Office of the Deputy Mayor for Health and Human Services

Task Force on School Mental Health Meeting

DATE: Friday, January 12, 2018
LOCATION: Department of Behavioral Health
64 New York Avenue NE – Room 284
TIME: 9:00 am – 11:00 am

Task Force Members

Appointee	Task Force Seat Designation	Attendance	Designee	Attendance
Deitra Bryant-Mallory	District of Columbia Public Schools	Present		
Councilmember Vincent Gray	DC Council - Committee on Health	Present		
Councilmember David Grosso	DC Council - Committee on Education	Present		
Michael Lamb	Non-Core Service Agency Provider Representative	Present		
Nathan Luecking	Department of Behavioral Health School Mental Health Program (SMHP) Clinician	Present		
Taiwan Lovelace	Department of Behavioral Health Mental Health Program Clinician	Present		
Dr. LaQuandra Nesbitt	Deputy Mayor for Health and Human Services Designee	Present		
Chioma Oruh	DCPS Parent Member	Present		
Michelle Palmer	Non-Core Service Agency Provider Representative	Not Present		
Marisa Parrella	Core Service Agency Provider Representative	Present		
Scott Pearson	Public Charter School Board	Present		
Juanita Price	Core Service Agency Provider Representative	Present		
Dr. Olga Price	School Mental Health Expert	Present		

Office of the Deputy Mayor for Health and Human Services

Appointee	Task Force Seat Designation	Attendance	Designee	Attendance
Dr. Tanya Royster	Department of Behavioral Health	Present		
Dr. Heidi Schumacher	Office of the State Superintendent of Schools	Present		
Chalon Jones	Deputy Mayor for Education (DME) Designee	Present		
Molly Whalen	Public Charter School Parent Member	Present		

Additional District Government or DCPCSB Staff Present

Name	Role	Office or Agency
Jay Melder	Facilitator	Office of the Deputy Mayor for Health & Human Services
Barbara Parks	Staff	Department of Behavioral Health
Charneta Scott	Staff	Department of Behavioral Health
Erica Barnes	Staff	Department of Behavioral Health
Denise Dunbar	Staff	Department of Behavioral Health
Osaze Imadojemu	Staff	Councilmember Vincent Gray
Anne Robinson		Councilmember David Grosso
Sakina Thompson	Staff	Office of the Deputy Mayor for Health & Human Services
Amelia Whitman	Staff	Office of the Deputy Mayor for Health & Human Services
Monica Hammond	Staff	Department of Behavioral Health
Jiselle O-Neal	Staff	DC Public Charter School Board
Erika Barnes	Staff	Department of Behavioral Health
Lanada Williams	Staff	Department of Behavioral Health
Omotunde Sowole-West	Staff	Office of the State Superintendent of Education
Monica Hammock	Staff	Department of Behavioral Health
Jocelyn Route	Staff	Department of Behavioral Health
Yair Inspektor	Staff	Office of the State Superintendent of Schools

Office of the Deputy Mayor for Health and Human Services

Public Attendees

Name	Role	Organization
Alyssa George	Public	Bazelon Center
Michael Villafranca	Public	Children's Law Center
Mark LeVota	Public	DC Behavioral Health Association
Sarah Baldauf	Public	George Washington University

AGENDA

I. Welcome & Introduction (10 minutes)

Facilitator, Jay Melder, opened the meeting by asking the Co-Chairs for opening remarks. Dr. Olga Acosta Price noted a shared commitment to start implementation in the SY 18-19. Dr. LaQuandra Nesbitt noted the need to keep equity as a core principle of the Task Force's work. Jay then had Task Force members introduce themselves.

II. Review Agenda (5 minutes)

III. Presentation and Discussion

A. Governance Framework for Proposed Comprehensive Plan

Dr. Charneta Scott (DBH): presented Slides 4 and 5. Roles and responsibilities beyond review of and input into the need/risk stratification determination and priority plan—annually or as needed—were to be determined. Did include QI/QA review. Coordinating Council (CC) would be comprised of any members of the current Interagency Behavioral Health Working Group (BWG) that volunteered and had identified specific people to fill the additional roles listed on Slide 5 (parent, peer specialists, etc.). DBH would provide the CC with the data and other information necessary to do their work. DBH had to pause continuing to flesh out the details of the CC when legislation was passed.

Dr. Olga Price: Would the CC have authority to oversee the many partners? Who would it report to? School-based BH work involves many partners not just providers? I see this body as not one that would be deciding qualifications or credentials, but rather, for example, as we implement if there were parts that didn't work well, this group would be able to figure out what didn't work well and determine different processes/improvements. Who would provide the data to the CC that would form the basis of their work? Does it make sense for it to be at the Mayoral or Deputy Mayor level?

Juanita Price: Who would own the baby (CC)?

Dr. Tanya Royster: Directors of the agencies that fund services would sit on the CC – each has the authority to affect each of their systems and can jointly agree to what should happen. But a director of one agency wouldn't have authority over another's agency. The CC doesn't need to report to anyone else as they report to each other. The responsibilities discussed here – risk index adjustments, keeping track of CBO capacity and performance, providing technical assistance to CBOs – are currently the responsibility of DBH, and would not be responsibilities of the CC.

Jay Melder: Best practice would say there should be a reporting requirement. After the Task Force completes its work, the BWG can continue its work to guide the pre-implementation work and get us to the implementation phase. The BWG membership can be opened up to make sure we have the right people at the table. The BWG role is to inform both the CC and DBH.

Dr. LaQuandra Nesbitt: Not all programs have specific legislative oversight – regular performance oversight processes are in place through the Council performance and budget reviews.

CM David Grosso: Out-of-School Time (OST) is one example that has been legislated and is a program model for partnership between the Mayor and the Council.

Dr. Olga Price: School mental health is about more than providers. It takes multiple partners to make a school mental health system function effectively. Where is the oversight of those many partners who are critical to the success of moving towards a system that identifies and supports kids' needs earlier, thus reducing need for Tier 3 services?

Dr. LaQuadra Nesbitt and Dr. Heidi Schumacher: Agree we are working to move beyond just looking at health outcomes to drive the work – looking to other partners, including education, human services, etc. to track and work on those outcomes. We are working hard on many fronts to increasingly create this integrated system of care.

B. Subcommittee Reports:

1. Provider Capacity:

Marissa Parrella: The BWG didn't include providers, resulting in the plan feeling like an unfunded mandate to providers. Providers have a challenge retaining qualified personnel. If funding is only through billable hours, we need to be clear what we are really committing to. Theoretically, providing Tier 3 services works where there is a highly supportive school team. But where there is not, the provider is challenged to survive fiscally, because there are many other things that need to be done to make their contribution successful. For example, because we have an integrated model, we will link

families to other social services, if the school doesn't have that capacity. I liked the part of the Plan that recognized the need for a coordinating person and other services.

Even where the clinician's Tier 3 work is well-supported in a school, there is down time for the clinician while the school year, and their case load, is ramping up. During that time, Mary's Center clinicians can perform other more administrative, or Tier 1 activities.

There is also a balance between having too few contributors to student mental health and too many. We need a coordinating person in the school – clinicians embedded in school can deliver other parts needed and have the relationships to do that. If you divide duties/tasks up among too many people it can be disjointed and not effective.

Scott Pearson: For charter schools, there is little overlap between DBH clinicians and provider or charter school funded clinicians. How do we decide what schools get which and how to pay for it? Are there other providers? Different resources in different schools resulting in a jigsaw puzzle?

Nathan Luecking: Why not have a clinician in every school? In 2012 an expansion of the DBH SMHP was discussed, but not funded.

Dr. Olga Price: I think EL Haynes provides us with a good example of the model we are looking for – across their three campuses and 1150 students, they deploy seven full-time EL Haynes employed clinicians/master's level; 2 Mary's Center clinicians at 1.5 full-time; a DBH Clinician; Insight Solutions, and others, for a team that has a dedicated coordinator and comes close to meeting the needs to the students. At a minimum, I think our plan needs to ensure that every school has Tier 1, 2, and 3 supports available.

Dr. LaQuandra Nesbitt: We have made significant investments in school health across the District through DOH, DBH, DCPS, and PCS. We need to see all these resources for the team that they are, bring them together and supplement with some grants. Are there jurisdictions where support for the CBOs is mixed funding?

Dr. Olga Price: Yes, Hennepin County and Baltimore City are two good examples that have successful SMH funding models. In Baltimore the hub is the school team, hired either by the school or the CBO, and is a mixed payment model, including a supplemental payment because they want to maximize what a clinician can do in the school.

Michael Lamb: That is the basis of our model, where we pay 50% of the clinician's time because building the supportive environment and capacity of the school is key.

Chioma Oruh: Need wrap-around services and consistency. What happens when the schools are closed? Need full-time support year round-need more community schools and we should be transforming how we service students.

Taiwan Lovelace: Consistency is core reason for SMHP success – when school is not in session, we either make arrangements with parent to see child in the home or community. Also, at my school there is full-time summer programming so can often continue seeing students at school.

Nathan Luecking: I also coordinate with students to see them over the summer

Marisa Parrella: We struggle to find the students over the summer – creates a funding gap as well.

2. Need Determination Subcommittee Report

Dr. Olga Price Reported out on Slides 6-7.

- Everyone on board with types of data, want to look at redundancy, whether certain types of data can be available by school.
- Are putting together a spreadsheet by school of current resources
- Definitely want to take into account qualitative information, including school climate, school readiness

C. Recommendations for Report

Jay Melder: Current deadline is February 9 – heard from a plurality of folks that still need to move with urgency to ensure services are provided next school year, but it might be a work in progress. What would be helpful for the executive is to codify the recommendations of this body in terms of what changes this group would like to see.

CM David Grosso: I think that's a good point, but timing is important in terms of funding. Also about the process and hearing from more people.

CM Vincent Gray: Budget that will be delivered to Council at the end of March – question for me is whether there will be a request to additional dollars. Some of this may result in a multi-year process – no harm in saying this will take time to get to where we want to get to. To me, it's about asking the question about what are we trying to get to and I don't think we are there yet.

CM David Grosso: Once we answer that question–and we've made a lot of progress on that–we have to be honest about how much that costs. We might not be able to get there this year, but we can bite off a little at a time. For example, this year, we could focus on getting more DBH providers into schools – expand coverage somehow. Biggest frustration last year was trying to get the cost – was told cost neutral, but I

saw the need. But needs to be done based on equity of need. Would like to see how we can support that – maybe it is expansion of community schools?

Scott Pearson: We could take this in steps with the first step more dedicated DBH clinicians in schools; also thinking about what Marissa said and it may be that there are two ways a school can go – dedicated DBH clinician or dedicated community-partner provider – and the city can contribute something to that, though not necessarily the full cost.

Chioma Oruh: I am concerned and I think part of the reason for this task force is because of concerns from families, so I want to make sure we include engagement with families and helping them understand

Dr. LaQuandra Nesbitt: To me a lot of this is putting the cart before the horse. At previous meetings we discussed all children needing to have needs assessed. From my perspective, that is a more noble goal and cause to achieve than figuring out staffing-that should follow.

Dr. Deitra Bryant-Mallory: At DCPS we use RTI for a screening, which works well, and use concept of teaming, which is important because ingrained in school community. But we want to be careful not to create a hierarchy among the partners, as that is counter to our goal of having people work together and work together well.

And, DCPS is changing and starting to have pre-K students assessed and monitored. We have started in clusters 2 and 3 and it will be expanding next year.

Dr. Olga Price: A core premise of the Plan should be that long-term sustainability is about partnerships and building the capacity of the provider community in DC. The way that I can imagine is that there is some plan where we have a sense of baseline with the goal being that every school has the presence of all tiers coordinated in their schools. That could be done through different configurations of players - at least two or three models already exist and are working well in schools.

To begin, we can look at the provider community and find the "ready to go" providers – those already in schools and doing work well in one of those configurations or are very close to it, but need to be incentivized to jump in the school mental health game, for example Community Connections, and provide an incentive for them to expand to additional schools. In addition, the DBH SMHP works very well in some schools, but where it's not working well for whatever reason, those clinicians could be redeployed to schools that are high need. We need to outline the set of services and our expectations so that there is accountability to some common framework or services.

The next set of providers would be those that could be ready to provide school-based services in the following school year (2nd year of implementation). These providers would receive an infusion of support over the next year to be able to do this, as long as they commit that they will go into some number of schools in school year 19-20. I don't know how many we need to develop – that depends both on provider capacity and needs.

Jay Melder: The Report could set out goals and strategy objectives that this group wants to be achieved. The BWG would then work on how to implement them.

Bullet points about a report – could be:

- Guiding principles of the group – values, responsibilities to students, school community, government, community partners
- Program goals – we have heard and discussed a lot of these – we want every student to have state supported access to tier 1 services, assessment, Tiers 2 and 3.
- Objectives around how to assess needs and continually looking at data.
- Recommendations around implementation priorities – prioritize X, then build on X to get to Y. Set priorities that government can follow.
- What is the ongoing working group and who's on that
- Governance structure – reporting requirements, QA/QI responsibilities, etc
- Persistent questions – some questions may not be able to be fully digested, but need to work toward answers.

Scott Pearson: This whole structure makes sense, but my concern is budget – if we want to make an impact immediately I would like this group to make specific recommendations regarding what should happen next year.

Juanita Price: We don't need to make a new plan, we need to determine what we can't live with in the current plan right now and then go from there.

Dr. LaQuandra Nesbitt: I concur that what we should produce is some revision of what the DBH plan was. I don't know that we should create something new. In saying that, I think a lot of things that what have been talked about is still possible—doesn't take away from how to build on things in the existing and current system. DBH's plan intended to do that as well. It may not have done it in the same way that some people in the task force would like them to do, but that's the point of this task force. We don't need to start from scratch. I would challenge the group to look at the report recommendations and look at in context of subcommittees and revise the current plan to move us in a different direction.

CM Vincent Gray: Re question of extending, need to know what you want to accomplish by the extended deadline.

Molly Whalen: The Task Force got started about 30-45 days late, but thought we could still be within budget timeline.

Jay Melder: The Mayor submits her budget March 21; we need a report that is succinct with digestible, clear directives. Would an extension through February be sufficient? Hearing agreement on March 1, that is the new due date.

III. Next Steps

Dr. LaQuandra Nesbitt: What we need to produce is a redline of the current Report. I charge each one of you with reading/re-reading the report and providing your specific proposed changes by redlining the document. Sakina is sending out a word version for you to do this.

Jay Melder: We have consensus that the new due date is March 1. The Task Force needs to meet at least 2 more times by the end of February.

VI. Adjourn

Having completed the agenda, the Task Force adjourned.

Any comments regarding these meeting minutes may be sent to Sakina B. Thompson at sakina.thompson@dc.gov.