Meeting the Mental Health Needs of Abused & Neglected Children

Findings and Recommendations regarding the District of Columbia Government's Implementation of the 2007 Department of Mental Health and Child &Family Services Agency Mental Health Needs Assessment

D.C. Citizens Review Panel

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Citizens Review Panel of the District of Columbia

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Introduction

Protecting children from abuse and neglect involves much more than responding to hotline calls. Most children subject to child protective investigations can and should remain with their families. In many cases, effective mental health services can enable children and families to stabilize and to stay together safely. When children are placed in foster care, prompt provision of effective mental health services facilitate reunifications. Such services also protect children from re-abuse and re-traumatization while in foster care, enhance their well-being and help achieve permanency in any form more quickly and effectively. For all these reasons, effective mental health services for children and families involved with the Child and Family Services Agency (CFSA) are essential elements of the District of Columbia's child protection system.

In 2007, CFSA and the Department of Mental Health (DMH) jointly developed a Mental Health Needs Assessment, which surveyed the foster care population and identified the specific number of children who needed a wide variety of mental health interventions. This report addresses how CFSA and DMH have implemented that document and filled the need for mental health services that it identified.

The Citizens Review Panel recognizes the 2007 Mental Health Needs Assessment as a critical first step towards providing effective mental health services to all children and families who need it. The Panel believes that effective implementation of the 2007 Mental Health Needs Assessment is essential to the protection of children. As Howard University Social Work Professors Ruby Gourdine and Annie Brown recently wrote, "Available and accessible mental health services for families and children are necessary to insure that families have options other than child placement if they are suffering from any form of mental health issues or have a child with mental health needs."[1] The converse is also true: The absence of accessible and effective mental health services will lead to preventable abuse and neglect of children and preventable entries into foster care.

The Panel believes that District agencies must work expeditiously to:

1) ensure that the services identified in the assessment are available
2) identify children in need of each specific service
3) provide specific services promptly to children identified as needing those services

[1] Gourdine, Brown and Smith, editors, *A Child Welfare Response in Times of Crisis*, at 55 (2009).

4) provide identified services in a high-quality manner with fidelity to evidence-based models
5) develop a system to ensure the long-term availability of qualified service providers
6) develop a system to ensure the quality of each service

The Citizens Review Panel chose in early 2009 to evaluate the District's implementation of the 2007 Needs Assessment and its achievement of the above-listed goals. The Panel submitted a series of written questions and follow up questions to the Child and Family Services Agency (CFSA), which responded to some questions and asked the Department of Mental Health (DMH) to respond to others. The Panel received written responses on June 15, 2009. After Panel members had time to review these responses, they drafted follow up questions and invited senior staff from both CFSA and DMH to discuss the Panel's continuing questions and concerns. Written responses were provided on September 2, 2009. Also on that date, senior CFSA and DMH staff attended a meeting of the Panel to discuss the Panel's evaluation of the government's implementation of the 2007 Needs Assessment.

This report presents the findings and recommendations of the Citizens Review Panel's evaluation of the responses and data received. Several limitations must be stated. First, the Panel is aware that the District's efforts to achieve these goals are ongoing. As a senior CFSA official told the Panel on September 2, 2009, implementing the Needs Assessment is "a work in progress." The Panel does not expect the District to have perfectly implemented all elements of the 2007 Needs Assessment, and hopes that its recommendations to the essential District agencies now will help the District pursue its goals in the most effective manner possible.

Second, the Panel is also aware that the District of Columbia's children's mental health system is complex, and that implementing the 2007 Needs Assessment is just one part of that system. This Report should not be taken as reaching any conclusions regarding any mental health issue beyond implementation of the 2007 Needs Assessment.

Third, the Panel's findings and recommendations are based almost entirely on responses provided by CFSA and DMH to the Panel's requests for information. Several individual Panel members have direct experience with elements of the government's Needs Assessment implementation, and this report notes those experiences, especially as they reinforce conclusions based on information provided by the government. Nonetheless, the Panel does not believe that it has a complete picture of the government's Needs Assessment implementation. Some information requested by the Panel was not provided, and some answers provided by the government indicate that the government may lack certain key information.

The lack of complete information leads to one overarching recommendation: All relevant District agencies should make as much information regarding implementation of the 2007 mental health needs assessment public as possible. More broadly, the government should make as much information about the broader mental health system public as possible. Public information fosters public accountability. Other branches of government, advocacy groups, the media and the public at large can hold the government accountable for its actions regarding these important issues – and, ultimately, improve government functioning.

The Panel will post all responses from the government on its website when that website is fully developed. We hope that this action is the first step in creating a more transparent and publicly accountable strategy to address the crucial issue of mental health services for children and families.

Citizens Review Panel of the District of Columbia:

Findings and Recommendations regarding the District of Columbia Government's Implementation of the 2007 Department of Mental Health and Child & Family Services Agency Mental Health Needs Assessment

Executive Summary

a. *Background*

In 2007, the Child and Family Services Agency (CFSA) and the Department of Mental Health conducted a joint *Mental Health Needs Assessment of Children in Foster Care.* The purpose of the Needs Assessment included quantifying the various mental health services needed by children in foster care and thus identifying service gaps. Since the Needs Assessment was completed, there has been some progress in filling those gaps, but the need for more implementation remains.

The Panel commends CFSA and DMH for several important steps towards implementing the Needs Assessment. CFSA and DMH have implemented concrete procedures to increase their collaboration. DMH clinicians are now placed in-house at the child protective services branch of CFSA, bi-weekly consultations between administrators at both agencies occur, clear protocols exist for evaluation and referral of children in care of CFSA to mental health services, and a small but specific funding stream exists to train providers on specialized mental health treatments identified in the Needs Assessment.

In addition, DMH and CFSA have worked to expand the number of qualified clinicians at "Choice Providers" – mental health core service agencies which won a RFP to provide a wider range of services, including many specialized mental health services, which foster children and children at risk of abuse and neglect need.

Some tangible implementation progress has already been made. A children's crisis mobile response service is now available, and Choice Provider clinicians are being trained to provide trauma-focused cognitive behavioral therapy. Over the past year, CFSA and DMH have solicited bids for outside contractors to provide training for other specialized mental health services identified in the Needs Assessment, including parent-child interaction therapy, child-parent psychotherapy for family violence, and functional family therapy (although it is not clear who was awarded these contracts or if training has begun).

The Panel also found DMH staff to be refreshingly open about significant challenges that remain. One senior staff member informed the Panel that the system is "not working the way it's

supposed to" and discussed specific steps DMH planned to take to address the shortcoming she had identified.

Other service needs identified in the Needs Assessment remain unmet, at least according to the information provided to the Panel – play therapy, anger management, grief counseling, sex abuse therapy, sex offender therapy, expressive therapies, and parent management training.

b. *Findings and Recommendations*

Successful implementation depends on more than simply increasing the capacity to provide identified services. Children who need these services must be promptly and accurately identified, and they must be quickly linked to service providers. Services must be provided in a high quality and culturally competent manner and have a measurable effect. Feedback loops must exist to permit CFSA and DMH to fix problems quickly and effectively.

The Panel's core recommendations for improvement are that CFSA and DMH need to work more transparently, develop a more detailed plan to develop the indicated services, develop and implement more comprehensive measures of implementation quality, and, perhaps most importantly, improve access to children at high risk of abuse or neglect and their families to these same mental health services so that abuse and neglect – and forced separation of children from their families – can be prevented.

The Panel reaches findings and makes recommendations in eight core areas:

1) Medicaid rates

Findings: The government has set competitive Medicaid rates for many specialized mental health services through a thorough methodology.

Recommendations: The government should

a) regularly reevaluate these Medicaid rates to ensure they remain adequate to recruit and retain qualified providers,

b) consider requiring contractual commitments from professionals receiving District-provided training to ensure they provide services to District residents, and

c) revaluate Medicaid rates for non-specialized services.

2) Data system for children entering foster care

Findings: DMH and CFSA have developed a detailed system for screening children entering foster care for mental health problems and promptly referring them for more thorough assessments and treatment. The Agencies measure most of the key data points to ensure this process works smoothly. Some delays, however, exist, and the Agencies have developed less

clear policies for tracking mental health services once children are referred to the "Choice Providers" for treatment.

Recommendations: The government should

a) publicly report the results of its data tracking,

b) explore existing delays between identification of mental health problems and provision of services and promptly develop strategies for reducing them,

c) consider requiring DMH staff providing mental health assessments to children entering foster care to directly refer children to DMH for treatment, thus avoiding delays that have occurred when waiting for CFSA social workers to refer children to DMH,

d) the agencies should clarify the processes for tracking mental health services once children are referred to Choice Providers and the results of them, and

e) the agencies should track the timeline from a child's referral for mental health series and the onset of actual services for each service and each Choice Provider.

3) Systems for other children in foster care

Findings: The Agencies lack clear procedures for identifying mental health problems after the beginning of a foster care case – even though many children's mental health conditions are not evident when they first enter foster care.

Recommendations:

a) CFSA should develop a more detailed structure to identify mental health needs throughout a foster care case.
b) The Agencies should develop more detailed structures to ensure that 90-day treatment reviews accurately assess whether children are receiving the correct service and whether it is effective.

4) Systems for children out of foster care

Findings: The relatively clear processes for accessing and tracking services for foster children is not replicated for children at risk of entering foster care – even though many of the services identified in the Needs Assessment are most effectively provided as preventative services. The specialized services are theoretically accessible to any child who needs them, but the agencies reported that they lacked data to determine how many children received such services, let alone the quality and effectiveness of such services.

Recommendations: The government should

a) Work to ensure that all Choice Providers accept all of the Medicaid MCOs to maximize access for families, and
b) Develop a means of tracking specialized mental health services, including the numbers of available slots and of children and families actually served.

5) Language access

Findings: Access to specialized mental health services for children and families who speak languages other than English is a major concern. The government reported that it had no means of determining a Choice Provider's ability to provide services in languages other than English. This failure raises questions about compliance with the District's Language Access Act.

Recommendations: The government should a) enforce the Language Access Act among all mental health providers, including the Choice Providers, b) the Language Access Director in the Office of Human Rights should investigate Choice Providers' compliance with the Language Access Act, and c) the Agencies should track the number of specialized mental health providers who can speak languages other than English and should require Choice Providers (collectively, if not individually) to have providers on staff who can speak all languages spoken by large numbers of District residents.

6) Needs Assessment estimates

Findings: The 2007 Needs Assessment contains impressive specificity regarding the need for different type of services. Still, questions remain whether the Assessment accurately captured all of the need.
Recommendations: The government should closely measure mental health assessments of children at all stages of a foster care case and compare those assessments to the need estimated in 2007.

7) Comprehensive feedback loops

Findings: The government has developed some impressive data collection methods, but has not yet developed a means of measuring how long a child receives a specific service, how many services a child receives, and a child's progress after receiving specific services.
Recommendations: The government should develop such comprehensive measurements promptly.

8) Outstanding information

Findings: Some of the Panel's data requests were not responded to.
Recommendations: The government should respond to these data requests promptly.

I. The District has appropriately set high rates for specialized mental health services, and should continue this work to ensure that high-quality providers serve District children.

a. *Findings*

The District must ensure that it appropriately compensates specialized mental health providers. Professionals qualified to provide evidence-based mental health services are in high demand. Market fundamentals dictate that they will leave the District for other jurisdictions if they are underpaid in the District.

This concern is especially large because the District has explained to the Panel that it is investing heavily in training mental health professionals at the Choice Providers in the specialized services identified in the needs assessment. This training is very involved and time consuming; District officials explained that it takes about 18 months for a provider to become certified in many specialized services. If the District invests significant time and money into training providers, only to have them leave the District for more lucrative jurisdictions, then the District will fail to fill the needs identified in 2007.

To the District's credit, it has set a very competitive Medicaid rate for many specialized mental health services: $173 per hour. As encouraging, the District government has set this rate through a thorough methodology, analyzing the qualifications needed to provide these services well, the prevailing rates around the country and in neighboring jurisdictions, and the cost needed to pay for Choice Providers' overhead and high quality supervision of specialty providers.

b. *Recommendations*

- The District should regularly reevaluate the Medicaid rates paid to specialized mental health providers to ensure they remain adequate.
- The District should consider seeking contractual commitments from professionals who receive District-provided training to ensure that they provide the specialized service to District residents for some set period of time. Such agreements are consistent with requirements in other professions such as education and law.

- The District should reevaluate the Medicaid rates provided for non-specialized services. Multiple Panel members have observed high rates of provider turn-over and other harmful results of regular Medicaid rates being set far too low. As a result, children and families who receive these services often fail to receive much benefit, and can even be harmed by the frequent changes in providers.

II. CFSA and DMH have established a data collection system to measure the time between CFSA's removal and the District implementing mental health services. This system should be improved, and the agencies should work to remedy problems identified by the system.

a. *Findings*

CFSA and DMH outlined the process applied to a child upon removal from his or her family and entry into foster care: The child is brought to CFSA's child protective services unit, where he or she is screened for indications of mental health conditions. When indicated, the child receives a more thorough mental health assessment provided by DMH staff. The results are provided to the child's CFSA social worker, who then refers the child to DMH. DMH then assigns the child to a Choice Provider – a core service agency contracted with the government to provide Medicaid-funded specialized mental health services. The Choice Provider then sets an intake appointment with the child and initiates services. Every 90 days after that, the Choice Provider is responsible for reviewing the child's treatment to ensure all needs are met and met effectively.

The Panel commends CFSA and DMH for their persistence in highlighting the importance of seeking effective means for screening all foster children when they are removed from their homes. The Panel also commends the agencies for working towards a data tracking system which measures the time each of the outlined steps takes. This data tracking system should be a significant mechanism for ensuring children are screened promptly with timely referral to DMH and Choice Providers for a full diagnostic assessment, as indicated, and appropriate services.

At the Panel's September 2, 2009, DMH reported one important data point – the timeline from a foster child's referral for mental health services to the onset of those services. DMH reported that the average timeline is 19 days. However, more specific data – such as the average

timeline for specific services or at specific Choice Providers – was not available. The absence of such data limits the government's ability to respond to problems quickly and effectively.

The Panel appreciates DMH's frank acknowledgement at the September 2, 2009 meeting that existing data shows that delays exist. DMH informed that Panel that delays exist in between children's initial screening and their referral by CFSA social workers to DMH for assignment to a Choice Provider. (The Panel requested additional information on the specific scope of those delays and has not received a response.) Such delays raise serious concerns and deserve prompt action by the agencies.

Finally, it is not clear how Choice Providers provide and track data for the 90 day reviews. The Panel is without an understanding of criteria used for determining the extent to which child/family treatment plans are completed, extended, changed or the reasons for each such action. For quality control and accountability purposes, and in order to determine the effectiveness of the Choice Provider services, these reviews need to explore whether initial assessments were correct and whether resulting services had a positive impact.

b. *Recommendations*

- CFSA and DMH should report to the Panel and, more importantly, publicize the results of the tracking system designed to quantify the time period from initial screenings of foster children to the onset of services.
- The agencies explore existing delays and report to the Panel and the public the factors that contribute to the referral delays at all points in the process, and the CFSA/DMH strategy for overcoming the delays.
- The agencies should consider requiring DMH staff providing mental health assessments to refer children directly to DMH for assignment to Choice Providers. According to DMH's report to the Panel, some delays are evident between children's screening and their referral for services by CFSA social workers, who are busy dealing with the many urgent issues associated with a new removal. Taking this burden off of social workers would speed the provision of services to children experiencing the crisis of a forced separation from their families.

- The agencies should publicize to the broader community – including social workers, foster parents, Family Court attorneys, and others – the steps that occur from a child's entry into foster care and the provision of services and data on average timelines. Doing so would establish a common and transparent language for obtaining services and troubleshooting problems in individual cases.
- The agencies should provide public information to clarify the 90 day review process and the aggregate results of them.
- DMH and CFSA should track the timeline from a foster child's referral for mental health services to the onset of services for each Choice Provider and each specific service. Doing so will inform the government quickly of any delays with particular providers or particular services and empower the agencies to respond appropriately.

III. The thorough processes for identifying children's mental health needs and linking children to services at the beginning of a foster care case is not matched by similar processes at later stages of a case. Filling this gap should be a high priority.

a. *Findings*

Despite the impressive structure DMH and CFSA have created at the beginning of foster care cases, no system will identify all foster children's mental health needs. As CFSA and DMH convincingly explained to the Panel, children and parents will not disclose all mental health issues at the time they are removed. Some mental health concerns will only become apparent over time after more is learned about the child's behavior and family background. In addition, a child's experiences in foster care may create new mental health concerns.

The reality that many foster children's mental health concerns will not be identified at the beginning of a case demonstrates the importance of identifying them later. The agencies, however, described a much less rigorous system for measuring such identification. Rather than the detailed screenings applied to all foster children at the beginning of a case, later identification of mental health needs depends on a social worker identifying risks and referring children for screening. That process will work for some cases, but will leave many issues un-identified, because social workers change (so workers will not always be up-to-speed). And, as in any large institution with hundreds of staff, some social workers will effectively identify a need for more

screening but some will not. Some will recognize the range of behaviors that might indicate a mental health condition; some will not. Some will have the skill to discuss with parents, foster parents, and kinship caregivers the range of specialized services offered and the need to access them; some will not. The Panel does not believe that the District has created sufficient structures to identify all children who have mental health needs at all points of a foster care case.

b. *Recommendations*

- CFSA should develop a more detailed structure to identify mental health needs. Automatic mental health screening similar to what is done when children first enter foster care is appropriate when warning signs exist – such as an unplanned placement change, new behavior problems at home or at school, especially concerning behavior reported by the foster parent or school, a physically or emotionally traumatizing event (such as being assaulted, learning of a parent's illness, substance abuse relapse, etc.).
- For children who are linked to some mental health services, CFSA and DMH should develop more detailed structures to ensure that their 90-day treatment reviews accurately assess whether children are receiving the correct service and whether it is effective. Ninety-day treatment reviews performed by Choice Providers should involve contacting the social worker, foster parent, GAL and other involved professionals to gauge the child's progress. If problematic behaviors continue or if new behaviors or risk factors present themselves, the Choice Provider should consider whether a new assessment is indicated or whether change in treatment plan is indicated, and should share this information with CFSA, the child's GAL, and, as appropriate, the child's parents, foster parents, or other family members. In addition, District agencies should ensure that providers are able to bill Medicaid for time spent on this collaboration.

IV. CFSA and DMH have created a comparatively clear structure to serve children in foster care. These agencies need to create a similarly clear structure to better serve children not in foster care.

a. *Findings*

Some of the mental health services identified by the Needs Assessment are particularly important for children outside of foster care. "Functional family therapy," for instance, is

described in the Needs Assessment as a "family intervention" that presents an "alternative to out-of-home placement." It will be most effective if it is provided to children living with, not separated from, their families. More broadly, protecting children requires a focus on the needs of children *both* inside and outside of foster care. The mental health needs of children in foster care – who have been abused or neglected and have endured the forced separation from their families – are well documented. In addition, many children living with their families need effective, specialized mental health services. The prevention of child abuse and neglect relies on accessible, affordable, and competent community mental health services which can quickly identify and treat mental health issues among adults and children.

Anecdotally, the professional experience of several Panel members indicates that a significant problem may exist in obtaining specialized mental health services for children and families with "in-home" or "community" cases. In such cases, CFSA has substantiated allegations of abuse or neglect, but determined that the maltreatment was not severe enough to open a court case or remove the children. Instead, CFSA seeks to arrange services for the family to prevent future abuse or neglect. It is essential that such services be provided effectively. Yet Panel members – in their day jobs – have encountered in-home social workers who appear unaware of the Choice Providers and the services offered, and know of cases in which CFSA's Office of Clinical Practice declining to refer children or families to Choice Providers if they are already linked with other core service agencies (even if those agencies may not offer the same specialized services). While it is unclear how widespread these problems are, that they occur at all is concerning.

The Panel commends the District for developing a system that, in theory, is accessible to children both in and out of foster care. Specialized mental health services called for in the Needs Assessment are or will be provided by Choice Providers – mental health agencies whose staff are specially trained to provide these services. These Choice Providers accept the form of Medicaid that is available to many children outside of foster care.

Unfortunately, the Panel's investigation revealed that means for measuring access to mental health services identified in the Needs Assessment are far better developed for children in foster care than for those outside of foster care. For instance, in response to multiple questions

about the number of available slots for specific services and the number of children receiving different services (both in and out of foster care), District agencies responded that they did not have answers, and that they currently lacked a "shared tracking and reporting system . . . between DMH and CFSA" to make answers "readily accessible."[2] The absence of "readily accessible" data is particularly disturbing. The Needs Assessment specifically quantified the number of children who need particular services. Thus, when it comes to implementing the Needs Assessment, the ultimate bottom line is whether the District has the capacity to provide those services and does, in fact, provide those services to the children who need them. The lack of this data is especially concerning for children not in foster care, because these children are not captured in other data points that the District does have.

The Panel recognizes that implementing the Needs Assessment for children not in foster care presents different challenges than doing so for children in foster care. The former group generally receives Medicaid coverage through the privately-operated managed care organizations while CFSA and DMH have more contact with and control over foster children. Nonetheless, reaching children outside of foster care is essential to the larger project of serving all children and families in need and doing so in the manner that will most effectively prevent abuse and neglect.

b. *Recommendations*

- The District should work with the Choice Providers and the Medicaid MCOs to ensure that all Choice Providers are linked with all MCOs. Children and families receiving Medicaid should have access to the broadest possible choices for service providers.
- District agencies should develop a means of tracking specialized mental health services, including the numbers of available slots and the numbers of children and families actually served. The District should also quantify the number of children not in foster care receiving particular services, and should work with Choice Providers and, if

[2] The full response provided on September 2, 2009 is: "The desired information must be reconciled manually between two separate sources. This process is feasible for a longer timeline is required to complete the reconciliation. Moving forward the information will be readily accessible when a shared tracking and reporting system is implemented between DMH and CFSA."

necessary, MCOs to ensure that children outside of foster care are receiving services in numbers similar to those identified in the Needs Assessment.

- The District needs to continue to provide low-barrier preventative and treatment services throughout the community, including through primary care providers, schools, and shelters.

V. Language access remains a significant concern.

a. *Findings*

Access to specialized mental health services for children and families that speak languages other than English is a significant problem. CFSA and DMH staff told the Panel on September 2, 2009 that they kept no data on whether any specialized mental health service providers can serve clients whose primary language is not English. This failure comes despite the RFP for choice mental health providers (provided by CFSA to the Panel) including preference points for linguistic competence.

This failure may constitute a violation of the District's Language Access Act, D.C. Law 15-167, D.C. Code § 2-1931 through § 2-1937. The Language Access Act requires both the DMH and its major contractors to annually determine what oral language services its clientele needs, and to every two years develop a language access plan.

CFSA's explanation for this shortcoming is not persuasive. CFSA stated to the Panel that the foster care population is largely homogenous and does not include many non-English speaking families. But CFSA did not have specific data regarding the number of non-English speaking children, parents, or other caregivers in the foster care system, and without such data, CFSA's assertion may not be corroborated. Even assuming CFSA's assertion is correct, there are still some non-English speaking foster children, and there are many more children and families *not* in foster care who need specialized mental health services. The District must do more to ensure these children and families have access to the services they need.

b. *Recommendations*

- DMH should enforce the Language Access Act among core service agencies and Choice Providers.

- The Language Access Director in the Office of Human Rights should investigate the compliance of DMH and its contracted Choice Providers with the Language Access Act. (The Panel will submit a copy of this report to the Language Access Director.)
- DMH and CFSA should track the number of specialized mental health care providers who can speak other languages and should require Choice Providers (collectively, if not individually) to have on staff providers who can speak all of the languages other than English spoken by large numbers of District residents.

VI. Some concerns remain regarding the accuracy of the Needs Assessment's estimate of the scope of needed services.

a. *Findings*

Although the Panel commends DMH and CFSA with the specificity with which they quantified various service needs in the 2007 Needs Assessment, the Panel questions whether the underlying Needs Assessment accurately captures all of the need, and thus whether implementation plans are sufficient to meet the true need.

The Needs Assessment states that CFSA and DMH continue exploring options "to accurately and comprehensively identify and track the mental health needs of children." The Needs Assessment promises that the "improved tracking system" will enable that effort. As has been noted, two years after the Needs Assessment was completed, the operational status of the tracking system remains unclear. It is now the end of 2009.

More specifically, the section of the assessment that addresses the number of children that may require sex abuse therapy is confusing. It identifies what appears to be a very low number of children in need of this service. It describes an expectation that other services may "have been implemented to meet individual needs" as they relate to sexual abuse. It claims further that sexual abuse therapy has been built into the "menu of specialty services to ensure that capacity is developed for children in the care of CFSA."

b. Recommendation

- The Panel urges CFSA and DMH to closely measure assessments of children entering foster care *and* of children at later stages of a foster care case to determine if a greater need for certain services than identified in the Needs Assessment may exist.

VII. Other implementation measurements

a. *Findings*

The Panel commends CFSA and DMH for working to develop detailed measurements to determine the quality and effectiveness of the District's Needs Assessment Implementation. The District stated its intention to develop means of measuring how long a child receives a specific service, how many services a child receives, and a child's progress after receiving specific services.

While the Panel acknowledges the complexity of developing such accountability measures and applauds the District for doing so carefully, it must be noted that the government has not yet developed comprehensive quality measures in the more than two years since the Needs Assessment was issued. Without such measurements, the District is without a feedback loop to identify and solve problems in implementation. Children could, for instance, be receiving one particular service in large numbers but have no appreciable benefit from it. Or children could be receiving duplicate services, or could be receiving certain services for longer than necessary (thus limiting overall capacity for that service). Clinicians at one Choice Provider may have markedly better (or worse) results than clinicians at others. Without more effective and comprehensive measurements, such issues cannot be identified and appropriate action cannot be taken.

b. *Recommendations*

- The Panel urges the District government to create comprehensive measurements in the very near future and build them into an ongoing feedback loop.

VIII. Outstanding information

Certain data requests from the Panel have not been responded to. These include the Panel's original and follow-up request for benchmarks for developing and monitoring Needs Assessment implementation. This would be of particular interest to the Panel since the Needs Assessment document stated that the Office of Clinical Practice was then developing polices that

may have "implications for mental health improvement activities." Did the MOUs and contracts reflect the policy development efforts of the Office of Clinical Practice? Were the MOUs and contracts executed before policy was development was completed? Is there some other inventory of policy directives that set out general goals and procedures for needs assessment issues, apart from what has been offered?

Recommendation: That CFSA provide the documents as requested and post them on the government website. Please advise when the documents will be provided or why they cannot be provided.

2. CFSA's 9/2 response stated that the status of progress by Choice Providers in providing specific service capacity was attached. It was not. The importance of this core information cannot be over-emphasized. It is critical in demonstrating at least two things: 1) support for the rationale for the Choice Provider approach; 2) evidence that the children/families are benefiting from competent Service providers. What is the status of the DMH initiative with the Court Social Services Guidance Clinic in providing training, supervision and coaching for Choice Providers in sexual abuse matters?

Recommendation: That CFSA provide the requested information without delay.

3. The Panel inquired about specialized training for foster parents in mental health issues, especially trauma issues, but did not receive a clear response. Foster parents are in a unique position to observe behavior changes/indications in children in their homes, and play an essential role in identifying mental health needs at points other than the beginning of a case (see Part VI). Such observation can be helpful to professionals who provide services, while keeping the foster parents in the loop. Foster parents are also the most central point of contact for social workers, school officials, the GAL and CASA representatives as well as medical personnel. The foster parent(s)' role is most useful when supported by informed observational skills they would acquire through specialized training.

Recommendation: That CFSA advise the Panel on its planning for training foster parents; what the training consist of; who will provide it; how the agency plans to incorporate the parents' input at steps in the provision of services process. For example, their contribution to the 90 day review would help complete the picture offered by the professionals.

4. The cost analysis chapter provided by the Annie E. Casey consultants was based on service projection estimates. In addition, a projected cost per child and aggregated values for each service area were provided. Utilizing the cost analysis, among other possible resource points, a multi-agency work group devised the multi-year plan of mental health services for foster children. The Panel did not receive a copy of the analysis, despite two requests. The basic information about Medicaid rates received at the September meeting was been helpful. What part did the analysis play in assisting the work group to identify needed changes in the Medicaid payment structure in order to attract high quality providers of services? Please explain if/how that effort has been successful. To what extent has it been unhelpful? Knowing how the multi-agency work group used the information to devise the multi-year plan would provide context in understanding current and projected progress in the services underway and that relationship to the Needs Assessment itself.

Recommendation: That CFSA provide a copy of the Cost Analysis Report; information on how it was used; and respond to the questions immediately above.