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Testimony Before the District of Columbia Council
Committee on Health
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Public Hearing:
Performance Oversight Hearing
Department of Behavioral Health
Mayor's Commission on Healthcare Systems Transformation

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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 nearly 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. The focus on my testimony is the Department of Behavioral Health's (DBH) implementation of the school based behavioral health expansion. I will also briefly address the Mayor's Commission on Healthcare Systems Transformation Report and Recommendations.

Mayor's Commission on Healthcare Systems Transformation

The Report and Recommendations of the Mayor's Commission on Healthcare Systems Transformation[2] focuses on many important areas that need improvement across the city. It is, however, largely silent on issues directly affecting children and children's mental health. As the Council and the Mayor consider implementation of these recommendations, I want to urge that children and children's mental health concerns are included, particularly in following areas:[3]

- Recruiting and retaining specialty providers. We have a significant shortage of mental healthcare providers for children, particularly in certain specialties,

and finding ways to increase that workforce will be key to meeting the existing need.

- Make telehealth a more viable option for certain types of care. Telehealth can be an important way to bring services to children where they are and can access them.

- Explore options to address behavioral health services for pediatrics to address the serious challenges that exist around psychiatric hospitalization for youth.

- Set up an ongoing mechanism to analyze workforce supply and demand and training needs so we can fill our gaps and shortfalls.

It is vital that transformation of our healthcare system include addressing child specific issues.

School Based Mental Health

The DBH led expansion of school based mental health services is currently in its second year of implementation. This expansion takes a public health approach to providing mental health services to children in their schools and communities and involves DBH partnering with community-based organizations (CBOs) to bring mental health services to all public schools – both traditional and charter – in the District of Columbia.

This endeavor is the culmination of many years of planning and effort. We appreciate this Committee's support for these efforts. In the second year of expansion adjustments have been made that have improved the program and gotten clinicians into schools faster. Dr. Bazron's leadership on the Coordinating Council on School

Behavioral Health (Coordinating Council) has been very helpful in moving this program forward.

Background

Year after year, Children's Law Center has testified that many of the children we work with – children in the foster care system or receiving special education services – only need our services because their mental health needs have gone unaddressed. Many of these children have faced multiple adverse childhood experiences and have resulting complex trauma and need access to high quality services to achieve stability.

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.

Providing school based mental health services throughout the District is a goal DBH has been working towards for more than a decade. After realizing existing programs were insufficient to meet the needs of DC children and youth, DBH led an inter-agency effort to develop a comprehensive public health approach to school based mental health, starting in 2016. In the years since, representatives from multiple government agencies, members of the Council's Health and Education committees, mental health providers, parents, and stakeholders from many advocate, academic, and

service organizations have participated in the process that led to the development of the public health model for the expansion of school based behavioral health.[4] This diverse group of stakeholders, currently known as the Coordinating Council on School Behavioral Health,[5] remain engaged in the process of ensuring the timely and successful implementation of the expansion under the new public health model.

The goal of this reform is for all public schools, traditional and charter, to have Tier 1, Tier 2, and Tier 3 behavioral health supports, consisting of a variety of programs, and services that individual schools can tailor to meet the needs of their students and community. We are currently in the second year of implementation of this expansion, with the intention of reaching all schools within four years.

Current Status

Implementation of the expansion for year two has gone significantly better than last year. In January of 2019, only 38 of the 52 schools in Cohort 1 had been matched with a CBO, and only a couple had actually started providing additional services.[6] This year over 75% of schools from Cohort 1 and 2 have new clinicians providing services.[7] Of the remaining schools only a couple have not yet been matched with a provider. For the vacant spots, for three schools from Cohort 1 and eleven schools from Cohort 2 that have been successfully matched with a CBO are still waiting for a CBO clinician to be hired for their school. Notably, all three of the Cohort 1 schools and two of the Cohort 2 schools have been matched with one particular CBO that has, as far as we know, failed

to place a single clinician in any of the seven schools it was matched with. This means a single CBO is responsible for over a third of the unfilled CBO clinician positions in Cohorts 1 and 2. We know that DBH is working with this CBO to address the reasons behind its failure to place clinicians and develop a better system of ensure prompt placement of clinicians. We anticipate this will be in place by the end of the year and will not be an issue with the next cohort of schools.

In addition to working to get CBO clinicians in schools, significant work has been done to support the program and ensure its success. One key part of the program is that each school have a School Behavioral Health Coordinator (SBHC) to ensure collaboration and coordination of the whole school behavioral health/wellness team. The SBHC also collaborates with the school behavioral health team to identify school-wide or classroom trends in social, emotional and behavioral health needs and develop student programming based on those trends. Most schools now have an identified SBHC. In addition, the SBHC is being supported by a team of DBH clinical specialists. DBH created this team to provide CBO's and schools with consultative services and technical assistance. Additionally, they help identify gaps in services.

With this infrastructure in place at the school level it has been possible for schools to complete the School Strengthening Tool & Work Plan. The School Strengthening Tool & Work Plan were adapted from the Center for Disease Controls (CDC) School Health Index and embrace the Whole School, Whole Community, Whole

Child (WSCC) framework. The WSCC framework is student-centered and emphasizes the role of the community in supporting the school, the connections between health and academic achievement and the importance of evidence-based school policies and practices. Based off the information from the School Strengthening Tool the SBHC develops and then uses that assessment to create the work plan for the school to address its unique needs. At this point the vast majority of schools have completed the School Strengthening Tool (95 schools) and a work plan based on the tool (85 schools).[8]

Lastly, this year the Community or Practice (CoP) for the program was launched. The George Washington University Milken Institute School of Public Health was awarded the contract to run the CoP. The CoP was launched on September 20, 2019. The CoP is an important addition to the program to help provide support, training and technical assistance for the school-based providers. The clinicians from the program will be meeting on a monthly basis with support from the CoP technical assistance managers and Program Coordinator to solve problems, discuss insights and share information, develop tools and frameworks to make their programs more successful.

Next Steps

We are continuing to learn lessons to improve the program and identifying barriers to success. Now that we have had almost one full year of clinicians in schools, we are ready to begin evaluation of the program and a deeper analysis of some of the barriers. One of the most important changes in year two was moving up the timeline

for releasing the Request for Proposals (RFPs) to the CBOs so that contracts could be awarded, and clinicians hired before the start of the school year. For year three, 60 schools have been identified to be part of the cohort. The timeline to release the RFPs has been moved up even further than last year to February which should lead to even more schools starting the year with the CBO matched and the staff hired.

Evaluation

The contract to evaluate the program has still not been awarded. The responses to the RFPs were received January 6 and are currently under review. We are hopeful that a contract will be awarded soon. Having this last large piece in place is critical as we assess the impact of having the expanded service in schools and look to find ways to improve effectiveness and impact.

As we evaluate the program it is likely that we will learn lessons that lead to additional adjustments. For example, the goal is to provide the needed Tier 1, 2 and 3 services to all schools. Is that goal being accomplished? Are their gaps in schools needs that are not being met? Does more tailoring need to be done by school? Is the business model sustainable for the CBOs? And most importantly, are children's needs being met?

All of these are questions that DBH and the Coordinating Council need to review over the next year.

Workforce Constraints

We have already learned that recruiting and retaining qualified clinicians is a challenge that will likely grow as the program expands. Last year it was recognized that may of the clinicians available for these positions were less experienced social workers. DBH recognized this and worked to adjust the supervisor to social worker ratio so that the social workers would be appropriately supported and supervised. DBH also developed a workforce pipeline portal to support CBO's staffing their programs by creating a pathway for employment and career advancements. This portal will allow licensed clinicians and graduate students to submit information where all participating CBO's will have access to review potential applicants. Hopefully, this will make it easier for potential employers and clinicians to connect.

However, the problem of recruiting and retaining qualified candidates is complex and will require longer term strategies to fully resolve. Over the next year DBH, with the Coordinating Council and its sister agencies, is going to have to review what other steps can be taken. These will need to include looking at the payment model, possible ways to streamline licensing and credentialing, possible incentives and loan repayment options, among others.

School Coordination

Schools have many different priorities and constraints. Ensuring that all the schools are integrating the new clinicians and supporting the SBHC is important for

success. DBH is in the process of completing an MOU with DCPS and OSSE to fund two dedicated staff to support schools in the expansion process. These new positions, as well as support from the DBH clinical specialists should help address this issue. For school based mental health expansion to work, there must be meaningful engagement between the individual school administration, the school wellness team, the school community, the CBO clinician and the CBO.

Conclusion

Thank you for the opportunity to testify. I look forward to answering any questions you may have.

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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 nearly 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] Available at: https://dmhhs.dc.gov/sites/default/files/dc/sites/dmhhs/page_content/attachments/Report%20and%20Recommendations%20of%20the%20MCHST_FINAL.pdf.

[3] The specific recommendations from the Report and Recommendations of the Mayor's Commission on Healthcare Systems Transformation, 2020, are:

Committee on the Equitable Geographic Distribution of Acute, Urgent, and Specialty Care: Recommendation #1 Provide increased loan repayment/incentives to recruit and retain primary care and designated specialty providers, as well as non-clinical staff, in Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs).

Committee on Emergency Room Overcrowding & General Reliance on Inpatient Hospital Care: Recommendation #5 Use telehealth to provide initial consultations, pre-arrival assessments, and follow-up care to promote appropriate care intervention in a timely fashion. Incentives and regulatory constraints should be assessed to entice participation by providers and patients. A successful model should include telehealth reimbursement rates that meet the market rate/cost of the service.

Committee on Access to Critical and Urgent Care Services: Recommendation #8 Incentivize the establishment of new Comprehensive Psychiatric Emergency Programs (CPEP) sites and endorse the Department of Behavioral Health proposal for a comprehensive waiver to redesign the CPEP. – Which specifically says, "the District should explore options to address behavioral health services for pediatrics to address the serious challenges that exist around psychiatric hospitalization for youth."

Committee on Allied Health Care Professionals and Workforce Development: Recommendation #4
Establish a center for health care workforce analysis to systematically gather, link, and analyze national and local data on current and projected workforce supply and demand and training needs; and develop policy documents and recommendations for District agencies, Council, and funders (e.g., shortages to be addressed, emerging industries, data to be collected through the licensure process, common core skill sets, training resources needed, career pathways, etc.).

[4] The District of Columbia's Comprehensive Plan to expand school-based behavioral health services was submitted on May 9, 2017 by the Deputy Mayor for Health and Human Services to the Committee on Health and the Committee on Education. Early Childhood and School-Based Behavioral Health Services, Comprehensive Plan, *retrieved from:* https://dcpcsb.org/sites/default/files/report/District%20Comprehensive%20Plan%20for%20Early%20Childhood%20and%20School-Based%20Mental%20Health%20Services.pdf. 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 was created. The 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. The Task Force reviewed the plan, recommended changes to the plan, and proposed a timeline for implementation in a report delivered to the Council on March 26, 2018. Report of the Task Force on School Mental Health, March 26, 2018, *retrieved from:* 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. Shortly after the report from the Task Force was released, the Coordinating Council on School Mental Health was formed to guide the implementation of the expansion. Children's Law Center is a member of the Coordinating Council.

[5] I serve on Coordinating Council on School Behavioral Health.

[6] Minutes of the Coordinating Council on School Behavioral Health on file with Children's Law Center.

[7] Data provided by the Coordinating Council. 119 schools were initially identified to be included in Cohorts 1 and 2 of the school based mental health expansion that began during the 2018-2019 school year. Of these, five schools are not currently participating. One of the charter schools closed and another is closing, two other schools requested to delay joining the program and one is not participating currently for another reason. Six schools have received clinicians through DBH. For the remaining 108 schools, 106 have been matched with a CBO and CBO clinicians have been placed in 85 of these 106 schools. 95 schools have been matched.

[8] Data provided by the Coordinating Council.