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Testimony Before the District of Columbia Council
Committee on Health
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Department of Behavioral Health

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Introduction

Good morning Chairman Gray and members of the Committee. My name is Sharra E. Greer. I am the Policy Director at Children's Law Center[1] and a resident of the District. I am testifying today on behalf of Children's Law Center, which fights so every DC child can grow up with a loving family, good health and a quality education. With more than 100 staff and hundreds of pro bono lawyers, Children's Law Center reaches 1 out of every 9 children in DC's poorest neighborhoods – more than 5,000 children and families each year.

I appreciate this opportunity to testify about the budget for the Department of Behavioral Health (DBH). I am going to focus my testimony on School Based Mental Health. The Mayor's Budget includes an enhancement of $6,089,694 and 1 Full Time Employee (FTE) to continue the expansion of this program, an important and necessary investment.[2] We do have some suggestions about the program and its budget that we think are important for its success. In addition, it is important to note that the SBMH expansion is only one piece of the larger effort to address the mental health needs of students and ameliorate the effects of trauma. Two other key pieces are the continued expansion of Community Schools and funding the full implementation of the discipline reform legislation, Student Fair Access to Schools.

We have testified year after year that many of the children we work with—children in the foster care system or receiving special education services—only need our

help because their mental health needs have gone unaddressed. Many have been faced with multiple adverse childhood experiences and resulting complex trauma and need access to high-quality services to achieve stability. But even our well-trained lawyers have difficulty connecting children to appropriate mental health services and cite the lack of timely, quality and appropriate mental health services as one of the greatest barriers to success for our children. Appointment delays and high staff turnover rates plague many of the Core Service Agencies (CSAs) that provide needed mental health services to many Medicaid-eligible children. In general, despite some progress over the past several years there are gaps that leave families, teachers, social workers, probation officers, lawyers and judges scrambling to meet the mental health needs of at-risk children in the District. There are also major systemic challenges due to the fragmentation of our public mental health system.[3]

One of the best ways to improve access to mental health care for children is to provide services where they are. Counseling services in school or at the school building can make a huge difference for the children who need them. In addition, prevention services and lower level services provided in the school can help children from escalating and needing high level and acute services.

A comprehensive public health approach to School Based Mental Health (SBMH) has been worked on in the District for the last several years. Until 2016, DBH had very slowly been expanding its School Based Mental Health Program (SMHP) by adding

additional DBH clinicians to schools.[4] In FY16, the SMHP operated in 68 DC Public and DC Public Charter Schools, only approximately 31% of the schools in DC.[5] It had become clear that expanding the model this way was unlikely to reach all schools and be able to provide all service levels.

In 2016 DBH lead an inter-agency process to propose a new and different approach to school based mental health. The result of that process was the District of Columbia's Comprehensive Plan to Expand School-Based Behavioral Health Services submitted on May 9, 2017 by the Deputy Mayor for Health and Human Services (DMHHS) to the Committee on Health and the Committee on Education.[6] There were many questions around the plan and how it would be implemented, so through the School-Based Behavioral Health Comprehensive Plan Amendment Act of 2017, passed as part of the FY 2018 Budget Support Act of 2017, the Task Force on School Mental Health ("Task Force") was created.[7] The Task Force was charged with reviewing the plan and recommending changes to the plan and a timeline for implementation. The Task Force's report[8] was delivered to the Council on March 26, 2018.

Shortly after the report from the Task Force was released, the Coordinating Council on School Mental Health (Coordinating Council) was formed to guide the implementation of the expansion.[9] The approach supported throughout this process, including in the Task Force report, is a public health approach to SBMH. The principles of this approach are:

- Population-based interventions that focus on the mental well-being of all children;
- Creating environments that promote and support mental wellness and resiliency;
- Balancing the focus on children's mental health problems with a focus on positive mental health
- Working collaboratively across service sectors and entities that impact children's well-being to support positive mental health; and
- Adapting the strategies employed to the needs and strengths of the children, families and caregivers to be served.[10]

Through this approach at the end of the expansion all public schools, traditional and charter, will have Tier 1 (Promotion and Primary Prevention), Tier 2 (Focused Group and Individual Interventions), and Tier 3 (Intensive Support) behavioral health supports. Each Tier's supports will consist of a variety of programs, services, and supports that individual schools can tailor to meet the needs of the students and their school. These services will be delivered through different combinations of internal and external providers depending on the need of the school and resources.

The first step to implement this model was to finalize the schools to be selected for the expansion. That process was finalized at the end of April 2018. The next major step was to select the Community Based Organizations (CBOs) that would be eligible to

be paired with schools to enhance the services in the school. It took until the end of August to finalize the providers. The process of matching schools with CBOs has taken time. As of March 18, 2019, most of the matches had occurred and many were in the process of completing Memorandums of Agreement (MOAs), but only 13 CBOs had started providing additional services in schools.[11] Unfortunately, this means that the vast majority of CBOs will be in the schools for only a few months before the school year ends.

Establishing a community of practice and technical assistance to support the CBOs is also a key component of the expansion. That process has also gone more slowly than hoped. That RFP was released at the end of September 2018, but for a variety of reasons a vendor had not been selected as of the March meeting of the Coordinating Council.

The challenges faced in year one of the expansion have provided insights and guidance on how to overcome the hurdles so that year two expansion should be easier and faster. There are several necessary components for this effort to be successful going forward. First, adequate funding so that the current cohort of schools can continue to work with the CBOs they are paired with. Steps need to be taken to ensure the current and pending grant awards and can be continued through SY19-20. Our understanding is that the enhancement in the FY20 budget is in addition to a base $3 million for the

program allocated last year. This should allow the continuation of the current relationships at the current service provision level.

Second, funding for each school must be sufficient for the public health model. For FY19 the decision was made to provide a set amount to each school to allow for a full-time clinician in each school at a cost of approximately $54,000 per school. The assumption was that the CBO provider would bill 50% of her time to insurance in order for the arrangement to be financially viable for the CBO. This was done not because that was the best ratio between billable and non-billable services, but because the goal was to expand to 52 schools with $3 million dollars. This same calculation was used for the budget this year, assuming approximately $54,000 per school to expand to 67 schools. A clinician having 50% billable time leaves very little time to provide other lower level services – specifically Tier 1 and most Tier 2 services. In many schools this will mean there will not be the full spectrum of needed services. This amount per school should be modified or the allocation model re-examined so that every school has the full range of needed services.

Ensuring that the resources are adequate to provide the full spectrum of services can be easily accomplished by slightly downsizing the number of schools for the planned year two expansion. A more modest expansion is also appropriate given that any expansion will require providers increasing their capacity significantly and that is time consuming and limited by available workforce. Further, since we have not had a

full year to evaluate how the current expansion is working a more modest expansion seems wise.

Third, dedicated staff has to be sufficient for the program. Our understanding is that a part of the enhancement is dedicated for staff to oversee the program. This is essential. The model is based on a school-based coordinator in each school who is responsible for coordinating all the services in the school. Most schools have multiple sources of behavioral health supports. DCPS and some Charter Local Education Agencies provide behavioral health staff. Some schools have other resources from non-profits. Some schools have resources from OSSE. Some schools are also community schools. The on the ground school point person has to ensure that combined all resources meet the needs of the school or they must identify gaps that need to be filled hopefully through the SBMH program. In order for this to be successful the school staff will need support, guidance and technical assistance. In addition, the work of the CBO matching also requires staff.

Lastly, money has to be available at the start of the school year and the funding needs to be secure. The fact that the money was not available until after October 1, 2018 was a significant challenge in starting services. Services in the school should start at the beginning of the school year. In addition, for community-based organization to make the investment in hiring staff and integrating into a school, it is important that they have confidence the funding will be available past the first year. The budget for

this program needs to start to be shifted so funds can be dispersed in alignment with the school year.

Conclusion

Thank you again for the opportunity to testify. I am happy to answer any questions.

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[1] Children's Law Center fights so every child in DC can grow up with a loving family, good health and a quality education. Judges, pediatricians and families turn to us to advocate for children who are abused or neglected, who aren't learning in school, or who have health problems that can't be solved by medicine alone. With more than 100 staff and hundreds of pro bono lawyers, we reach 1 out of every 9 children in DC's poorest neighborhoods – more than 5,000 children and families each year. And, we multiply this impact by advocating for city-wide solutions that benefit all children.

[2] DBH FY20 Proposed Budget pg 14.

[3] We just published a paper with Children's National Health System and the DC Behavioral Health Association that outlines the current system and demonstrates its fragmentation and complexity. https://www.childrenslawcenter.org/resource/behavioral-health-district-columbia-children-youth-families-understanding-current-system

[4] *South Capitol Street Memorial Amendment Act of 2012* required that a comprehensive school based mental health plan, with a strategy for expanding early childhood and school-based behavioral health programs and services to all schools, be developed by SY2016-2017.

[5] DBH FY16 Performance Oversight Responses, Q25. That number remained static for FY17. DBH FY17 Performance Oversight Responses, Q25.

[6]https://dmhhs.dc.gov/sites/default/files/dc/sites/dmhhs/publication/attachments/District%20Comprehensive%20Plan%20for%20Early%20Childhood%20and%20School-Based%20Mental%20Health%20Services.PDF

[7] School-Based Behavioral Health Comprehensive Plan Amendment Act of 2017, passed as part of the Fiscal Year 2018 Budget Support Act of 2017, Law L22-0033 Effective from Dec 13, 2017.

[8] See https://dmhhs.dc.gov/sites/default/files/dc/sites/dmhhs/page_content/attachments/Task%20Force%20on%20School%20Mental%20Health%20Report%20%28Final%20Submitted%29%203%2026%2018.pdf.

[9] Children's Law Center is a member of the Coordinating Council.

[10] https://dmhhs.dc.gov/sites/default/files/dc/sites/dmhhs/publication/attachments/District%20Comprehensive%20Plan%20for%20Early%20Childhood%20and%20School-Based%20Mental%20Health%20Services. At 13.

[11] Data provided to the Coordinating Council on School Mental Health, March 18, 2019, on file with Children's Law Center.