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School-Based Behavioral Health Goals

- Provide 100% of students in all DC Public and Public Charter Schools with Primary/Universal prevention supports (Tier 1)
- Ensure that all students who need early intervention services (Tier 2) and all students who need clinical treatment (Tier 3) are connected to and receive quality services and supports.

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Need Determination

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Need Determination and Dosage

Plan's Guiding Principle

- Maximize available resources to all students; no disparity in resources allocated for similarly situated schools; all levels provided in all schools; delivery aligned with school's needs

Goal of the Risk/Need Stratification at the School Level

- Access to quality services and addressing equity

Purpose of the data

- Define the population health risk for mental health concerns in the school building

Practical Use of the data

- Tiered risk categories inform: targeted outreach for recruitment into the different phases of roll-out; allocation of Tier 1 support from DBH clinician (% of time in building); CBO/School matching of services and specialties

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Needs Assessment – Data

- Data Driven
- Begin with Available School-Level Data – “Proxy measures”
 - ✓ OSSE “At-Risk” School Profile ($\geq 70\%$)
 - ✓ 504 Plans ($\geq 10\%$)
 - ✓ Individual Education Plans (IEP) ($\geq 20\%$)
 - ✓ Community Eligibility Provision (CEP) Site Designation ($\geq 40\%$)
 - ✓ Attendance Rate ($< 80\%$)

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Needs Assessment – Models

Model A:

- Low Need = 0 or 1 factor
- Medium Need = 2 factors
- High Need = >2 factors or >70% School At-Risk

Result:

- 51 schools (out of 225) were “high need”
 - of which 48 qualified based on At-Risk Profile >70%
- 15 schools were “medium need”
- 159 (or 71%) were “low need”
- Results did not reflect personal experience and knowledge of school need.

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Needs Assessment – Models

Model B:

- Use number of enrolled children who qualified for each indicator (same as in Model A)
- > 75th percentile for a given indicator = 1 point
 - Low Need = 0 points
 - Medium Need = 1-2 points
 - High Need = ≥ 3 points or >75th percentile for School At-Risk

Result:

- 64 schools (out of 225) were “high need”
- 48 schools were “medium need”
- 113 (or 50.2%) were “low need”
- Results did not reflect personal experience and knowledge of school need.

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Need Determination Considerations

- What is a school's need determination used for?
- Should the need determination be coupled with a resource determination?
- Does the need determination reflect what people know about our schools?
- How can we include input from principals, behavioral health team, folks on the ground, student specific level data, data that is beyond an anecdotal/narrow scope?

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Behavioral Health Service Tiers

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Tier 1 Services

Promotion and Primary Prevention Services and Supports (Tier 1)

- Creates positive school climate, reinforces positive behaviors, supports resiliency and recovery among students, and reduces stigma
- Promotes pro-skill development among children and youth
- Includes staff development, mental health education & social skill building for students, staff or parents/guardians

Examples of Tier 1 Services and Supports

Implementation of manualized curriculums to entire classrooms

Parent workshops

Teacher workshops

Social skills groups for the students

Teacher consultation

Universal screening

Linkages and care coordination

Committee work on school climate and culture initiatives

Parent education groups

Student psychoeducation groups

Crisis intervention

Networking and brokering resources for families

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Tier 2 and Tier 3 Services

Focused Interventions (Tier 2)

- Services include support groups, skill building groups such as social skill development or anger management groups, and training or consultation for families, teachers and other school personnel who work with identified

Intensive Support (Tier 3)

- Individual, group or family treatment services and crisis intervention, offered at school or in the home/community at the discretion of the parents/guardian.

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School-Based Mental Health Professional and Services

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DCPS and DC Public Charter School Workforce

- DCPS has 189 Licensed Independent Clinical Social Workers; 3 Art Therapists; 84 Masters level and OSSE Licensed School Psychologists; and 34 Doctorate level OSSE Licensed School Psychologists.
- Public Charter Schools have 37 Counselors; 44 Social Workers; 66 Psychologists; and 7 Psychiatrists (taken from May, 2017 Comprehensive Plan)

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DBH/SMHP Workforce

- 2 Licensed Psychologists (2 PsyD in Clinical Psychology)
- 1 Licensed Psychology Associate (PhD in Psychology)
- 3 Licensed Graduate Social Workers (MSW)
- 42 Licensed Independent Clinical Social Workers (1 PhD; 1 Dual MA in Psychology & MSW; 1 Dual MSW & Master of Divinity; 39 MSW)

Current Implementation Plans created for each school placement are based on school need and include tiered services that incorporate Evidence Based Programs (EBPs) approved for the current school year.

Frequent themes within the SY17-18 plans include addressing:

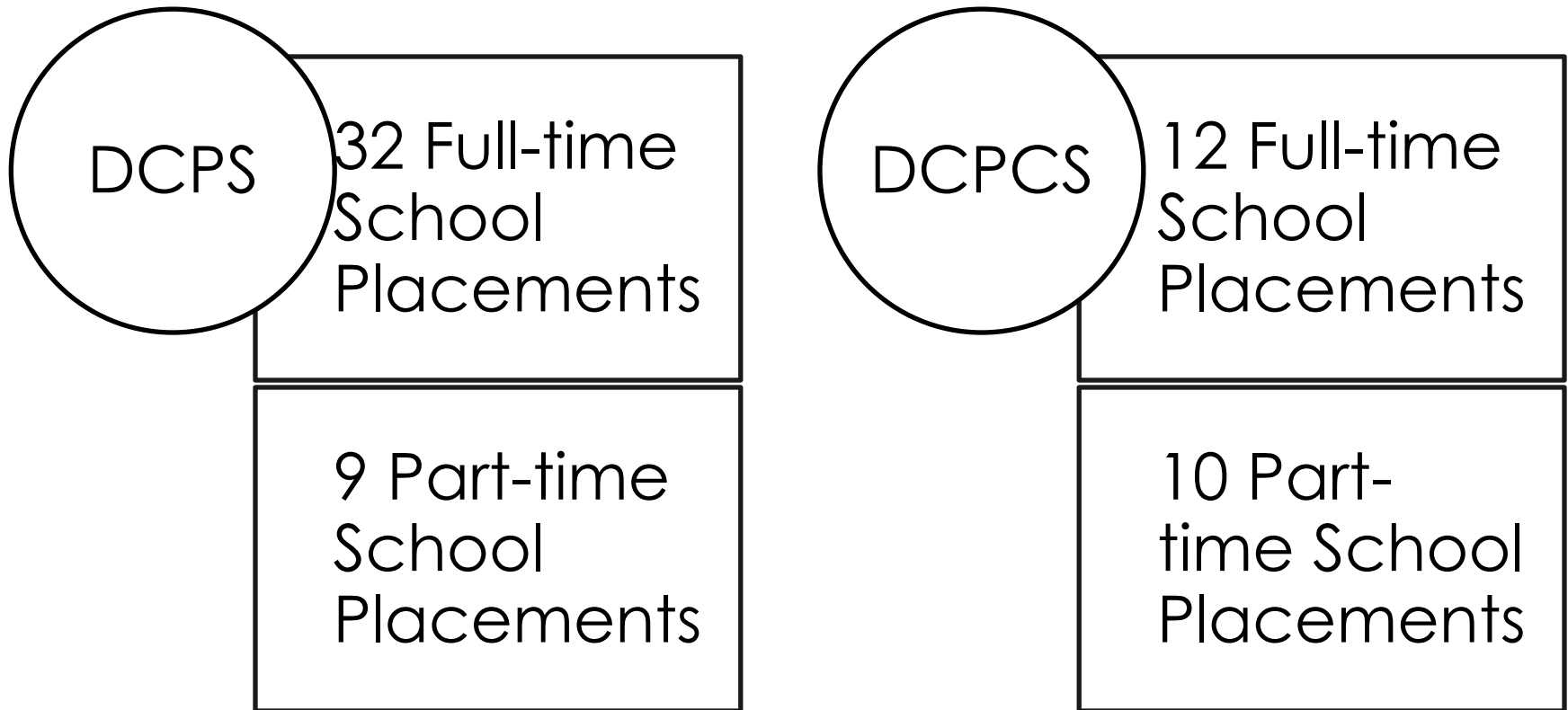
- Skills in coping; emotional regulation and impulse control; grief/loss/trauma; communication and social skills; conflict resolution; relationship-building; and negotiating healthy relationships

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Snapshot of DBH/SMHP SY17-18 Capacity and Reach – 63 Schools

Currently 48 staff with capacity for 53 staff



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Proposed Plan Implementation Overview

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Phased-In Rollout of Plan SY 2017-2018

Cohort 1: Schools with DBH Clinicians

Dates: May 1 - December 31, 2017

Activities:

- **Transition students currently receiving services from DBH Clinicians:**
 - Identify community-based behavioral health provider
 - Complete all steps for provider to begin providing services
 - Work with the provider, families, and the school to smoothly transition students currently receiving services from a DBH Clinician to the new provider
 - Until a child is appropriately transitioned, the DBH Clinician will continue providing direct health services
- **Coordinate referrals for new students.**
- **Work with schools to tailor and implement**
 - Prevention and universal screening, and
 - Technical assistance

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Phased-In Rollout of Plan SY 2017-2018

**Cohorts 2-4: Schools Currently Not Served by
DBH Clinicians Choose their Cohort:**

Cohort 2 (Start of School): June 1, 2017 – August 31, 2017 [Notify DBH by May 31]

Cohort 3 (Fall Semester): September 1, 2017 – Dec. 31, 2017 [Notify DBH by Aug. 15]

Cohort 4 (Spring Semester): January 1, 2018 – April 30, 2018 [Notify DBH by Dec. 15]

- **School Readiness Factors in Selecting a Cohort:**
 - Want to take advantage of the new behavioral health resources;
 - Ready to work with the DBH Clinician to develop plan and begin implementing prevention and screening activities; and
 - Ready to be matched with a community-based behavioral health provider and complete onboarding the provider
- **DBH Clinician role:**
 - Work with each cohort school's designee to assess the school's existing Tier 1 resources, identify remaining Tier 1 needs, and coordinate with and/or provide Tier 1 services to the school as appropriate;
 - Work with each cohort school's designee to identify additional resources needed; and
 - Coordinate with families and schools to link students to appropriate services across all Tiers of services.

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Provider Feedback

Define the following with input from providers and education partners

- Expectations
- Roles and Responsibilities
- Cost model
- Agreement Template

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Next Steps Paused By School-Based Behavioral Health Comprehensive Plan Amendment Act of 2017

- Completion of the Evaluation and Monitoring Instruments
- Selection of Screening Tool
- Finalize Needs Assessment Model
- Complete DBH and OSSE Data Sharing MOA feed from OSSE
- Parent Engagement sessions
- Meet and Greet with Cohort 2 and 3 DC Public Charter School LEAs and CBOs

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Comprehensive Plan

“Update” Communications

- Letter from DBH Director was sent to stakeholders to provide update on the status of the “Comprehensive Plan”
- List provided to LEAs of Community Based Organizations still interested in adding partnerships during SY17-18 for providing treatment services in the schools
- Names provided to LEAs of grant recipients from the Office of Victim Services and Justice Grants (OVSJG) who provide mental health services. The services are not limited to the schools in which the grantee has a presence
- Prospective Coordinating Council members notified of update on status of the “Comprehensive Plan” and the role of the soon to be established Task Force on School Mental Health

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CAFAS Deep-Dive

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Contemporary Family Services

July – Dec 2016

Initial CAFAS Assessments

- Data includes only children who had at least two CAFAS's within this timeframe (n=355)
- **207 children** with low acuity (score of 70 or lower) = 58% of sample
- **148 children** with high acuity (score of 80 or higher) = 42% of sample

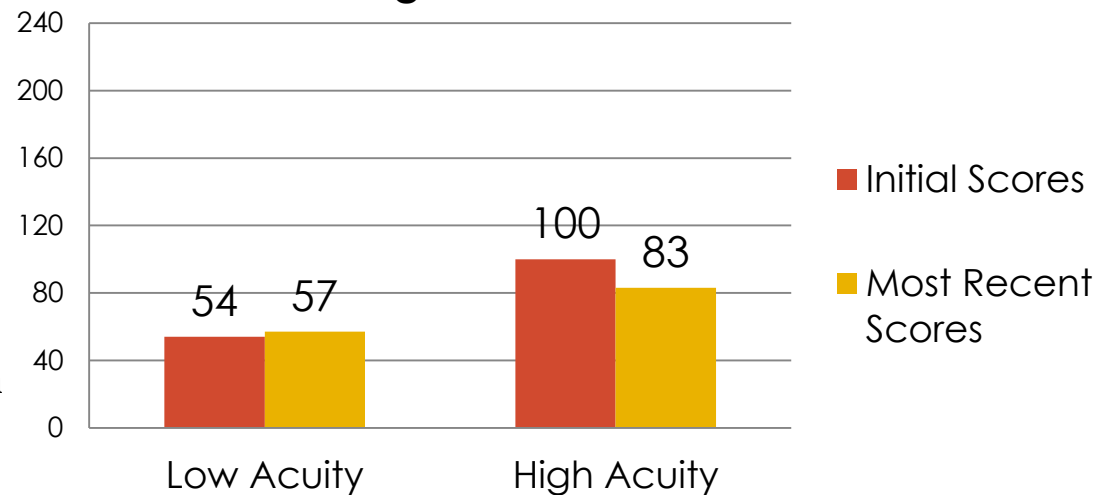
Youth Demographics

- Average Age: 11 years old (range = 4 to 18)
- Gender:
 - **59% Male** (n=210)
 - **39% Female** (n=139)
 - **2% Missing Information** (n=6)

Most Recent CAFAS Assessments

- Time between and initial and most recent varies.
- Average **increase of 3 points** for children starting at **low acuity**.
- Average **decrease of 17 points** (20 points is significant) for children starting at **high acuity**.

Change Over Time



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Contemporary Family Services

Jan – June 2017

Initial CAFAS Assessments

- Data includes only children who had at least two CAFAS's within this timeframe (n=183)
- **102 children** with low acuity (score of 70 or lower) = 56% of sample
- **81 children** with high acuity (score of 80 or higher) = 44% of sample

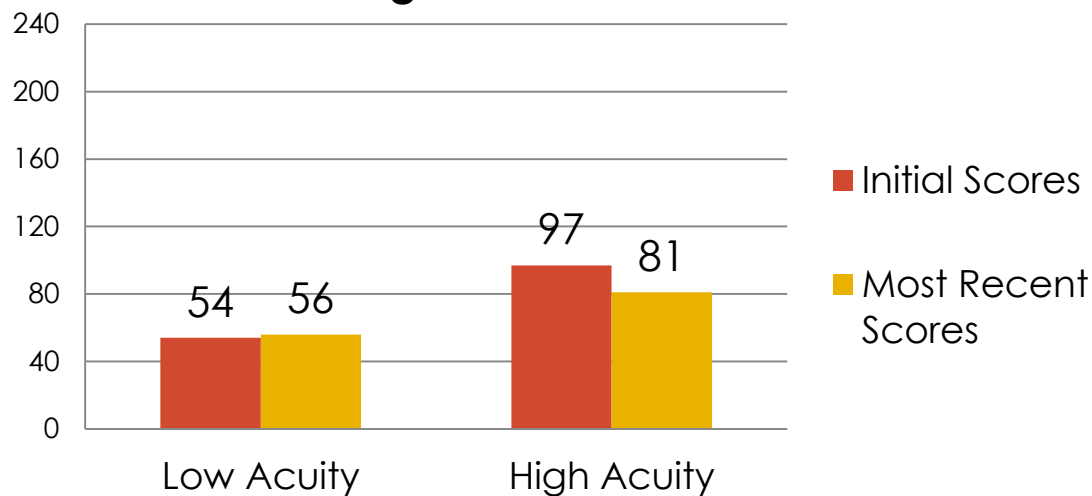
Youth Demographics

- Average Age: 11 years old (range = 5 to 18)
- Gender:
 - **62% Male** (n=113)
 - **36% Female** (n=67)
 - **2% Missing Information** (n=3)

Most Recent CAFAS Assessments

- Time between and initial and most recent varies.
- Average **increase of 2 points** for children starting at **low acuity**.
- Average **decrease of 16 points** (20 points is significant) for children starting at **high acuity**.

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First Home Care

July – Dec 2016

Initial CAFAS Assessments

- Data includes only children who had at least two CAFAS's within this timeframe (n=617)
- **358 children** with low acuity (score of 70 or lower) = 58% of sample
- **259 children** with high acuity (score of 80 or higher) = 42% of sample

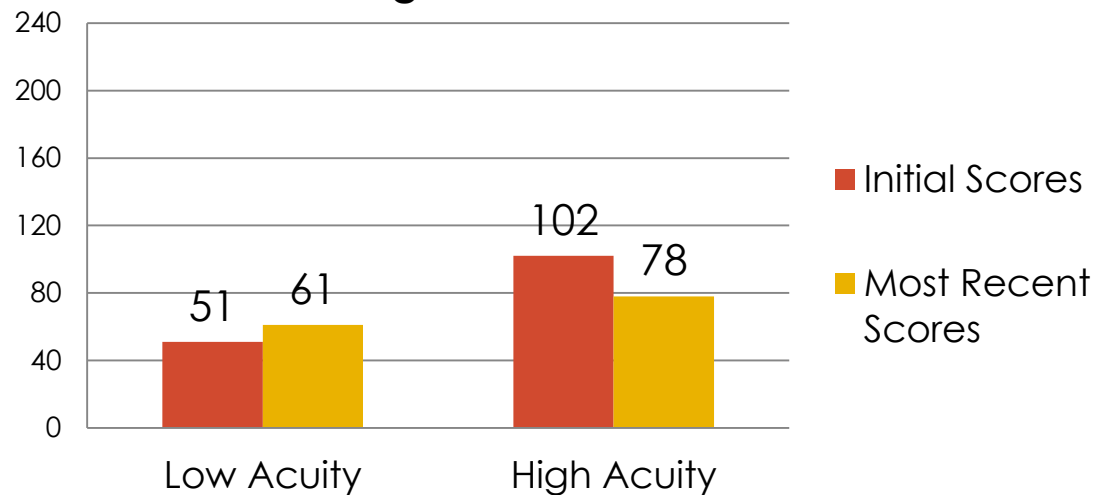
Youth Demographics

- Average Age: 12 years old (range = 5 to 20)
- Gender:
 - **60% Male** (n=371)
 - **39% Female** (n=242)
 - **1% Missing Information** (n=4)

Most Recent CAFAS Assessments

- Time between and initial and most recent varies.
- Average **increase of 10 points** for children starting at **low acuity**.
- Average **decrease of 24 points** (20 points is significant) for children starting at **high acuity**.

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First Home Care

Jan – June 2017

Initial CAFAS Assessments

- Data includes only children who had at least two CAFAS's within this timeframe (n=561)
- **343 children** with low acuity (score of 70 or lower) = 61% of sample
- **218 children** with high acuity (score of 80 or higher) = 39% of sample

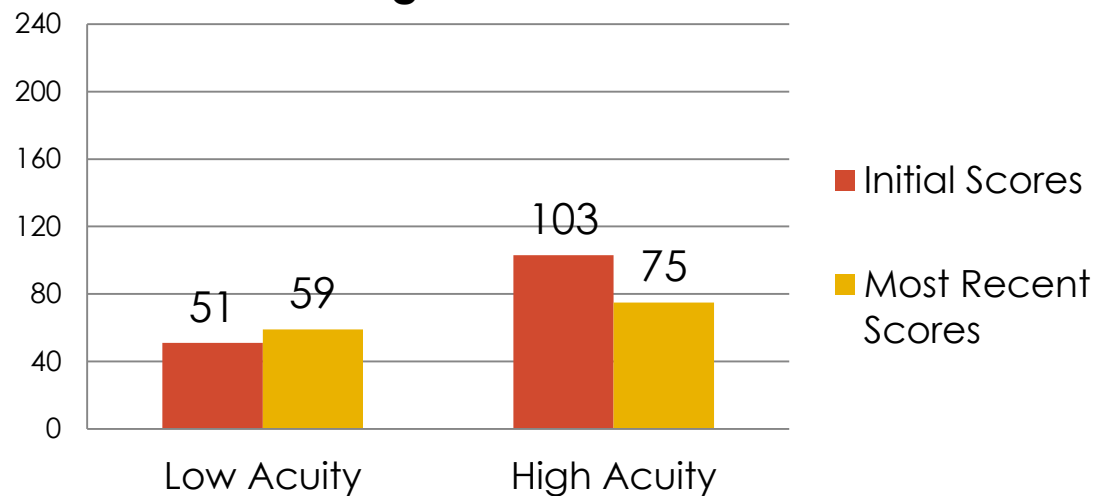
Youth Demographics

- Average Age: 12 years old (range = 5 to 20)
- Gender:
 - **59% Male** (n=332)
 - **41% Female** (n=229)

Most Recent CAFAS Assessments

- Time between and initial and most recent varies.
- Average **increase of 8 points** for children starting at **low acuity**.
- Average **decrease of 28 points** (20 points is significant) for children starting at **high acuity**.

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Family Matters

July – Dec 2016

Initial CAFAS Assessments

- Data includes only children who had at least two CAFAS's within this timeframe (n=70)
- **50 children** with low acuity (score of 70 or lower) = 71% of sample
- **20 children** with high acuity (score of 80 or higher) = 29% of sample

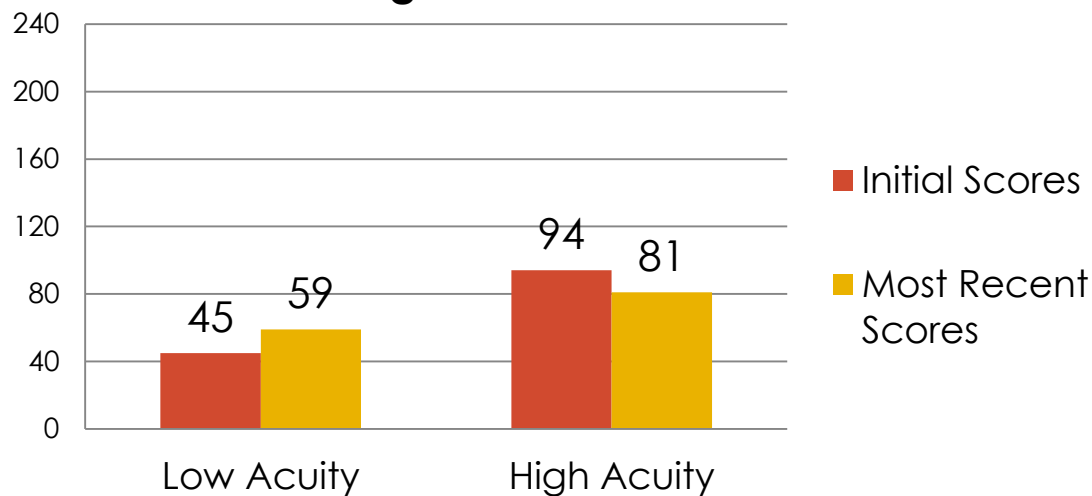
Youth Demographics

- Average Age: 12 years old (range = 5 to 19)
- Gender:
 - **66% Male** (n=46)
 - **33% Female** (n=23)
 - **1% Missing Information** (n=1)

Most Recent CAFAS Assessments

- Time between and initial and most recent varies.
- Average **increase of 14 points** for children starting at **low acuity**.
- Average **decrease of 13 points** (20 points is significant) for children starting at **high acuity**.

Change Over Time



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Family Matters

Jan – June 2017

Initial CAFAS Assessments

- Data includes only children who had at least two CAFAS's within this timeframe (n=53)
- **39 children** with low acuity (score of 70 or lower) = 74% of sample
- **14 children** with high acuity (score of 80 or higher) = 26% of sample

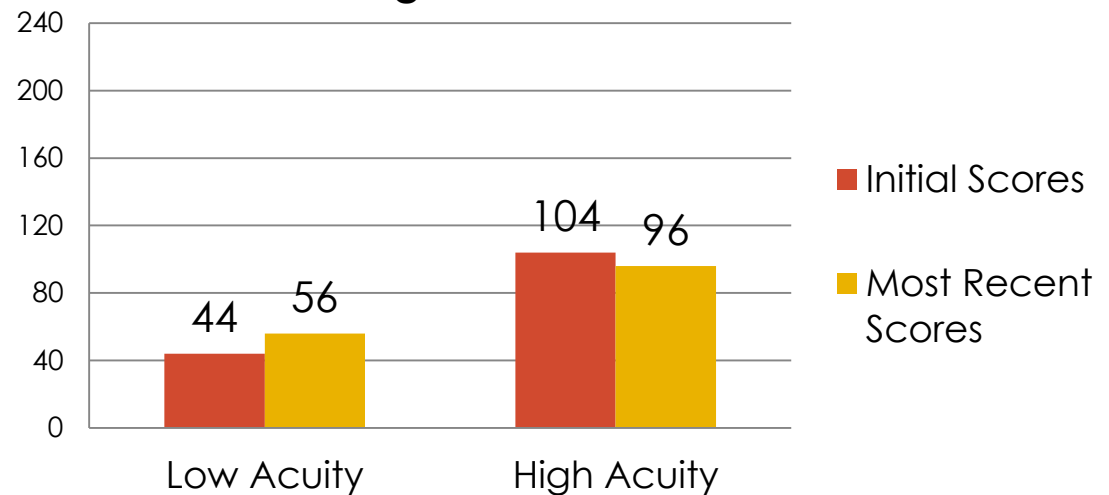
Youth Demographics

- Average Age: 12 years old (range = 5 to 20)
- Gender:
 - **60% Male** (n=32)
 - **40% Female** (n=21)

Most Recent CAFAS Assessments

- Time between and initial and most recent varies.
- Average **increase of 12 points** for children starting at **low acuity**.
- Average **decrease of 8 points** (20 points is significant) for children starting at **high acuity**.

Change Over Time



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Mary's Center

July – Dec 2016

Initial CAFAS Assessments

- Data includes only children who had at least two CAFAS's within this timeframe (n=16)
- **5 children** with low acuity (score of 70 or lower) = 31% of sample
- **11 children** with high acuity (score of 80 or higher) = 69% of sample

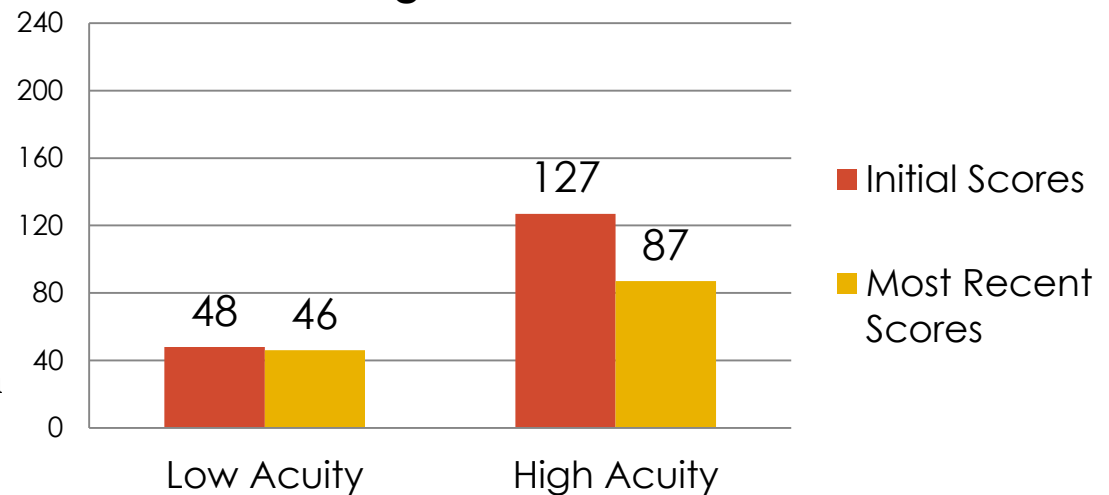
Youth Demographics

- Average Age: 13 years old (range = 5 to 19)
- Gender:
 - **50% Male** (n=8)
 - **44% Female** (n=7)
 - **6% Missing Information** (n=1)

Most Recent CAFAS Assessments

- Time between and initial and most recent varies.
- Average **decrease of 2 points** for children starting at **low acuity**.
- Average **decrease of 40 points** (20 points is significant) for children starting at **high acuity**.

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Mary's Center

Jan – June 2017

Initial CAFAS Assessments

- Data includes only children who had at least two CAFAS's within this timeframe (n=6)
- **2 children** with low acuity (score of 70 or lower) = 33% of sample
- **4 children** with high acuity (score of 80 or higher) = 67% of sample

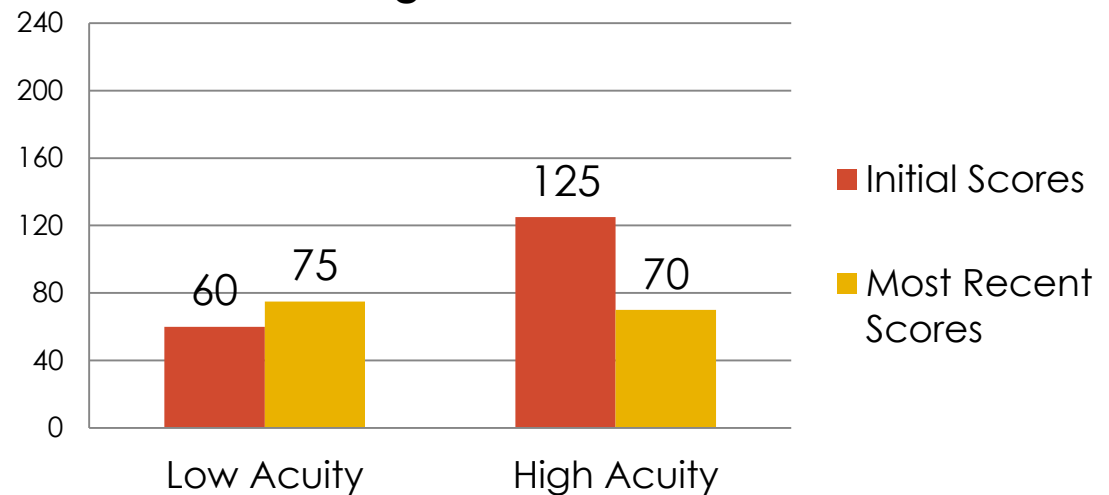
Youth Demographics

- Average Age: 14 years old (range = 6 to 17)
- Gender:
 - **67% Male** (n=4)
 - **33% Female** (n=2)

Most Recent CAFAS Assessments

- Time between and initial and most recent varies.
- Average **increase of 15 points** for children starting at **low acuity**.
- Average **decrease of 55 points** (20 points is significant) for children starting at **high acuity**.

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School Mental Health

July – Dec 2016

Initial CAFAS Assessments

- Data includes only children who had at least two CAFAS's within this timeframe (n=404)
- **325 children** with low acuity (score of 70 or lower) = 80% of sample
- **79 children** with high acuity (score of 80 or higher) = 20% of sample

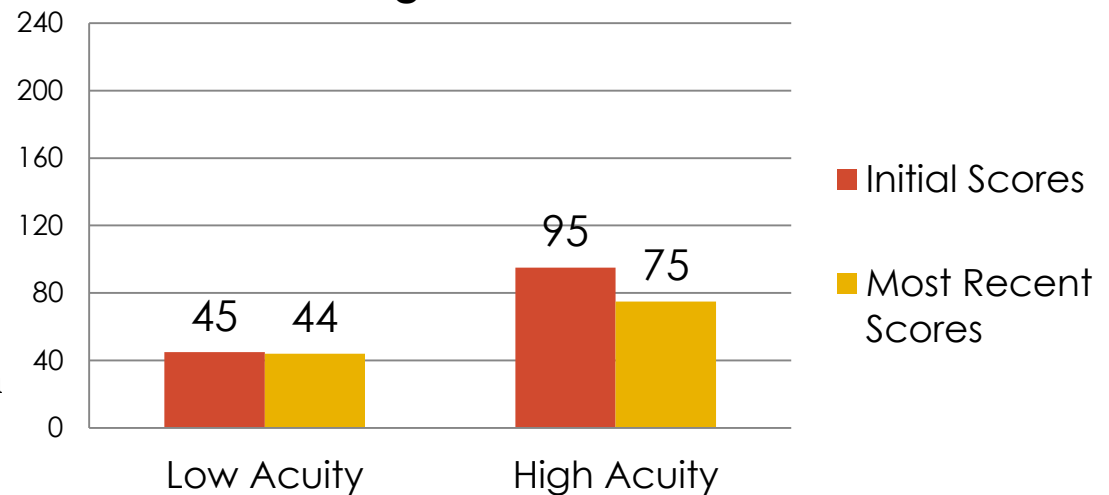
Youth Demographics

- Average Age: 12 years old (range = 4 to 18)
- Gender:
 - **55% Male** (n=221)
 - **44% Female** (n=179)
 - **1% Missing Information** (n=4)

Most Recent CAFAS Assessments

- Time between and initial and most recent varies.
- Average **decrease of 1 point** for children starting at **low acuity**.
- Average **decrease of 20 points** (20 points is significant) for children starting at **high acuity**.

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School Mental Health

Jan – June 2017

Initial CAFAS Assessments

- Data includes only children who had at least two CAFAS's within this timeframe (n=472)
- **406 children** with low acuity (score of 70 or lower) = 86% of sample
- **66 children** with high acuity (score of 80 or higher) = 14% of sample

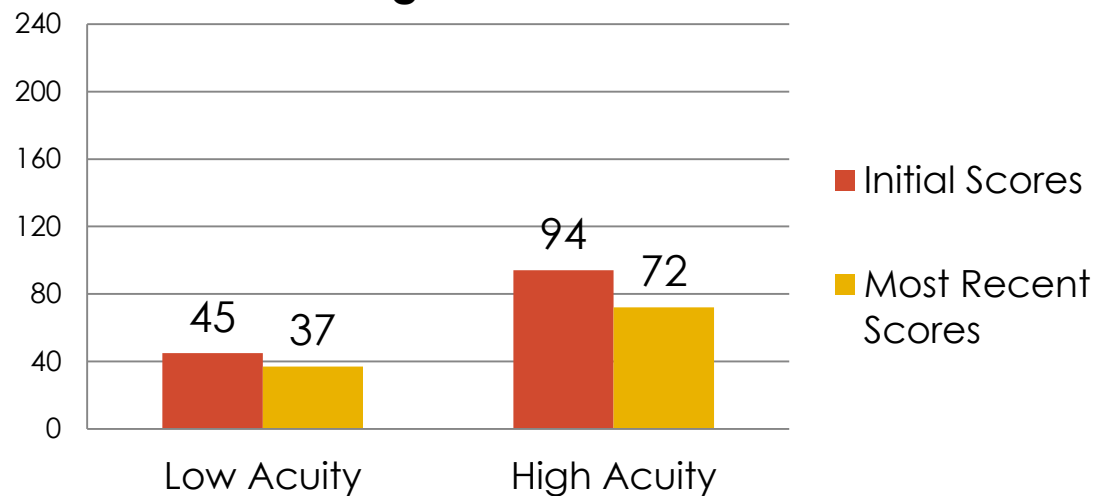
Youth Demographics

- Average Age: 12 years old (range = 5 to 19)
- Gender:
 - 49% Male (n=231)
 - **51% Female** (n=241)

Most Recent CAFAS Assessments

- Time between and initial and most recent varies.
- Average **decrease of 8 point** for children starting at **low acuity**.
- Average **decrease of 22 points** (20 points is significant) for children starting at **high acuity**.

Change Over Time



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Existing School/Community Partnerships and Outcomes

- In SY 16-17, Local Education Agencies entered into agreements with four community-based providers of behavioral health services.
 - **First Home Care** (12 DCPS and 4 DCPS/Turnaround)
 - **Family Matters** (1 DCPS)
 - **Contemporary Family Services** (3 DCPS, 1 DCPCS, 1 Private)
 - **Mary's Center** (5 DCPCS, 9 DCPS)
- Community providers achieved positive outcomes similar to those achieved by the DBH School Mental Health Program.
 - Findings derived from data collected using the same Child and Adolescent Functional Assessment Scale (CAFAS) used by DC Child Serving Agencies.

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CAFAS Outcome Comparisons CBOs and SMHP

- The range of decrease in scores of youth with high acuity was 8-55 points (20 points is significant)
- First Home Care and Mary's Center had the most significant decrease among the 4 CBOs
- SMHP continuously showed a decrease in CAFAS scores in youth who are both low and high acuity
- The scores of the high acuity youth of the providers from First Home Care (now named Foundations), Mary's Center, and SMHP show a significant decrease in their scores

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