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Testimony Before the District of Columbia Council
Committee on Health
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Public Oversight Hearing:

The Department of Behavioral Health

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Introduction

Good evening, Chairman Gray and members of the Committee. My name is Tami Weerasingha-Cote. I am a Policy Attorney at Children's Law Center[1] and a resident of the District. I am testifying this evening 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 Department of Behavioral Health (DBH). I am going to focus my testimony on school based mental health. This is the second year of implementation for the public health model of school based mental health, which involves working with community-based organizations (CBOs) to bring mental health services to all public schools. As you know, this endeavor is the culmination of many years of planning and effort. We commend DBH for its significant work leading the expansion of school based mental health through the public health model. We also appreciate this Committee's support for these efforts and urge continued investment in this essential program. We have some suggested areas of focus for the Committee to provided targeted support and resources, but above all, we ask the Committee to continue to make the expansion of school based mental health a top

priority, both in terms of funding and in terms of programmatic oversight and attention.

As you know, 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 been faced with multiple adverse childhood experiences and 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.

Before going further, I want to acknowledge how far we've come. 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 mental health.[2] This diverse group of stakeholders, currently known as the Coordinating Council on School Behavioral Health, 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, services, and supports 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.

As of this month, 109 of the 116 schools in Cohorts 1 and 2 have been matched with a CBO and CBO clinicians have been placed in 72 of these 116 schools.[3] At first glance, these numbers may seem a bit discouraging. Indeed, there are significant barriers to hiring and placing CBO clinicians in school – including problems with the funding structure, a limited pipeline of qualified professionals, and coordination challenges at the individual school level. We can start to address these barriers with targeted budget and programmatic support. With respect to funding, it is important that the timeline for grant allocations and CBO contracts be moved up so that there is sufficient time to hire and place clinicians in schools by early August – before the school year starts. It's also important for the Mayor and the Council to commit to funding this

program in the long-term, so that schools, CBOs, and CBO clinicians can count on stable services and employment, which would also help with recruiting the right professionals for these positions. Finally, as we continue to learn how the public health model works on the ground in individual schools, funding for the program must be updated to reflect the true cost of the program. For example, in the first and second years of implementation, we learned that the cost of the CBO clinician is a bit higher in the first few months as the clinician builds a caseload and gains billable hours. The budget for future years should be adjusted accordingly to cover these startup costs.

The problem of recruiting qualified candidates is complex and may require longer term strategies to fully resolve. In the short term, however, this Committee can support DBH's efforts to market and structure the program to attract more qualified candidates. It would be particularly helpful to support an effort to eliminate or reduce licensure and certification barriers that make it unnecessarily difficult for clinicians to start working.

With respect to school coordination challenges – again, this is a nuanced problem that is closely tied to the culture and resources of individual schools. We would like to see this Committee work with the Education Committee to identify and support resources to facilitate coordination from the school side. For school based mental health expansion to work, there must be meaningful engagement between the individual school administration, the CBO clinician, the CBO, and DBH. Some schools are

struggling with this. As the program is currently structured, an existing staff person at each school must take on the role of mental health coordinator without additional resources or compensation. We need to develop a strategy for supporting schools and individuals in this position to ensure meaningful engagement and program success. Further, more work needs to be done to educate school leaders and the broader school community on the differences of Tier 1, Tier 2, and Tier 3 services, their relationship to each other and to student mental health outcomes; and the roles of various members of the school's mental health support team. This work must be done so that schools can make effective use of the additional resources being provided through this program, CBO clinicians are able to build sufficient billable caseloads, and the public health model is financially sustainable in the long run.

Work on many of these fronts is already underway – in large part due to the support of this Committee, the Council more broadly, and the efforts of DBH, DCPS, OSSE, the Coordinating Council, and other stakeholders. To name a few – we understand that the Council approved an increase in the CBO grants to allow for a tighter supervision ration of 6 CBO clinicians for every one DBH clinical supervisor; DBH was able to award the CBO grants earlier this year, and plans to award the funds even earlier next year in an effort to get CBO clinicians in place before the start of the school year; DBH is about to sign an MOU with DCPS and OSSE to fund two dedicated staff to support schools in the expansion process; and progress has been made in

developing a community of practice designed to provide technical assistance and facilitate the development of best practices. These efforts reflect lessons learned from the first year of implementation. We are already seeing improvement with respect to implementation this year and expect to see continued improvements for subsequent cohorts.

Things are moving in the right direction. Like any new effort, challenges exist. But we feel strongly that with continued support from this Committee and sustained effort by DBH, DCPS, OSSE and the many partner schools and organizations involved in this work, these challenges can be overcome. We need to take time to do this work right, and that may require adjusting the timeline for expansion to allow for a more gradual rollout over three additional years, instead of two. We're finding that in many ways expansion is a highly school-specific endeavor. Working with smaller cohorts of schools will enable program administrators to work more closely with individual schools to address specific obstacles to implementation. It would also give CBOs time to figure out the best ways to scale up their programs, as well as give DBH time to recruit the additional CBOs that will be needed to provide services to the more than 230 traditional and charter public schools in DC.

Conclusion

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

[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] 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://dmhhs.dc.gov/sites/default/files/dc/sites/dmhhs/publication/attachments/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. 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.

[3] Data provided by the Coordinating Council on November 19, 2019. Cohorts 1 and 2 previously included three additional charter schools, bringing the total number of schools for both cohorts to 119. One of these charter schools closed, and two other requested to delay joining the program. Accordingly, we are not including them in our assessment of implementation progress.