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Testimony Before the District of Columbia Council
Committee on Health
February 1, 2023

Public Oversight Hearing:
Performance Oversight
Department of Behavioral Health

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Introduction

Good Afternoon, Chairperson Henderson and members of the Committee on Health. My name is Amber Rieke. I am the Path Forward Project Lead at Children's Law Center. Children's Law Center believes every child should grow up with a strong foundation of family, health and education and live in a world free from poverty, trauma, racism and other forms of oppression. Our more than 100 staff – together with DC children and families, community partners and pro bono attorneys – use the law to solve children's urgent problems today and improve the systems that will affect their lives tomorrow. Since our founding in 1996, we have reached more than 50,000 children and families directly and multiplied our impact by advocating for city-wide solutions that benefit hundreds of thousands more. CLC is a member of the Strengthening Families Through Behavioral Health Coalition which brings together a diverse group of advocates who share a commitment to improving DC's behavioral health care system for children and families.[1]

I appreciate this opportunity to testify regarding the performance of the Department of Behavioral Health (DBH) over the past year. My testimony will underscore why full implementation of the School-Based Behavioral Health (SBBH) Expansion Program must be a top priority for DBH. I'll first share national and local data about the mental health crisis facing children and adolescents, and the barrier to proper care. My testimony will then outline how the SBBH program has begun to address the crisis through strategic investments. I will briefly summarize some of the implementation challenges experienced by DBH, partnering

organizations, schools, and families in need of services. Finally, I set forth steps needed to fully implement a sustainable, data-driven program, so that every DC child has access to high-quality, consistent, and culturally responsive behavioral health care, specifically:

1. Ensure stable compensation per clinician in Fiscal Year 2024.
2. Use – and share – reliable, actionable data as the foundation for planning and payment.
3. Provide DC students and families with better and more easily accessible information about available services in schools.
4. Have Council host a public roundtable about SBBH to hear insights from all stakeholders involved in the program and answer key questions about the evaluation and the cost study.

National and local data show the mental health of children and adolescents trending in dangerous directions

In late 2021, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association – together representing more than 77,000 physicians and more than 200 children's hospitals – declared a national state of emergency in child and adolescent mental health.[2] Their report warned of "soaring rates of depression, anxiety, trauma, loneliness and suicidality" in children that will have a long-lasting impact on their lives. The U.S. Surgeon General shortly followed with an advisory highlighting the urgent need to address the nation's youth mental health crisis.[3]

The COVID-19 pandemic undeniably impacted childhood well-being. The proportion of all emergency department visits for kids related to mental health increased substantially in 2020.[4] The DC State Board of Education's Student Advisory Committee found that "mental

health was a concern for many students due to loneliness, family issues, heightened anxiety, technology troubles, and excessive workload—and that these were contributing factors to lower rates of class participation, engagement, and productivity."[5]

It is important to remember that the pandemic is not the sole driver of these troubling trends. Mental health symptoms – including depressive symptoms and suicidal ideation – have been steadily increasing among American youth for over a decade. In 2018, suicide was the second leading cause of death for young people ages 10–24.[6] Of children aged 3-17 years old in the U.S. in 2019 (our most recent comprehensive data and pre-pandemic), 9.4% were diagnosed with anxiety, 4.4% with depression, and 8.9% with behavior problems. In 2019, 36.7% of adolescents (12-17 years) had persistent feelings of sadness or hopelessness, 15.1% had a major depressive episode, 18.8% has seriously considered attempting suicide and 8.9% had attempted suicide. Further, 4.1% of adolescents had a substance use disorder before the age of 18.[7]

Many behavioral health issues begin in early childhood, with as many as one in six (17.4%) children 2-8 years old diagnosed with a mental, behavioral, or developmental disorder. The rates are higher (22%) for children living in poverty.[8] However, only one-fifth of children with mental, emotional, or behavioral disorders ever receive care from a specialized provider.[9] Further, this unmet need for mental health services is worse for children of color in than for white children.[10]

In DC, the rates of children and teens with anxiety or depression in 2020 were the

highest in the previous five years of data: 11.7% of kids.[11] About 23% of DC children had one or more emotional, behavioral, or developmental conditions in 2019-2020 (a slight increase from 21% in 2018-2019).[12] Nearly 15% of DC high school students reported attempting suicide in 2019, a full 5% more than the national rate.[13]

We know that children's environments directly impact their health and well-being; adverse childhood experiences and social conditions can become risk factors for poor outcomes, including housing instability, poverty, community violence, and other stresses. The health of the family is also relevant. It's alarming, then, that as of October 2022, 24% of adults living in DC households with children reported feeling felt down, depressed, or hopeless for more than half of the days or nearly every day for the past two weeks.[14] Even higher, 37% reported that they felt nervous, anxious or on edge for more than half of the days or nearly every day in the past two weeks; only 10 states saw higher numbers.[15]

The School-Based Behavioral Health Expansion Program is an essential endeavor to embed an array of in-demand services in convenient and trusted community spaces

The data above lays out the dangerous trends for our youth, and we each surely see the stories and harms play out from our respective vantage points – in our families, neighborhoods, and community. Research shows us, however, that early intervention, from screening to treatment, can change lives of individuals and improve the health of their families. The District of Columbia government has been rising to the occasion with strategic investments in programming, including SBBH. This program envisions a licensed clinician embedded in every public school in DC. This co-location model is a public health best practice,

and opens access for services to all District kids, ranging from group lessons about managing anger to more intensive one-on-one therapies. The SBBH Program lowers barriers to behavioral health care, so kids are getting the help they need right where they are spending most of their day.

The goal of this program is for all DC traditional public and charter schools to provide a full array of behavioral health supports at three tiers:

- Tier 1 encompasses mental health promotion and prevention for all students,
- Tier 2 includes focused interventions for students at risk of developing a behavioral health problem, and
- Tier 3 is comprised of intensive supports and treatment for individual students who are experiencing a behavioral health problem.[16]

One of the strengths of SBBH is the partnership with community-based organizations (CBOs) that have the capacity to provide all tiers of service. Most participating CBOs offer a broader range of health services through the District and are well-positioned to create effective and lasting care relationships with whole families. SBBH clinicians also serve an essential and distinct purpose within the school ecosystem, focused on the behavioral health of all staff and students. Once integrated, clinician can work with the other members of the school team (social workers, learning specialists, psychologists, leadership, etc.) to assess the needs of the school community, identify existing resources, and determine whether there are gaps that need to be filled.

DBH works with DC Public Schools (DCPS), the Office of the State Superintendent for Education (OSSE), and the Public Charter School Board (PCSB) to match specific CBOs with

individual schools. Once a school has been successfully matched with a CBO, they work together to hire a licensed clinician to provide full-time behavioral health services at the school. CBOs receive grants from DBH to cover a part of the compensation and supervision costs for these highly skilled clinicians. The grant amount was based on early estimates regarding the costs of the program, as well as the projected amount of Tier 3 treatment work that would be reimbursable to the CBOs by Medicaid and other insurance.

Full implementation of the School-Based Behavioral Health program has been impeded by COVID-19, virtual learning, workforce shortages and other challenges

DBH is currently in the fifth year of implementing SBBH, though most of the program has operated during a public health emergency. From the first year, roll-out was incremental, bringing on more schools in each year through four cohorts. Many schools and CBOs were forced to start new programs during interrupted school years and virtual learning. Fortunately, their commitment – and that of the Mayor, DBH and DC Council – maintained stable funding for the nascent program.

As of January 2023, 155 of 253 DC public and charter schools (61% percent) have a full-time CBO clinician providing services in school through the program. There are a total of 25 schools that have not yet been "matched" with a CBO, while 71 matched, or partnered, schools have vacant clinician positions. DBH reports that CBO and DBH clinicians and supervisors are providing interim support where there are current vacancies. Two schools have opted out of the program (Roots Public Charter School and Maya Angelou Academy at DC Jail) and are not participating in the expansion resources.[17]

Comprehensive data on the performance of the program is not yet available (see need for evaluation below). Preliminary data paints the picture of a program still working up to its service capacity. Clinician surveys completed last spring (April 2022) showed that clinician caseloads ranged from 5-9 students at a time to the largest average caseload of 11-15 students. The average number of sessions performed increased over time, ranging widely from 12-48 sessions per month. Generally, most clinicians conducted one-on-one (Tier 3 services), but only about half conducted Tier 1 or Tier 2 activities in a month. Clinicians in schools received fewer than four formal referrals each month, on average. These numbers suggest programs still ramping up to meet their potential, though measuring caseloads and referrals cannot tell the full story. For example, not every student or family desiring services gets a documented referral from the principal, School Behavioral Health Coordinators (SBHCs), or other gatekeeper of the referral process. Further, any behavioral health needs on an IEP document would not be reflected in these numbers, as those services are tracked separately.[18] In addition, we have very little information on the important nontreatment-based work the clinicians are providing in the school. In summary, more robust, inclusive evaluation is necessary to begin to analyze successes and gaps.

The original funding model should also be considered in context; it relied on CBO clinicians spending at least 50% of their time on Tier 3 (individual) services that are reimbursable by Medicaid. This has not played out as envisioned.[19] Fundamentally, many clinicians reportedly haven't reached their service capacity yet. While CBO clinicians can bill

Medicaid Managed Care Organizations (MCOs) for services, low numbers of referrals and low caseloads during and since COVID-19 closures decreased potential billing. DBH noted a year ago that a minority of CBOs actively billed private insurance, though they could apply to be paneled with private insurances.[20] As a result, the billing expectation isn't achievable in all schools and some CBOs are operating at a loss. Different schools have different needs; some need their clinicians to prioritize Tier 1 (whole school) and Tier 2 (small group) services, which are not reimbursable by Medicaid. Insured families may not know of the opportunity for billable treatment in their school. Lastly, many aspects associated with Tier 3 services are not billable (for example, following up with parents and teachers). Results of forthcoming evaluations and cost study should reveal how the billing model needs to be adjusted.

In short, this relatively new program is meeting a critical need, but several circumstances and challenges have hampered the roll-out. As with many new programs, there is a need for time to make necessary adjustments.

The District must continue stable investment, focused oversight, and wider communication efforts to achieve a strong, sustainable, and well-utilized program

To ensure our investments and efforts lead to a strong, sustainable – and well-utilized – program, the District must:

1. Ensure stable compensation per clinician in FY 2024
2. Use – and share – reliable, actionable data as the foundation for planning and payment.
3. Provide DC students and families with better and more easily accessible information about available services in schools.

Ensure stable compensation per clinician in Fiscal Year 2024

The FY 2023 budget included funding to place a CBO clinician in each of DC's 253 public schools with a total grant of $80,000 per clinician per school.[21] DBH has been open about, and responsive to, the fact that recent years have seen the costs of staffing increase. Even since last fiscal year, DBH has increased funds for CBOs by more than 40% on a per-clinician basis to meet the salary demands of this job pool. DBH reported new funding levels of $99,000 per clinician per school in December 2022.[22] Even with this increase, CBOs are struggling to recruit and retain clinicians. Staffing challenges are driven by the shortage of behavioral health care professionals in the District, a nationwide problem.[23]

As a member of the Strengthening Families Coalition, we applaud DBH for increasing the per-clinician funding amount and finding creative solutions to resolve workforce development challenges. We encourage DBH to continue these investments moving forward. Anything less than what DBH is providing to CBOs now in the FY24 budget would take the District backwards.

Use – and share – reliable, actionable data as the foundation for planning and payment

For effective oversight and functioning, the DC Council and other stakeholders need access to important data on the program collected by DBH. Results from the DC Council-mandated cost study (also referred to as the rate study) were due December 2022, but the study has not been completed. DBH shared in January that the contractors, Public Consulting Group (PCG), continue to collect information directly from providers on staffing, costs, and

revenue. The survey is an important milestone and source to gain a better understanding of the current landscape of services and the cost of delivering services.

It is also important to understand how the program is functioning to ensure it is meeting its goals, and to see where improvements and adjustments are necessary. It is our understanding that program evaluations conducted by ChildTrends on behalf of DBH are completed for school year 2020-21 and school year 2021-22. We look forward to the release of these evaluations.

In addition to DBH's evaluations, the DC School Behavior Health Stakeholder Learning Community (SLC) Report offers a robust source of recommendations and best practices.[24] The SLC was launched in 2018 by the Center for Health and Health Care in Schools (CHHCS) in partnership with the Bainum Family Foundation. SLC brings together local school-based and child behavioral health stakeholders to strengthen the DC school behavioral health system and enhance equity. The 2022 report engaged students, parents/caregivers, and teachers, and over 20 organizations. Thus, this is a robust source of accumulated knowledge for reference, with broad and diverse stakeholder input.

Given the importance of this program, and all the information currently and soon to be available about it, we urge the Council to hold a public Roundtable on the program so DBH can answer key questions about the program evaluation and the cost study. In addition, CBOs, students, families, and educators can share on-the-ground insights and dig into the implementation challenges and opportunities.

Provide DC students and families with better and more easily accessible information about services available in schools

Families and youth self-advocates need to know what services are available in their schools, who is providing services, and the route to a referral for those services. While DBH maintains a spreadsheet of school-CBO partnerships, along with staff information and vacancy status, only an extraordinarily knowledgeable family member would be able to find it (parent stakeholders also note that contact information they have tried is out of date.) Further, this document does not include information about how to access services, which varies from school to school. CBOs usually work through school leadership to disseminate information, and not all are empowered to reach out to school communities independently. We would like to see more standardized, consistent, and intentional communication from DBH and schools, through multiple mediums throughout the school year. With successful outreach, we can feel more confident that the kids who need services can utilize them, with the added potential for more reimbursement from insurance.

To that end, one specific strategy the Strengthening Families Coalition suggests that the Mayor direct OSSE to work with DBH and CBOs to post information about available services to each school's MySchoolDC profile, including relevant contact and referral information. Since thousands of families already use the MySchoolDC website to enroll their children in school, including information about free or low-cost behavioral health services on the website is a commonsense way to boost program awareness and utilization. In addition, DBH and

school leaders should make a more concerted effort to share information with families and engage them in services, including service evaluation and improvement.

Other considerations for future planning

As described above, many factors have delayed the SBBH program from meeting the initial goals of locating one clinician in every DC school. While we continue to focus on fulfilling this goal, we know that some schools will need more than one full-time clinician. While mental health challenges can affect individuals and families of all socio-economic statuses, the stress of poverty, neighborhood violence, racism, and involvement with the criminal, judicial, and/or foster systems exacerbate needs in certain neighborhoods. Although the focus this year must be on getting one clinician in every school, it is important to recognize that this is simply the baseline for this program. Once we have a clinician in every school, we will be better able to assess the needs of each community and identify those that need additional supports and resources, including additional clinicians. We urge the Committee to support these and future efforts to expand this program so that it can fully meet behavioral health needs in all schools.

Conclusion

Ensuring the School-Based Behavioral Health program is strong and sustainable will help us realize its long-term potential. As with all successful interventions, this will require sufficient investments, adequate compensation, actionable evaluation, focused oversight, and effective communication with stakeholders.

Thank you for the opportunity to testify today. I welcome any questions the Committee may have.

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