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IVA Response to BCDSS Behavioral Health Plan (rev. 2/4/2020)

Background

The *L.J.* Modified Consent Decree requires the Baltimore City Department of Social Services (BCDSS) under the Health Care Section, Additional Commitments to complete the following:

By December 31, 2010, DHR/BCDSS shall operationalize a system to meet the mental health needs of children in OHP. The system will include access to mental health screening and assessment as well as a continuum of treatment services designed to secure ongoing treatment that meets the needs of the children in OHP. DHR/BCDSS will seek the advice and input from the Health Care Advisory Group in the development and implementation of this system.

At the June 12, 2019 *L.J.* problem solving forum, Counsel for Plaintiffs requested an update on this additional commitment. The parties agreed that the Defendants would provide an update within 60 days. A document titled "Child Welfare Mental Health Strategic Plan" was provided in response to Plaintiff's request. It was shared with IVA and Health Care Advisory committee on 8/14/19 and shared more widely on 8/22/19.

Following the receipt of the proposed plan, the IVA submitted comments and questions to the Defendants. The Defendants submitted an amended document titled Baltimore City Department of Social Services Behavioral Health Plan to the IVA shortly before the *L.J.* problem solving forum held on February 10, 2020. The Defendants asserted that they had answered the IVA's questions in the text of this updated document.

This memo is in response to the Defendants' BCDSS "Behavioral Health Plan" dated February 4, 2020.

Initial Mental Health Assessments

The Defendants asserted that the initial mental health assessment process is working well. What evidence is there to support this assertion? This question was not answered in the Defendants most recent version of the plan.

If the process for obtaining an initial mental health assessment is working well as asserted, what is being done to ensure that the recommendations in the initial mental health assessment are being followed by the staff members responsible for ensuring their implementation? Who will be responsible for this follow up and how will it be tracked? These questions were not answered

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in the latest version of the plan. Follow-up on recommendations is essential to good outcomes for foster youth with behavioral and mental health needs.

The Plan (p. 3) says that the Comprehensive Health Assessments are being sent to primary care doctors. This is a requirement under the MCD but questions by the IVA about this issue yielded different responses from different members of the DSS staff. Please provide clarification.

We were heartened to see in the “wish list” for the new MATCH contract that we were provided on April 20 that the intention is for MATCH staff, rather than BCDSS staff, to be responsible for the completing the Comprehensive Health Assessment.

Psychiatric Oversight

We understand that Dr. Barnett will be used more strategically and that she has already co-located to Biddle Street to be more accessible to BCDSS staff. We look forward to her efforts to establish standard operating procedures for review of all psychotropic medication consents and monitoring and hearing more about how Dr. Barnett will be involved once her hours are increased under a new contract.

Recently, we have been told that Dr. Barnett also will be available to do Certificates of Need (CONs) required for placement in residential treatment centers, and the new Mental Health Plan has her providing guidance for the mental health navigators.

This announcement raises two concerns:

- (1) If she provides the CON for a child, it would raise concerns if she is also the person who is asked to provide the assessment as to whether or not congregate care placement is appropriate.
- (2) The significant expansion of her duties raises questions as to whether .75 FTD will be sufficient to ensure her availability to staff as needed.

Crisis Intervention and Stabilization Services

Several of the IVA’s questions regarding these services were not answered in the Defendants’ most recent plan. These questions remain and are as follows:

How are the cases being tracked to determine how these efforts are impacting mental health outcomes for children in foster care?

Has placement stability improved since implementation of these services?

What follow up is done after the six weeks of services? Who is responsible for ensuring that the youth is linked with a long-term provider?

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Regarding the availability of the BCARS program, what is DSS doing to educate MATCH, DSS staff, foster parents (TFC and regular) and kinship care providers of these services?

Mental Health Navigators and Therapists

The updated plan stated that the newly hired social work therapists would be available to provide mental health navigation services as well as direct mental health therapy to children in foster care. These social work therapists were viewed as an essential component in both versions of the plan. However, at the February 10th L.J. Problem Solving Forum, David Beller, counsel for DHS, stated that these employees would not be able to provide direct mental health therapy because DHS/BCDSS are not a HIPAA covered entity. How will these critical interim mental health services be provided?

How is the work of the navigators being tracked to determine its efficacy?

Additional Comments

Renewal of the MATCH contract is currently in negotiation. The IVA has very limited information regarding the role that MATCH will play in the future for behavioral and mental health issues. A study completed by Health Management Associates found large gaps in these types of services for children/youth in BCDSS care. It also found significant problems with the integration of the work of the MATCH and the BCDSS staff. If MATCH continues to have social work staff under the new contract, how will they be better integrated with BCDSS staff? How will their work be integrated with that of the mental health navigators?

The IVA continues to be concerned about the adequacy of this plan.

First, as previously shared, the plan focuses on initial assessments and crisis intervention with little attention to on-going mental health care. Many foster children and youth will need on-going mental health care without ever having reached a crisis point. We know that children are likely to experience many changes between their first 30 days in foster care and 6 months, or a year or more later. The average length of stay for children exiting foster care was still more than 30 months as of the 62nd Report. What regularly-scheduled opportunities will there be for comprehensive re-assessments?

Second, the plan is very child-centered rather than family-entered. Crisis services under BCARS frequently occur in the foster home and do not involve the biological family. How will engagement of the biological family, essential for permanency, be enhanced?

Third, we frequently are told by BCDSS and MATCH of problems getting youth to attend therapy or take medications. What efforts will there be to find culturally-competent, innovative

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ways to provide therapeutic services that would be more appealing and meaningful to older youth, in particular?

Lastly, this plan does not address evidence-based treatment and recognition of ACES and trauma. BCDSS needs to ensure that the appropriate and effective therapeutic interventions are provided to children and families in the child welfare system.