Office of the Deputy Mayor for Health and Human Services

Task Force on School Mental Health Meeting

DATE: Monday, December 11, 2017
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	Not Present	Osazee Imadojemu	Present
Councilmember David Grosso	DC Council - Committee on Education	Present	Katrina Forrest	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	Present		
Marisa Parrella	Core Service Agency Provider Representative	Present		
Scott Pearson	Public Charter School Board	Not Present	Audrey Williams	Present
Juanita Price	Core Service Agency Provider Representative	Present		
Dr. Olga Price	School Mental Health Expert	Present		

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

Additional District Government 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
Audrey Williams	Staff	DC Public Charter School Board
Lenora Robinson Mills	Staff	DC Public Charter School Board
Aurora Steinle	Staff	Office of the Deputy Mayor for Education
Sakina Thompson	Staff	Office of the Deputy Mayor for Health & Human Services
Amelia Whitman	Staff	Office of the Deputy Mayor for Health & Human Services
Claudia Price	Staff	Department of Behavioral Health
Jacqueline Droddy	Staff	Department of Behavioral Health
Keri Nash	Staff	Department of Behavioral Health
Omotunde Sowole-West	Staff	Office of the State Superintendent of Education
Monica Hammock	Staff	Department of Behavioral Health
Rachel Bradley Williams	Staff	DC Public Schools
Kerriann Peart	Staff	OSSE

Office of the Deputy Mayor for Health and Human Services

Public Attendees

Name	Role	Organization
Julio DeAngelo	Public	Children's National
Sharra Greer	Public	Children's Law Center
Davene White	Public	Howard University Hospital
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 sharing that the Task Force has a slightly different structure now as we have two Co-Chairs – Dr. Olga Acosta Price from the private sector and Dr. LaQuandra Nesbitt from the public sector – which is good for the Task Force as it proceeds. Jay asked for opening remarks from each Co-Chair.

Dr. Nesbitt reviewed the agenda, noted that it is robust, and based on next steps from the last meeting. Today's meeting will also generate next steps to inform the next meeting's agenda.

Dr. Price noted that the legislation sets out specific deliverables to be submitted as part of the Report—strengths of the Plan, timelines for implementation, funding source, workforce development, District-wide need, and evaluation criteria—and while going through today's agenda it would be helpful to listen for recommendations on these aspects of our work.

Dr. Nesbitt then asked Task Force members and other attendees to introduce themselves.

II. Review Agenda (5 minutes)

III. Proposed Comprehensive Plan to Expand School-Based Behavioral Health Services – (DBH Presentation – 30 minutes)

Dr. Royster began the DBH Presentation by reiterating the goals and then asked Dr. Charneta Scott to present on the Need Determination section.

A. <u>School & Student Need Determination</u> – Dr. Scott presented slides 3-8.

Discussion on Needs Determination:

<u>Framework:</u>

Dr. Tanya Royster: We have population data and, as we implement, we will be able to get more accurate population and student level data.

CM David Grosso: We need individual-based assessment to begin collecting data from the beginning of the year. Feel this is a weakness of the plan. These 2 approaches have to happen simultaneously.

Dr. Chioma Oruh: School-based assessments can miss the needs of the individual student. Our ability to identify kids and their needs is one of our weaknesses; take Child Find for example, which is very weak within our schools. We also need to be able to identify the nature of the students' needs – social, biological, or other.

Dr. Tanya Royster: One question before us today, is whether the data we have right now is good enough? The Interagency Behavioral Health Working Group (BWG) that developed this plan wrestled with this issue for 18 months. We could spend years on this issue and still be debating it. My bias is for action to move us forward.

Dr. Olga Acosta Price: We need to remember that the purpose of the algorithm (i.e., need determination) is to take a crude cut at school need—it is not for evaluation purposes. Ideally, the evaluation framework should be designed before implementation happens.

<u>Potential Data Sources</u>:

Dr. Olga Acosta Price: I see the current data (from OSSE) that has been identified as a strength. In addition, there is surveillance and administrative data that I may be able to identify. We need to allow for schools to respond to their "ranking" and self-identify as higher. Suggest we also look at discipline data – but is it defined the same across schools?

CM David Grosso: Discipline data could include restorative justice.

Dr. Olga Acosta Price: Can we look at Child Protective Services (CFSA) reports? Can Youth Risk Behavior Survey (YRBS) data be requested by school? What can data from our Managed Care Organizations (MCOs) show us?

CM David Grosso: 70% of our students are currently served by our MCOs. AmeriHealth is not opposed to participating.

Dr. Olga Acosta Price: We need a readiness assessment. One of the greatest predictors of SMHP success is a school's readiness.

Dr. Charneta Scott: School discipline data would need to look at both in-school and out-of-school suspensions, but this data can be more of an indicator of adult behavior. Low rates might not mean low need if school is doing a good job.

Dr. LaQuandra Nesbitt: One variable that needs strengthening are the number of 504 plans and Individualized Education Programs (IEPs), which are undercounted. Can't count them for students not yet identified as needing them, because we don't have eyes on every child. Universal screening may capture that, resulting in stronger population level data.

Audrey Williams: We need to look at IEPs at the beginning of the school year and at the end of the school year.

CM David Grosso: This is an issue that gives Council pause – how to measure the need? Are there other factors we should use, such as Well-Child visits?

Dr. Taiwan Lovelace: Clinical data is another metric we need to figure out how to measure. Clinical need data doesn't always manifest into these datasets. Sometimes it is data on incarcerations – juvenile and adult—or community violence

Nathan Luecking: Suggests incarceration rates – juvenile and adult – and community violence are key indicators of need. As a school-based clinician, I check the daily news, multiple sites, to see if there is a shooting, whether and how it connects with our students. We have to know what is happening in the neighborhood and how it impacts them.

Dr. Charneta Scott: We looked at MPD data but what we saw didn't look highly relevant.

Dr. Bryant-Mallory: We can look at special education programs and housing, especially if there are homeless shelters zoned to certain schools.

Dr. Charneta Scott: Kids don't always in live in the neighborhood where the school is located.

Dr. Bryant-Mallory: Suggest looking at in-school and out-of-school suspension rates. The Office of Human Rights (OHR) has a 3 year "Improving Safe Schools" grant in their Office of Bullying and Prevention. All students took the School Climate Survey.

Dr. Charneta Scott: We also looked at the OHR "Improving Safe Schools" School Climate grant, but a condition of the grant was that the data would stay internally confidential.

Dr. Chioma Oruh: Collecting data from Out-of-School programming is also an opportunity to ensure that we are capturing student need and providing the supports and interventions they need.

Dr. Bryant Mallory: I worry about chasing data.

Timing

Dr. LaQuandra Nesbitt: School enrollment data is not finalized until October. Should we use the data from the previous May to determine need, or wait until final enrollment data in October? How much does it change year to year?

Dr. Taiwan Lovelace: How do we get qualitative data and capture school-level changes during the year?

Nathan Luecking: We should look at both last year's data and current data.

Moving Forward:

CM David Grosso: We need to be specific on next steps from this group and we need to have this by February. We need funding, staffing, and agreements in place by early next year.

Michelle Palmer: We don't know what we don't know. What is our timeframe?

Osazee Imadojemu: CM Gray will want to weigh in on proper date for Task Force Report.

Dr. Tanya Royster: What we have right now is point-in-time data. What we want is a live feed to provide us with real-time, up-to-date data Furthermore, we will only know the information we are seeking once we are in all the schools. Currently we don't have a person in two-thirds of the schools.

Dr. LaQuandra Nesbitt: As CM Grosso has a pressing concern with how we determine need at this point in the process; we need to improve our thinking on how we do that before next school year. But even though we can't answer all questions today, we need to proceed full throttle with a sense of urgency towards the February delivery date.

B. Behavioral Health Service Tiers – Dr. Royster presented slides 9-11.

Dr. Tanya Royster:

- Of the 60+ schools in the DBH SMHP none of them have 100% of any of the tiers, especially Tier 3, where the caseload is an average of 10-15 students.

Dr. Olga Acosta Price:

- Two parking lot issues: (1) can we get information about what is happening in the schools by provider? (2) what is the capacity of our community-based organizations (CBOs) to engage with schools and provide good quality services at Tiers 1, 2, and 3?
- Tier 1 is about systems capacity, knowledge building, and what is missing now is coordination. We need to link schools to outside providers, but we need to understand the capacity of the CBOs to meet the Tier 3 needs of students.

Dr. LaQuandra Nesbitt:

- Want to get clarity that Charter schools often (or may be more likely than DCPS schools) have to supplement Tier 1 services out of their budget, so proposed plan where the Tier 1 would be provided by DBH would free up the charters and other schools to not have to provide that.
- This model we are discussing goes to The Whole School, Whole Community, Whole Child model, which we are implementing. Integrating the school, with the community, is vital to ensuring that all needs of the child are met. We are spending a lot of time on this integration.

Marissa Parella:

- Does DBH have data showing that providing full Tier 1 in schools will reduce the need for Tier 2 and Tier 3?

Dr. Tanya Royster:

- Yes, national data shows that fully providing Tier 1 can reduce need for Tier 2 and Tier 3 services. Don't have local data because all 3 Tiers have not been fully offered in any school.

C. <u>School-Based Mental Health Personnel & Services</u> – Slides 12-15

Dr. Bryant-Mallory presented for DCPS:

Schools have multiple teams:

- **Mental Health Team** is in each school that meets 2x/month
  - School Social Worker (will provide handout)
  - School Psychologist (will provide handout)
  - School Nurse
  - DBH Clinician
  - CBOs working in the school
- **Response to Intervention (RTI) Team**
  - Focus on academic, behavior, attendance issues as early warning indicators
- **504 Teams**

- **IEP Teams**
- **School Climate Teams** – 3rd year of initiative

Audrey Williams presented for DC Public Charter Schools:

- School behavioral health resources are not centralized
- About 22 have DBH Clinicians
- Also participate in DBH's Primary Project

Barbara Parks presented for SMHP:

- Conduct a needs assessment annually with administration
- SMHP is fluid and responsive to changing school needs

Discussion:

Dr. Chioma Oruh:

- Expressed concerns about DCPS Psychologist ability to identify signs of behavioral health needs in 3 and 4 year olds.
- Expressed concerns about principals ability to deliver school climate outcomes.

Dr. Bryant-Mallory:

- Yes, we recognize that training our psychologists to increase their awareness and expertise in identifying signs of behavioral health needs in pre-K students is a priority and an evolving need.
- Whether 180+ staff for DCPS is enough, goes to how we measure student need, and also may go to the degree to which we have Tier 1 services in our school.
- Where we have a good RTI program, we see a decrease in need for our Tier 2 and Tier 3 services.

D. Proposed Plan Implementation Overview – Dr. Royster presented Slides 16-18

E. CAFAS Deep-Dive- Gloria Mensah (DBH) presented Slides 22-34

- The Child and Adolescent Functional Assessment Scale (CAFAS) is designed to measure change in behavior and clinical indicators. Used at intake and every 90 days
- 240 is the possible total score
- Measures all domains of a child's experience, including school, home, community, thinking, substance use, behavior towards others, moods/emotions, self-harm.
- A 20 point change over 90 days is considered a significant change.
- Low Acuity is ≤ 70; high acuity is > 80.
- The slides are for providers of school-based services, but the data is not limited to school-based services.

Discussion

Marissa Parella:

- I find the Mary's Center data misleading as only 3-5% of the data in the CAFAS for Mary's Center represents school-based services.
- In our experience, students with the highest Tier 3 needs much prefer to be served in the school and the highest-risk, highest need families and students wouldn't connect with CBOs when referred.

Dr. Olga Acosta Price:

- Summed up a back and forth discussion by finding that providers are expressing that they like the CAFAS, and if there if it is too costly for providers to use data about their own services, maybe that is a funding question for the group.
- Possible problems with comparisons between providers as could be many variables- how do we know quality of CBOs, and how do we evaluate quality of SMHP? Context matters.

Dr. LaQuadra Nesbitt:

- No, the CAFAS is not used as the basis for deciding in the plan to use DBH staff for Tier 1 and CBOs for Tier 2 and Tier 3. What it is showing is that CBOs can have similar and even better outcomes than the SMHP.

V. Next Steps

- Send out doodle poll for working group meetings on (1) Needs Assessment and (2) Provider Capacity. Task Force members can self-select for either or both.

- Next meeting will be in early January.

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.