the State where the juvenile committed the offense for which they were being held.

Foster Care



Data Source: Trends analysis of data from the Adoption and Foster Care Analysis and Reporting System (AFCARS) was made available through the National Data Archive on Child Abuse and Neglect.
NOTE: The number and rate per 1,000 of children under age 18 in the foster care system. Most states allow children to remain in the foster care system until their 18th birthday, though some states have age limits that extend a few years beyond this. To allow for comparison across states, this indicator includes the population under age 18 in foster care. Children are categorized as being in foster care if they entered prior to the end of the current fiscal year and have not been discharged from their latest foster care spell by the end of the current fiscal year. Census numbers indicate population estimates of children ages 0 to 17 in each state as of July 1st of the respective year.

APPENDIX 6: ESTIMATES OF THE PROPORTION OF MENTAL HEALTH DIAGNOSES IN YOUTH RECEIVING MHRS[11]

Appendix 6A. Diagnosis Summary

Diagnosis Summary for DC Children and Youth Aged 0-17 by Fiscal Year			
Condition	**FY 2010 n (%)**	**FY 2011 n (%)**	**FY 2012 n (%)**
Bipolar Disorder, Manic, Depressive & Other Episodic Mood Disorders	1215 (32)	1339 (32)	1511 (36)
Psychosis	75 (2)	56 (1)	68 (2)
Post Traumatic Stress Disorder	139 (4)	144 (3)	111 (3)
Schizophrenic Disorders	12 (0)	9 (0)	12 (0)
ADHD	1035 (27)	1136 (27)	1156 (28)
Adjustment Disorders	674 (18)	719 (17)	566 (14)
Anxiety Disorders	116 (3)	154 (4)	156 (4)
Disruptive Behavior (Conduct Disorder and ODD)	484 (13)	528 (13)	507 (12)
Other Diagnosis	62 (2)	108 (3)	100 (2)
TOTAL	**3812**	**4193**	**4187**

Data Source: DBH eCura System and provided by DBH's ARE Unit
NOTE: Includes children and youth aged 0-17; Diagnosis is from the last claim during the fiscal year.

[11] Diagnosis data for children and, youth accessing services provided by the MCOs and, Medicaid FFS were unavailable due to inaccuracies in DHCF's data collection system for this data element. Since a majority of DC children and, youth are enrolled in Medicaid MCOs, lack of data on this population presents a major limitation in estimating the prevalence of behavioral health problems. As the diagnosis data only includes those enrolled and, receiving MHRS through DMH, the data provides information on only a small subset of youth who are receiving behavioral health services.

Appendix 6B: Detail Diagnosis Categories for Child and Youth Consumers Ages 0-17 Enrolled in MHRS

Diagnosis Detail For Child and Youth Consumers Ages 0-17 Enrolled in MHRS	
Code	**Description**
ADHD (that includes with and without hyperactivity, hyperkinetic disorder)	
314.01	Attention Deficit Disorder Of Childhood With Hyperactivity
314	Attention Deficit Disorder Of Childhood Without Mention Of Hyperactivity
314.9	Attention Deficit/Hyperactivity Disorder, NOS
314	Attention Deficit Disorder Of Childhood
Adjustment Disorder	
309.4	Adjustment Disorder With Mixed Disturbance of Emotion
309.9	Adjustment Disorder Unspecified
309	Adjustment Disorder With Depressed Mood
309.28	Adjustment Reaction With Mixed Emotional Features
309.24	Adjustment Disorder With Anxiety
309.3	Adjustment Disorder With Disturbance of Conduct
309.8	Other Specified Adjustment Reactions
Anxiety	
300	Anxiety Disorder NOS
300	Anxiety States
300.02	Generalized Anxiety Disorder
309.21	Separation Anxiety Disorder
312.3	Impulse Control Disorder, Unspecified
300.3	Obsessive-Compulsive Disorder
300.01	Panic Disorder, Without Agoraphobia
Disruptive Behavior (Conduct and Oppositional)	
313.81	Oppositional Defiant Disorder
312.9	Unspecified Disturbance Of Conduct
312.82	Conduct Disorder, Adolescent Onset Type
312.81	Conduct Disorder, Childhood Onset Type
312.89	Conduct Disorder, Unspecified Onset
312.8	Conduct Disorder
Other	
V71.09	No Diagnosis on Axis II
312.34	Intermittent Explosive Disorder
313.89	Other Emotional Disturbances Of Childhood Or Adolescence
299.8	Asperger's Disorder
V62.82	Uncomplicated Bereavement
313.9	Disorder of Infancy, Childhood, or Adolescence NOS
314	Hyperkinetic Syndrome Of Childhood

Diagnosis Detail For Child and Youth Consumers Ages 0-17 Enrolled in MHRS	
Code	**Description**
300.9	Unspecified Mental Disorder (nonpsychotic)
V61.21	Child Abuse
296.4	Bipolar I Disorder, Most Recent Episode Manic, Unspecified
302.4	Exhibitionism
312.39	Trichotillomania
313.1	Misery and Unhappiness Disorder Specific To Childhood and Adolescence
V62.2	Other Occupational Circumstances Or Maladjustment
298.8	Other and Unspecified Reactive Psychosis
315	Reading Disorder
291	Alcohol Intoxication Delirium
304.3	Cannabis Dependence
302.85	Nontrnssexual Gendr Identy Disordr/Adult or Adoles
799.9	Other Unknown and Unspecified Cause Of Morbidity Or Mortality
297.1	Paranoia
V71.02	Child or Adolescent Antisocial Behavior
Bipolar Disorders, Manic, Depressive & Other Episodic Mood Disorders	
296.8	Bipolar Disorder NOS
296.64	Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features
296.5	Bipolar Affective Disorder, Depressed, Unspecified Degree
296.52	Bipolar Disorder, Depressed, Moderate
296.6	Bipolar Affective Disorder, Mixed, Unspecified Degree
296.62	Bipolar I Disorder, Most Recent Episode Mixed, Moderate
296	Bipolar I Disorder Single Manic Episode Unspecified
296.53	Bipolar Affective Disorder, Depressed, Severe Degree, Without Mention Of Psychotic Behavior
296.41	Bipolar Affective Disorder, Manic, Mild Degree
296.42	Bipolar Affective Disorder, Manic, Moderate Degree
296.7	Bipolar Affective Disorder, Unspecified
296.44	Bipolar Affective Disorder, Manic, Severe Degree, Specified As With Psychotic Behavior
296.63	Bipolar Affective Disorder, Mixed, Severe Degree, Without Mention Of Psychotic Behavior
296.43	Bipolar Affective Disorder, Manic, Severe Degree, Without Mention Of Psychotic Behavior
296.61	Bipolar Affective Disorder, Mixed, Mild Degree
296.03	Bipolar I Disorder Single Manic Episode Severe w/o
296.06	Bipolar I Disorder Single Manic Episode In Full Re
296.05	Manic Affective Disorder, Single Episode, In Partial Or Unspecified Remission
296.54	Bipolar Affective Disorder, Depressed, Severe Degree, Specified As With Psychotic Behavior
311	Depressive Disorder NOS
296.9	Mood Disorder NOS
296.32	Major Depressive Disorder, Recurrent, Moderate

Diagnosis Detail For Child and Youth Consumers Ages 0-17 Enrolled in MHRS	
Code	**Description**
300.4	Dysthymic Disorder
296.3	Major Depressive Disorder, Recurrent, Unspecified
296.22	Major Depressive Affective Disorder, Single Episode, Moderate Degree
296.9	Other and Unspecified Affective Psychoses
296.34	Major Depression, Recurrent, with Psychotic Features
296.33	Major Depression, Recurrent, Severe, without Psychotic
296.31	Major Depression, Recurrent, Mild
296.23	Major Depression, Single Episode, Severe, without Psychotic
296.89	Bipolar II Disorder
296.21	Major Depressive Disorder, Single Episode, Mild
296.24	Major Depressive Disorder, Single Episode, Severe With Psychotic Features
296.26	Major Depression, Single Episode, in Full Remission
296.3	Major Depressive Disorder, Recurrent Episode
296.2	Major Depression, Single Episode, Unspecified
296.35	Major Depressive Disorder, Recurrent, In Partial Remission
296.25	Major Depressive Disorder, Single Episode, In Partial Remission
296.2	Major Depressive Disorder, Single Episode
Post-Traumatic Stress Disorder	
309.81	Posttraumatic Stress Disorder
Psychoses	
298.9	Psychotic Disorder NOS
Schizophrenic Disorders	
295.7	Schizo-affective Type Schizophrenia, Unspecified State
295.3	Paranoid Type Schizophrenia, Unspecified State
295.9	Unspecified Schizophrenia
295.9	Schizophrenia, Undifferentiated type, Unspecified
295.1	Disorganized Type Schizophrenia, Unspecified State

Data Source: DBH eCura System and provided by DBH's ARE Unit

NOTE: Includes children and youth ages 0-17; Diagnosis is from the last claim during the fiscal year.

APPENDIX 7: ACCESS HELPLINE

Summary of DBH's Access Helpline*					
#	Crisis Line	Number	Description	Pathway	Consumers
1	Main Crisis Line	888-793-4357	The main crisis line is intended for District residents but receives calls from all over the country and sometimes other nations. The line rings until answered.	Routed to the Access Helpline with 15 staff members.	Accessed by anyone with phone service. All lines have the capacity to address all services (MHRS, Medicaid and non-Medicaid).
2	National Suicide Prevention Lifeline	800-273-8255	The calls are routed to the Access Helpline based upon the area code of the caller. The line rings until answered.	Routed to the Access Helpline with 15 staff members.	Accessed by anyone with phone service. All lines have the capacity to address all services (MHRS, Medicaid and non-Medicaid).
3	WMATA Lifeline	855-320-5433	This is the newest crisis line. It has been heavily advertised by the local transit system and is for anyone served by the Metro. The line rings until answered.	Routed to the Access Helpline with 15 staff members.	Accessed by anyone with phone service. All lines have the capacity to address all services (MHRS, Medicaid and non-Medicaid).
4	Youth Line	866-245-6340	This is a long existing crisis line. It is actively being advertised among schools and youth social service agencies. The line rings until answered.	Routed to the Access Helpline with 15 staff members.	Accessed by anyone with phone service. All lines have the capacity to address all services (MHRS, Medicaid and non-Medicaid).
5	Consumer Response Line	800-961-8528	This is the newest line intended to resolve issues raised by community providers related to the delivery of services to individuals receiving mental health services from CSAs and other DBH providers. It is intended for providers within the DBH system. It is answered Monday through Friday between 9am and 5pm. The line rings until answered.	Routed to the Access Helpline with 15 staff members.	Intended for providers within the DBH MHRS system, though the insurance of the consumer is irrelevant. The consumer affected only needs to be in the DBH system or trying to access the system of care.
6	Administrative Line	202-671-3070	This is advertised as a line for providers to call regarding authorizations, enrollments, information, and other non-crisis matters. This line does put callers on hold until staff members become available to answer.	Routed to the Access Helpline with 15 staff members.	Intended for any provider and is currently answered by all staff. **

*Information provided by DBH

**However, authorization requests are referred to coordinators who can make those determinations. Coordinators in the Access Helpline authorize all MHRS services for the consumers in the DBH system who are funded by local dollars or Medicaid, as well as involuntary psychiatric admissions in the District regardless of funding source.

APPENDIX 8: DETAILED DESCRIPTION OF MHRS CORE AND SPECIALTY SERVICES

Detailed Description of MHRS Core and Specialty Services	
Service Type	**Description of Services**
Assertive Community Treatment (ACT)**	Intensive, integrated, crisis, treatment, and mental health rehabilitative community support provided by an interdisciplinary team to children and youth with serious emotional disturbance and to adults with serious and persistent mental illness by an interdisciplinary team. ACT is provided with dedicated staff time and specific staff to consumer ratios. Service coverage by the ACT team is required twenty-four (24) hours per day, seven (7) days per week. ACT is a specialty service. Includes**:** Collateral Contact Group Individual
Community-Based Interventions (CBI)**	Time-limited, intensive mental health services delivered to children and youth ages six (6) through twenty-one (21) intended to prevent utilization of an out-of-home therapeutic resource or detention of the consumer. CBI is primarily focused on the development of consumer skills to promote behavior change in the child or youth's natural environment and empower the child or youth to cope with his or her emotional disturbance. Includes**:** Level 1 – MST Level II & III - 90/180 Day Authorization Level IV – FFT
Community Support*	Rehabilitation and environmental support considered essential to assist a consumer in achieving rehabilitation and recovery goals. Community Support services focus on building and maintaining a therapeutic relationship with the consumer. Community Support is a core service. Includes: Group Home Group Setting Individual - Collateral Contact Individual - Face to Face Individual - Family/Couple w/Consumer Individual - Family/Couple w/o Consumer Telephone
Counseling*	Individual, group, or family face-to-face services for symptom and behavior management, development, restoration, or enhancement of adaptive behaviors and skills, and enhancement or maintenance of daily living skills. Mental health supports and consultation services provided to consumer's families are reimbursable only when such services and supports are directed exclusively to the well-being and benefit of the consumer. Counseling is a core service. Includes: Family w/Consumer Group Individual, Adult Individual, Child/Adolescent Offsite (In-Home) Without Consumer
Crisis/Emergency**	Mental health services that support the consumer through a crisis, such as meeting with the consumer in the community or an emergency department to help calm the consumer; implementing the crisis plan developed for the consumer; assisting the consumer to reach an emergency department; and providing pertinent mental health information about a consumer to an emergency department to assist in addressing a crisis. Includes: Crisis Stabilization Emergency – CMHF Emergency – Home Emergency – Mobile Unit Emergency – Other/Not Identified No Authorization Crisis Stabilization

Detailed Description of MHRS Core and Specialty Services	
Service Type	**Description of Services**
	Psych Bed
Day/Rehabilitation Services**	A structured, clinical program intended to develop skills and foster social role integration through a range of social, psycho-educational, behavioral, and cognitive mental health interventions. Rehabilitation/Day Services are curriculum-driven and psycho-educational and assist the consumer in the retention, or restoration of community living, socialization, and adaptive skills. Includes cognitive-behavioral interventions and diagnostic, psychiatric, rehabilitative, psychosocial, counseling, and adjunctive treatment. Rehabilitation/Day Services are offered most often in group settings. Rehabilitation/Day Services is a specialty service. Includes: Face to Face, w/Consumer
Diagnostic and Assessment*	Intensive clinical and functional evaluation of a consumer's mental health condition that results in the issuance of a Diagnostic/Assessment report with recommendations for service delivery. A Diagnostic/Assessment shall determine whether the consumer is appropriate for and can benefit from MHRS, based upon the consumer's diagnosis, presenting problems and recovery goals. Diagnostic/Assessment is a core service. Includes: Brief Comprehensive
Integrated Community Care Project (ICCP)	Project designed to discharge individuals with long-term episodes of care at St. Elizabeth's Hospital, and who need a creative approach to service delivery in the community to help them remain in their communities. ICCP is delivered by a community provider using mental health and non-mental health services and supports. Includes ICCP
Jail Diversion	Programs that divert individuals with mental illness, and often co-occurring substance use disorders, away from jail and provide linkages to community-based treatment and support services. The individual may be allowed to enter a deferred prosecution agreement (misdemeanor) or a deferred sentencing agreement (felonies) for participating in treatment (both mental health and substance abuse treatment) during the process of the adjudication of the offense. Not the same as Juvenile Behavior Diversion Program. Includes: Criminal Justice System
Medication Somatic*	Medical interventions, including physical examinations, prescription, supervision or administration of mental-health related medications, monitoring and interpreting the results of laboratory diagnostic procedures related to mental health-related medications, and medical interventions needed for effective mental health treatment provided as either an individual or group intervention. Medication/Somatic Treatment is a core service. Includes: Adult Child/Adolescent Group
Supported Employment	An evidence-based supported employment program run by DBH that involves helping adult consumers find and maintain a job. Therapeutic activities include assessment, benefits, counseling, follow-along supports, and on-going individual job coaching Includes: Therapeutic Vocational
Team Meetings	Includes services such as Youth Family Team Meetings (YFTMs) at DYRS detention facilities, hospital treatment team and discharge planning meetings, Family Team Conferences (FTCs), Team Conferences, discharge planning meetings between levels of care when there is a primary provider billing Medicaid Includes: Team Meeting

***Core Services**

****Specialty Services**

Data Source: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005); as amended by Final Rulemaking published at 53 DCR 9197 (November 10, 2006); as amended by Final Rulemaking published at 57 DCR 10392, 10406 (November 5, 2010); as amended by Notice of by Emergency and Proposed Rulemaking published at 58 DCR 1482 (February 18, 2011)[EXPIRED]; as amended by Notice of Final Rulemaking published at 58 DCR 3476, 3482 (April 22, 2011); as amended by Notice of Final Rulemaking published at 58 DCR 8366, 8370 (September 30, 2011); as amended by Notice of Final Rulemaking published at 59 DCR 4785, 4787 (May 11, 2012); DBH KPI Report, 2013; Standard Operating Procedures for the Integrated Care Division, 9/15/2010; MHRS Provider Authorization and Billing Manual, August 7, 2013.

APPENDIX 9: Evidence-Informed, Evidence-Based, and Promising Practices

Appendix 9A. Evidence-Informed, Evidence-Based, and Promising Practices Administered by DBH

Evidence-Informed, Evidence-Based, and Promising Practices Administered by DBH			
Name of Practice	**Age Range**	**Description**	**DBH Project/Program**
Botvins Life Skills Training Program	DCPS Schools - Elementary Only, DC Charter Schools – Elementary, Middle, and High Schools	A SAMHSA approved, evidence-based substance abuse prevention program that addresses the most important factors leading children and adolescents to use drugs.	SMHP
Chicago Parent Program	Elementary, Middle and High Schools	A parenting program for parents with children 2-5 years old that aims to increase parenting self-efficacy and positive parent behavior, promote positive and consistent discipline strategies, and reduce child behavior problems.	SMHP
Child Parent Psychotherapy for Family Violence (CPP-FV)	0-6	A therapeutic intervention for young children with a history of trauma exposure or maltreatment and their caregivers. This treatment approach supports child development, restores the child-parent relationship and the overall feelings of safety, while reducing symptoms associated with the experience of trauma.	DBH P.I.E.C.E. Program DBH System of Care Implementation Grant
Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)	10-15 years (Elementary, Middle, and High Schools)	A treatment program for youth who have experienced a violent or traumatic event. Program provides screening and CBT.	SMHP
Connect with Kids	Elementary, Middle and High Schools	An evidence-informed program that improves student behavior in significant and important ways across multiple character skills, including teasing and bullying behaviors, cheating and lying, respect for classmates and teachers, violence prevention, and academic perseverance.	SMHP
Early Childhood Mental Health Consultation	0-5	An evidence-based intervention model designed to increase the capacity of preschool program staff (teachers, administrators and support staff) to effectively work with and support children with disruptive behaviors. The model is based on a supportive relationship between program staff and a trained mental health provider.	Healthy Futures
Effective Black Parenting Program	Elementary, Middle and High Schools	A parenting program for parents with children 0-18 years old. This program focuses on reducing parental rejection, increasing positive parenting practices, and reducing delinquent, withdrawn, and hyperactive behavior among children.	SMHP
Functional Family Therapy (FFT)	10-18	A family focused intervention for at-risk and juvenile justice involved youth.	DBH System of Care

Evidence-Informed, Evidence-Based, and Promising Practices Administered by DBH			
Name of Practice	**Age Range**	**Description**	**DBH Project/Program**
			Implementation Grant
Good Touch/Bad Touch	Pre-school-6th grade (Elementary and Middle Schools)	A primary prevention curriculum designed to give children the tools needed to prevent abuse.	SMHP
Incredible Years (Child Treatment Group)	Elementary Schools	A SAMHSA approved, evidence-based program targeting children 4-8 years old who may be experiencing aggressive or "disruptive" behaviors. The program focuses on teaching children social skills, problem solving skills and anger management strategies.	DBH P.I.E.C.E. Program Healthy Futures SMHP
Incredible Years (Parenting Program)	Elementary, Middle and High Schools	A SAMHSA approved, evidence-based program for parents with children 0-12 years old that focuses on increasing parent's involvement in their child's school environment as well as provides parents with the tools and knowledge necessary to parent effectively. This program helps to promote children's academic, social and emotional competencies as well as reduce conduct problems.	Healthy Futures SMHP
Love is Not Abuse	High School	A practice designed to teach high school age students about teen dating violence.	SMHP
MST for Youth with Problem Sexual Behavior (MST-PSB)	10-17	An intensive family and community-based treatment program that addresses the many factors that influence problem sexual behavior. It focuses on the influence of the offender's home family, school, neighborhood and peers.	DBH System of Care Implementation Grant
Multisystemic Therapy (MST)	10-17	An intensive treatment for youth with complex issues. The emphasis is on empowering parents/caregivers effectiveness as they assist the youth in successfully making and sustaining changes in the individual, family, peer and school systems.	DBH System of Care Implementation Grant
Parent Child Interaction Therapy (PCIT)	2-6	A supported treatment for conduct-disordered young children. It places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns.	DBH P.I.E.C.E. Program DBH System of Care Implementation Grant
Parenting Wisely	Elementary, Middle and High Schools	A SAMHSA approved, evidence-based program for parents with children 3-18 years old. The program can be implemented in a variety of formats. Parents have the ability to use a CD-ROM or on-line formats to learn parenting skills that help to reduce behavior problems in their children. The program can also be implemented by a clinician in a group format.	SMHP
Parents as Teachers (PAT)		A home visiting model that aims to increase parental knowledge of early childhood development, provide early identification of developmental delays and other health issues, prevent child abuse, and improve	DBH P.I.E.C.E. Program

Evidence-Informed, Evidence-Based, and Promising Practices Administered by DBH			
Name of Practice	**Age Range**	**Description**	**DBH Project/Program**
		children's readiness for school.	
Question, Persuade, and Refer (QPR)	Elementary, Middle, and High Schools	A program geared towards teachers and staff to teach them how to recognize the warning signs of suicide and to refer an individual.	SMHP
Signs of Suicide (SOS)	Middle and High schools	A prevention program that teaches students about the signs and symptoms of depression and suicidality, and how to ACT (Acknowledge, Care, Tell) when they or a friend are experiencing symptoms.	SMHP
Stark's Cognitive-Behavioral Therapy for Depression - Taking Action	Elementary and Middle Schools	An evidence-informed program based on a report by the Surgeon General that targets 9-13 year old girls experiencing feelings of depression. Taking Action is a cognitive behavioral intervention that uses interactive activities to teach problem solving skills, coping skills and cognitive interventions. (While the curriculum was created for use with girls, it can also be adapted for boys as well as for younger and older children).	SMHP
Too Good for Violence	Elementary, Middle, and High Schools	A prevention program that reduces aggression and focuses on four areas including conflict resolution, anger management, respect for self and others, and effective communication.	SMHP
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	4-18	An intervention designed to help children, youth and their parents overcome the negative effects of traumatic life events and address feelings.	SMHP DBH System of Care Implementation Grant

Data Sources: DBH Child Dashboard; DBH Evidence-Based Practices Fact Sheet, revised 5/1/2013, provided by Carol Zahm; DBH SMHP Evidence-Based Programs, revised 9/26/2012, provided by Barbara Parks; DBH Block Grant, Attachment I-1 Page 7, 2012.
NOTE: For the 2012-2013 school year. Not every program is offered at all SMHP schools-based on population needs.

Appendix 9B. Current Evidence-Based Practices, Service Providers, and System Capacity

Current Evidence-Based Practices, Service Providers, and System Capacity				
#	Name	Provider(s)	System Capacity	
			# of Therapists	Maximum Capacity
1	Child Parent Psychotherapy for Family Violence (CPP-FV)	• DBH P.I.E.C.E. Program • Hillcrest Children & Family Center • Universal Healthcare • Latin America Youth Center • Post Permanency Center of Adoptions Together	19 (2 bilingual)	96
2	Parent Child Interaction Therapy (PCIT)	• DBH P.I.E.C.E. Program • Mary's Center	9 (4 bilingual)	45
3	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	• First Home Care • Community Connections • MD/DC Family Resource • Hillcrest Children & Family Center • Universal Healthcare	16	111
4	Functional Family Therapy (FFT)	• First Home Care • Hillcrest Children & Family Center • Community Connections • Parent & Adolescent Support Services (PASS)	15 (5 part-time)	178
5	Multisystemic Therapy (MST)	• Youth Villages	10	50
6	MST for Youth with Problem Sexual Behavior (MST-PSB)	• Youth Villages	5	15

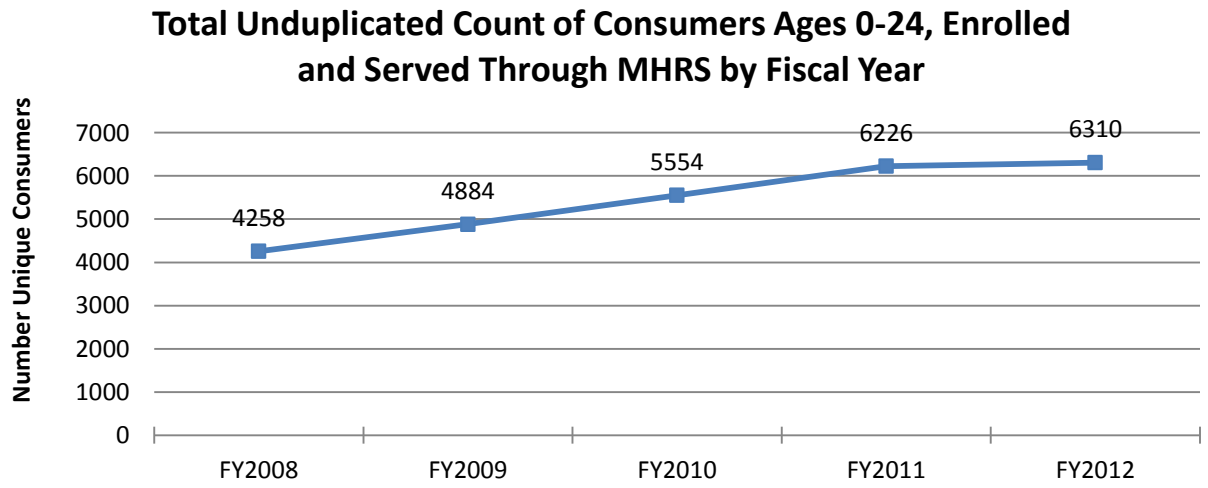
Data Source: DBH Evidence-Based Practices Fact Sheet; Provided by Carol Zahm.
NOTE: As of May 1, 2013

APPENDIX 10. SUMMARY OF ChAMPS DATA FOR FYS 2010, 2011, AND 2012

Summary of ChAMPS Data for FYs 2010, 2011, and 2012						
Fiscal Year	**Total Children Served***	**Total Calls Received**	**Total Deployments**	**CFSA Youth**	**Total FD-12s**	**Total Cases Resulting in Acute Care Admissions**
2010	414	1015	585	279	74	76
2011	324	979	482	131	78	117
2012	882	1276	644	284	116	126

*Unduplicated count
NOTE: Provided by DBH's ARE team

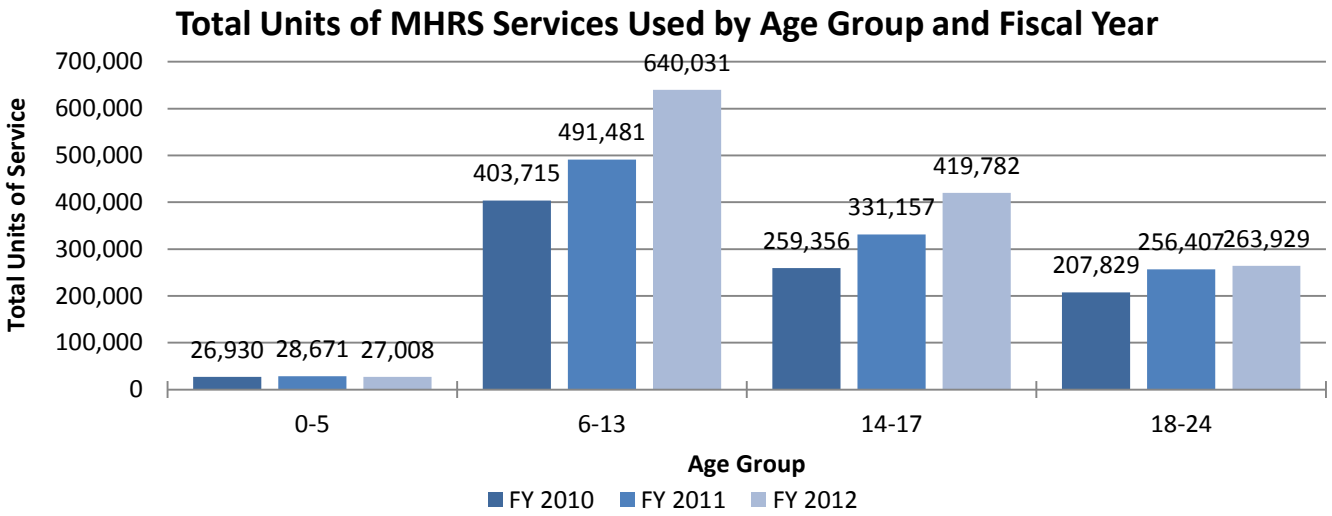
APPENDIX 11: TOTAL UNDUPLICATED COUNT OF CONSUMERS AGES 0-24, ENROLLED AND SERVED THROUGH MHRS BY FISCAL YEAR



Data Source: DBH eCura System and provided by DBH's ARE Unit, Mental Health Expenditure and Service Utilization (MHEASURE) Report - Page 2 (through 6/30/2013).
NOTE: This is an unduplicated count based on claims submitted for dates of service within the specified timeframe for consumers ages 0-24.

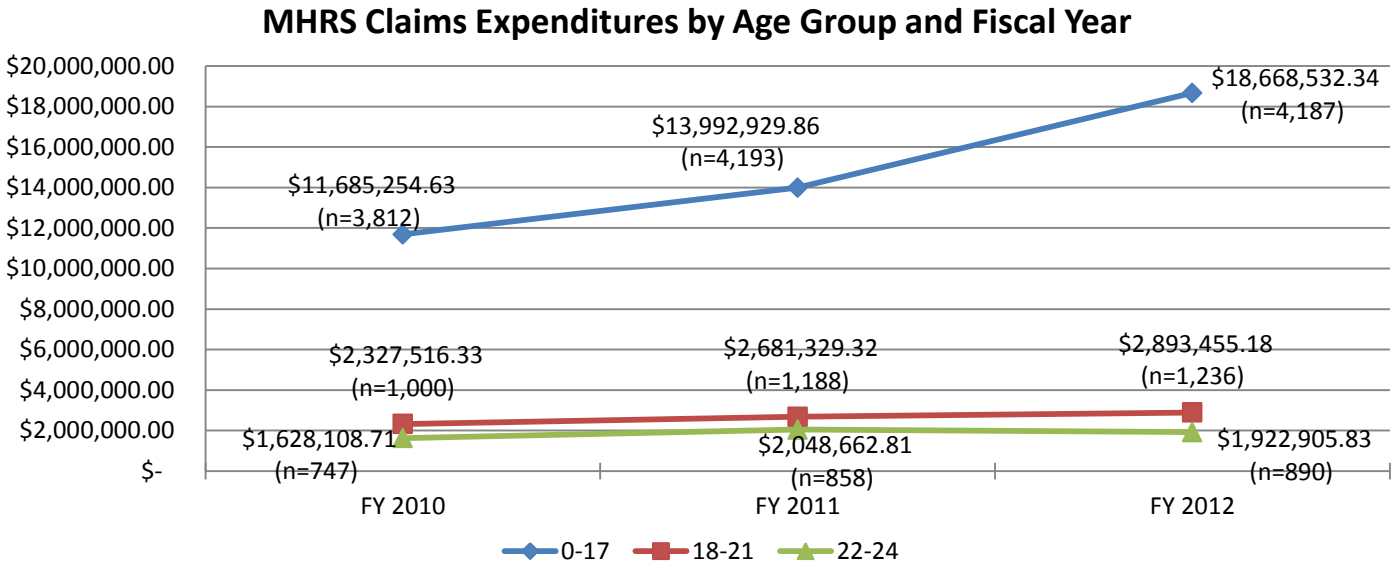
APPENDIX 12: MHRS UTIIIZATION DATA

Appendix 12A. Total Units of MHRS Used by Age Group and Fiscal Year



Data Source: DBH eCura System and provided by DBH's ARE Unit, customized KPI Report
NOTE: This report is based on Claims Submitted for dates of service within the specified timeframe; the numbers will increase based on additional Claims and Encounter submitted. Includes consumers ages 0-24.

Appendix 12B. MHRS Claims Expenditures by Age Group and Fiscal Year



Data Source: DBH eCura system and provided by DBH's ARE Unit, Mental Health Expenditure and Service Utilization Report (MHEASURE), July 15, 2013, page 10.
NOTE: Aggregate cost of Medicaid and Non-Medicaid (locally funded) services from Fiscal Year 2010 to Fiscal Year 2012. This total includes MHRS and Non-MHRS Contracted Services (Jail Diversion, Supported Employment (FY 2012), Crisis Bed and the Integrated Care Coordination Project).

Appendix 12C. MHRS Consumer Counts, Service Utilization And Expenditures By Service Cluster For Individuals Ages 0-24: Fiscal Year 2010

MHRS Consumer Counts, Service Utilization and Expenditures by Service Cluster for Individuals Ages 0-24: Fiscal Year 2010

Specified/Included Services	Consumer Counts	Units of Service	Total Amount Paid	Average Paid Per Consumer	Average 15 Min Increments Per Consumer	Units
Cluster 1: Initial and Ongoing Services						
Counseling	**1,682**	**96,593**	**$ 1,489,218**	**$ 885.39**	**57**	Each type of Counseling is billed in 15 minute units
Family w/Consumer	71	878	$ 10,201	$ 144	12	
Group	122	4,887	$ 36,489	$ 299	40	
Individual, Adult	449	6,179	$ 95,393	$ 212	14	
Individual, Child/Adolescent	862	28,075	$ 412,789	$ 479	33	
Offsite (In-home)	793	56,417	$ 932,327	$ 1,176	71	
Without Consumer	22	157	$ 2,020	$ 92	7	
Community Support	**4,585**	**584,934**	**$ 8,228,643**	**$ 1,795**	**128**	Each type of Community Support is billed in 15 minute units
Group Setting	319	23,897	$ 148,045	$ 464	75	
Ind - Collateral Contact	1,615	31,302	$ 448,598	$ 278	19	
Ind - Face to Face	4,262	426,529	$ 6,163,695	$ 1,446	100	
Ind - Family/Couple w/Consumer	2,072	77,692	$ 1,104,986	$ 533	37	
Ind - Family/Couple w/o Consumer	1,408	25,514	$ 363,320	$ 258	18	
Diagnostic Assessment (at least 3 hours)	**867**	**1,020**	**$ 156,641**	**$ 181**	**1**	Occurrence
Brief	117	128	$ 8,109	$ 69	1	
Comprehensive	761	892	$ 148,532	$ 195	1	
Medication Somatic	**2,082**	**18,458**	**$ 502,434**	**$ 241**	**9**	Each type of Med Somatic is billed in 15 minute units
Adult	1,001	7,614	$ 211,745	$ 212	8	
Child/Adolescent	1,296	9,961	$ 278,051	$ 215	8	
Group	124	883	$ 12,637	$ 102	7	
TOTAL*:	**5,100**					
Cluster 2: Intensive Community-based Services						
Assertive Community Treatment (ACT)	**55**	**13,177**	**$ 310,788**	**$ 5,651**	**240**	Each type of ACT is billed in 15 minute units
Collateral Contact	4	96	$ 1,786	$ 447	24	
Individual	55	13,081	$ 309,002	$ 5,618	238	
Community-based Intervention (CBI)	**553**	**133,620**	**$ 3,466,629**	**$ 6,269**	**242**	Each type of CBI is billed in 15 minute units
Level 1 - MST	119	32,862	$ 1,342,192	$ 11,279	276	
Level II & III - 90/180 Day Auth	453	100,758	$ 2,124,437	$ 4,690	222	
TOTAL*:	**606**					
Cluster 3: Specialty Services						
Day	**40**	**1,186**	**$ 122,142**	**$ 3,054**	**30**	Per Day
Face to Face, w/Consumer	40	1,186	$ 122,142	$ 3,054	30	
Team Meeting	**183**	**1,520**	**$ 19,530**	**$ 107**	**8**	Team Meeting is billed in 15 minute units
Team Meeting	183	1,520	$ 19,530	$ 107	8	
Jail Diversion	**29**	**857**	**$ 17,209**	**$ 593**	**30**	Rate Negotiated by individual contract
Criminal Justice System	29	857	$ 17,209	$ 593	30	
TOTAL*:	**243**					
Cluster 4: Crisis Services						
Crisis Services	**748**	**46,465**	**$ 1,315,637**	**$ 1,759**	**62**	
No Auth Crisis Stabilization	18	41	$ 12,246	$ 680	2	Per Day
Emergency - CMHF	496	41,368	$ 1,122,409	$ 2,263	83	Crisis Emergency is billed in 15 minute units
Emergency - Home	8	116	$ 2,726	$ 341	15	
Emergency - Mobile Unit	128	1,083	$ 28,282	$ 221	8	
Emergency - Other/Not Identified	293	3,676	$ 93,140	$ 318	13	
Crisis Stabilization	19	181	$ 56,834	$ 2,991	10	
TOTAL*:	**748**					
TOTAL:**	**5,554**	**897,830**	**$ 15,628,871**	**$ 2,814**	**162**	

*Total unduplicated consumer count within the specified service cluster
**Total unduplicated consumer count for all services
Data Source: DBH eCura System and provided by DBH's ARE Unit, customized KPI Report
NOTE: This report is based on Claims Submitted for dates of service within the specified timeframe; the numbers will increase based on additional Claims and Encounter submitted. This report provides unduplicated counts of consumers within each service category, thus the columns will not add up to the total. Includes consumers ages 0-24.

Appendix 12D. MHRS Consumer Counts, Service Utilization And Expenditures By Service Cluster For Individuals Ages 0-24: Fiscal Year 2011

MHRS Consumer Counts, Service Utilization and Expenditures by Service Cluster for Individuals Ages 0-24: Fiscal Year 2011

Specified/Included Services	Consumer Counts	Units of Service	Total Amount Paid	Average Paid Per Consumer	Average 15 Min Increments Per Consumer	Units
Cluster 1: Initial and Ongoing Services						
Counseling	**1,560**	**84,541**	**$ 1,288,622**	**$ 826**	**54**	
Family w/Consumer	42	496	$ 5,896	$ 140	12	
Group	91	1,929	$ 15,138	$ 166	21	Each type of Counseling is billed in 15 minute units
Individual, Adult	319	5,459	$ 79,434	$ 249	17	
Individual, Child/Adolescent	943	33,067	$ 478,667	$ 508	35	
Offsite (In-home)	653	43,352	$ 706,279	$ 1,082	66	
Without Consumer	25	238	$ 3,207	$ 128	10	
Community Support	**5,292**	**750,786**	**$ 10,087,815**	**$ 1,906**	**142**	
Group Home	4	340	$ 4,424	$ 1,106	85	
Group Setting	250	7,907	$ 48,633	$ 195	32	
Ind - Collateral Contact	1,917	37,165	$ 501,536	$ 262	19	Each type of Community Support is billed in 15 minute units
Ind - Face to Face	4,869	601,800	$ 8,139,551	$ 1,672	124	
Ind - Family/Couple w/Consumer	2,226	72,223	$ 971,821	$ 437	32	
Ind - Family/Couple w/o Consumer	1,622	31,328	$ 421,419	$ 260	19	
Telephone	6	23	$ 429	$ 72	4	
Diagnostic Assessment (at least 3 hours)	**1,234**	**1,450**	**$ 206,825**	**$ 168**	**1**	
Brief	311	388	$ 24,353	$ 78	1	Occurrence
Comprehensive	949	1,062	$ 182,472	$ 192	1	
Medication Somatic	**2,515**	**23,783**	**$ 647,990**	**$ 258**	**9**	
Adult	1,163	8,966	$ 239,892	$ 206	8	Each type of Med Somatic is billed in 15 minute units
Child/Adolescent	1,731	14,642	$ 405,725	$ 234	8	
Group	10	175	$ 2,374	$ 237	18	
TOTAL*:	**5,779**					
Cluster 2: Intensive Community-based Services						
Assertive Community Treatment (ACT)	**68**	**23,885**	**$ 540,125**	**$ 7,943**	**351**	
Collateral Contact	8	184	$ 3,980	$ 497	23	Each type of ACT is billed in 15 minute units
Group	7	49	$ 380	$ 54	7	
Individual	68	23,652	$ 535,765	$ 7,879	348	
Community-based Intervention (CBI)	**765**	**162,667**	**$ 4,124,327**	**$ 5,391**	**213**	
Level 1 - MST	120	23,314	$ 945,007	$ 7,875	194	Each type of CBI is billed in 15 minute units
Level II & III - 90/180 Day Auth	592	135,806	$ 2,994,152	$ 5,058	229	
Level IV - FFT	80	3,547	$ 185,168	$ 2,315	44	
TOTAL*:	**831**					
Cluster 3: Specialty Services						
Day	**52**	**2,621**	**$ 266,391**	**$ 5,123**	**50**	Per Day
Face to Face, w/Consumer	52	2,621	$ 266,391	$ 5,123	50	
Team Meeting	**199**	**1,825**	**$ 24,060**	**$ 121**	**9**	Team Meeting is billed in 15 minute units
Team Meeting	199	1,825	$ 24,060	$ 121	9	
Jail Diversion	**18**	**419**	**$ 8,732**	**$ 485**	**23**	Rate Negotiated by individual contract
Criminal Justice System	18	419	$ 8,732	$ 485	23	
TOTAL*:	**255**					
Cluster 4: Crisis Services						
Crisis Services	**800**	**55,728**	**$ 1,493,686**	**$ 1,867**	**70**	
No Auth Crisis Stabilization	14	34	$ 10,676	$ 763	2	Per Day
Emergency - CMHF	474	50,989	$ 1,334,722	$ 2,816	108	
Emergency - Home	3	28	$ 658	$ 219	9	Crisis Emergency is billed in 15 minute units
Emergency - Mobile Unit	167	850	$ 22,237	$ 133	5	
Emergency - Other/Not Identified	312	3,712	$ 89,283	$ 286	12	
Crisis Stabilization	14	115	$ 36,110	$ 2,579	8	
TOTAL*:	**801**					
TOTAL:**	**6,226**	**1,107,716**	**$ 18,712,551**	**$ 3,006**	**178**	

*Total unduplicated consumer count within the specified service cluster
**Total unduplicated consumer count for all services
Data Source: DBH eCura System and provided by DBH's ARE Unit, customized KPI Report
NOTE: This report is based on Claims Submitted for dates of service within the specified timeframe; the numbers will increase based on additional Claims and Encounter submitted. This report provides unduplicated counts of consumers within each service category, thus the columns will not add up to the total. Includes consumers ages 0-24.

Appendix 12E. Mhrs Consumer Counts, Service Utilization And Expenditures By Service Cluster For Individuals Ages 0-24: Fiscal Year 2012

MHRS Consumer Counts, Service Utilization, and Expenditures by Service Cluster for Individuals Ages 0-24: Fiscal Year 2012

Specified/Included Services	Consumer Counts	Units of Service	Total Amount Paid	Average Paid Per Consumer	Average 15 Min Increments Per Consumer	Units
Cluster 1: Initial and Ongoing Services						
Counseling	**1,243**	**76,988**	**$ 1,160,137.80**	**$ 933.34**	**62**	Each type of Counseling is billed in 15 minute units
Family w/Consumer	12	136	$ 1,586	$ 132	11	
Group	57	1,415	$ 11,200	$ 196	25	
Individual, Adult	273	4,369	$ 65,056	$ 238	16	
Individual, Child/Adolescent	720	39,245	$ 561,331	$ 780	55	
Offsite (In-home)	509	31,795	$ 520,646	$ 1,023	62	
Without Consumer	5	28	$ 319	$ 64	6	
Community Support	**5,357**	**895,243**	**$ 12,096,599**	**$ 2,258**	**167**	Each type of Community Support is billed in 15 minute units
Group Home	7	1,129	$ 15,136	$ 2,162	161	
Group Setting	277	11,340	$ 70,482	$ 254	41	
Ind - Collateral Contact	1,660	40,696	$ 550,029	$ 331	25	
Ind - Face to Face	5,020	735,145	$ 10,016,094	$ 1,995	146	
Ind - Family/Couple w/Consumer	2,140	69,300	$ 936,503	$ 438	32	
Ind - Family/Couple w/o Consumer	1,544	37,593	$ 507,586	$ 329	24	
Telephone	3	40	$ 768	$ 256	13	
Diagnostic Assessment (at least 3 hours)	**1,046**	**1,340**	**$ 166,846**	**$ 160**	**1**	Occurrence
Brief	395	547	$ 31,198	$ 79	1	
Comprehensive	666	793	$ 135,648	$ 204	1	
Medication Somatic	**2,144**	**18,241**	**$ 493,365**	**$ 230**	**9**	Each type of Med Somatic is billed in 15 minute units
Adult	1,060	7,711	$ 204,223	$ 193	7	
Child/Adolescent	1,331	10,358	$ 286,608	$ 215	8	
Group	5	172	$ 2,534	$ 507	34	
TOTAL*:	**5,809**					
Cluster 2: Intensive Community-based Services						
Assertive Community Treatment (ACT)	**78**	**26,788**	**$ 597,669**	**$ 7,662**	**343**	Each type of ACT is billed in 15 minute units
Collateral Contact	1	47	$ 861.86	$ 861.86	47	
Group	11	354	$ 2,743.15	$ 249.38	32	
Individual	78	26,387	$ 594,063.53	$ 7,616.20	338	
Community-based Intervention (CBI)	**1,036**	**270,425**	**$ 7,165,656**	**$ 6,917**	**261**	Each type of CBI is billed in 15 minute units
Level 1 – MST	126	26,907	$ 1,084,480	$ 8,607	214	
Level II & III - 90/180 Day Auth	758	222,690	$ 4,944,094	$ 6,523	294	
Level IV – FFT	222	20,828	$ 1,137,083	$ 5,122	94	
TOTAL*:	**1114**					
Cluster 3: Specialty Services						
Day	**31**	**1,938**	**$ 196,525**	**$ 6,340**	**63**	Per Day
Face to Face, w/Consumer	31	1,938	$ 196,525	$ 6,340	63	
Supported Employment	**28**	**2,513**	**$ 40,804**	**$ 1,457**	**90**	Each type of Supported Employment is billed in 15 minute units
Therapeutic	19	1,284	$ 20,849	$ 1,097	68	
Vocational	22	1,229	$ 19,955	$ 907	56	
Team Meeting	**151**	**1,019**	**$ 14,175**	**$ 94**	**7**	Team Meeting is billed in 15 minute units
Team Meeting	151	1,019	$ 14,175	$ 94	7	
Jail Diversion	**7**	**103**	**$ 2,147**	**$ 307**	**15**	Rate Negotiated by individual contract
Criminal Justice System	7	103	$ 2,147	$ 307	15	
TOTAL*:	**212**					
Cluster 4: Crisis Services						
Crisis Services	**829**	**56,143**	**$ 1,533,597**	**$ 1,850**	**68**	
No Auth Crisis Stabilization	14	32	$ 10,048	$ 718	2	Per Day
Emergency – CMHF	437	50,661	$ 1,342,844	$ 3,073	116	Crisis Emergency is billed in 15 minute units
Emergency – Home	1	16	$ 376	$ 376	16	
Emergency - Mobile Unit	134	655	$ 17,295	$ 129	5	
Emergency - Other/Not Identified	348	4,634	$ 110,848	$ 319	13	
Crisis Stabilization	14	129	$ 40,506	$ 2,893	9	
Psych Bed	2	16	$ 11,680	$ 5,840	8	
TOTAL*:	**829**					
TOTAL:**	**6,310**	**1,350,750**	**$ 23,483,423**	**$ 3,722**	**214**	

*Total unduplicated consumer count within the specified service cluster
**Total unduplicated consumer count for all services
Data Source: DBH eCura System and provided by DBH's ARE Unit, customized KPI Report
NOTE: This report is based on Claims Submitted for dates of service within the specified timeframe; the numbers will increase based on additional Claims and Encounter submitted. This report provides unduplicated counts of consumers within each service category, thus the columns will not add up to the total. Includes consumers ages 0-24.

APPENDIX 13: MEDICAID MCO AND MEDICAID FFS CONSUMER COUNTS BY OTHER SERVICES CATEGORY FOR FISCAL YEARS 2010, 2011 AND 2012

Medicaid MCO and Medicaid FFS Consumer Counts by Other Services Category for Fiscal Years 2010, 2011 and 2012			
Specified Services	**FY 2010**	**FY 2011**	**FY 2012**
Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximated 20 to 30 minutes face to face with the patient	293	629	790
Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face to face with the patient; with medical evaluation and management services	132	160	221
Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face to face with the patient	1,436	2,011	2,226
Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face to face with the patient; with medical evaluation and management services	206	222	230
Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face to face with the patient;	90	231	300
Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face to face with the patient; with medical evaluation and management services	#	#	#
Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face to face with the patient; with medical evaluation and management services	#	#	#
Environmental intervention for medical management purposes on a psychiatric patients behalf with agencies, employers or institutions	#	23	#
Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (e.g., for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional doppler wave form recording and analysis	#	#	#
Developmental screening, with interpretation and report, per standardized instrument form	2,643	2,507	2,699
Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report	457	630	487
Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g. acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychology	33	47	74
Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face to face with the patient; initial assessment	#	43	#
Health and behavior intervention; each 15 minutes, face to face; individual	#	#	#
Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one on one) patient contact by the provider, each 15 minutes	#	#	#
Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one on one contact by provider, with written report	62	85	99
Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)	163	155	135
MH Service - Treatment Planning Inpatient	#	#	#
Mental health partial hospitalization, treatment, less than 24 hours	#	#	#
Community psychiatric supportive treatment program, per diem	#	#	#
Respite care services, not in the home, per diem	#	#	#
Intensive Day Treatment	#	#	#
Psychosocial rehabilitation services, per diem	#	#	36
Residential treatment - therapeutic behavioral services are provided for a short period of time for serious emotionally disturbed youth - per diem	244	170	103
Intensive, extended multidisciplinary services provided in a clinic setting to children with complex medical, physical, mental and psychosocial impairments, per diem	82	108	105
TOTAL*:	**5,370**	**6,031**	**6,383**

- Cell sizes of 25 or fewer are not reported for privacy purposes

*Total number of unique beneficiaries, ages 0-24, within the specified service cluster with a paid Encounter and/or non-zero FFS claim with a First Date of Service in the given fiscal year

Data Source: DHCF MMIS System and provided by DHCF's Division of Research and Rate Setting Analysis

NOTE: Total number of unique beneficiaries, ages 0-24, with a paid Encounter and/or non-zero FFS claim with a First Date of Service in the given fiscal year. Excludes MHRS services (Provider type code T01). Only includes claims that had one of the DBH-identified procedure codes (see Appendix 8 for full list of procedure codes included in this analysis).

APPENDIX 14: LIST OF DBH-IDENTIFIED PROCEDURE CODES INCLUDED IN MEDICAID MCO/FFS ANALYSIS

Consumer Counts of Those Accessing Specific Services, by Cluster and by Year, Among Individuals Ages 0 - 24	
Service Cluster	**Relevant Procedure Codes**
Initial and Ongoing Services include counseling, community support, diagnostic assessment and med somatic	H0004, H0036, T1023, H0002, T1502
Intensive Community-Based Services include ACT, CBI II, III, MST & FFT	H0039, H2033
Specialty Services include day, ICCP, supported employment, team meeting and jail diversion	H0025, H2023
Crisis Services include non-authorized crisis beds, psych beds and emergency services	H2011
Other includes all other procedure codes, not elsewhere classified here	See following list

List of DBH Identified Procedure Codes	
Procedure Code	**Procedure Code Description**
90804	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 20 TO 30 MINUTESFACE-TO-FACE WITH THE PATIENT;
90805	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 20 TO 30 MINUTESFACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION and MANAGEMENT SERVICES
90806	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 45 TO 50 MINUTESFACE-TO-FACE WITH THE PATIENT;
90807	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 45 TO 50 MINUTESFACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION and MANAGEMENT SERVICES
90808	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 75 TO 80 MINUTESFACE-TO-FACE WITH THE PATIENT;
90809	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 75 TO 80 MINUTESFACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES
90817	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARESETTING, APPROXIMATELY 20 TO 30 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION and MANAGEMENT SERVICES
90882	ENVIRONMENTAL INTERVENTION FOR MEDICAL MANAGEMENT PURPOSES ON A PSYCHIATRIC PATIENT'S BEHALF WITH AGENCIES, EMPLOYERS, OR INSTITUTIONS

List of DBH Identified Procedure Codes	
Procedure Code	**Procedure Code Description**
93923	COMPLETE BILATERAL NONINVASIVE PHYSIOLOGIC STUDIES OF UPPER OR LOWER EXTREMITYARTERIES, 3 OR MORE LEVELS (EG, FOR LOWER EXTREMITY: ANKLE/BRACHIAL INDICES ATDISTAL POSTERIOR TIBIAL AND ANTERIOR TIBIAL/DORSALIS PEDIS ARTERIES PLUSSEGMENTAL BLOOD PRESSURE MEASUREMENTS WITH BIDIRECTIONAL DOPPLER WAVEFORM RECORDING AND ANALY
96110	DEVELOPMENTAL SCREENING, WITH INTERPRETATION AND REPORT, PER STANDARDIZED INSTRUMENT FORM
96111	DEVELOPMENTAL TESTING, (INCLUDES ASSESSMENT OF MOTOR, LANGUAGE, SOCIAL, ADAPTIVE, AND/OR COGNITIVE FUNCTIONING BY STANDARDIZED DEVELOPMENTAL INSTRUMENTS) WITH INTERPRETATION AND REPORT
96116	NEUROBEHAVIORAL STATUS EXAM (CLINICAL ASSESSMENT OF THINKING, REASONING AND JUDGMENT, EG, ACQUIRED KNOWLEDGE, ATTENTION, LANGUAGE, MEMORY, PLANNING AND PROBLEM SOLVING, AND VISUAL SPATIAL ABILITIES), PER HOUR OF THE PSYCHOLOG
96150	HEALTH AND BEHAVIOR ASSESSMENT (EG, HEALTH-FOCUSED CLINICAL INTERVIEW,BEHAVIORAL OBSERVATIONS, PSYCHOPHYSIOLOGICAL MONITORING, HEALTH-ORIENTEDQUESTIONNAIRES), EACH 15 MINUTES FACE-TO-FACE WITH THE PATIENT; INITIALASSESSMENT
96152	HEALTH AND BEHAVIOR INTERVENTION, EACH 15 MINUTES, FACE-TO-FACE; INDIVIDUAL
97533	SENSORY INTEGRATIVE TECHNIQUES TO ENHANCE SENSORY PROCESSING AND PROMOTE ADAPTIVE RESPONSES TO ENVIRONMENTAL DEMANDS, DIRECT (ONE-ON-ONE) PATIENT CONTACT BY THE PROVIDER, EACH 15 MINUTES
97755	ASSISTIVE TECHNOLOGY ASSESSMENT (EG, TO RESTORE, AUGMENT OR COMPENSATE FOR EXISTING FUNCTION, OPTIMIZE FUNCTIONAL TASKS AND/OR MAXIMIZE ENVIRONMENTAL ACCESSIBILITY), DIRECT ONE-ON-ONE CONTACT BY PROVIDER, WITH WRITTEN REPORT
G0176	ACTIVITY THERAPY, SUCH AS MUSIC, DANCE, ART OR PLAY THERAPIES NOT FOR RECREATION, RELATED TO THE CARE AND TREATMENT OF PATIENT'S DISABLING MENTAL HEALTH PROBLEMS, PER SESSION (45 MINUTES OR MORE)
H0002	BRIEF DIAGNOSTIC ASSESSMENT
H0004	BEHAVIORAL HEALTH COUNSELING AND THERAPY, PER 15 MINUTES
H0025	DAY SERVICES
H0032	MH SERVICE - TREATMENT PLANNING INPATIENT
H0035	MENTAL HEALTH PARTIAL HOSPITALIZATION, TREATMENT, LESS THAN 24 HOURS
H0036	COMMUNITY SUPPORT
H0037	COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT PROGRAM, PER DIEM
H0039	ASSERTIVE COMMUNITY TREATMENT - ACT

List of DBH Identified Procedure Codes	
Procedure Code	**Procedure Code Description**
H0045	RESPITE CARE SERVICES, NOT IN THE HOME, PER DIEM
H2011	CRISIS EMERGENCY
H2012	INTENSIVE DAY TREATMENT
H2018	PSYCHOSOCIAL REHABILITATION SERVICES, PER DIEM
H2020	RESIDENTIAL TREATMENT - THERAPEUTIC BEHAVIORAL SERVICES ARE PROVIDED FOR A SHORT PERIOD OF TIME FOR SERIOUS EMOTIONALLY DISTURBED YOUTH -PER DIEM
H2033	COMMUNITY-BASED INTERVENTION - CBI LEVEL I and IV
H2022	COMMUNITY-BASED INTERVENTION - CBI LEVEL II and III
T1023	SCREENING TO DETERMINE THE APPROPRIATENESS OF CONSIDERATION OF AN INDIVIDUAL FOR PARTICIPATION IN A SPECIFIED PROGRAM, PROJECT OR TREATMENT PROTOCOL, PER ENCOUNTER
T1025	INTENSIVE, EXTENDED MULTIDISCIPLINARY SERVICES PROVIDED IN A CLINIC SETTING TO CHILDREN WITH COMPLEX MEDICAL, PHYSICAL, MENTAL AND PSYCHOSOCIAL IMPAIRMENTS, PER DIEM
T1502	MED SOMATIC

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