REPORT
of the
TASK FORCE ON SCHOOL MENTAL HEALTH

Submitted to:
Mayor Muriel Bowser &
The Council of the District of Columbia
March 26, 2018

The Honorable Muriel Bowser
Mayor of the District of Columbia
John A. Wilson Building
1350 Pennsylvania Avenue, NW
Washington, DC 20004

Dear Mayor Bower:

As required by the School-Based Behavioral Health Comprehensive Plan Amendment Act of 2017 (Fiscal Year 2018 Budget Support Act of 2017, Title V, Subtitle E), passed by the Council of the District of Columbia on June 27, 2017 and signed into law by Mayor Muriel Bowser on July 31, 2017, effective October 1, 2017, please find enclosed the Report of the Task Force on School Mental Health.

The Task Force was charged with reviewing the District of Columbia's Comprehensive Plan to Expand School-Based Behavioral Health Services (Comprehensive Plan) submitted to the Committee on Health and the Committee on Education on May 9, 2017 by the Deputy Mayor for Health and Human Services (DMHHS). From early November 2017 through March 15, 2017, the Task Force met, researched and analyzed data, and delved into key aspects of the Comprehensive Plan.

The Task Force Report affirms the goal of the Comprehensive Plan, which is to create a coordinated and responsive behavioral health system for all students in all public and public charter schools. And, the Task Force Report affirms the public health, multi-tiered, model envisioned by the Comprehensive Plan. In other key areas, the Task Force Report recommends changes to the Comprehensive Plan.

Specifically, the Task Force Report recommends: (1) phasing-in implementation over at least the next three years, starting with those schools with the highest need; (2) keeping the current role of the DBH Clinician, at least for the next school year, and setting out certain considerations and processes to inform any future considerations to changes in that role; and (3) providing robust technical and financial investments in community-based providers to support their ability to expand school-based partnerships. In addition, the Task Force Report highlights the District's significant investment in and the central role played by school-hired behavioral health staff in implementing the new school-based behavioral health system.

The Task Force recommends that the Mayor and Council increase the FY 2019 local budget for school-based mental health by an additional $3 million to expand the current program in line with the Task Force's report.

Please feel free to contact Jay Melder, DMHHS Chief of Staff, at 202-427-5731, if you have any questions.

Sincerely,

Olga A Price

Dr. Olga Acosta Price
Co-Chair

LaQuandra S. Nesbitt

Dr. LaQuandra Nesbitt
Co-Chair

Enclosure

cc:

Deputy Mayor HyseSook Chung
Director Tanya A. Royster

The Honorable Phil Mendelson
Chairman
Council of the District of Columbia
1350 Pennsylvania Avenue N.W., Suite 504
Washington, D.C. 20004

Dear Chairman Mendelson:

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Enclosure

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Director Tanya A. Royster

Executive Summary:

The Task Force on School Mental Health ("Task Force") was formed by the School-Based Behavioral Health Comprehensive Plan Amendment Act of 2017 (Fiscal Year 2018 Budget Support Act of 2017, Title V, Subtitle E), which was passed by the Council of the District of Columbia on June 27, 2017 and signed into law by Mayor Muriel Bowser on July 31, 2017, effective October 1, 2017.

The Task Force was charged with reviewing the District of Columbia's Comprehensive Plan to Expand School-Based Behavioral Health Services (Comprehensive Plan) 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. The Task Force is required to submit a report to Mayor Bowser and the Council of the District of Columbia by March 31, 2018[1] and include any recommended changes to the Plan, timeline for implementation, and any dependencies.

The Task Force, comprised of representatives from a robust cross-section of stakeholders committed to the successful expansion of behavioral health services to District students, met frequently between November 2017 and the date of the submission of this Report. The Task Force delved deeply into the key aspects of the Comprehensive Plan, including: (1) the proposed framework; (2) provider interest and capacity; (3) current school behavioral health programs, agencies, and providers operating in public schools, including best practices; (4) timeline for expanding school-based behavioral health services to all District public and public charter schools; (5) any recommendations for changes to the Comprehensive plan to move forward; and (6) budget recommendations for year #1 implementation in school year 2018-2019.

The Task Force agrees with and embraces the vision and many key aspects of the Comprehensive Plan. Specifically, the Task Force agrees with (1) the goal of expanding comprehensive behavioral health services; (2) the use of the public health model as the framework for service delivery; and (3) the core program design, which aligns and ties together school, agency (DOH, DBH and others), and community-based resources around a common vision that emphasizes access to prevention, screening, early intervention, and intensive treatment for all students in all public and charter schools. To realize this comprehensive approach the Task Force agrees implementation of the Plan must be led and driven by the combined efforts of all major stakeholders.

The Task Force recommends changes to the Comprehensive Plan in a few key areas, specifically, (1) the role of the DBH Clinicians and the timing and factors to consider before changing the role of the DBH Clinician; (2) provider capacity, and what is needed to grow the pool of

[1] The legislation calls for the Report to be submitted by February 9, 2018, however, because the Task Force began its deliberations in November, 2017, the Chairs of the Committees on Health and Education agreed to an extension until March 31, 2018 to allow the Task Force sufficient time to complete its work.

available community-based partners, including the need to identify additional funding sources to enable providers to deliver school-based services; and (3) the governance structure to guide implementation.

This Report reflects the Task Force's deliberations on these key matters as follows:

Section I begins with a declaration of the values and guiding principles held by the Task Force.

Section II outlines the goal and framework for the District's new Comprehensive School-Based Behavioral Health System.

Section III summarizes the Task Force's work, its deliberations and findings, including areas where the Task Force diverges from the Comprehensive Plan.

Section IV sets out the Task Force recommendations.

The Deputy Mayor for Health and Human Services, HyeSook Chung would like to thank the members of the Task Force for sharing their time and expertise and elbow grease to the success of this Task Force and to their staff who contributed their time and hard work.

The Task Force membership, in accordance with the legislation, is made up of the following persons:

Appointee	Task Force Seat Designation
Dr. Deitra Bryant-Mallory	District of Columbia Public Schools
Councilmember Vincent Gray	DC Council - Committee on Health
Councilmember David Grosso	DC Council - Committee on Education
Chalon Jones	Deputy Mayor for Education (DME) Designee
Michael Lamb	Non-Core Service Agency Provider Representative
Nathan Luecking	Department of Behavioral Health School Mental Health Program Clinician
Dr. Taiwan Lovelace	Department of Behavioral Health School Mental Health Program Clinician
Dr. LaQuandra Nesbitt	Deputy Mayor for Health and Human Services Designee
Dr. Chioma Oruh	DC Public School Parent
Michelle Palmer	Non-Core Service Agency Provider Representative
Marisa Parrella	Core Service Agency Provider Representative
Scott Pearson	Public Charter School Board
Juanita Price	Core Service Agency Provider Representative
Dr. Olga Acosta Price	School Mental Health Expert
Dr. Tanya A. Royster	Department of Behavioral Health
Dr. Heidi Schumacher	Office of the State Superintendent of Schools
Molly Whalen	DC Public Charter School Parent

Section I – Guiding Principles

- ❖ All students deserve quality, sustainable behavioral health supports that allow them to come to school ready to learn.

- ❖ All students benefit from a school environment that promotes and supports mental wellness and resiliency.

- ❖ A supportive school environment results from all parts of the school community understanding how they can contribute to and work together toward the shared goal of student wellness.

- ❖ School-wide mental health promotion, universal screening for student mental wellness, and early intervention for children at risk of developing mental health issues can often have a substantial preventive effect.

- ❖ Student well-being is the responsibility of and affected by all support systems that interact with children and families, including private and public health care systems, human service agencies, and education systems.

- ❖ The District can maximize its ability to support the emotional well-being of all City youth by leveraging the District's rich investments in school-based behavioral health care and the robust behavioral health services in the community, and delivering interventions through an integrated and collaborative public health framework.

- ❖ Student need informs and is the basis for allocating resources among schools. Not all students and schools start from the same place or have the same needs.

- ❖ Schools need to have the flexibility to individualize the array of resources and the roles and responsibilities of each partner within their school in accordance with the unique needs of its students.

Section II – Framework

The Task Force agrees with the goal of the Comprehensive Plan, which is ***to create a coordinated and responsive behavioral health system for all students in all public and public charter schools.***

The Task Force also agrees that:

- ✓ A multi-tiered system of supports, as described by the Public Health model set out in the Comprehensive Plan, is the best organizing framework for the District's Comprehensive School-Based Behavioral Health System.

- ✓ The distribution of need for any given level of tiered support may vary by school from what is described in this public health model, especially in schools with the highest needs.

- ✓ Student need should inform and drive the allocation of resources and should be determined across all schools through an agreed upon methodology.

- ✓ All three tiers of supports need to be available in all public and public charter schools, with specific resources matched to the identified needs of the students in each school.

- ✓ There is currently significant public investment in school behavioral health through DC Public Schools (DCPS) and DC Public Charter Schools (PCS), the Department of Behavioral Health (DBH), the Department of Health (DOH), among others.

- ✓ There are currently a number of community-based providers who partner with schools and that deliver a variety of Tier 1, Tier 2, and Tier 3 supports.

- ✓ Maximizing these public and private resources and developing additional community-based capacity needed to meet student need is key to the long-term success of a new Comprehensive School-Based Behavioral Health System.

- ✓ School and provider readiness and capacity to partner in delivering a multi-tiered, school-based behavioral health system are essential to the success of this model.

- ✓ Schools and community-based providers need to work collaboratively to deliver interventions and supports that are integrated and coordinated. Developing strong school-based teams with clearly identified roles and responsibilities is critical to operationalizing this framework.

Section III – Task Force Deliberations and Analyses

As set out in the establishing legislation, the Task Force undertook an evaluation of the Comprehensive Plan, including an analysis of provider interest and capacity, DC Public School and Public Charter School interest, school behavioral health programs and providers currently operating in public schools, including best practices, and the current School Mental Health Program administered by the Department of Behavioral Health. Through full Task Force meetings and meetings of the Subcommittees on Need Determination and Provider Capacity, the Task Force reviewed, analyzed, and deliberated key aspects of the Plan as follows:

A. Service Delivery and Coordination

The Task Force focused much of its time (both in the full Task Force and in Subcommittee meetings) on the program design, including key roles and responsibilities among the school, DBH, and provider partners and whether and how community-based providers can fulfill the role set out for them in the Comprehensive Plan.

Specifically, the Task Force considered:

- Currently available resources among education, health, and community partners;
- Strengths of the different partners, including current school staffing, programs, and clinical capacities, including the DBH School Mental Health Program (SMHP);
- Provider financing and alignment with expectations for school-based practice;
- The importance of school readiness;
- Need identification; and
- Governance, Implementation, and Timeline.

Role of the DBH Clinician

Initial Comprehensive Plan

The Comprehensive Plan submitted to Council on May 9, 2017 envisions students in all public and public charter schools will have access to a comprehensive array of supports (Tier 1, Tier 2, and Tier 3) provided through an integrated and collaborative framework. Each Tier is made up of a variety of programs, services, and supports that individual schools need to tailor to meet the needs of the students and their school.[2] In addition, the Comprehensive Plan envisions crisis

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[2] **Tier 1** - Mental Health Promotion and Primary Prevention Services and Supports for 100% of students with the goal of creating a positive school climate that reinforces positive behaviors, supports resiliency and recovery among students, and reduces stigma related to mental illness. Includes support for students, staff, and parents/guardians and evidence-based or evidence-informed school-wide or classroom-based programs.

Tier 2 - Focused Interventions for the approximately 10% - 15% of the school population who are at elevated risk for developing a mental health problem. Mental health clinicians provide consultation and support to teachers and school staff to develop child/youth-specific strategies to address identified educational or behavioral concerns.

Tier 3 - Intensive Support for the approximately 1%-5% of the school population who have active mental health support will be available to all schools from the Child and Adolescent Mobile Psychiatric Service (ChAMPS), the DCPS Crisis Teams, and the DBH/SMHP Crisis Teams for all youth, regardless of the population. The Comprehensive Plan re-envisioned the role of the DBH Clinician[3] as a key strategy to roll out the expansion to all schools.

Under the Comprehensive Plan, the DBH clinician's role would change from providing all three Tiers within their assigned school to some of the students to ensuring primary prevention and universal screening for behavioral health needs for all students in their assigned schools. Delivery of Tier 2 and Tier 3 services would shift to other service providers, either school-based or community-based. While not delivering these other services, the DBH clinician would assist in identifying students needing these higher levels of care, identifying community partners, and helping the school make the appropriate linkages to meet these students' needs. The DBH clinicians would be assigned full-time or part-time to every DCPS and PCS school, depending on level of need, in their new role. The expected outcome is to provide value-added services within schools through intervening early and changing the trajectory of students with regard to behavioral health concerns.

Task Force Deliberations on the Initial Comprehensive Plan

After hearing from Task Force members, including DBH clinician representatives, Turnaround for Children, DCPS, PCS, and others with school-based experience, the Task Force concluded that having a school-based behavioral health professional in each school that has a school-wide perspective, and is responsible for coordinating and helping the school to integrate all three Tiers of support (screening, primary prevention, Tier 2 and Tier 3 interventions)—as proposed in the Comprehensive Plan—is critical. However, the Task Force expressed significant concerns, at least for the first year of implementation, with changing the role of the DBH clinicians and the plan to deploy them among all DC Public and Public Charter Schools.

Specifically, without concrete provider commitments for the 2018-2019 school year, the Task Force expressed concern that taking the DBH clinicians away from providing Tier 2 and Tier 3 interventions would result in fewer students receiving early intervention and intensive treatment, rather than more, as the Comprehensive Plan intends. In addition, a number of Task Force members stated that to be effective, whomever serves in the "Coordinator" role would need to be in a school at least half-time. For larger and/or higher need schools, they believed that this person would need to be in a school full-time to be effective. Therefore, rather than having the Coordinator role fulfilled by the DBH Clinician in every school, the Task Force recommends a "hybrid" approach. This approach would allow schools to identify, based on resources available,

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symptoms that meet diagnostic criteria and need individualized treatment to assist the child/youth to improve functioning in school, home and community. Services include evidence-based or evidence-informed individual, group or family treatment services and crisis intervention offered on-site at the school or in the home/community. For more information, see Comprehensive Plan, pages 14-15.

[3] In School Year 2017-2018, the DBH School Mental Health Program had a maximum capacity of 62 clinicians, which could serve 45 schools full-time and 17 schools part-time.

the person in their school that is best positioned to play these roles. In the hybrid model schools could fill the Coordinator role through a variety of staff, including existing staff that play a coordinating role, such as a Response to Intervention (RTI) Coordinator, Student/School Support Team (SST) Coordinator, or, through a DBH clinician, or an appropriate DOH School-Based Health Center[4] person, or a school-hired clinician, as is currently the case in the E.L. Haynes schools.[5] The Task Force felt that the E.L. Haynes model served as an excellent example of how this hybrid approach could allow expansion of behavioral health support in schools without taking DBH Clinicians away from continuing to provide Tier 2 and Tier 3 services. It is important to note, that in year 1 when the DBH clinician's role will remain unchanged that it may be challenging for a DBH clinician to take on the Coordinator role, especially in schools with high clinical need, until additional clinical resources are identified and available.

In future years, if the role of the DBH Clinician changes from providing all three tiers to focusing on Tier 1 and the Coordinating role, the agency and school should work together to (1) transition any other services previously provided by the DBH clinician, including Tier 2 and Tier 3 services, (2) integrate new partners within the school community; and (3) listen to and help address any stakeholder concerns.

Finally, school-hired mental health staff should be allowed and encouraged to function in their professional roles and to provide coordination and service delivery in their respective schools. To meet the depth of needs across any school, school-hired mental health staff are often asked to perform duties that limit their ability to provide mental health support in the schools they serve. Duties outside of their professional role, however, especially those that reduce time for assessment, services documentation or coordination should be limited. In order for a school-based mental health system to be effective, clear communication and strong collaboration needs to be evident across all adults in a school building.

B. Provider Capacity

Another core principle of the Comprehensive Plan is that expanding the number of community-based behavioral health providers partnering with schools is key to the long-term success of the new School-Based Behavioral Health System. The Task Force identified two factors necessary to ensure that provider capacity can expand at the rate needed to achieve comprehensive coverage as soon as possible.

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[4] The Department of Health oversees seven School-Based Health Centers in the District. The SBHCs are located at Anacostia, Ballou, Cardozo, Coolidge, Dunbar, Roosevelt and Woodson High Schools. All sites offer behavioral health services. There are currently no School Based Health Centers at public charter schools.

[5] At its January 4, 2018 Subcommittee on Provider Capacity meeting, the Task Force heard from a representative from the E.L. Haynes Public Charter Schools who has hired a Social Work Administrator whose responsibility is to coordinate all behavioral health resources among the school's three campuses (Elementary, Middle, and High School).

Provider Financing

First, the Task Force Subcommittee on Provider Capacity took a close look at how current providers finance their school-based work. While some providers are able to supplement their work with grants or other private funding, the large majority of provider funding is through insurance reimbursement for billable services. Providers consistently noted, however, that insurance reimbursement by itself is insufficient to cover the costs of providing school-based services. And, the proportion of costs that insurance reimbursement can provide can vary widely depending on the type of provider. For example, providers designated as a Federally Qualified Health Center can get substantially higher reimbursement rates than providers that are not FQHCs.

In addition to clinical services, which are billable, the Task Force underscored that school-based practice requires provider clinicians to spend time on other activities, such as teacher and parent consultation, school team meetings, care coordination, and crisis management. These activities are not billable but are necessary for the clinician to have all the information they need to effectively provide treatment that helps students maximize their ability to succeed academically. Where providers are unable to finance these activities, they risk having to make trade-offs between sustainability and best practices.

The Task Force urges the District to explore additional funding sources for community-based providers, including additional Medicaid options and other non-Medicaid resources. The Task Force believes that without additional funding that enable providers to deliver high-quality school-based services, that relying on community providers to expand behavioral health to all students will be very challenging. The Task Force also makes the point that additional behavioral health resources recommended by this Report are not intended to supplant existing DCPS, DCPCS or other school-based resources, but are generally intended to augment them.

Supporting Provider and School Readiness

As the Provider Financing section illustrates, the Task Force emphasized that delivering behavioral health services in schools is different than clinic-based practice. Schools need providers who understand and are prepared to deliver school-based services. And, schools need to understand how developing school-wide behavioral health awareness and ways all adults in the school can support the emotional well-being of students can improve student academic success.

The Task Force recommends the District establish guidelines for schools and providers outlining what they need to consider and are recommended to have in place to deliver the new behavioral health model. The Task Force believes that the District is well-positioned to provide leadership and technical assistance to support and accelerate school readiness and provider capacity. Moreover, to provide quality assurance and fidelity to the model, the Task Force recommends that provider agreements incorporate key aspects of the model, roles and responsibilities, and reporting requirements.

C. Identifying Student Behavioral Health Needs and Evaluation

The Task Force also convened a Subcommittee on Need Determination to review the Comprehensive Plan's proposed need determination approach. Task Force members agree with the Comprehensive Plan's proposal that the District should identify the behavioral health needs of students across all DC public and public charter schools to inform resource and provider development and matching, and provide a baseline to measure progress.

The Task Force reviewed the Plan's proposed data, which was selected as proxy measures correlated with student exposure to trauma and other stressors that could lead to a need for behavioral health supports and/or interventions. The data suggested by the Comprehensive Plan included the following:

- OSSE At-Risk formula
- Percent of students with a 504 Plan
- Percent of students with an Individual Education Plan
- Community Eligibility Provision (CEP)
- Attendance Rate

The Subcommittee also explored community-wide data, including the District's Early Development Instrument (EDI) data and the District's Youth Risk Behavior Survey (YRBS), and discussed using school classification data, i.e., the Elementary and Secondary Education Act (ESEA) Classification for DCPS and the DC Public Charter School Board School Quality Ratings. While the Task Force sees value in both community-wide data surveys, the data is either not school-based or available from all schools, and therefore the way in which that data can be used should continue to be studied for future use. In subsequent years, however, the Task Force recommends looking at including select items from the YRBS as part of the index. For SY 2018-109, the Task Force recommends the District use the proxy measures set out in the Plan, except for the 504 Plan data and the CEP, and consider suspension, Strong Start, and Early Stages data.

The Task Force also reviewed the methodology, which applies a percentage threshold for each data element. If the percent of students in a school met or exceeded the threshold for that data element[6], for example if 20% or more of the students in a school had an IEP, then that factor

[6] For each data set, see below for the threshold percentage:

- At-risk = 70% or more of the students meet this measure
- 504 Plan = 10% or more of the students have a 504 Plan
- IEPs = 20% or more of the students have an IEP
- Community Eligibility Provision (CEP) = 40% or more of the students are eligible
- Attendance Rate = Less than 80%

would be considered as a risk indicator for that school. The Task Force Subcommittee on Need Determination found that this methodology had the unintended consequence of measuring "high need" or "not high need," rather than the continuum of need across all schools. As a result, the Subcommittee recommends the District choose a methodology to apply to the data that will give the intended result of measuring the relative level of need across all schools.

Further, the Task Force recommends that once the methodology is finalized that it be tested as valid and reliable over the next school year. This might include analyses of its concurrent and predictive validity, as well as its reliability as an index. In addition to measuring progress against these proxy measures, the Task Force recommends that the District develop a comprehensive evaluation framework.

D. Budget Implications

The changes proposed by the Task Force to the Comprehensive Plan in this Report are expected to have a budget impact starting in year 1 of implementation. The Task Force envisions a budget impact in at least three areas:

- The Task Force recommends the District support development of a robust and effective Community of Practice to increase school and provider readiness, including providing direct technical assistance to providers as appropriate;

- The Task Force recommends additional funding to support the expansion of a multi-tiered behavioral health system to additional schools through community-based providers to deliver, in addition to billable clinical services, non-billable interventions and supports integral to a school-based practice , including but not limited to teacher and parent consultation, school team meetings, care coordination, and crisis management.

  - **In the alternative**, some Task Force members recommend additional funding to support the expansion of a multi-tiered behavioral health system to additional schools through additional DBH School Mental Health Program clinicians.

- The Task Force recommends conducting an evaluation of year 1 implementation to inform additional improvements in the model for subsequent years.

E. Governance

The Comprehensive Plan calls for the Interagency Behavioral Health Working Group (BWG), facilitated and led by the Department of Behavioral Health, to continue to guide implementation of the Plan. In addition, the Plan envisioned creating a "Coordinating Council", composed of any BWG members who wanted to participate, and expanded to include parents and other interested stakeholders. One role of the Coordinating Council would be to review the need determination and prioritization plan, annually or as needed.

Some Task Force members expressed the viewpoint that school-based behavioral health is by its nature dependent on cross-sector participation and collaboration, involving numerous LEAs, health, behavioral health and other agencies, community-based organizations, universities, and other non-profit agencies. As such, some Task Force members advocated for creating a governance/oversight body with the Offices of the Deputy Mayors for Health and Human Services and Education, as opposed to assigning responsibility for implementation of this plan to one District agency (i.e. DBH) as potentially problematic. These members noted that creating a governance structure at this level would communicate the importance of this initiative and provide sufficient authority over key agencies.

Other Task Force members expressed the viewpoint that DBH was the proper entity to lead and provide oversight for school-based behavioral health. These members noted that keeping the primary responsibility in the agency squarely on point for implementation would be more effective and ensure that responsibility and accountability was clearly vested, with the normal Mayoral and Council oversight applied. DBH pointed out that all partner agencies represented on the BWG or the Coordinating Council have the authority, and responsibility, to deploy their resources in accordance with the Comprehensive Plan adopted by the District. DBH agreed that the BWG membership could be expanded to include stakeholders not previously represented. DBH also noted that they are the agency with the responsibility and authority to oversee community-based behavioral health providers, and will continue in this role.

It is worth noting that while the Task Force was somewhat divided between these two viewpoints, there were a diversity of stakeholders within each of these groups.

F. Implementation Timeline

Given the current number of providers who provide school-based services, the Task Force projected that scaling the model will take a minimum of three years and could take as many as five years. The Task Force members share a commitment to working toward the shortest feasible timeframe, recognizing the urgency of expanding behavioral health supports to all students in all public and public charter schools.

To maintain a sense of urgency, and track progress toward full implementation, the Task Force suggests the District take the following steps:

- Set numerical targets to expand to all public and public charter schools in three years;
- Name the governance entity by Friday, March 30, 2018, including naming and inviting all key stakeholders;
- Convene the first meeting by Friday, April 20, 2018, which should include a discussion of the budget;

- Set benchmarks for key tasks that drive timely implementation, including developing guidelines of minimal expectations for school and provider readiness and conducting need determination as recommended in Section III C; and
- Request the governance entity submit semi-annual reports to the Mayor and Council through the end of school year 2019, and annual reports thereafter.

IV. Recommendations

Recommendation #1: Need Identification

Identify student behavioral health needs for all District public and public charter schools.

- Use available population and student level data, such as the OSSE At-Risk formula, and students with an Individual Education Plan, student absenteeism, students receiving out-of-school suspension, and other data as determined appropriate. The Task Force also recommends the District apply a methodology to the data that will give the intended result of measuring the relative level of need across all schools.

- The Task Force recommends considering the proper weight to give each element. After reviewing preliminary data analyses using the four indicators above, the Task Force saw the most variation in the school data in the OSSE At-Risk Formula data when schools are ranked by the other data indicators. This may indicate a need to give more weight to the OSSE data when combined with the other indicators.

- The Task Force also recommends looking at whether and how the differences in the data for Elementary, Middle, and High Schools should be taken into account.

Recommendation #2: Phased Implementation and Year 1

Prioritize implementation in Year #1 (SY 2018-19) in the top 25% of schools identified by behavioral health need from highest to lowest.

- Prioritizing the top 25% of schools identified by behavioral health needs for implementation in year #1 means that the District will build upon existing resources in these schools to develop a school-wide plan for assessment, primary prevention, and provision of Tier 2 and Tier 3 services through school and community-based partners, tailored to the needs of that school, and including provision of support to increase school readiness as needed.

- The Task Force recommends the District assess the type and amount of crisis response resources available and whether those resources are sufficient to meet the need, especially given the expansion of access to Tiers 1 through Tier 3 in the year #1 implementation.

- Implementation in year #1 also includes making a concerted effort to make all schools aware of all available behavioral health resources across all tiers, including crisis services, and supporting the continued growth in Tier 1, 2, and 3 services in all schools.

Recommendation #3: Role of the DBH School Mental Health Clinicians

In Year 1, keep the role of the DBH SMHP Clinician as currently defined, with the flexibility to provide Tier 1, Tier 2, and/or Tier 3 supports in their assigned schools.

- Data suggests that DBH Clinicians are currently serving some of the highest need schools. While generally the Task Force does not recommend a change in resources among schools as a result of focusing on the highest need school, Year #1 may necessitate reassignment of some DBH SMHP clinicians to different schools. If this occurs, DBH will work with the school and other partners to develop a transition plan to support continuity of care for students.

- In future years, discussion of changes to the role of the DBH SMHP Clinician should include DBH clinicians and their representatives and be guided by input from the Coordinating Council and Governance entity. In addition, a discussion of changes to the role of the DBH clinicians should be informed by an evaluation of resources available to replace those Tier 2 and Tier 3 services that would no longer be provided by the DBH clinician, with the goal of avoiding an unintended reduction in clinical services in schools served by DBH clinicians.

Recommendation #4: Support Provider and Schools to Expand

To support successful expansion of school-based behavioral health the District should develop a Community of Practice and provide technical assistance to help providers and schools increase their readiness and capacity to implement the new model.

- The goal of the Community of Practice is to share best practices, develop training, improve communications, and provide mentoring and technical assistance for providers, schools, community organizations, and family stakeholders, to deepen school-based behavioral health practice in the District and encourage a shared commitment to child well-being among education, health, and community partners. Several successful communities of practice exist in the District's special education and disability community and have significant results in the past few years.

Recommendation #5: Budget Recommendations

The Task Force considered three budget recommendation options for implementation in SY 2018-19 (Year 1) that varied primarily by (1) whether and how much the expansion would use community-based providers and/or additional clinicians through the DBH School Mental Health Program, and (2) the level and scope of technical assistance that should be available. In addition, Task Force members voted on a whether to recommend funding for a graduate-level internship program as a workforce development investment.

Each budget recommendation option and the number of Task Force members who voted for each are set out below. **Option #3 received the highest number of votes making it the Task Force's "Preferred Option".** Along with their vote, Task Force members added a number of comments that are captured below.

Additional comments from Task Force members:

- Several members recommended increasing the supervisor/clinician ratio at community-based providers to 1:5 to further support successful implementation, especially in year 1.

- Members recommend future year funding should increase to support specific growth goals informed by the Year 1 evaluation.

- One Task Force member recommended Year 2 funding at $5 million, but did not provide specifics on funding allocated and target expansion goals.

- Several members stressed the importance of funding a community partner liaison to manage the development of Memorandum of Understanding, assist with matching and brokering with schools, coordinating shared training opportunities, and working toward standardization of school mental health progress monitoring and data collection within the schools.

- Several members stressed the importance of technical assistance to both schools and CBO providers, especially around entering to and managing school/CBO partnerships.

Expansion Recommendation Option #1 – Received 1 Vote as a single option. Received 2 additional votes in combination with Option 2 (i.e., 2 members voted for both Option 1 and Option 2):

Provide $2,276,000 in additional funding in the FY 2019 budget for year 1 implementation through increased partnerships with community-based organizations, including:

- $1,901,000 in grant funding to community-based behavioral health providers to support 33 clinicians and 4 clinical supervisors. Grant funds will support CBOs to provide, in addition to billable clinical services, non-billable interventions and supports integral to a multi-tiered school-based practice, including but not limited to teacher and parent consultation, school team meetings, care coordination, and crisis management;

- $250,000 to develop a robust and effective Community of Practice to increase provider readiness, including providing direct technical assistance as appropriate; and

- $125,000 to support an evaluation of the first year of implementation.

Expansion Recommendation Option 1 (Partner with Community-Based Providers)

Description	Full Cost	% Cost to DC*	Unit Price*	Units	Total Cost
CBO Licensed Clinicians	$90,000	50%	$45,000	33	$1,485,000
CBO Clinician Supervisors	$104,000	100%	$104,000	4	$416,000
Development of a Community of Practice and Technical Assistance to Grantees	$250,000	100%	$250,000	1	$250,000
Program Evaluation	$125,000	100%	$125,000	1	$125,000
TOTAL					**$2,276,000**
******The % and unit price per clinician and/or supervisor may vary depending on the actual proposed services provided.*					

Expansion Recommendation Option 2 - Received 2 votes in combination with Option 1 (i.e., 2 members voted for both Option 1 and Option 2):

Provide $3,640,160 in additional funding in the FY 2019 budget for year 1 implementation through expansion of the DBH School Mental Health Program, including:

- $3,365,160 to expand the DBH School Mental Health program by 33 clinicians and 3 supervisors.

- ➢ $150,000 to develop a robust and effective Community of Practice to increase alignment and integration of school behavioral health partners, including providing direct technical assistance as appropriate; and

- ➢ $125,000 to support an evaluation of the first year of implementation.

Expansion Recommendation Option 2 (Expand with more DBH Clinicians)

Description	Full Cost	% Cost to DC	Unit Price	Units	Total Cost
DBH Clinicians	$104,000	88%	$91,520	33	$3,020,160
DBH Clinician Supervisors	$115,000	100%	$115,000	3	$345,000
Development of a Community of Practice and Technical Assistance to Grantees	$150,000	100%	$150,000	1	$150,000
Program Evaluation	$125,000	100%	$125,000	1	$125,000
TOTAL					**$3,640,160**
**The 88% cost allocation is assuming proficiency in billing reaches 12%, which is not always the case. In the event this level of proficiency is not achieved the cost allocation for each DBH Clinician would be 100%, increasing the cost of the estimate by $411,840.*					

<u>Expansion Recommendation Option 3 – Received 14 votes making it the "Preferred" Task Force Budget Recommendation:</u>

Provide $3,000,000 in additional funding in the FY 2019 budget for year 1 implementation through increased partnerships with community-based organizations and a short-term expansion of the DBH School Mental Health Program, including:

- ➢ $1,901,000 in grant funding to community-based behavioral health providers to support 33 clinicians and 4 clinical supervisors. Grant funds will support CBOs to provide, in addition to billable clinical services, non-billable interventions and supports integral to a multi-tiered school-based practice, including but not limited to teacher and parent consultation, school team meetings, care coordination, and crisis management;

- ➢ $450,000 to fund 5 DBH contracted clinicians to provide interim support in Year #1 while CBOs build their capacity.

- ➢ $524,000 to develop a robust and effective Community of Practice to increase provider and school readiness and ability to implement the multi-tiered model. These funds can also support technical assistance to providers, schools, and to fund coordination support.

- $125,000 to support an evaluation of the first year of implementation, including an assessment of school-based crisis intervention services and response.

Expansion Recommendation Option 3 (Partner with Community-Based Providers; Expand DBH Clinicians to support transition; and increase support for all partners)

Description	Full Cost	% Cost to DC	Unit Price	Units	Total Cost
CBO Licensed Clinicians	$90,000	50%	$45,000	33	$1,485,000
CBO Clinician Supervisors	$104,000	100%	$104,000	4	$416,000
DBH Contracted Clinician Expansion	$90,000	100%	$90,000	5	$450,000
Development of a Community of Practice and Technical Assistance to Grantees (Provider and School Support, and provide coordination support.	$524,000	100%	$524,000	1	$524,000
Program Evaluation (includes scope for determining school-based crisis response needs through the Lab @ DC)	$125,000	100%	$125,000	1	$125,000
TOTAL					**$3,000,000**

Additional budget recommendation for Workforce Development & Internship Support – Received 12 votes.

Provide an additional $250,000 in new funding in the FY 2019 budget for expansion of a graduate level-internship program to serve both DC Public and Public Charter Schools.

Additional Budget Recommendation (Workforce Development & Internship Support)

Description	Full Cost	% Cost to DC	Unit Price	Units	Total Cost
Graduate-Level Internship Program at DCPS and DCPCS to support Program Expansion	$250,000	100%	$250,000	1	$250,000
**DCPS currently has a program that supports graduate-level internships with a cost-sharing agreement in place with participating schools (for instance, $125,000 would support 5 interns at DCPS). This recommendation also includes an equal amount for Charter Schools.*					

Recommendation #6: Governance

Create an effective governance body and/or structure that holds agencies and participating stakeholders accountable for timely implementation of the expanded School-based Behavioral Health System. As noted in the Report, some Task Force members expressed a preference for a governance body at the Deputy Mayor level and others expressed a preference for the governance body to be led by DBH. There were about equal representation and diversity of stakeholders within each of these groups.

The role and functions of this governing body should be to:

- Guide implementation of all elements of the Comprehensive Plan, including engagement with stakeholders, including families and school leaders, while ensuring coordination of resources among key district agencies (DBH, DCPS, OSSE, DOH).

- Assist in identifying criteria and metrics that support provider readiness and capacity-building efforts (training, mentorships, etc.), including providing recommendations for standards of care for school-behavioral health and a shared understanding of school-based behavioral health staff roles and responsibility across position descriptions.

- Provide input to DBH regarding development of an on-going learning collaborative for providers ("Community of Practice") that will help ensure quality of services and support providers to expand and/or improve performance.

- Support creation of a comprehensive inventory of behavioral health resources in schools and annually provide input to and help ensure accuracy of the school-based inventory in partnership with key stakeholders (schools, providers, district agencies, etc.). Identify resource gaps and provide input to guide resource development and/or more effective utilization of those resources.

- Review and provide on-going guidance on the task of the annual need determination and prioritization process.

- Advise on how cross-agency and public-private agreements reflect the established standards for the Comprehensive School-Based Behavioral Health system.

- Help support linkages and coordination between the School-Based Behavioral Health System and:

- Providers serving youth through other child serving agencies, including CFSA, DYRS, DPR, DHS, and others;

- DC child/youth initiatives (i.e., school climate initiative; truancy prevention, school-based health centers, Out-of-School Time providers, etc.); and

- Policy activities and requirements at the intersection of school health and education (i.e., South Capitol Street Memorial Act, Youth Suicide Prevention and School Climate Survey Act, Student Fair Access bill, etc.)

- Help coordinate broader health and education activities, such as education leadership development or Medicaid reform efforts. In addition, assist with the coordination and delivery of relevant training to key audiences and dissemination of evidence-based programs and practices. This may include attention to methods for institutionalizing best practices for long-term benefit.

- Explore workforce development strategies, including agreements with local university or training sites to increase the school mental health workforce.

- Guide development of evaluation framework, plan, and implementation.