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Testimony Before the District of Columbia Council
Committee on Health
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Performance Oversight
Board of Social Work

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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.

I appreciate this opportunity to testify regarding the Board of Social Work, which has an important role in DC's behavioral health care landscape. At Children's Law Center, the children we work with – including those in the foster care system, receiving special education services, or dealing with unhealthy housing conditions – often have significant behavioral health needs compounded by trauma, loss, or instability. We are here today to highlight the Board of Social Work's responsibilities in the current workforce crunch. Today's testimony will outline three recommendations for the Board of Social Work and the Health Regulation and Licensing Administration (HRLA) to improve DC residents' access to timely, high-quality, consistent, and culturally responsive behavioral health care:

1. Align activities of the Board with other agencies – DHCF and DBH – to focus on maintaining an adequate network of behavioral health professionals as a matter of

patient safety.

2. Increase capacity for licensing administration.
3. Create and maintain a database to inform behavioral health workforce planning.

National and local data show the mental health of children and families 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.[1] 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.[2]

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.[3] However, only one-fifth of children with mental, emotional, or behavioral disorders ever receive care from a specialized provider.[4] Further, this unmet need for mental health services is worse for children of color in than for white children.[5]

An increasing pool of District programs need as many social workers as possible

Reacting to the dangerous trends playing out in DC families and neighborhoods, the District of Columbia government has been rising to the occasion with strategic investments to employ behavioral health professionals - specifically, licensed independent clinical social

works (LICSWs). For example, the Department of Behavioral Health's (DBH) School-Based Behavioral Health (SBBH) Expansion Program envisions a licensed clinician embedded in all 253 public and charter schools in DC. The SBBH Program lowers barriers to behavioral health care, so kids are getting the help they need where they are spending most of their day. In the same vein, DC has been expanding an array of other supports related to developmental and behavioral health - HealthySteps, Healthy Futures, DC MAP, violence interruption, just to name a few. Recent budgets have represented a significant paradigm shift in recognition of the centrality of behavioral health to community well-being. At the same time this shift has revealed sizable workforce challenges.

Community-based organizations (CBOs) and government alike are struggling to recruit and retain licensed clinicians amid the nationwide shortage of behavioral health care professionals.[6] For example, as of this month, only 159 of 253 DC public and charter schools (63% percent) have a full-time CBO clinician providing services in school through the SBBH program.[7] Our clients consistently report being unable to find providers offering the services they need, such as individual and family therapy, counseling, autism evaluations, and medication management appointments. If they do connect with a provider, the wait for an appointment is often prohibitively long.

During the Department of Behavioral Health's oversight hearing earlier this month, we applauded DBH for increasing funding to resolve workforce development challenges.[8] We also testified that Department of Health Care Finance (DHCF) should increase oversight and

enforcement of Medicaid "network adequacy" standards to ensure a sufficient field of behavioral health providers, especially those working with children, speaking languages other than English, and/or delivering specialty therapies.[9] There is the clear foundational need to attract and train more future-social workers into the vocation.

The Board should align activities with other agencies' focus on maintaining an adequate network of behavioral health professionals as a matter of patient safety

There are many imperatives for expediting the licensing of social workers. Federal Medicaid regulations require that participating states maintain an adequate network of providers "to achieve greater equity in health care and enhance consumer access to quality, affordable care."[10] This Committee has consistently heard about the gaps in services, vacancies, and the associated costs. It is critical we address the workforce issue as DHCF begins the integration of behavioral health services into Managed Care Organizations (MCOs) this year. The District must ensure that licensing through the Board of Social Work and MCO's credentialing requirements are not too burdensome or exclusive as to delay entrance into the workforce.

The Board of Social Work has largely effectuated its mission to protect resident safety[11] by restricting the professional population – through sanctions and discipline, for example – with an individual scope. The scope of the mission, however, may be at odds with the broader systemic impacts of a limited workforce capacity. When provider networks are functionally inadequate, that is a patient safety issue. When clients frequently lose their trusted therapist to turn-over, that is a patient safety issue. If patients are not getting the right therapies from a

specialized provider, or can't communicate in the same language, those are patient safety issues. If the District's Emergency Departments are treating patients in crisis because they were waiting on months-long waitlists for services, that is a patient safety issue. Therefore, we recommend that Board encompass workforce development and remediation of obstacles to licensure as part of its mission, without jeopardizing service quality.

The Board could consider, for example, the data from the Association of Social Work Boards (ASWB) showing that over half of Black exam-takers in DC (52%) don't pass the exam on the first attempt, compared to 93% of white exam-takers.[12] In 2022, ASWB CEO Stacey D. Hardy-Chandler, PhD, JD, LCSW declared the data "a call to action" for Boards "toward addressing the systemic and institutional factors that disproportionately affect Black licensure candidates and those of other historically marginalized groups" and working "to make social work more equitable and to ensure the profession reflects values of antiracism, diversity, equity, and inclusion."[13] Additionally, the Board should reconsider other policies that have the effect of restricting workforce capacity. For example, there are calls to extend the length of supervised practice that the Board allows.[14] It may also want to re-scope the criteria and definition of "unlicensed social work practice"[15] which may unduly disqualify applicants from any social work or other licensure.

The Board of Social Work needs increased capacity for licensing administration

In 2022, we asked the Council to ensure funding for three additional FTEs to help expedite the licensing procedures in the District for social work and professional counseling in

order to increase the behavioral health workforce.[16] While HRLA did receive funding for ten licensing specialists, they were not distributed to support behavioral health Boards.[17] In the administration's 2023 oversight responses, HRLA noted that additional staff would be "beneficial" to the Board of Social Work, The Board of Psychology and The Board of Professional Counseling because "these licensing processes are traditionally longer due to the various supervision periods needed prior to licensure."[18]

The Board of Social Work was granted one contractor briefly in 2022, which improved processing time, particularly for Licensed Graduate Social Work (LGSW) and Licensed Independent Clinical Social Worker (LICSW) applications.[19] HRLA's performance oversight responses note that this additional staff helped with inquiry response, sorting and tracking down documents supporting applications, and communicating with applicants, ultimately "leading to greater customer satisfaction."[20] Unfortunately, the position was not permanent. Therefore, we urge this Committee to work with DC Health to ensure adequate staffing for licensing specialists to process social work license applications in a timely manner. This should include at least one permanent FTE be added to the Board of Social Work, with possible additional support for the two other behavioral health boards.

Create and maintain a database to inform behavioral health workforce planning

While some behavioral health workforce data is currently collected at the time of license renewal application, it is not published publicly, and it is insufficient to measure the adequacy of the behavioral health workforce, especially those serving children. Without a systematic

collection of comprehensive workforce data, opportunities to make informed decisions regarding workforce development are limited. Our 2021 report, *A Path Forward: Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia*, recommends that DBH and DC Health collaboratively establish a data collection approach.[21] This could be done in part through data collected during the licensure process. Additionally, an assessment of the current workforce makeup is needed to determine gaps and inform policy and financing decisions. The data should be used to develop, and then evaluate, behavioral health workforce recruitment and retention strategies.

Such data collection requires a centralized, permanent data infrastructure that can collect data from stakeholders (providers, consumers, and health care managers), then analyze and disseminate that data to inform plans and policy decisions. The data set to inform workforce planning efforts might include:

- **Demographics:** Name, age, race/ethnicity, sex and gender, sexual orientation, place of birth and residence, military/veteran status, language skills;
- **Licensure and Certification**: Type of job-related licenses held, type of job-related certificates held, national provider, identification number, state identification/registration number;
- **Education and Training:** Degrees obtained and years of completion, field of study/specialty, completion of other educational programs (e.g., internships), current enrollment in degree program;
- **Occupation and Area of Practice**
- **Practice Characteristics and Settings:** Number of current positions, number of hours and weeks worked per year, use of telehealth, employer practice setting, hours per week spent on activities (e.g., clinical supervision, diagnosis), etc.

We were glad to learn that DC Health made several technology improvements in 2022,

including the addition of a workforce survey for every renewal application.[22] We hope this is used for applicants for behavioral health professions, as it would serve the kind of data collection and analysis we describe above.

Conclusion

Ensuring the behavioral health workforce is strong and sustainable will improve the safety and well-being of people with behavioral health needs in our community. We ask the Board of Social Work to align with the many other DC agencies and programs working to staff an adequate provider network. We further ask the Board to engage in conversations to correct inequities and inefficiencies in licensing criteria and processes. Through these efforts, with increased data collection and analysis, the Board can help create a more inclusive, diverse behavioral health workforce in DC.

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

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