

Strengthening the DC School Behavioral Health System and Enhancing Equity



The Center for
Health and Health Care
in Schools

The DC School Behavioral Health
Stakeholder Learning
Community (SLC)'s
Approach to Community-Driven Change

The Center for Health and Health Care in Schools

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- The Social System Design Lab (SSDL), for conducting community-based system dynamics group model building workshops and building the capacity of the SLC and community members to engage in system modeling.
- PoP Health, for conducting the policy landscape analysis and for the writing and design of this report.

EXECUTIVE SUMMARY

The DC Stakeholder Learning Community (SLC) – launched in 2018 by the Center for Health and Health Care in Schools (CHHCS) in partnership with the Bainum Family Foundation – brings together local school-based and child behavioral health stakeholders to strengthen the DC school behavioral health system and enhance equity.

The SLC is composed of family advocates, education and healthcare practitioners, school administrators, researchers, and policymakers. The multisector group began meeting bimonthly with the goal of improving mental health outcomes and reducing mental health disparities among students in the District.

Rooted in values of equity and justice, the SLC has taken a community-driven and participatory approach to building systems dynamics models and examining the local policy landscape to identify systems levers that could help ensure every *child* in DC schools has early access to the supports and services needed to improve their mental health and well-being.

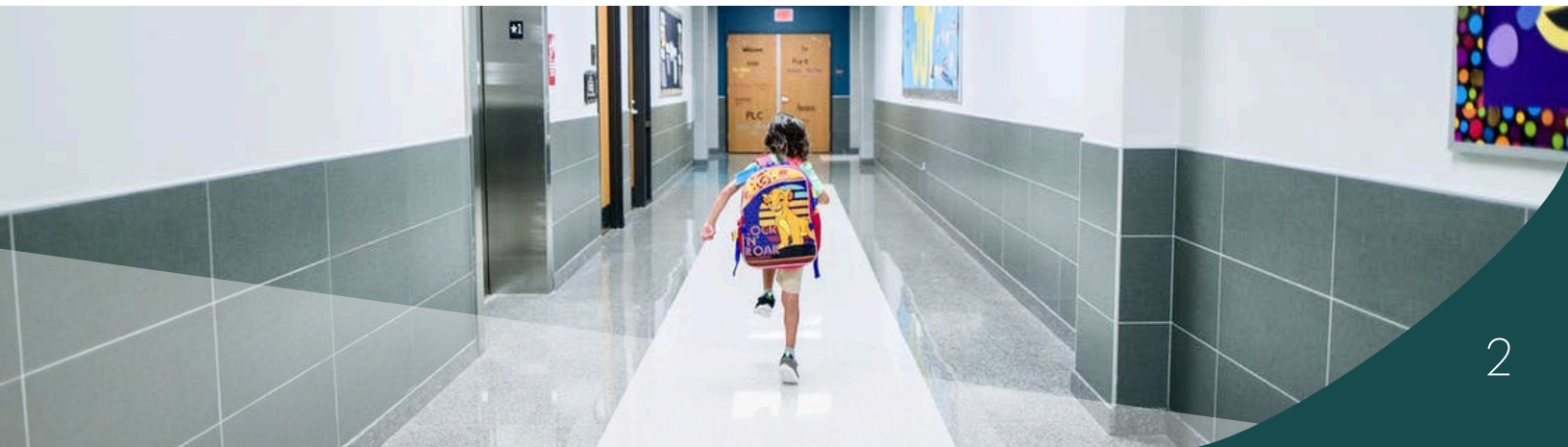
Specifically, the SLC has engaged in three key phases of work over the last three years.

1

SYSTEMS MAPPING with school and behavioral health leaders, students, parents/caregivers, and teachers

A series of four community-based system dynamics (CBSD) group model building workshops were conducted with members of the SLC, high school students, parents/caregivers, and teachers. Across models from these different groups, two central features emerged: an “inner engine” of multi-tiered systems of support and racism as a fundamental cause of school behavioral health outcomes and

inequities. Around this central core – which all stakeholder groups identified – unique insights from students, caregivers, and teachers emerged. These included students’ perceptions that adults don’t care and often discipline them for “attitude” instead of understanding the root causes of their behavior; caregivers’ experiences with ineffective communication, unsuccessful attempts to get their child help at school, racist responses to behavioral challenges; and teachers’ need to be healthy, empowered, and well themselves in order to effectively promote student wellness.



2

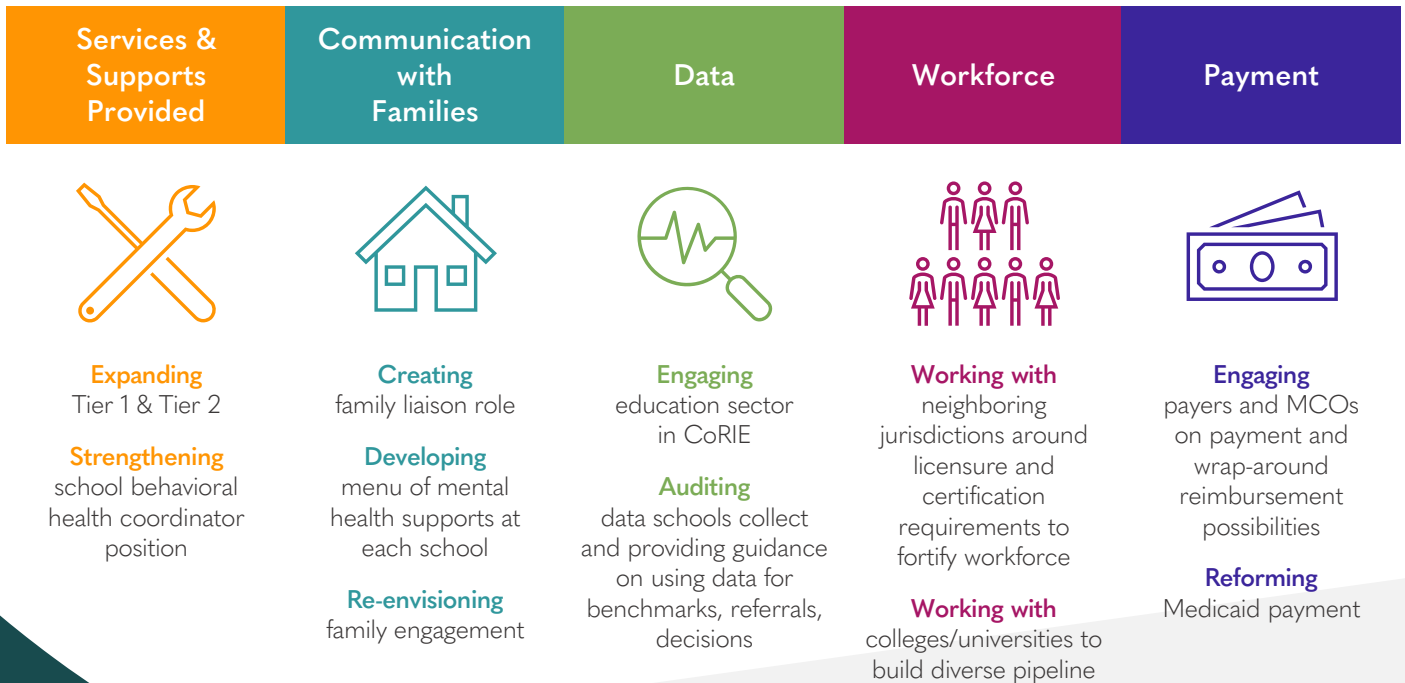
IDENTIFYING AND PRIORITIZING high leverage systems interventions through synthesis of systems model insights and a DC policy landscape analysis

Insights from the systems dynamics models were integrated with a policy landscape analysis, which included a landscape analysis of DC policies (with policies identified in the areas of schools, family and community, healthcare, and other key government programs and services) and key informant interviews (with local leaders, experts, and advocates). Key themes that emerged from the interviews included the need to:

- Build buy in across all stakeholders;
- Explicitly acknowledge the role of racism in the current system and take action to address disparities and promote equity at the levels of policies, schools, and families;
- Coordinate and integrate both horizontally (across DC agencies, within schools, between schools and other sectors, and between healthcare and other sectors) and vertically (from government to schools; within schools from administrators to teachers/staff, and from schools to families; and within healthcare, from payers to providers);

- Provide sufficient infrastructure and resources, financial incentives, accountability, and information and data sharing; more effective governing structures and political processes; and the flexibility and autonomy needed for on-the-ground application and tailoring of approaches;
- Share ownership (with widespread representation and meaningful involvement in decision making) and define ownership (with clarity regarding who owns what and who should be doing what in a way that aligns roles with expertise); and
- Provide strong leadership, including prioritizing and committing to comprehensive school behavioral health and related efforts.

This information was then integrated with systems dynamics insights, culminating in the identification of five key “clusters”: multi-tiered systems of supports, student engagement, family engagement, teacher and school leader workforce, and behavioral health services and workforce. The SLC divided into working groups to further discuss systems models and policy insights within each cluster and to generate a list of specific ideas around systems-level improvements. Ultimately, the SLC chose to prioritize 11 key systems-level improvements across five topical categories.



3

OPERATIONALIZING high leverage systems interventions through a collective information gathering effort

The SLC dived more deeply into the five priority items within the *services and supports provided* and *communication with families* categories, using a series of small group working meetings to engage in collective information gathering with respect to what activities related to the priority

are already happening in DC, what organizations/ groups/entities are engaged in those activities, what the key gaps or obstacles are in making progress on this priority, and what further information or data might be needed to act on the priority. Each small group developed a list of potential next steps the SLC could engage in to further understand or act on the priority. A sample of these next steps is provided below.

Priority Item	Potential Next Step
Expanding Tier 1 & Tier 2 Services	Synthesize/collect data, including data from OSSE School Health Profiles and DC Community of Practice Surveys, Tier 2 referral rates, and data on mental health awareness.
Strengthening School Behavioral Coordinator Position	Determine which specific schools are most struggling with effectively filling and executing this role so school-specific solutions can be crafted.
Creating Family Liaison Role	Poll a small group of DC principals to get their insight into these processes (i.e., current roles with similar descriptions; desire to incorporate a liaison in their school environment).
Developing Menu of Mental Health Supports	Create a "day in the life" map of the specific moments and places in a child's day within a particular school where the importance of behavioral health "shows up" and where they do or could receive various supports.
Reenvisioning Family Engagement	Collect information directly from parents/caregivers about what's effective family engagement consists of on-the-ground and capture them in "learning journey" stories or case studies.

Through this work, the SLC has carved a unique niche for itself within the landscape of school behavioral health efforts in DC, pursuing community-driven systems level change and coordination. Moving forward, the SLC will continue its efforts, including operationalizing and implementing the prioritized action items; quantifying elements of the system dynamics models to inform programmatic and policy decisions; and continually engaging those most directly impacted by the system in the SLC's processes and actions. By continuing its work in collaboration with fellow school behavioral health stakeholders and community members, the SLC is taking strides towards its **ultimate aim:**

Ensuring every child in DC schools has early access to the supports and services needed to improve their mental health and well-being.

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THE SLC'S HISTORY, AIMS & APPROACH

2017

In 2017, the Bainum Family Foundation and the Center for Health and Health Care in Schools (CHHCS) conducted a landscape analysis to inform efforts to strengthen school behavioral health and decrease racial disparities. This analysis uncovered a widely-shared desire to regularly convene a group of key stakeholders in DC to better coordinate and strengthen school-based responses to unmet mental health needs.

2018

In 2018, CHHCS, together with the Foundation, launched a District-wide Stakeholder Learning Community (SLC). Composed of 15+ local school-based and child behavioral health stakeholders (family advocates, education and healthcare practitioners, school administrators, researchers, and policymakers), the SLC began meeting bimonthly with the goal of improving mental health outcomes and reducing mental health disparities among students in the District – through improved coordination, addressing service and capacity gaps, sharing knowledge and resources, and designing and implementing new strategies.

2019

In initial meetings **in early 2019**, SLC members highlighted the need to develop a shared, long-term vision for improving child behavioral health in Washington, DC among stakeholders working in programmatic silos, and to prioritize high leverage system changes. Given these goals, the SLC partnered with the Social System Design Lab (SSDL) at Washington University in St. Louis to engage in a series of Community Based System Dynamics (CBSD) model building workshops, beginning with the SLC itself in Spring 2019.

2020

Model building workshops with students, caregivers, and educators occurred in **Spring 2020**. To complement these models, the SLC also commissioned a policy landscape analysis (involving both a review of current and proposed DC policies related to school behavioral health as well as a series of key informant interviews with local leaders, experts, and advocates). Key insights from across this policy landscape analysis and the systems dynamics model building workshops were synthesized, and the SLC spent Fall 2020 using this information to identify and prioritize high leverage systems interventions.

2021

In Spring 2021, the SLC engaged in a collective information gathering effort to help operationalize the prioritized action items, exploring existing activities, stakeholders, gaps, obstacles, and data needs related to each priority. This report summarizes the work of the SLC from Spring 2019 through Spring 2021.

The key aims of this work have been:



To **develop a shared language** and understanding for a comprehensive school behavioral health system in DC



To **integrate diverse perspectives and voices** in the modeling process to ensure models reflected the lived experience of students, caregivers, and teachers



To **build capacity** of a broad range of stakeholder groups in DC to understand school behavioral health from a system dynamics perspective



To **identify high impact systems and policy levers** to strengthen DC's school behavioral health system



To **enact and advocate for changes in policymaking and program design** for comprehensive school behavioral health in DC

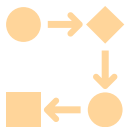
The SLC's approach in pursuing this work has been:



Rooted in the values of equity and justice, both in terms of process (community-driven and participatory, as described below) and the resulting work (examining the role of structural racism within the system and developing policy priorities with an eye to improving equity and empowering families).



Community-driven and participatory, with systematic input from those most impacted by the system - students, caregivers, and teachers – and participation in the SLC by family advocates and advocacy groups.



Focused at the systems level, building systems dynamics models and examining the policy landscape to identify systems levers.



Coordinated across stakeholders, intentionally seeking varied perspectives from organizations and entities across the District and using a participatory, consensus-driven approach to developing and prioritizing action items.

Ultimately, the SLC's work has been driven by the question,

“ How do we make sure **every child** in DC schools has early access to the supports and services needed to improve their mental health and well-being? ”

To address this question, the SLC has engaged in three key phases of work over the last three years.

1

SYSTEMS MAPPING

with school and behavioral health leaders, students, parents/caregivers, and teachers
(Spring 2019 – Spring 2020)

2

IDENTIFYING AND PRIORITIZING

high leverage systems interventions through a synthesis of systems model insights and a DC policy landscape analysis
(Spring 2020 – Fall 2020)

3

OPERATIONALIZING

high leverage systems interventions through a collective information gathering effort
(Spring 2021)

Notably, this work is ongoing and there remains great need and interest in continuing these efforts, translating the insights and information gathered thus far into meaningful action, systems changes, and ultimately, improved mental health and equity for students in DC schools.

In addition to a description of each of the completed phases noted above, future plans are also outlined at the end of this report.

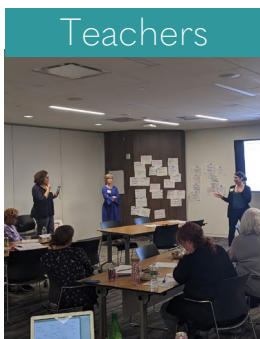


PHASE 1: SYSTEM MAPPING

PHASE 1: SYSTEMS MAPPING

with school and behavioral health leaders, students, caregivers, and teachers

Diagrams and insights from each of the four groups with whom model building was conducted were synthesized by the SSDL and CHHCS team to formulate systems dynamics models (see Appendix A for all models).



Across models from these different groups, two central features emerged: an “inner engine” of multi-tiered systems of support and racism as a fundamental cause of school behavioral health outcomes and inequities.

Systems Mapping Methods

Community Based System Dynamics (CBSD) is a participatory method for involving communities in the process of understanding and changing systems. System dynamics uses informal causal maps and formal models to uncover feedback sources of system behavior. CBSD offers a set of structured and practical tools that make mental models explicit and test assumptions about a complex system. Developing a model can lead to counterintuitive insights about the structure and behavior of a system, which can lead to more effective actions. CBSD empowers communities to co-create the models that lead to insights and recommendations, and to mobilize for change based on these insights.

In Spring 2019, the SLC participated in a series of structured group model building activities designed to elicit key variables related to school behavioral health in DC, and to identify interconnections and feedback loops between the parts. The SSDL combined these causal loop diagrams into a synthesis model, bringing it back to the SLC for further negotiation, critique, and revision. While the model synthesized structural barriers to child behavioral health from the perspective of the school and behavioral health leaders that compose the SLC, the SLC noted that it was missing the key perspectives of students, caregivers, and teachers.

Thus, members of the SLC worked with the SSDL and CHHCS team to co-design and facilitate group model building workshops with three stakeholder groups in Spring 2020: high school students (n=32), parents/caregivers (n=38), and teachers (n=10). In each workshop, participants engaged in group model building activities in response to the prompt: “What helps and gets in the way of all kids getting the social and emotional support they need?” Participants brainstormed variables and worked in groups to create connection circles and causal loop diagrams.

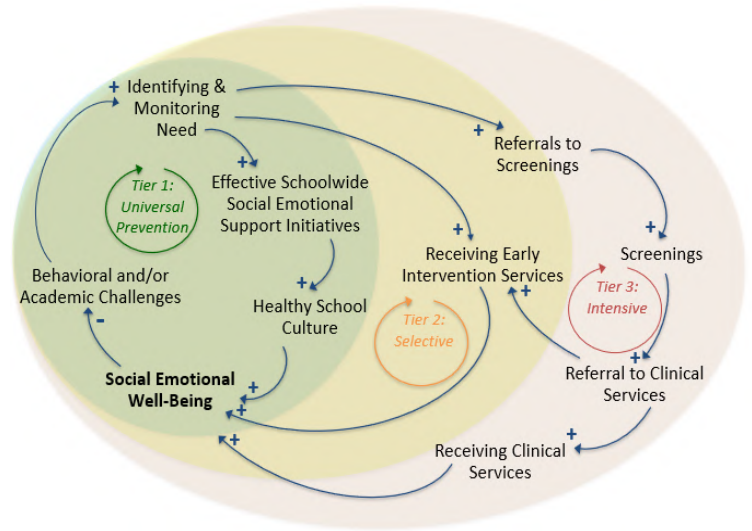
The aims of these workshops were to:

- Integrate diverse perspectives and voices in the modeling process;
- Build capacity of a broad range of stakeholders in DC to understand behavioral health from a systems perspective;
- Develop system dynamics models to inform policymaking and program design;
- To support efforts to prioritize high leverage systems changes to improve child mental health in DC.

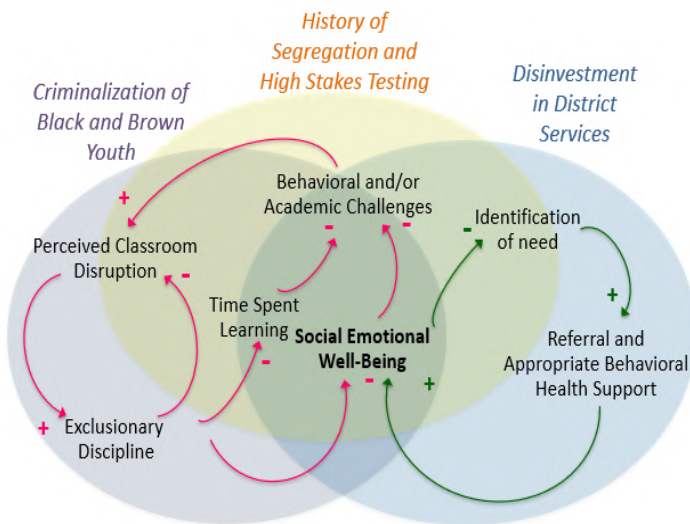
PHASE 1: SYSTEM MAPPING

One central feature across models from the different groups was an “inner engine” of core services and supports that can enhance students’ social emotional well-being. These core services and supports span across the three MTSS tiers (universal prevention, selective intervention, and intensive intervention). At the Tier 1 level, effective schoolwide social emotional support initiatives contribute to a healthy school culture. At the Tier 2 level, identifying and monitoring need as well as formal screenings can help students receive early intervention services. At the Tier 3 level, identifying and monitoring need, screenings, and referral to clinical services can all help put students on the path to receiving the clinical services they need.

“Inner Engine” of Multi-Tiered Systems of Supports



Racism as a Fundamental Cause of School Behavioral Health Inequities



A second central insight across all groups was that racism pervades the entire structure of the behavioral health system in DC. This causal loop diagram depicts how stakeholders expressed the mechanisms by which racism functions as a fundamental cause of school behavioral health inequities.

The local history of high stakes testing, which grew out of efforts to maintain racially-segregated schools in the 1960’s, drives a culture of exclusionary discipline used to maximize time on task in order to raise test scores.

Exclusionary discipline reduces perceived disruption but also reduces the excluded student’s time spent learning and leads to unmet behavioral health needs and poorer social emotional wellbeing.

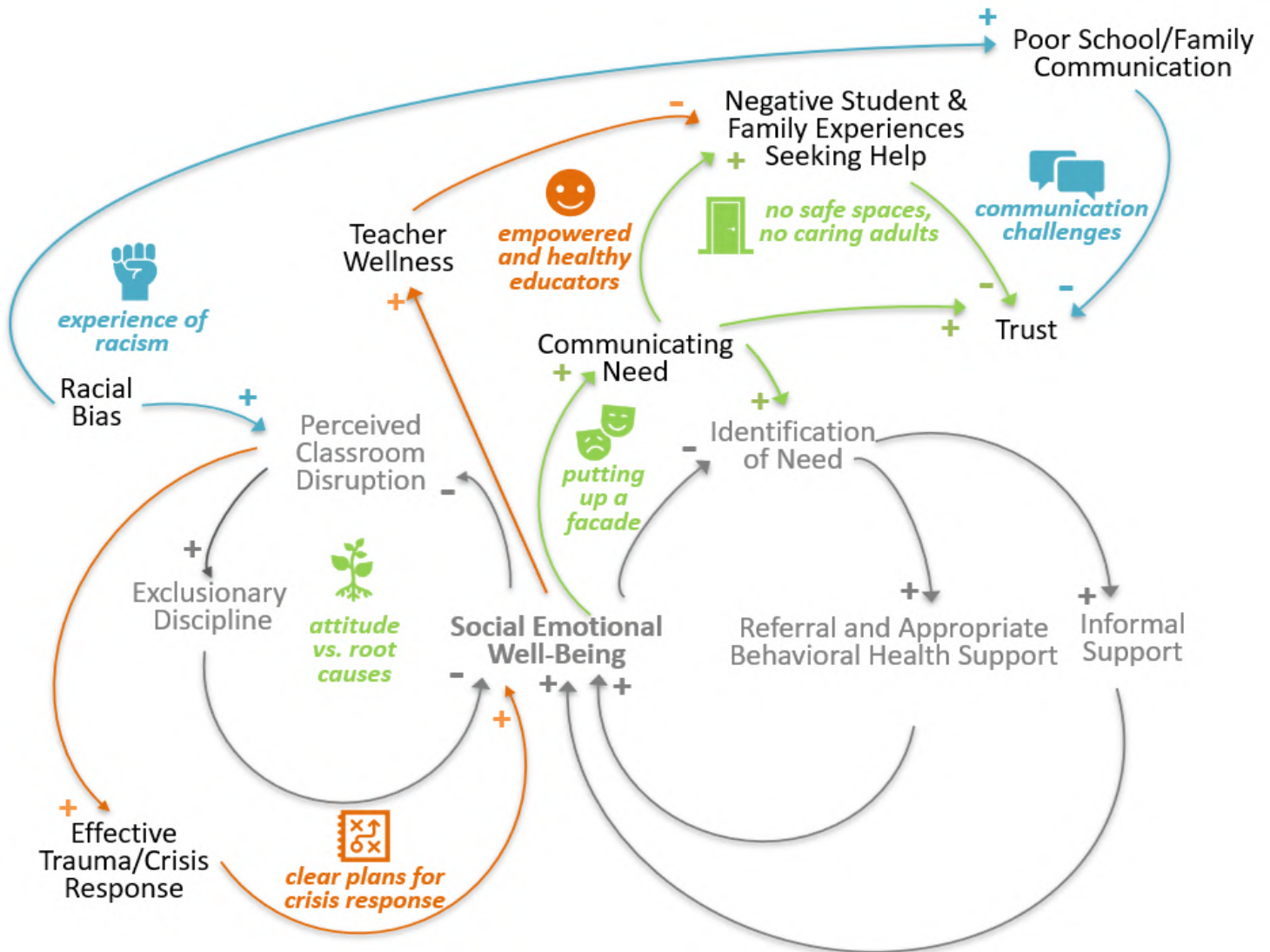
Identification of behavioral health need and subsequent referral systems and quality clinical care, the central focus of most school leaders seeking to improve student behavioral health, serve as an important, but inadequate balancing loop.

PHASE 1: SYSTEM MAPPING

In the model below, these two features (multi-tiered systems of supports and racism as a fundamental cause of behavioral health inequities) are simplified into a central core of identifying need and providing supports on one side, and engaging in exclusionary discipline in the face of perceived classroom disruptions on the other. Around this **central core** (which all stakeholder groups identified), unique insights from **students**, **caregivers**, and **teachers** are mapped.

A Systems Map of School Behavioral Health in DC

highlighting unique insights from **students**, **caregivers**, and **teachers**



Systems Insights from **Students**, **Caregivers**, and **Teachers**

no safe spaces,
no caring adults



When students are ready to talk, they have bad experiences asking adults for help, diminishing trust and discouraging future attempts to reach out. Even when an adult professional is available, students feel they or their communities won't maintain confidentiality, or simply don't care.

*"Adults make you feel like your problems **don't matter**."*

putting up
a facade



Even when supports are available, students may not be willing to access them because they do not have the emotional literacy skills to identify and communicate their need and/or they fear judgment from peers and others.

*"Some people have a hard time **explaining what it is that they're feeling**. Maybe they know what they're feeling isn't healthy but don't know how to converse about that. That can **prevent people from getting support**."*

attitude vs.
root causes



Students are getting disciplined for behavior without addressing underlying need, undermining relationships and worsening social emotional well-being.

*"Adults think you have an attitude – **they ask you why you fight, not what's going on at home...** maybe that person is going through something."*

communication
challenges



Caregivers experience a lack of effective communication from school staff and behavioral health providers (in part due to lack of staff time and bandwidth). These experiences, particularly in the context of unsuccessful attempts to get their children help at school, diminish trust in school staff and providers.

*"As a parent, when I first started, **I was frustrated because I do not know you and you do not know me**. Now there is communication and they understand why my son acts the way he does."*

Systems Insights from **Students**, **Caregivers**, and **Teachers**

experience of racism



Caregivers are traumatized by racist responses to behavioral challenges (e.g., seclusion, restraint, use of force), which disproportionately impact Black and Brown Students.

These responses create more trauma, reinforce the initial behavioral health challenge, undermine staff skill-building to provide an appropriate response, and strain staff bandwidth.

"[We see] kids be grabbed the wrong way... when they get frustrated and they are wrestling these kids and slamming them..."

empowered and healthy educators



Teachers emphasized that their wellness and student wellness are reinforcing, and that their wellness requires sufficient time to do their jobs, build relationships with students and families, and collaborate with other adults in the school.

They also noted the need for a path to teacher leadership in policymaking in order to ensure demands on teachers are realistic.

*"The negative things came from **policymakers not understanding teacher wellness** by putting unreasonable and un-resourced demands."*

clear plans for crisis response



Teachers underscored the importance of a healthy school climate and suggested that law enforcement response to crisis can exacerbate trauma and undermine school climate.

They felt that clearer crisis response and follow through plans could provide concrete alternatives to a law enforcement response and thus help reduce students in crisis.

*"No one spoke about how **law enforcement plays a role in children's behavioral health**. We tell students how to interact with police in schools. Police can traumatize children...One time when a chair was thrown, police were called, and police were talking to child before a parent was present."*

PHASE 2: IDENTIFYING AND PRIORITIZING

high leverage systems interventions

Insights from the system dynamics models from the SLC and student, caregiver, and educator workshops were integrated with a policy landscape analysis, in which CHHCS documented the breadth and depth of school behavioral health related policy activities in DC – and key challenges/gaps – to identify key levers to improve school behavioral health. This analysis involved key informant interviews with local leaders, experts, and advocates in the school

behavioral health space as well as a review of current and proposed DC policies on the topic of school behavioral health. This information was then integrated with systems dynamics insights and presented to the SLC, which used this information to identify and then prioritize key systems-levels actions to pursue moving forward. Results from the policy landscape analysis and subsequent synthesis with insights from the system dynamics models are described below.

DC Policy Landscape Analysis: Policy Review + Interviews

Policies identified through the DC Policy Review fell into the following categories:

Schools

- Behavioral Health Expansion
- Discipline
- Climate

Family & Community

- Place-Based Supports
- Violence Prevention
- Resiliency

Healthcare

- Medicaid Reforms
- Medicaid Coverage
- Hospital Community Benefit

Other Government Programs & Services

- Early Childhood Mental Health
- Crisis Services
- High Needs Youth

For a complete description of the DC Policy Review, including a full list of policies identified and their key provisions, as well as information on implementation, funding, and assessment, please see Appendix B.

DC Policy Review Methods

Policies most relevant to the behavioral health of children in DC schools were reviewed, with a focus on current policy activities and gaps highlighted by key informant interviewees.

This was *not* a comprehensive overview of all District policies on this topic.

Policies were identified through:

- A review of the most recent agency oversight documents from [DBH](#), [OSSE](#), and [DCPS](#);
- A review of key resources identified by interviewees (e.g., legislation summaries, annual reports, etc., as noted in the DC Policy Review in Appendix B);
- An online search to identify additional resources and policies.

While the focus of the DC policy interviews were around policy and regulatory activities, respondents emphasized that *how* implementation of school behavioral health is approached (including school-level actions and school and community-based programmatic efforts), and *who* is involved (including students, families, school leaders, teachers, and other school personnel, the behavioral health workforce, and policymakers and District agency personnel) are critical considerations in achieving optimal mental health for children in DC schools, including effective execution of relevant policies.

Key themes that emerged from the interviews, along with a brief description and illustrative quote, are introduced in the table on the next page. The subsequent section delves more deeply into interview insights in the context of the systems dynamics models.

DC Policy Interviews Methods

Seventeen key informant interviews (with parent advocates, DC government officials, policy researchers, healthcare leaders and education/school behavioral health leaders) were conducted via Zoom between February-May 2020 (with most interviews taking place in February 2020 prior to COVID-related restrictions and changes). Detailed notes from the interviews were open-coded and analyzed thematically using NVivo qualitative analysis software.

The key aim of the interviews was to understand what interviewees – and their organizations – viewed as necessary for every child in DC schools to achieve optimal mental health, and the policies and regulations needed to make those things possible. Questions focused on interviewees' perspectives regarding policy, regulatory, implementation, resource, and other systems-level changes that impact the mental health of children in DC schools.



Interview Themes Regarding **HOW We Work**

Buy In



Building buy in is essential for efforts to improve school behavioral health to be successful.

This work must occur at **all levels** – among community and families, among all school personnel from bus drivers to teachers to administrators, among health practitioners, and among District agency leadership and staff.

Buy in requires:

- **Listening deeply and communicating effectively** to establish bidirectional relationships, which foster trust.
- **Making it easy** to engage with, access, and utilize supports and services.

Garnering buy in is a **slow and deliberate process**, thus requiring **dedicated resources**. Without sufficient buy-in, policies can backfire or stall, be ignored or skirted, or be seen as out of touch.

“Get the laws – first and foremost... But that thing won’t work if we don’t then go around and do the human work, emotional intelligence work, the work that wins people and shifts mental models and creates new cultures around how we think about legislation.” (Parent Advocate)

Equity & Inclusion



A range of disparities exist across the levels of policies, schools, and families/students – including with respect to race/ethnicity, disability status, mental health status, gender, sexual orientation, and socioeconomic status.

It is important to explicitly acknowledge the role of racism, patriarchy, and other inequities in current systems, have “honest conversations” about these forces, and examine problems and solutions through a **“justice lens”**.

There is need to **take action** to address disparities and promote equity and inclusion in school behavioral health at both:

- The policy level (including a focus on early childhood, aligning resources with needs, enhancing workforce diversity, and equity-related data collection), and
- The level of schools and families (including engaging the entire school community and all families in efforts to improve school behavioral health, providing the accommodations necessary for equitable participation).

“Knowing that any movement is reinvigorated when marginalized voices find themselves at the center, we all benefit from the realization that we’re not equally carrying the weight of having poor systems...We’re just not making the right connections because we’re not looking at it from a justice lens – we need a better justice articulation with respect to behavioral health.” (Parent Advocate)

Interview Themes Regarding **WHAT We Do**

Coordination & Integration



Coordinating and integrating efforts both directly and indirectly related to school behavioral health is essential to more effectively enhancing the mental health of students and families.

There is a need to **coordinate and integrate horizontally** – across DC agencies and policies, within schools and between schools and other sectors, and between healthcare and other sectors.

There is also a need to **coordinate and integrate vertically** – from government to schools, as well as within schools (from administrators to school teachers and staff; from schools to families) and within healthcare (from payers to providers).

Effective coordination and integration requires address **key facilitators/barriers**, both strategically (in terms of vision, planning, and roles) and operationally (in terms of infrastructure, incentives, information/data sharing, and regulatory/administrative requirements).

There is a “recognition that children exist within families, and families within communities, and youth well-being and their behavioral health has as much to do with everything in their life [as] with simply a clinical...or behavioral health approach.”
(Policy Advisor)

Implementation Factors



Implementing effective approaches requires sufficient: infrastructure and resources, financial incentives, accountability, and information and data sharing.

In DC specifically, more effective governing structures and political processes could also help more effectively pass and implement effective policies.

On-the-ground application and tailoring and adapting of approaches is also key to successful implementation. This includes:

- Providing the **flexibility** and **autonomy** necessary for evidence-based approaches and programs to be adapted to the **needs of specific communities or schools**; and
- Recognizing the **balancing act** involved in tailoring solutions with other considerations, including **scaling, accountability, fidelity**, and the need for universal **standards**.

“On the ground, school by school, how is this going to work optimally, is money well spent.”
(CBO Director)

Interview Themes Regarding **WHO Does It**

Shared & Defined Ownership



Shared ownership – with widespread representation (i.e., various stakeholders having “a seat at the table”) as well as **everyone being involved, including in decision making** – is key to buy in and effective implementation of efforts to improve school behavioral health.

In particular, there **needs to be someone designated to execute and move things forward**, especially in the context of large coordinating bodies.

Defined ownership – with clarity regarding who owns what, as well as who *should* be doing what (with roles aligned with expertise) – is also essential.

Ownership should be both shared and clearly defined **at all levels**, from within individual school buildings to across District agencies.

“What’s the secret sauce? Everyone has to own a piece...The places where we can’t seem to make a dent and there’s this feeling [that] no matter how many practitioners are there, there’s never enough...the reason why [is] we don’t all feel equal in the room and have equal ownership of what has to happen.” (CBO Director)

Strong & Committed Leadership



Whether within schools, across District agencies, or in communities and cities overall, **strong and committed leadership** is essential to effectively supporting comprehensive school behavioral health.

Ultimately, **change is leadership-driven**, particularly coordination and integration efforts, which require strong leaders taking ownership of the process and laying out both a vision and path for such efforts (see *Coordinate and Integrate* and *Shared and Defined Ownership* sections).

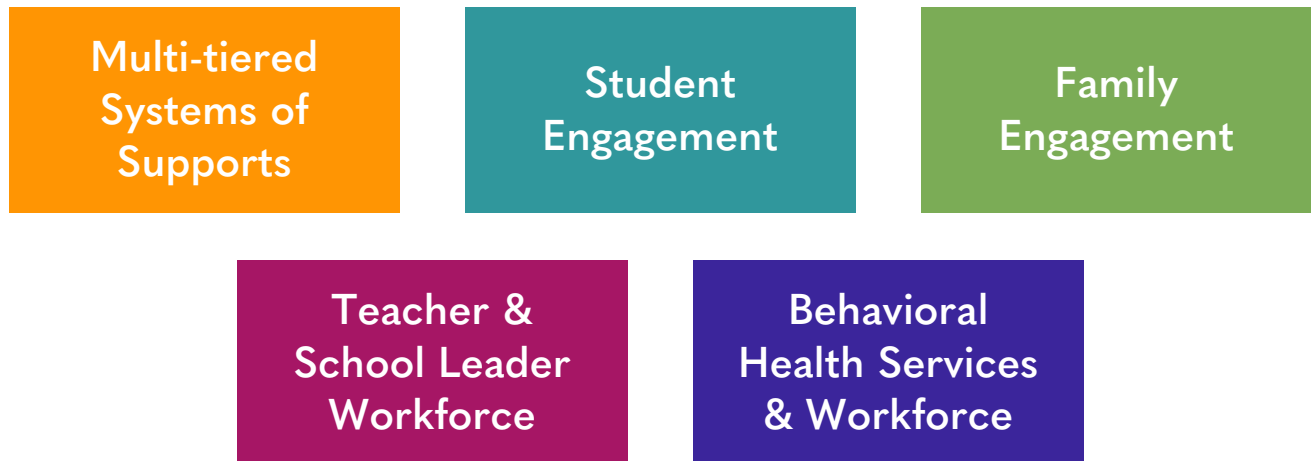
Key actions of strong leaders include prioritizing and committing to comprehensive school behavioral health and related efforts; fostering trust and garnering buy in for such efforts; managing projects well; designating clear roles and holding individuals accountable; holding *themselves* accountable, particularly on transparency and outcomes; and wrestling bureaucratic systems as needed.

Strengthening the leadership workforce requires proper training, recruitment and preparation, and enhancing retention including via higher pay and provision of supports that make leaders lives easier.

“When good leaders are in place, they can move the needle in a positive direction.” (Policy Researcher)

Integrating Policy Analysis with Systems Dynamics Insights

Once the policy landscape analysis and systems dynamics model building workshops were complete and results of each were synthesized, key insights from these two efforts were integrated with one another. This integration culminated in the identification of five key “clusters”: multi-tiered systems of supports, student engagement, family engagement, teacher and school leader workforce, and behavioral health services and workforce.



Simplified cluster-specific systems models and related policy insights from the interviews and policy review (see Appendix C) were presented to the SLC, after which the SLC divided into three working groups to focus on related clusters:

- Multi-tiered Systems of Supports
- Student & Family Engagement
- School & Behavioral Health Workforce

Within each working group, the corresponding cluster-specific models and policy insights were used to facilitate discussion. Using the cluster-specific systems model as a key tool to drive discussion, groups mapped on a variety of additional factors and relationships onto the existing model, explored connections with other clusters, and used the insights from this conversation to collectively identify related system-level improvements to strengthen school behavioral health performance.



Multi-tiered Systems of Support

The MTSS systems model represented stocks (accumulations within a system) and flows (actions that either build or drain the stock) as students' mental health related risk increases and they need services – at which point they may not seek or receive services, or they may move through the process of diagnosis, referral to Tier 2 or Tier 3 services, and receiving these services, proceeding to either complete or drop out of services. At each of those stages and in between stages, there is the potential that students drop out before completing the stage or proceeding to the next.

The working group discussion revolved around the interview themes of ownership and coordination: Who is identifying where students are dropping out/not seeking services? Who is responsible for which Tier, and who is responsible for the referral/coordination process? What coordination needs to take place at what levels to enable this system to work effectively and help more students receive the services they need?

Working group participants honed in on:

- The importance of teaming practices and procedures at the school level, which enable screening and decision-making across teachers, staff, and behavioral health professionals to happen at each juncture;
- The need for consistency in screening processes and data sharing between schools, healthcare, and CBOs;
- The role of training teachers to recognize early warning signs and better know when and how to refer students;
- Learning what is happening to the students who drop out of services after having poor experiences and figuring out how to get them reengaged – including exploring the opportunity for CBOs to provide additional supports as well as consider the role of family and peer influence, stigma, and trust.

Student & Family Engagement

The student and family engagement cluster models were characterized by interconnecting cycles of interactions between student and family trust in school, support received from a variety of sources (school staff, clinicians, peers, and family) which can help increase trust, exclusionary discipline responses which decrease trust, and communication (in terms of students and families asking for help as well as school personnel and families identifying behavioral health need).

The working group discussion revolved around the interview themes of equity and inclusion, buy in, and shared ownership: How can families and students be equitably engaged, treated respectfully, and listened to? How can the system be designed so their input is acted upon?

Working group participants honed in on:

- School-family communication (including family awareness and understanding of school services) as a strong leverage point within the system, enabling families to be better equipped to provide support to students;
- The role of different kinds of support

systems, including support from immediate family, extended family, and families collectively (e.g., through family advocacy organizations);

- The importance of sufficient teacher and staff training to build buy-in and capacity around linking implicit racial bias and staff behaviors and ultimately reducing implicit racial bias and employing alternatives to exclusionary discipline;
- The need for more staff and staff time as well as a more diverse workforce to strengthen school-family communication and cultural relevancy of both communication and behavioral health services;
- Specific ways to build trust with students and families, including addressing historic trauma, making necessary accommodations such that all students and families can participate in the school and its activities (both broadly and with respect to behavioral health services and supports specifically), valuing all voices, and demonstrating consistent and genuine engagement, transparency, and accountability.





School & Behavioral Health Workforce

The school and behavioral health workforce cluster models centered around the skills, time, and buy-in necessary for the school workforce to meaningfully support behavioral health initiatives and the stocks and flows of establishing a sufficiently large and qualified behavioral health workforce (including the role of higher education training, licensing, salary, caseload, billability of activities, management and supervision, professional development, and career development pathways).

The working group discussion focused primarily on the behavioral health workforce and revolved around the interview themes of integration, implementation factors, and equity. How can schools, health care services, and social services be better connected? What is the role of billing and reimbursement in determining the services that the behavioral health workforce can provide to students within and outside of schools? How can we develop a pipeline and workforce within both schools and behavioral health care that better reflects the diversity of DC families and students?

Working group participants honed in on:

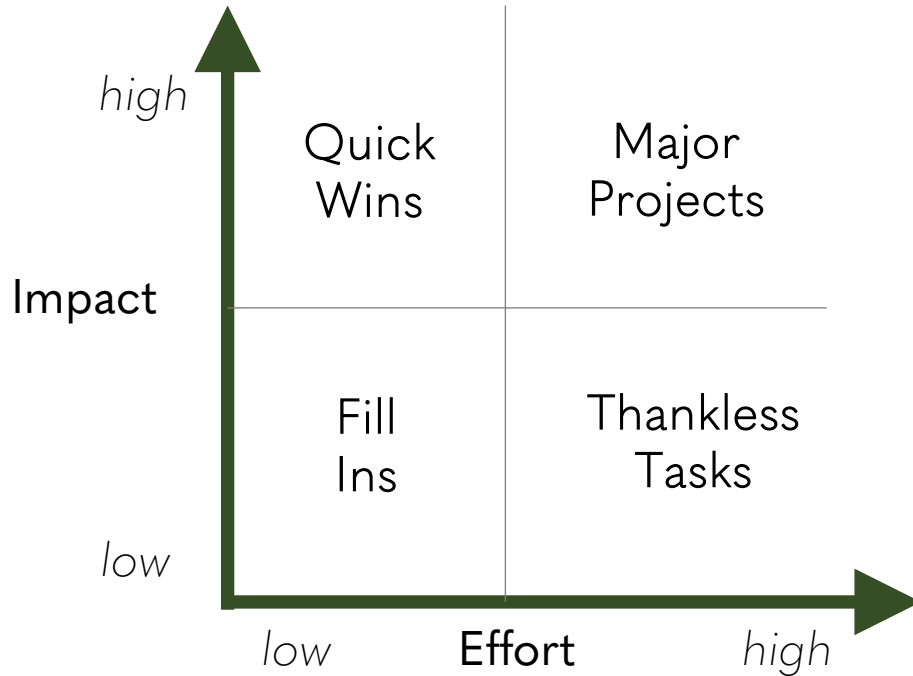
- The need for a more diverse pipeline of school and healthcare workforce generally

and the need for more equitable and streamlined licensing for the behavioral health workforce specifically;





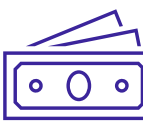
- The importance of diversifying both teachers' and clinician's responsibilities and career pathways to increase retention by mitigating turnover as well as the loss of skilled teachers and clinicians to supervisory and administrative roles;
- The value of paraprofessionals taking on some of the responsibilities that currently fall on the licensed workforce;
- The need for sufficient training and stronger supervision to enable behavioral health care providers to effectively manage their caseload and mitigate burnout and resulting turnover;
- The challenge posed by the behavioral health workforce being unable to bill for important activities – such as teaming to enhance coordination or engaging students and families to build trust; and
- The need for more team-based, multidisciplinary, and coordinated care – which can both better serve students and help reduce workforce burnout and turnover.

PHASE 2: IDENTIFYING AND PRIORITIZING

Each of the working groups generated a list of specific ideas around systems-level improvements based on their discussion. The entire SLC then met to prioritize these ideas (42 in total across the five clusters) based on the level of effort and impact involved, aiming to select a combination of “major projects” and “quick wins” to pursue moving forward.



Ultimately, the SLC chose to prioritize 11 key systems-level improvements across five topical categories.

Services & Supports Provided	Communication with Families	Data	Workforce	Payment
 <p>Expanding Tier 1 & Tier 2</p> <p>Strengthening school behavioral health coordinator position</p>	 <p>Creating family liaison role</p> <p>Developing menu of mental health supports at each school</p> <p>Re-envisioning family engagement</p>	 <p>Engaging education sector in CoRIE</p> <p>Auditing data school collect and providing guidance on using data for benchmarks, referrals, decisions</p>	 <p>Working with neighboring jurisdictions around licensure and certification requirements to fortify workforce</p> <p>Working with colleges/universities to build diverse pipeline</p>	 <p>Engaging payers and MCOs on payment and wrap-around reimbursement possibilities</p> <p>Reforming Medicaid payment</p>

PHASE 3: OPERATIONALIZING

high leverage systems interventions

In order to act on these priorities, they needed to be further operationalized. This in turn required more information about what activities related to the priority are already happening in DC, what organizations/groups/entities are engaged in those activities, what the key gaps or obstacles are in making progress on this priority, and what further information or data might be needed to act on the priority.

Thus, the SLC engaged in a **collective information gathering effort**. Each member of the SLC has been involved in and aware of different school behavioral health related activities and initiatives in DC, as well as different sources of data and information, so this effort served to bring all that knowledge and insight into one place as a first step in determining how the SLC as a group could move forward on these prioritized items.

Given that other coordinating groups in the District are already involved in understanding data (Community Resource Information Exchange - CoRIE) and workforce and payment (Mental Health Transformation Group), a decision was made to further investigate those priorities in collaboration with those groups.

In the meantime, the SLC would focus on the five priority items within the *services and supports provided* and *communication with families* categories. A series of small group working meetings were held to gather information about each of these priorities, which were documented in a shared file online that all SLC members could edit. Key considerations from these discussions are summarized Appendix D, and potential next steps that arose from these conversations are outlined in the subsequent pages.



Expanding Tier 1 & Tier 2 Services

- **Synthesize/collect data, including:**
 - Relevant data from OSSE School Health Profiles and DC Community of Practice surveys
 - Tier 2 referral rates
 - Data on mental health awareness broadly
- **Determine how best to create a list of Tier 1 and Tier 2 services/supports available by school** (see Menu of Mental Health Supports priority)
- **Ensure clinical intake/screenings systems** (for pediatricians, care coordinators, etc.) track which school a student attends, since schools are one of the best entry points for timely access to therapeutic care
- **Continue to generate ideas around:**
 - How to improve coordination/integration across services within a school and across organizations engaged in Tier 1 and Tier 2 related work
 - How best to put more authority (along with time and resources) in the hands of paraprofessionals and teachers to lead Tier 1 and Tier 2 work



Strengthening School Behavioral Health (SBH) Coordinator Position

- **Gather information from other groups**
 - Learn from DCPS what activities are part of clarifying/strengthening role.
 - Connect with Child Trends about survey data and what is included in evaluation focus groups with SBH coordinators this Fall (which will place schools into high and low implementation buckets).
 - Learn from CHHCS/CoP what they have come to understand about successful school teams (role of strengthening assessment/work plan in anchoring this work, role of distributed leadership, etc.).
 - Connect with Every Day Counts! task force, which is discussing the Student Support Team and similar challenges of fulfilling that role with individuals who have a whole other job; consider if there is a way to address these roles together.
- **Gather/synthesize new information**
 - Interview 5-10 SBH coordinators in schools where things are going well and coordinators express high satisfaction (including schools that split related roles as well as those that hold all related roles within this one position). Find out more about what is happening and what are key elements of success.
 - Determine which specific schools (e.g., top 50) are most struggling with effectively filling and executing this role so school-specific solutions can be crafted.
 - Map out multiple types of models regarding how to fill this role effectively, including options for different existing positions that could fill this role, different ways to share responsibilities between this role and related ones, etc.
- **Continue to generate ideas around**
 - Better articulating the structure and function of this role;
 - Increasing funding and accountability around this role; and
 - Managing the workload for this position

Creating Family Liaison Role

- Gather information on which schools already have this position.
- Poll a small group of DC principals to get their insight into these processes (i.e., current roles with similar descriptions; desire to incorporate a liaison in their school environment).
- Continue to generate ideas around:
 - Better articulating the structure and function of this role
 - Determining appropriate qualifications for this role



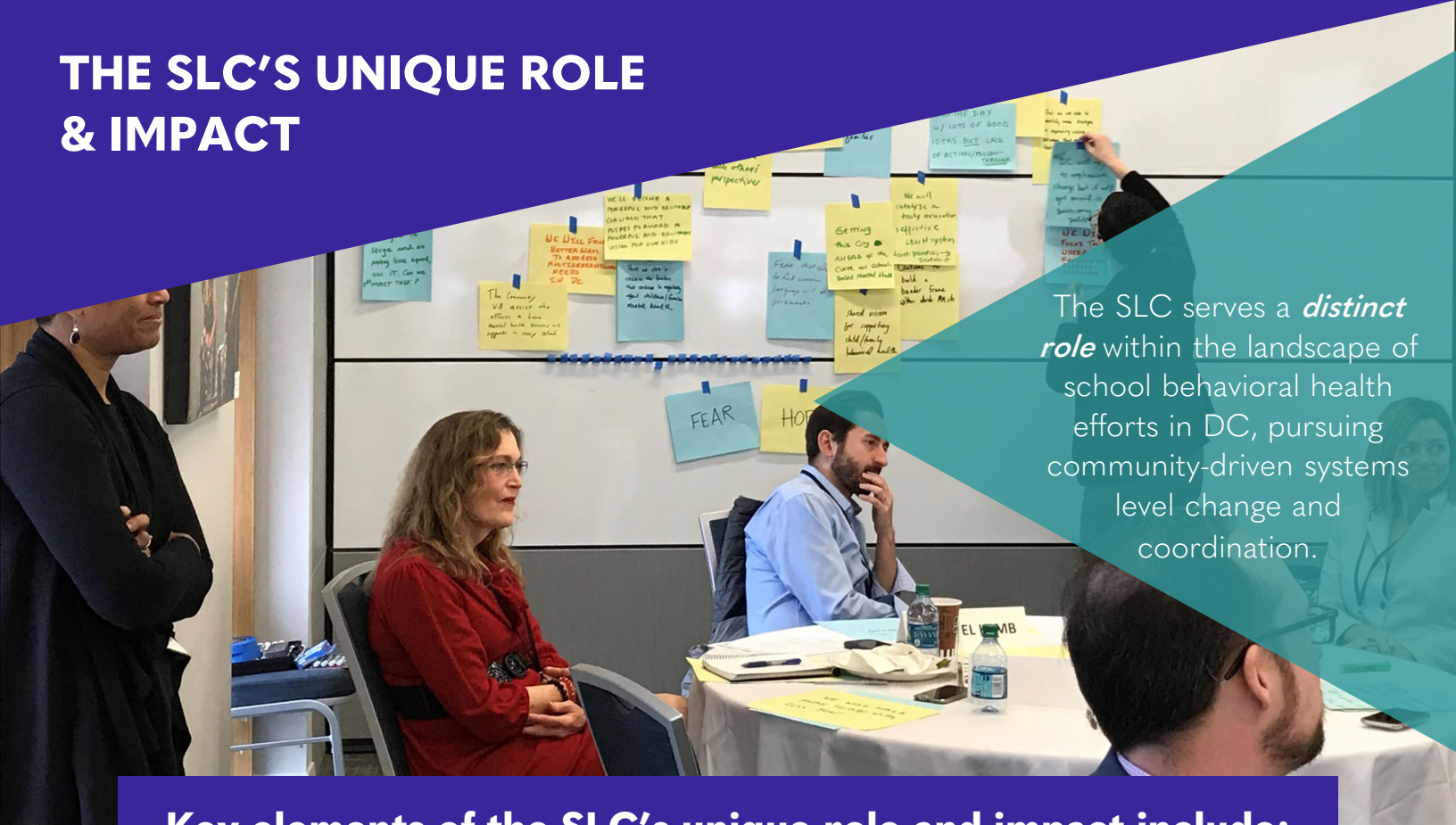
Developing Menu of Mental Health Supports at Each School

- Create a "day in the life" map of all the specific moments and places in a child's day within a specific school where the importance of behavioral health "shows up" and where they do or could receive various supports.
- Identify some of the spaces where effective conversations with families are being or could be had, and finding ways to sustain and support those.
- Continue to generate ideas around:
 - Building a searchable and accessible database of school-specific mental health supports with accurate and regularly updated data;
 - Synthesizing across relevant existing data sources;
 - Providing schools the guidance and tools they need to maintain and share this kind of information;
 - Clearer expectations around how strengthening workplans will be used, and advancing messaging, ownership, and prioritization of these work plans.

Re-envisioning Family Engagement

- Collect information on a very granular level about what's currently working well and include parents in the process of thinking through what effective family engagement looks like. Consider developing "learning journey" stories/case studies. Questions to answer include: what does effective family engagement consist of on-the-ground, what do effective planning processes that engage families from start to finish look like, what methods of communication are working to reach families, what specific services do families find useful, where are schools and families having "a ha" moments, how has family engagement been meaningfully utilized?
- Continue to generate ideas around:
 - Understanding which family engagement approaches are most effective;
 - How effective family engagement approaches can be shared and scaled;
 - How to develop a leadership pipeline that values authentic family engagement;
 - How to embed effective family engagement into planning processes and policies.

THE SLC'S UNIQUE ROLE & IMPACT

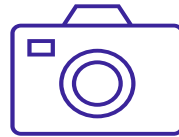


The SLC serves a *distinct role* within the landscape of school behavioral health efforts in DC, pursuing community-driven systems level change and coordination.

Key elements of the SLC's unique role and impact include:



Bringing together stakeholders and existing coordination bodies to intentionally strengthen alignment across all these entities.



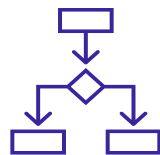
Taking a wide lens to examine DC's school behavioral health system as a whole and then identify and pursue systems-level changes.



Systematically gathering and incorporating input from those most impacted by the system – students, caregivers, and teachers.



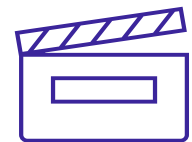
Utilizing a systems dynamics modeling approach to both quantify and provide narrative context to the dynamics of DC's school behavioral health system.



Leveraging systems models to be decision making tools, both for the SLC internally and for policymakers and other stakeholders externally.



Prioritizing action steps using nominal group decision-making processes.



Operationalizing these priorities to enable concrete action to make these systems-level changes.


LOOKING FORWARD

Members of the SLC remain committed to this work and have expressed that they find significant value in the space the SLC has created – both for coordination and for taking a step back and examining the DC school behavioral health system as a whole.

SLC members are eager to continue moving toward concrete, coordinated action to strengthen DC’s school behavioral health system. To that end, the SLC will continue to convene on a regular basis and engage in information gathering, prioritization, and collective action.

Upcoming phases of this work over the next two years will include:

- Continued collective information gathering and operationalization of the prioritized action items;
- Quantification of elements of the systems dynamics models using DC-specific data in order to inform programmatic and policy decisions as well as inform ongoing assessment of impact;
- Continued engagement of those most directly impacted by the system in the SLC’s processes and actions, including via convening a youth leadership group to use system dynamics to prioritize actions to address racism and behavioral health issues in DC schools; and
- Moving towards implementation of select action items (with continued input from key stakeholder groups and monitoring of potential and realized impact through system dynamics modeling), collaborating with other coalitions and advocacy groups to co-lead action items.

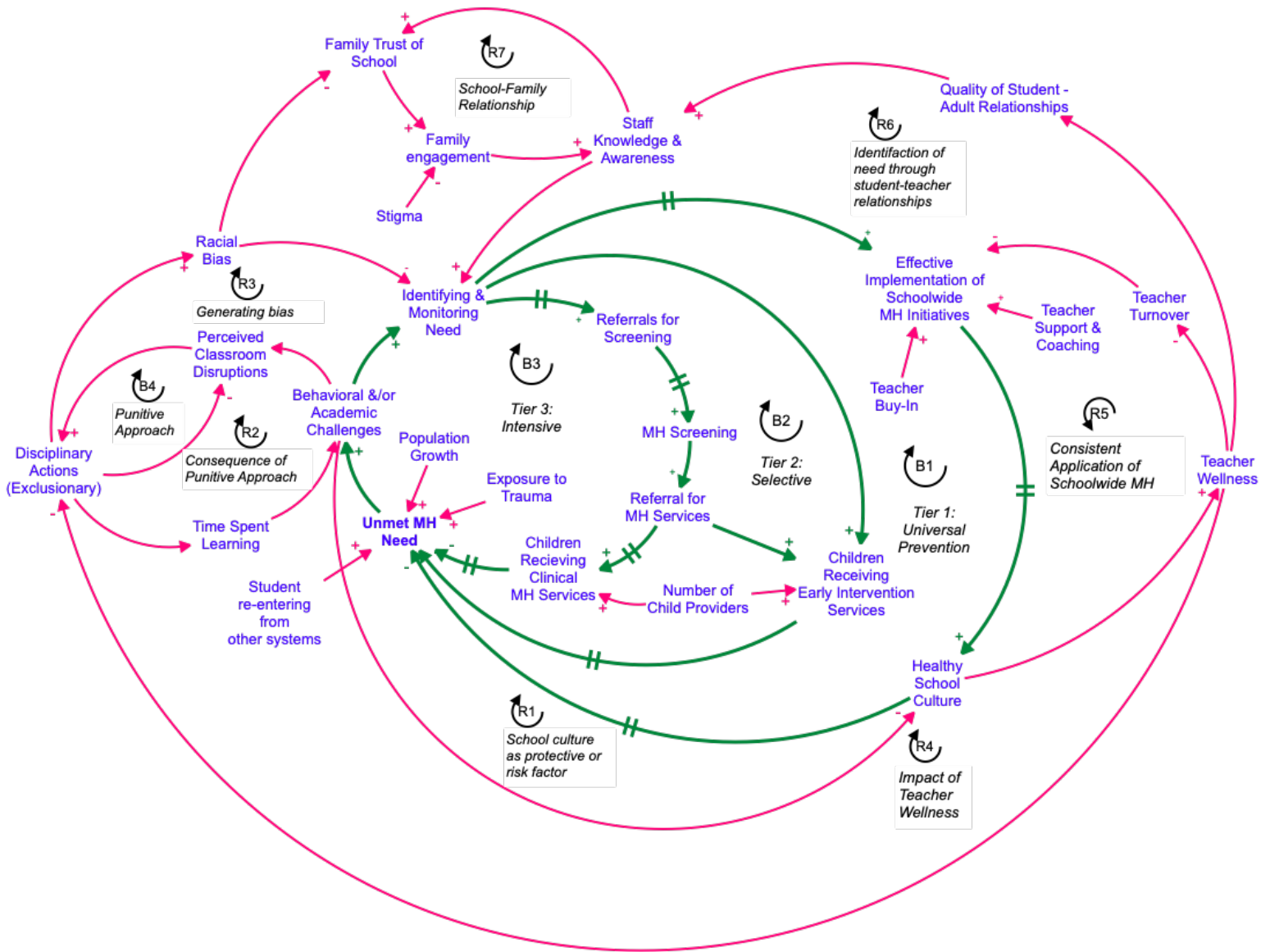
A photograph of two young girls laughing joyfully in front of a brick wall. The girl on the left has curly hair and is smiling broadly. The girl on the right is wearing a maroon beanie and has her mouth wide open in a laugh. They are both wearing school uniforms. The image is partially obscured by a teal diagonal graphic element in the bottom left corner.

By continuing its work in collaboration with fellow school behavioral health stakeholders and community members, the SLC is taking strides towards its ultimate aim:

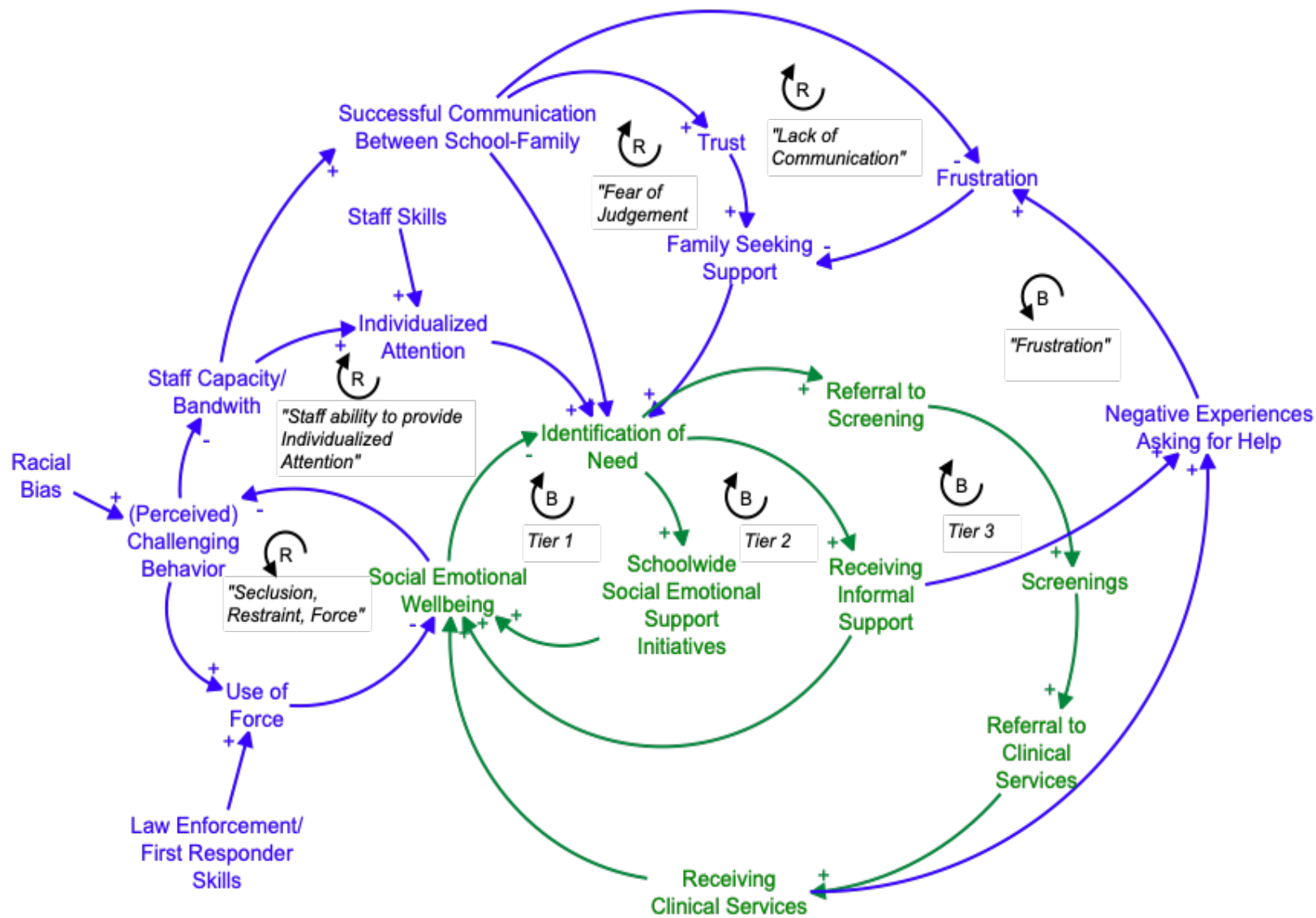
Ensuring **every child** in DC schools has early access to the supports and services needed to improve their mental health and well-being

APPENDIX A: SYSTEMS MODELS

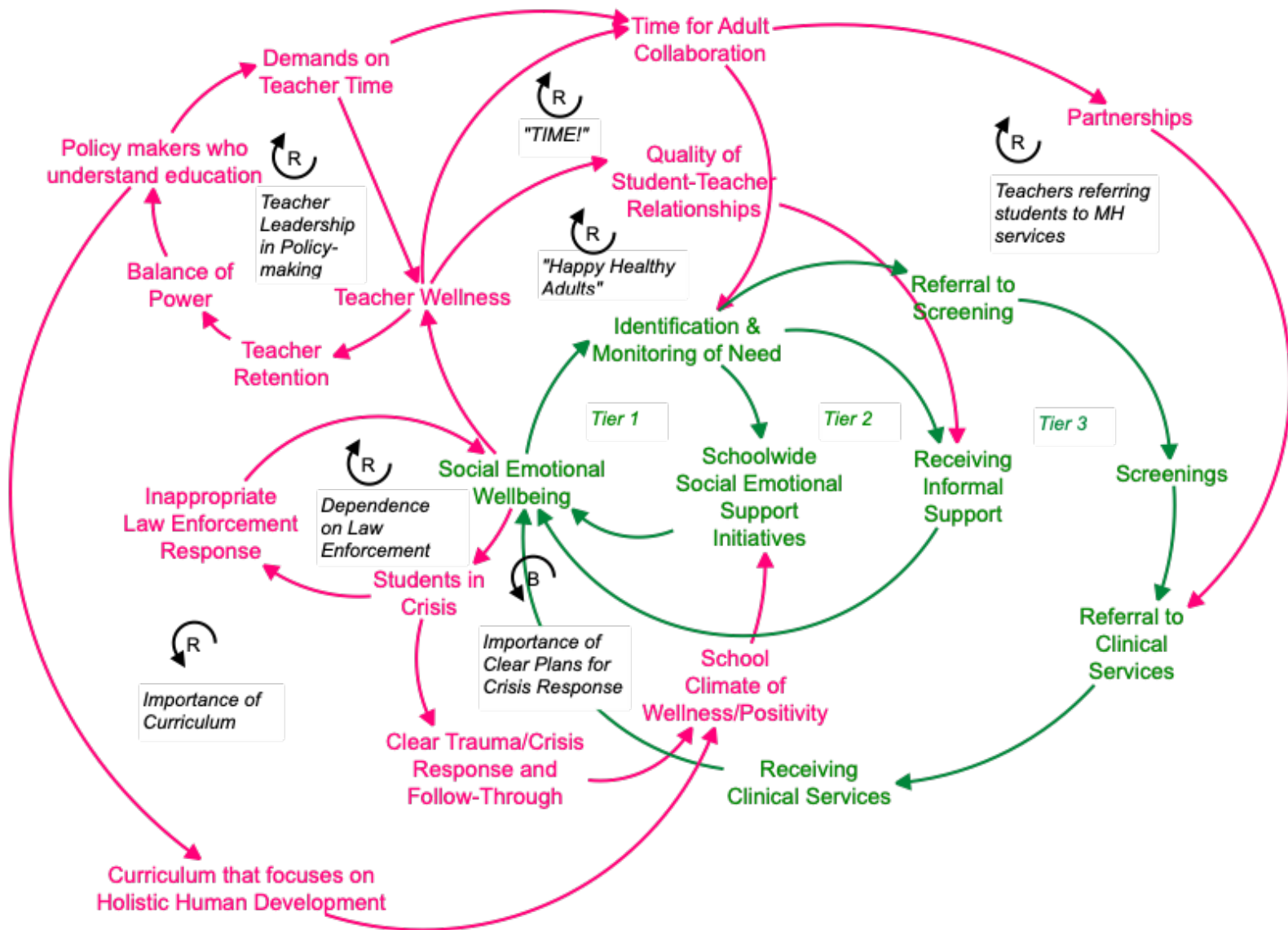
Stakeholder Learning Community Model



Caregiver Model



Teacher Model



APPENDIX B: DC POLICY REVIEW

This DC policy review aims to identify the policies most relevant to the mental health of children in DC schools and within the context of the aims of the Stakeholder Learning Community, and is not a comprehensive overview of all District policies on this topic.

Policies were identified through:

- A review of the most recent agency oversight documents from [DBH](#), [OSSE](#), and [DCPS](#);
- A review of key resources identified by key informant interviewees;
- An online search to identify additional resources and policies.

This review focuses on four notable aspects of the policies identified (note: not all aspects of all policies are discussed here; summaries of policies focus on the most pertinent information, with additional references provided where available):



Policies identified are organized into four categories:

Schools	Family & Community	Healthcare	Other Government Programs & Services
<ul style="list-style-type: none"> • Behavioral Health Expansion • Discipline • Climate 	<ul style="list-style-type: none"> • Place-Based Supports • Violence Prevention • Resiliency 	<ul style="list-style-type: none"> • Medicaid Reforms • Medicaid Coverage • Hospital Community Benefit 	<ul style="list-style-type: none"> • Early Childhood Mental Health • Crisis Services • High Needs Youth

Key resources that are helpful in more comprehensively understanding the District landscape around behavior health and related laws and regulations include:

- [Behavioral Health in the District of Columbia for Children, Youth & Families: Understanding the Current System](#) (a 2019 report by Children’s Law Center, Children’s National Health system, DC Behavioral Health Association)
- [DC Compilation of School Discipline Laws and Regulations](#) (as of April 2019, prepared by Child Trends and EMT Associates for Safe Supportive Learning)
- [This profile](#) examining coverage of the Whole School, Whole Community, Whole Child framework in DC statutes and regulations, part of the Child Trends report, [Using State Policy to Create Healthy Schools: Coverage of the Whole School, Whole Community, Whole Child Framework in State Statutes and Regulations \(School Year 2017-2018\)](#).



THE SOUTH CAPITOL STREET MEMORIAL AMENDMENT ACT OF 2012 + SCHOOL-BASED BEHAVIORAL HEALTH SERVICES COMPREHENSIVE PLAN

Expands behavioral health services to every public school and public charter school in the city by placing a community-based behavioral health provider in each school and identifying a school behavioral health coordinator in each school; engagement, learning, and problem solving enhanced via Community of Practice; guidance provided by DBH-led Coordinating Council.

Key Provisions

- Places a community-based behavioral health provider in each school (with a phased-in rollout by need) to provide billable Tier 3 services as well as grant-funded non-billable interventions and Tier 1 and 2 supports integral to a multi-tiered school-based practice
- Schools identify a School Behavioral Health Coordinator, responsible for coordinating all school behavioral health efforts, including the completion of the School Strengthening Tool and Work Plan
- Community of Practice engages school professionals and community leaders, alongside CBO clinicians, offering learning activities, supporting implementation of best practices, and solving persistent problems of practice
- DBH-led Coordinating Council composed of teachers, parents, and community providers guides development/ implementation of the Expansion

Implementation

Effective February 2022 62 percent of the 251 schools in Cohorts 1 through 3 of the Expansion have a DBH or CBO provider offering services and supports. AprilMay Company, Inc., Catholic Charities of the Archdiocese, Community of Hope, Hillcrest Children and Family Center, Howard University School-Based Behavioral Health Program, Latin American Youth Center, Mary's Center, Maryland Family Resource, MBI Health Services, LLC, One Common Unity, Paving the Way, Smile Therapeutic Services, LLC., and Volunteers of America Chesapeake, Inc. are the current CBO partners.

School Behavioral Health Coordinators have been identified for most participating schools, but coordinators do not receive compensation for the additional responsibilities that accompany this role. DCPS has noted the most consistent feedback they have received from staff is concern about the capacity to effectively realize this role as intended while maintaining responsibility for other core components of the job.

- Each school/CBO partner completes the School Strengthening Tool needs assessment and a corresponding Work Plan (with information re: self- assessment, needs, resources, and annual goals across tiers).
- 1 full-time staff person at DCPS (Expansion Outreach Manager) and 1 full-time staff person at OSSE (School Behavioral Health Outreach Manager) have been hired to support implementation.
- The current expansion builds upon DBH's pre-existing School Behavioral Health Program, which, as of March 2022, consists of 62 clinicians/supervisors serving 63 partner schools.
- Federal funding for Project AWARE complements local funding for behavioral health expansion, and specifically supports development of multi-tiered systems of mental health supports for students, educators, and school communities in partnership with DCPS, KIPP, and Friendship.
- The Center for Health and Health Care in Schools at the George Washington University executes the DC School Behavioral Health Community of Practice, which advances both expansion and Project AWARE by bringing schools and CBOs together in a peer learning environment. CoP members have leveraged the creation of Practice Groups on topics including trauma-informed practices, crisis intervention and response, positive school climate/social- emotional learning, and family/youth engagement, as well as a teacher wellness workgroup, and a mental health-primary care collaboration workgroup.

Funding

- For FY 2022, District policymakers made significant investment in School-Based Behavioral Health Expansion totaling \$31.5 million, of which \$6.5 million was allocated to the DBH School Behavioral Health Program and \$25 million for additional components of the School Behavioral Health Expansion, for the 251 schools in the initiative.
- Funding includes:
 - Grant funds to community-based behavioral health providers to 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

- Funds to develop a Community of Practice to increase provider and school readiness to implement the multi-tiered model; support technical assistance; fund coordination support
- Funds to support program evaluation

Assessment

- Child Trends has been selected as the Expansion initiative evaluation contractor. The evaluation process is currently in progress with the initial phase of the assessment and evaluation focused on the process and quality improvement aspects of the implementation of the public health model. The evaluation of the effectiveness of the approach will be conducted in the second phase of the assessment.
- Surveys are distributed each spring to students, families, school staff, and school behavioral health coordinators to measure awareness of services and experiences with behavioral health supports as well as staff wellness. From school behavioral health coordinators, we also learn how schools plan and monitor the variety of behavioral health supports offered.

For more information, see:

[DBH's overview of the School Behavioral Health Program and Expansion](#);

the [Early Childhood and School-Based Behavioral Health Services Comprehensive Plan](#) that guides current efforts; [expansion implementation guidance](#) and [other information from the Coordinating Council](#);

Information on implementation progress available in Responses to FY2019 Performance Oversight Questions from [DBH](#) (Q26-35), [OSSE](#) (Q73), and [DCPS](#) (Q12-13); and

the [Report of the Task Force on School Mental Health](#) (March 2018) that informed current efforts.

Legislation:

<https://lims.dccouncil.us/Legislation/B19-0211>

STUDENT FAIR ACCESS TO SCHOOL AMENDMENT ACT OF 2018

Sets limits on schools' use of suspensions, expulsions, and involuntary transfers as disciplinary consequences and directs OSSE to support LEAs/schools in making such changes as well as fostering positive school climates.

Key Provisions

- Attendance-related (i.e., unexcused absence, late arrival) discipline outlawed
- Out-of-school suspension duration limits + outlaws extended suspensions because a parent has not come to school + requires earlier due process (administrative hearing if out-of-school suspension six days or longer) + requires continued education plan
- Schools must consider whether ALL disabilities (not only primary one listed on IEP) were root cause of behavior
- LEAs required to develop more transparent, robust, evidence-based school discipline policies (in consultation with school personnel, students, and parents + copy of policy must be publicly available and provided to students and parents/guardians)
- OSSE required to support schools with guidance, technical assistance, and professional development, including with respect to:
 - Trauma-informed and restorative practices;
 - Classroom management and disciplinary approaches;
 - Implementation of high-quality functional behavior assessments, behavioral intervention plans, and manifestation determination reviews (in accordance with the Individuals with Disabilities Education Act); and
 - Implicit bias and culturally responsive corrective action techniques.

Implementation

- OSSE's required supports are provided by OSSE staff or contracted vendors, including:
 - Classroom management/discipline policy workshops in collaboration with CT3
 - Trauma informed care trainings in partnership with InSite Solutions and MedStar Georgetown University Hospital Division of Child & Adolescent Psychiatry
 - Whole School Restorative Justice program and a range of other restorative justice training, professional development, and coaching from Restorative DC (a project of SchoolTalk Inc)
- To support implementation, DCPS added two Restorative Practice Specialists and three Social-Emotional Learning (SEL) Specialists to the Social-Emotional Learning & School Climate team, which supports building capacity and providing support at the school level. The School Behavioral Health Team also works with school-based providers to ensure that students have a Functional Behavior Assessment (FBA) and a Behavior Intervention Plan (BIP) when necessary.
- DCPS also provides training and technical assistance on compliance and regulations related to the Act; has contracted with the International Institute for Restorative Practices to certify trainers within DCPS; and will include trainings on school-wide positive behavior support models, trauma-informed best practices, and equipping students with the ability to develop conflict and stress management skills.

Funding

- Technical assistance/professional development supports provided by OSSE to schools funded (via School Safety and Positive Climate Fund).

Assessment

- LEAs must report discipline data, demographic information, a description of the misconduct/reasoning behind disciplinary action, further actions/referrals (e.g., student was subject to disciplinary unenrollment or a school-related arrest, referred to an alternative education setting or law enforcement, etc.), and special education services data. The law includes requirements for data at the student-level, school-level, and district-level.
- DCPS has designed the DCPS Data Analysis Center (DDAC) to provide daily updates on student discipline data. The SEL- School Culture Team analyzes this data weekly and collaborates with identified schools to address student discipline practices.

- The SEL-School Culture team monitors suspension data. The School Behavioral Health team monitors and receives notifications when a student has been suspended for ten (10) or more days. DCPS also monitors schools' compliance through reviewing data in the Student Behavior Tracker (SBT).

For more information, see:

[OSSE's Response to FY2019 Performance Oversight Questions](#) (Q33 (behavioral health and trauma-informed care professional development) and Q34 (restorative justice)),

[DCPS's Response to FY2019 Performance Oversight Questions](#) (Q6 (implementation of this Act)),

[DCPS's overview of this Act](#) (including the [corresponding regulations](#) as well as current [student discipline policy guidance](#)), and

The Children's Law Center's [summary of the legislation and discipline reporting requirements](#).

Legislation:

<https://lims.dccouncil.us/Legislation/B22-0594>



YOUTH SUICIDE PREVENTION AND SCHOOL CLIMATE SURVEY AMENDMENT ACT OF 2016

Improves OSSE's communication around and requires mental/behavioral health and suicide related training for school personnel; establishes a pilot program to improve school climate, informed by annual surveys; and requires OSSE to annually report on school climate data.

Key Provisions

- Requires teachers and principals to complete youth behavioral health program once every 2 years
- Requires OSSE to:
 - Provide written guidance to assist LEAs in developing/adopting policies/procedures for handling mental/behavioral health for students;
 - Develop and annually publish online a catalogue of all professional development and training programs offered;
 - Establish a pilot program for select schools (serving grades 7-10) to administer annual school climate surveys - Improving School Climate in DC Project;
 - Three-year study offers on-going support and guidance to 26 District schools to improve school climate and promote positive development among DC's grade 7-10 grade students via Safe School Certification.
 - Schools provided assistance in making data-based decisions based on survey data from students, staff and parents. Schools work towards completing flexible benchmarks under each of eight key components of the framework (data, leadership, buy-in, policy enforcement, student engagement, family engagement, programs, and training).
 - Participating schools are invited to apply for grant funding to support the implementation of evidence-informed programs after reaching key benchmarks.
 - To annually report on school climate survey data.

Funding

- Pilot program funded under a grant from the National Institute of Justice at the US Department of Justice.

Assessment

- School climate data reported annually.

For more information, see:

OSSE's [tools for supporting mental health in schools](#); overview of the [Improving School Climate in DC Project](#) pilot; and [the latest annual school climate report](#) (Oct 2019) – all required under this law.

Legislation:

<https://code.dccouncil.us/dc/council/laws/21-120.html>

THE YOUTH BULLYING PREVENTION ACT OF 2012 + CITYWIDE BULLYING PREVENTION PROGRAM

Requires schools and youth-serving agencies to adopt comprehensive anti-bullying policies, report and investigate incidents, and train staff.

Key Provisions

- Requires LEAs and schools to:
 - Establish an anti-bullying policy that includes each of five key components (definition, scope, reporting procedures, investigation procedures, appeal process)
 - Report data relating to the YBPA to the DC Office of Human rights on an annual basis.
 - Disseminate the bullying prevention policy to students and parents by publishing in the LEA's handbook and on its website.
 - Provide training to all employees on an annual basis.
- The philosophy of the Citywide Youth Bullying Prevention Program discourages an overreliance on discipline and adopts a public health approach focused on prevention, supporting at-risk youth and addressing incidents to change behavior.
- Program staff ensures schools and youth-serving agencies adopt and implement policies in ways consistent with best practices adopted by the Youth Bullying Prevention Task Force and demonstrated in the Task Force's model policy, coordinates high-level trainings, advises stakeholders as they develop curriculum, and evaluates existing initiatives aimed at bullying prevention.

Assessment

- Law requires schools and youth-serving agencies to maintain and report annually (to the DC Office of Human Rights) incident data/data relating to the YBPA.
- Law requires the Mayor to report to Council, on a biennial basis, the current implementation of the Act and to provide a summary of the status of bullying in DC.
- Citywide program provides oversight to ensure agencies are compliant with the YBPA.

For more information:

See OHR's [overview of the Citywide Youth Bullying Prevention Program](#) (created June 2013) and the [Youth Bullying Prevention Task Force](#) and its [District-wide Model Bullying Prevention Policy](#) (released January 2013), as well as [the latest biennial compliance report](#) (for SY17-18).

Legislation:

<https://lims.dccouncil.us/Legislation/B19-0011>

COMMUNITY SCHOOL INCENTIVE INITIATIVE ACT OF 2012*

**and the Truancy Prevention and Literacy Pilot Program Emergency Amendment Act of 2019 (Section 4112 of the Fiscal Year 2020 Budget Support Act of 2019), which amended the Community Schools Incentive Amendment Act of 2012*

- Provides funding, administered by OSSE, to grantees to create community schools (public and private partnership to coordinate educational, developmental, family, health, and after-school-care programs); OSSE currently administers funding to 17 grantees.
- For FY20, OSSE awarded two \$300,000 grants (to East of the River School Consortium, which includes Turner Elementary School in Ward 8, and to Students Motivated through the Arts, which includes Landon Elementary School in Ward 5) to increase attendance and literacy support for students in grades K-5; the goal of this program is to test if additional resources and community partners dealing with social-emotional issues among other things will significantly improve attendance and state assessment outcomes.

For more information: [OSSE's overview of the Community Schools Incentive Initiative.](#)

Legislation: <https://code.dccouncil.us/dc/council/code/titles/38/chapters/7B/subchapters/IV/>

SCHOOL ATTENDANCE CLARIFICATION AMENDMENT ACT OF 2016

- Prohibits the expulsion, suspension, or de-enrollment of a student because of an unexcused absence or late arrival; requires law enforcement officers to return children suspected of truancy to schools instead of truancy centers; and requires OSSE to collect, publish, and make public data concerning absenteeism, withdrawals from school, and referrals to District agencies and offices.

For more information: [OSSE's most recent Attendance Report](#) (required under this Act)

Legislation: <https://lims.dccouncil.us/Legislation/B21-0508>

[INTRODUCED] SOCIAL EMOTIONAL LEARNING TASK FORCE ESTABLISHMENT ACT OF 2020

- Requires OSSE to convene a task force to study issues relating to best practices for the promotion of SEL in schools, promote and expand SEL, and to submit recommendations to the Council. The duties of the task force include aligning the standards and benchmarks for SEL with other relevant standards and guidelines including the health and physical education K-12 learning standards and early learning and development guidelines and analyzing the suspension and expulsion rates, prior to and after, a successful model has been implemented in a school district.
- Requires OSSE to analyze the suspension and expulsion rates, prior to and after, a successful model has been implemented in a school district.

Legislation: <https://trackbill.com/bill/district-of-columbia-bill-646-social-emotional-learning-task-force-establishment-act-of-2020/1886019/>



BIRTH-TO-THREE FOR ALL DC AMENDMENT ACT OF 2018

- Builds on the District’s universal pre-K3 and pre-K4 expansion by focusing on better serving infants and toddlers before they get to pre-school.
- Fully funds the District’s child care subsidy program and calls for competitive compensation for early educators.
- Advances healthy child development by:
 - Expanding the number of child development centers participating in Healthy Futures (program that supports social-emotional development and behavioral health) and other evidence-based programs to provide behavioral health care services in all child development centers.
 - Investing local funds to expand and sustain the HealthySteps model, which connects families with wrap-around services during pediatric visits.
 - Establishing a Lactation Certification Preparatory Program.
- Supports parents and families by:
 - Improving and expanding home visiting programs.
 - Investing in Help Me Grow, a phone-based, care coordination system to help families navigate support services and to maintain centralized records of developmental screenings and data.
 - Setting child care co-payments for all parents that rise with one’s income, such that no family spends more than 10 percent of their income on child care.
- For FY20, the DC Council passed a nearly \$16 million investment as a partial down payment on this Act, with funding allocated towards childcare subsidies, home visiting for Early Head Start, Healthy Futures, Healthy Steps (funding two new sites), Help Me Grow, and lactation consultants.

For more information, see the [DC Fiscal Policy Institute’s summary of the Act](#) and [DC Action for Children’s summary of FY20 funding for the Act](#).

Legislation:
<https://code.dccouncil.us/dc/council/laws/22-179.html>

FAMILIES FIRST DC (MAYOR-FUNDED) + FEDERAL FAMILY FIRST PREVENTION SERVICES ACT

- Families First DC is a Mayor-funded, \$4.75 million initiative for ten Family Success Centers in targeted neighborhoods in Wards 7 and 8, where approximately three-quarters of the children and families served by CFSA live.
 - This is a neighborhood-based, whole family approach to provide upstream, primary prevention services and neighborhood driven resources. The initiative aims to empower communities and families, integrate government services and programs to build on family strengths, and focus upstream.
 - Each neighborhood will establish a Community Advisory Council, which will consist of residents and stakeholders in the targeted community to determine the services offered at the Family Success Centers using a family strengthening model to increase protective factors, mitigate trauma, fill in gaps in services, and set families up for successful outcomes.
- CFSA's Family First Prevention Plan in accordance with the federal Family First Prevention Services Act serves as a complement to Families First DC by serving the most vulnerable and at-risk populations of children and families through evidence-based services to prevent foster care entry. The two initiatives align and intersect without overlapping, providing a comprehensive approach to preventing child maltreatment in the nation's capital.

For more information, see [CFSA's overview of Families First DC](#) and the agency's [Family First Prevention Plan](#).

OPPORTUNITY ZONES (FEDERAL TAX CUTS AND JOBS ACT)

- Opportunity Zones (Ozs) is a federal program that provides tax incentives for investments in new businesses and commercial projects in low-income communities. 25 census tracts in DC are certified Opportunity Zones.
- DC's priorities for Opportunity Zone investment include: delivering new, neighborhood-serving amenities (e.g., fresh food grocers); providing investment capital and growth opportunities for DC small businesses, especially those led by underrepresented entrepreneurs; creating jobs for DC residents and pathways to the middle class; and increasing affordable and workforce housing.
- Local Initiatives Support Corporation, with a grant from the Rockefeller Foundation and in partnership with BCT Partners, is providing: technical assistance to support local projects seeing OZ financing; grants to support community-driven projects in OZs; and two community engagement specialists to support outreach.

For more information, see the [Office of the Deputy Mayor for Planning and Economic Development's overview of Opportunity Zones](#).

NEIGHBORHOOD ENGAGEMENT ACHIEVES RESULTS AMENDMENT ACT OF 2016

- Key provisions in the areas of:
 - Implementing a public health approach to violence prevention and intervention that prioritizes community-centered violence interruption and trauma-informed care (establishing the Office of Neighborhood Safety and Engagement, which seeks to engage those who are high risk of participating in or being a victim of violence crime; the Office of Violence Prevention and Health Equity, which uses therapy and service coordination to combat the spread of violence and serves those who have experienced violent crime; and the Community Crime Prevention Team to identify and serve individuals with signs of mental illness or substance use),
 - Community policing (requiring an opinion survey of police-community relations and requiring additional training for police officers on community policing, preventing bias-based policing, and cultural competency), and
 - Data collection (around police stops/use of force incidents and felony crime).
- Each of the 20 provisions of the NEAR Act has been fully funded and implemented.

For more information, see the District government's [summary of NEAR Act implementation](#)

Legislation: <https://trackbill.com/bill/district-of-columbia-bill-360-neighborhood-engagement-achieves-results-act-of-2015/1203225/>

OFFICE OF RESILIENCY AND RECOVERY ESTABLISHMENT ACT OF 2020

- Establishes an Office of Resilience within the City Administrator's Office to develop and report on the implementation of policies, programs and actions with respect to Urban Resilience (i.e., the capacity of individuals, communities, institutions, businesses, and systems within a system to survive, adapt, and thrive regardless of stresses and shocks encountered – including systemic stresses (e.g., climate change, housing costs, gun violence), temporary shocks (e.g., government shutdowns, Metro breakdowns, severe weather), and underlying stresses (e.g., ACEs, social inequality)).

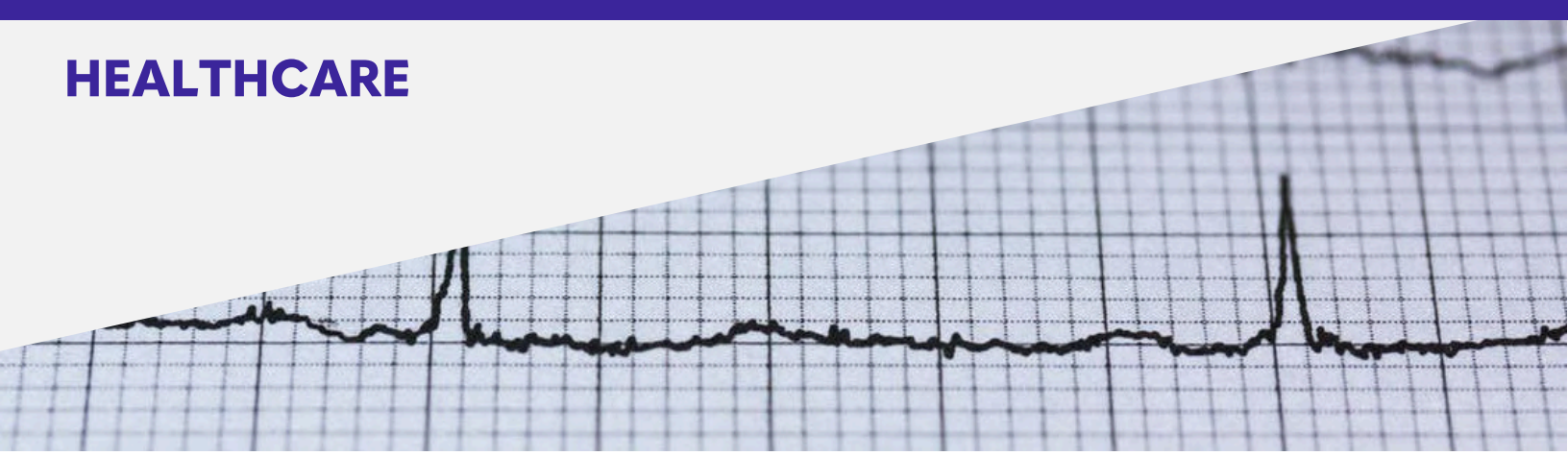
For more information, see the District's [Resilient DC website](#) and [Resilience Strategy](#).

Legislation: <https://ims.dccouncil.us/Legislation/B23-0130>

[INTRODUCED] ADVERSE CHILDHOOD EXPERIENCE PREVENTION PILOT PROGRAM AMENDMENT ACT OF 2020

- Expands the Deputy Mayor for Public Safety and Justice's duties to include creating an pilot program to provide access to trauma-informed family supports for families with young children exposed to violence as well as supports for staff engaged in violence response and interruption efforts

Legislation: <https://ims.dccouncil.us/Legislation/B23-0647>



DHCF MEDICAID PROGRAM REFORMS

- In September 2019, DC Healthcare Finance (DHCF) announced plans to move towards a fully managed Medicaid program over the next five years – beginning with a transition of 22,000 individuals currently in the Medicaid fee-for-service program to the Medicaid managed care program, effective October 1, 2020. In addition, DHCF plans to expand value-based purchasing requirements in the managed care program and to implement universal contracting for critical providers in the city’s health care market. Together, these changes will increase access to care coordination and health care providers for Medicaid enrollees, as well as promote an enhanced focus on health outcomes.

For more information, see: <https://dhcf.dc.gov/release/dhcf-announces-medicaid-program-reforms-and-intent-re-procure-managed-care-contracts>

For information regarding DC’s approved section 1115(a) demonstration, titled “Behavioral Health Transformation”, see <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/dc/dc-behavioral-health-transformation-ca.pdf>.

MEDICAID COVERAGE OF CHILDREN’S MENTAL HEALTH

- The Medicaid program’s benefit for children and adolescents is known as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and aims to ensure children and adolescents receive appropriate preventive dental, mental health, developmental, and specialty services at the right time.
- The following services are covered by each Managed Care Organization (MCO): 1) diagnostic and assessment; 2) medication evaluation and management; 3) counseling/psychotherapy; and 4) crisis services. However, if the child needs more intensive in-home or community based services, the responsibility shifts from the MCO to Mental Health Rehabilitation Services (provided by DBH) reimbursed by fee-for-service.

[INTRODUCED] COMMUNITY HEALTH INVESTMENT ACT OF 2019

- The proposed legislation would require health care facilities to add community benefits as a requirement for obtaining or maintaining a certificate of need. Health care facilities would also be required to direct the community benefits to District residents, as a condition of holding or receiving a certificate of need.
- The legislation would add and amend definitions for the terms charity care, community benefits and uncompensated care, better aligning the community benefit criteria of the District to investments that reduce barriers to accessing health services, address local public health priorities that eliminate health and healthcare access disparities, strengthen community health resilience, advance education or research that benefits the public, and provide community supports (e.g., child care and mentoring programs for vulnerable populations, violence prevention programs, disaster readiness, etc.).

Legislation: <https://lims.dccouncil.us/Legislation/B23-0187>

OTHER KEY GOVERNMENT PROGRAMS & SERVICES



DBH EARLY CHILDHOOD MENTAL HEALTH PROJECTS

These include:

- DC Social Emotional and Early Development (DC SEED) project which is expanding early childhood-specific evidence-based treatment programs.
- Parent Child Infant Early Childhood Enhancement Program (PIECE) which provides early childhood mental health treatment services to young children and families.
- Healthy Futures which implements Early Childhood Mental Health Consultation services within Child Development Centers across the District.
- Primary Project which screens children in PK4 through grade 3 to identify those having mild problems with social-emotional adjustment in the classroom and provide them an “intervention” of one-to-one, nondirective play sessions.

CRISIS SERVICES

These include:

- ChAMPS which provides mobile crisis interventions to youth ages six to 17 which includes screening for mental health and substance use needs, and referral to appropriate resources, including longer-term mental health or substance use rehabilitative services. Services are provided in the community, schools, or in homes. In FY19, 1,125 youth were served.
- Inpatient services for acute, short-term stabilization serving children and adolescents from ages 2-17 (provided by Children’s National and Psychiatric Institute of Washington).

PROGRAMS FOR HIGH NEEDS YOUTH

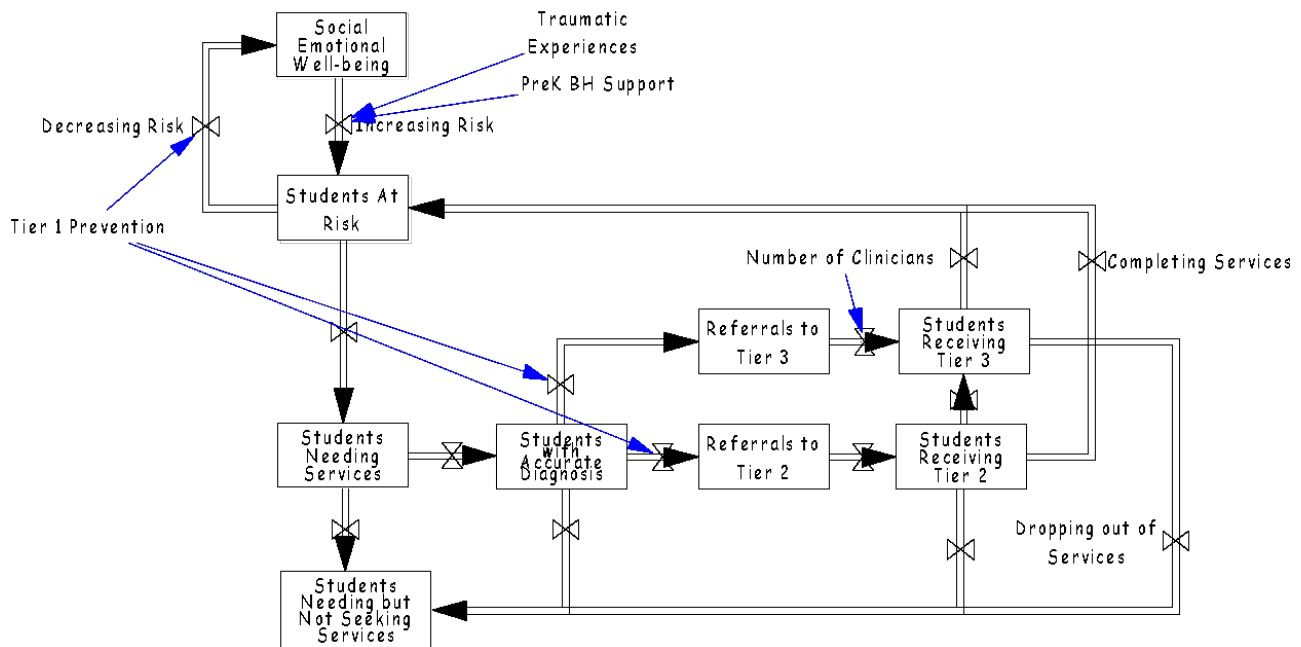
- The Juvenile Behavioral Diversion Program (JBDP) is a mental health based solution or specialty court that provides intensive case management and mental health services to youth in the juvenile justice system with significant mental health concerns and HOPE Court meets the unique needs of youth at risk of or affected by commercial sexual exploitation. JBDP served 72 youth and Hope Court served 52 youth in 2019.
- High Fidelity Wraparound is a care coordination service and collaborative team-based care planning process provided via contract with MBI Health Services and intended to benefit families with complex unmet needs, multisystem involved, at risk of out of home or residential placement, disruption in school setting and high utilization of acute care. Sixty-three youth and families were served in FY19.
- The Youth Services Division of the Department of Human Services includes multiple programs that form a system of services and support for youth at-risk of court-involvement, school disengagement, homelessness, and repeat teen pregnancy.
 - Alternatives to the Court Experience (ACE) Diversion Program
 - Parent and Adolescent Support Services (PASS)
 - Strengthening Teens Enriching Parents (STEP)
 - Teen Parent Assessment Program (TPAP)
 - Youth Homeless Services (YHS)
 - Functional Family Therapy (FFT)

For more information, see: [Behavioral Health in the District of Columbia for Children, Youth & Families: Understanding the Current System](#); [DBH's overview of Children, Youth and Family Services](#); [DHS's overview of the Youth Services Division](#); Responses to FY2019 Performance Oversight Questions from [DBH](#).



APPENDIX C: CLUSTER MODELS & RELATED POLICY INSIGHTS

Cluster 1: Multi-Tiered Systems of Supports – Model



Cluster 1: Multi-Tiered Systems of Supports – Policy Insights



Shared & Defined Ownership

What's Working: The Expansion is a positive step towards improved Tier 3 supports by clearly identified clinician; as the work continues, we will better understand what is needed to make Tier 3 work – including how much capacity is needed at the Tier 3 level, what skillsets we need clinicians to have, etc.

Key Recommendations:

- School coordinator role requires some percentage of time to be designated to this role and/or outside support
- Ownership and chain of command within school should be clarified (e.g., designating a “head of wellness”)
- Coordinating Council and other coordinating bodies need clearer ownership and responsibility around execution

Suggestions Needed: To improve Tier 1/Tier 2, we need clear roles aligned with expertise.

- What entities (agencies, CBOs, schools) should be responsible for which Tier? Which individuals within a school should be responsible for which Tier? How can we establish clear roles and chain of command?
- How do we better align responsibilities with expertise? Can paraprofessionals play a leadership role in Tier 1 and 2 work, and how do we make that happen?



Coordination & Integration

What's Working:

- Coordinating Council brings together right people and enabled economies of scale (e.g., launching MTSS, Turnaround for Children/DCPS collaboration)
- Early childhood mental health consultation model includes teacher, class, and school-level approaches, as well as clinicians.

Key Recommendations:

- *Across Agencies:*
 - Map how policies overlap
 - Examine which agency is best positioned
 - Establish a technical assistance center to support MTSS rollout
- *Between Agencies & Schools:*
 - Ensure school personnel are represented in District-wide groups
 - Have government agencies and CBOs align and coordinate upstream of school leaders to reduce fragmentation and overwhelm on the ground in schools (need concrete, applied approach + balancing flexibility and autonomy; consider providing menu of options)
- *Between Schools & Healthcare:*
 - Establish processes to connect with hospitals around discharge, with MCOs around annual visits
 - Information and data sharing including universal health form and sharing charter school enrollment with MCOs

Suggestions Needed: Schools should be provided with a broader coordinating purview as well as the necessary staffing, training, and other resources to play that role.

- What exactly does that entail?
- How do we make that happen?



Implementation Factors

What's Working:

- Partnership – Turnaround for Children trauma efforts
- Community-led efforts - restorative justice practices in Anacostia/Dunbar
- Cross-agency data sharing agreements

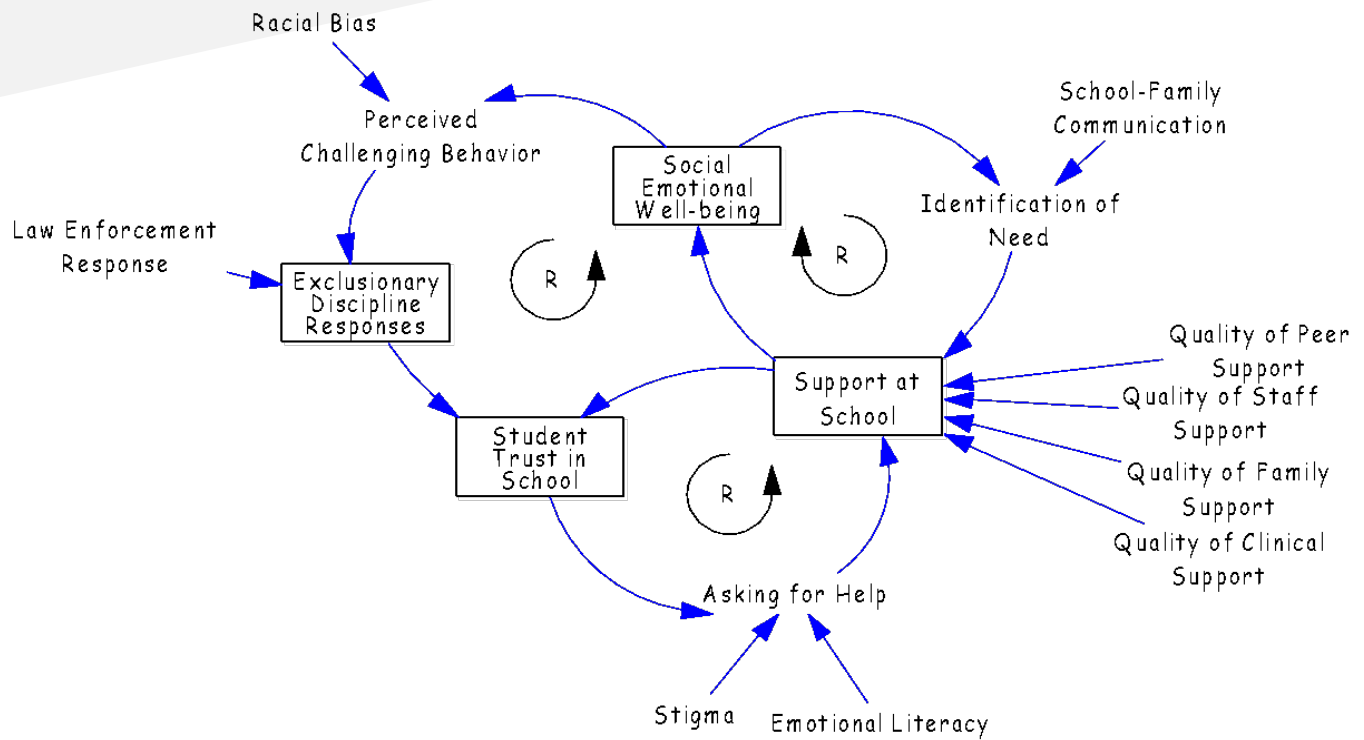
Key Recommendations:

- Trauma informed strategies, SEL, school climate, etc.
 - District-wide standards and practices; data collection; training approach
 - Evidence-based but adaptable approaches
 - Compliance mechanisms for legislation
- Sufficient resource allocation for schools, especially workforce – better pay, training, and well-being supports
- Align resources (\$) and people) to need more strategically, equitably (including Expansion)
- Enhance data sharing (upgrade technology, address privacy barriers)

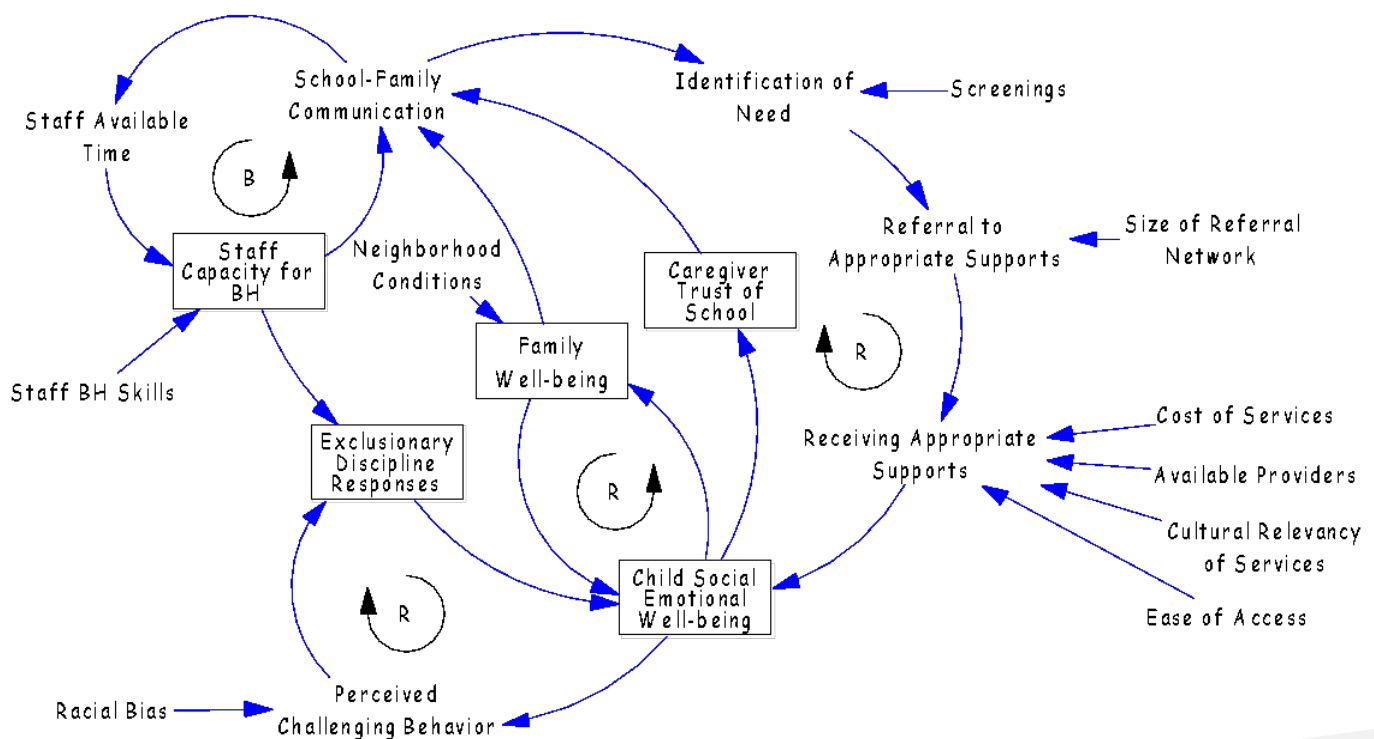
Suggestions Needed: Leverage incentives and accountability measures to prioritize social/emotional needs (not just test performance and STARs ratings).

- How can this be done?
- What are the key barriers and how can they be overcome?

Cluster 2: Student Engagement - Model



Cluster 3: Family Engagement - Model



Clusters 2 & 3: Student & Family Engagement – Policy Insights



Buy In

Listen Deeply

- Ethnographic studies
- Listening toolkits
- Monthly parent chats; student chats
- Citywide canvassing/focus groups
- Shadow families and students
- Show respect and commitment in all interactions

Communicate Effectively

- Educational outreach campaign for families
- Training for parents and caretakers
- Robust follow-up to complaints/incidents

Utilize effective engagement approaches

- Strong, trusted school family engagement team
- Peer supports for youth + parents
- Family to family models
- Employ a family navigator at each school

Intentionally set up school staffing, physical design, and services/supports to serve needs of students and families

- **Engage a broad** (e.g., yoga class, school assembly) and intergenerational (including families and school personnel) group
- **Colocate** clinical and other safety net/social/family services on-site in schools (also other community spaces)
 - Psychiatrist hours, community schools, Family Success Centers, family well-being clinics in early learning settings
- Transform **parent/teacher conference** (community service providers, health activities, counselor available)
- Improve **clinical supports** – telehealth, ability to stay in school while receiving treatment, more of a family focus
- Employ approaches that **appeal to youth** (e.g., MindRight) and are **proactive** (reach out to students without annual visits)
- Employ **destigmatizing approaches** – supports for families and kids that aren't about specific clinical issues (nutrition supports, workshop on handling homework at home, etc.), group sessions for kids that are popular
- *Requires dedicated resources (including space in schools), changes to billing/reimbursement, improved EMR data/integration, training on approaches that support students' mental health for everyone in and associated with the school that encounters kids



Equity & Inclusion

Engage ALL families, which requires:

- Compensating families
- Providing necessary accommodations including offering programs at different times, providing transportation, including virtual options, and having interpreters/mental health/other personnel present
- Properly identify learning disabilities and establish specialized schools for those with disabilities
- Reflect the diversity of families in the school and school behavioral health workforce including via: changes to national exams, paraprofessional advancement pathways, and more bilingual staff
- Address key policy areas:
 - Exclusionary Discipline
 - Policies don't include sufficient resources for staff training (classroom management, prevention, early intervention) – what should teachers do instead?
 - Student Fair Access Act – also need to strengthen trauma supports/trainings and need to not count Expansion funding
 - **What's Working**
 - Early childhood mental health consultation in childcare centers can help improve equity re: preschool expulsion
 - Schools having honest conversations, addressing role of racism in suspensions head-on with teachers, have an easier time changing mindset of teachers when it came to reducing suspensions
 - ACEs – including trauma informed approaches/supports; Office of Resilience and Recovery Establishment Act and DC's corresponding Resilience Strategy; ACE Prevention Pilot Program Amendment Act; DBH follow ups for police incidents
 - Family Well-Being (Upstream Factors) – including Families First, Opportunity Zones, NEAR Act
- Take a "justice lens" to identify and address racism, patriarchy, and other inequities in current systems



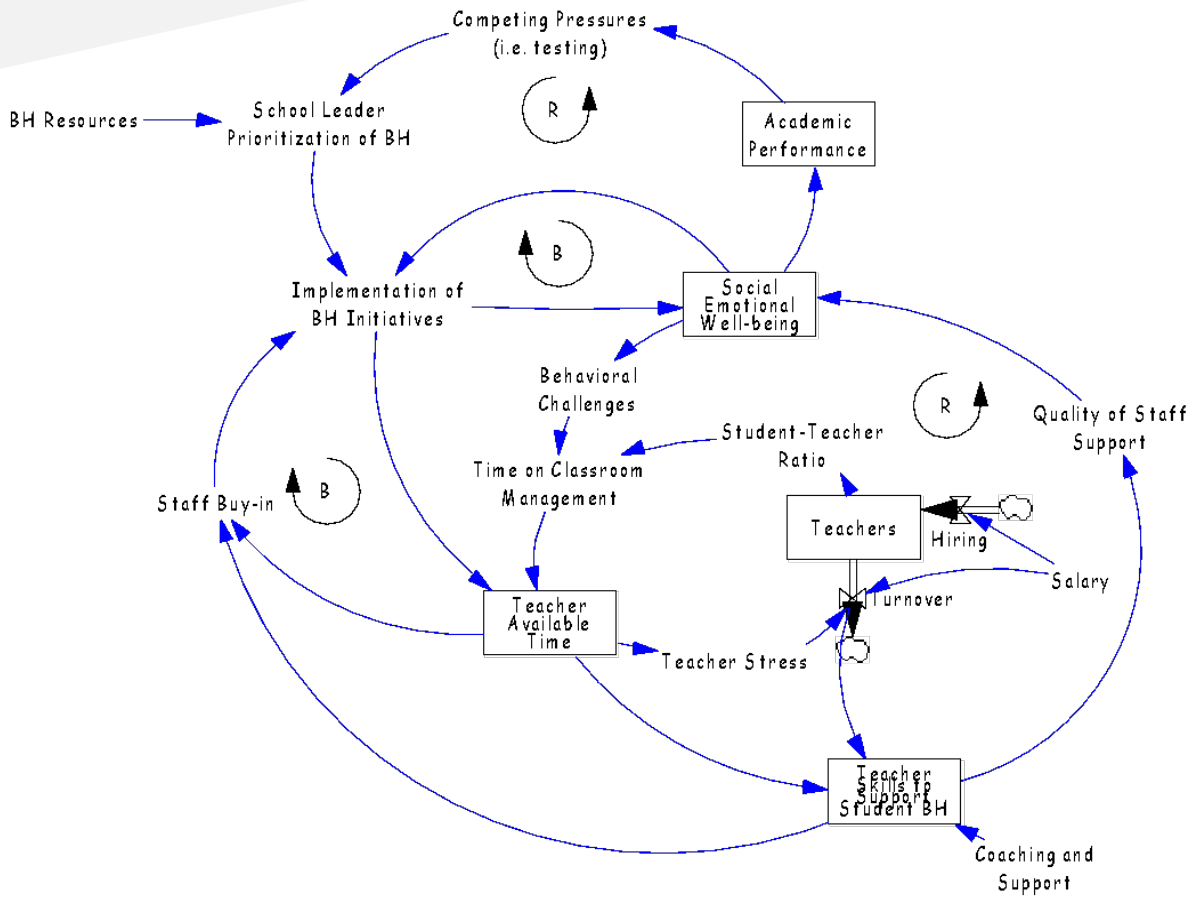
Coordination & Integration

What's working:

- The kind of parental engagement and "well thought out balance of power" between parents and other stakeholders that Individuals with Disabilities Education Act and Head Start employ
- Students and families involved in planning and decision making at District (committees and task forces) and school (decisions around programming, staffing, execution of tiered supports) level

What's needed: Determine how to empower schools to play a coordinating role across sectors and organizations.

Cluster 4: Teacher and School Leader Workforce - Model



Cluster 4: Teacher and School Leader Workforce – Policy Insights



Strong & Committed Leadership

Key leadership challenges include:

- Principal turnover
- Variations in leaderships' priorities and commitment
- Lack of school leader buy-in to policies (often top/down mandate from policymakers)
- Lack of diverse school leadership



Buy In

Recruitment & Retention

- Need more strategic recruitment (of those who understand interrelatedness of behavioral health and academics; of diverse leadership)
- Need to improve retention (with more positive environment, better training, more accessible well-being supports, higher salaries)

Training & Preparation

- Teacher ed/preparation programs should better incorporate psychology, mental health, handling behavior/discipline + training in classroom
- Need comprehensive District-wide approach
 - Department of Education/University entity partnership (for training and evaluation – like in Maryland)
 - Universal, systemic approach from OSSE with common standards and practices around trauma informed approaches, suicide prevention, etc
- Training approaches – coaching (modeling, reflection, repetition) + tailoring training approaches to individual school

Communication

- Use site visits and video case studies to showcase what works and increase school leader buy in
- Conduct an educational campaign for school leaders around benefit of SEL, other health/wellness supports



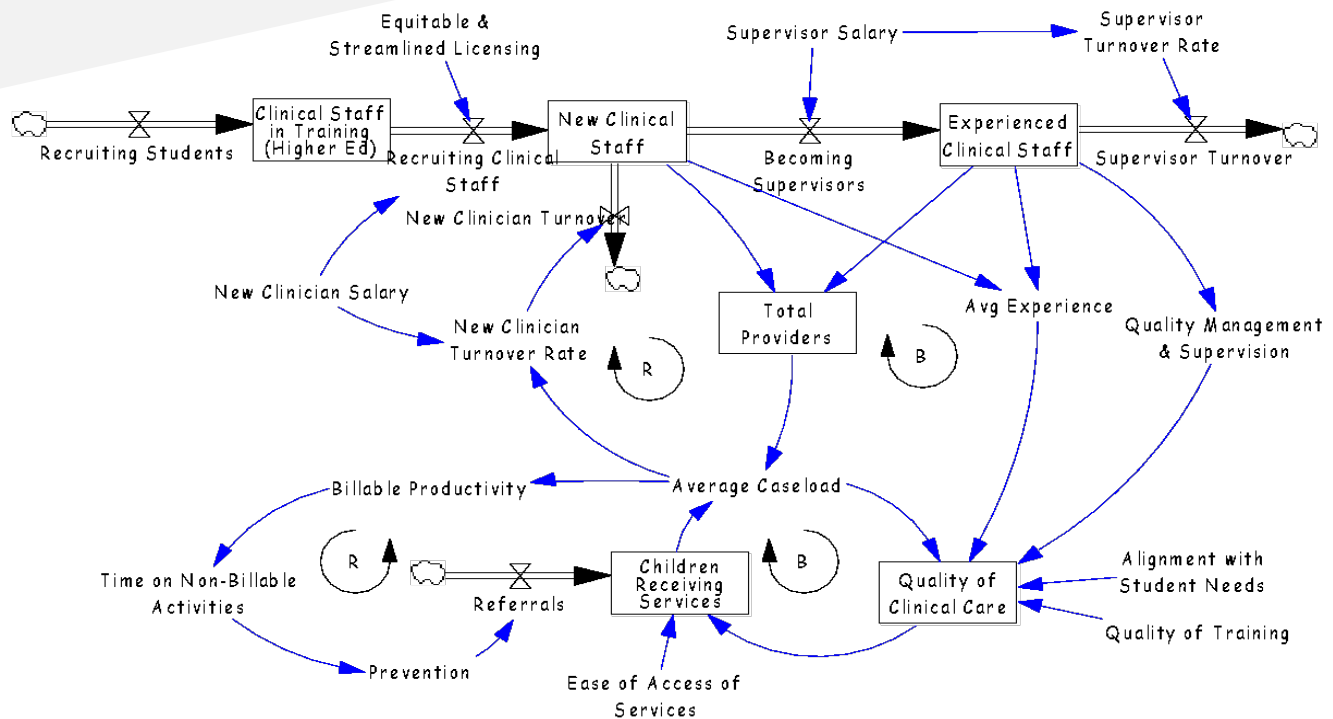
Implementation Factors

Specific areas for investment include:

- Salaries
- High quality management and supervision
- Training
- Other supports, including additional school behavioral health personnel and necessary physical space in the school building

Beyond resources, there is also a need to hold school leaders accountable for effectively addressing mental health.

Cluster 5: Behavioral Health Services and Workforce – Model



Cluster 5: Behavioral Health Services and Workforce – Policy Insights



Shared & Defined Ownership

Workforce Needs

- Data analysis, policy work needed
- Some suggested landscape analysis (including understanding who can play different roles); others worried structured assessment would be duplicative
- Some suggested a set standard – establish ratio (based on national metrics) for adequate clinical staffing at each school or allocate half time/full time person per campus for schools with high at-risk populations
 - Steps in right direction:
 - Components of the Expansion (School Strengthening Tool and Work Plan, CoP, potential inclusion of workforce analysis in evaluation) can help
 - OSSE/DCPS data collection/sharing

Retention

- Sufficient salaries
- Professional advancement opportunities
- Clearly defined roles
 - Utilization of mental health staff (e.g., social workers shouldn't have lunch duty)
 - Define differences (e.g., between counselors and social workers)
 - Align roles with expertise (should clinicians in school be responsible for Tier 1&2 or just for Tier 3?)

Substantial Investment – for above as well as supervision, training, etc.



Equity & Inclusion

Higher Education Programs/Workforce Preparation

- Discontinue Master's degree programs that don't meet credit hour requirements for becoming a Licensed Professional Counselor
- Work with area colleges/universities to incentivize graduates to come work in DC schools

Licensing

- Changes to national exams to address higher failure rates among AA and LatinX candidates; entity in DC could offer training courses and tuition could be subsidized
- Formal reciprocity agreements with other states (and more aligned requirements with VA/MD)
- Streamlining licensing process
- Changes to how scope of work defined (e.g., for social work – take out non-clinical pieces)

Recruitment/Hiring

- Incentives to attract talent to come work for DC vs. private practice
- DC contracts' first source hiring requirements can be problematic
- Duplicative processes (like both DBH and DCPS conducting criminal background checks) can delay clinician hiring



Coordination & Integration

Tighten connections (coordinated hand-offs; streamlined processes for schools/healthcare provider connections)

Better connect healthcare and social services (co-location, ensure capacity to address needs identified through ACEs screening, integrate early childhood services into clinics, etc.)

Health system should play role in getting children ready for school (address access to postnatal appointments, social skills and services, health literacy)

Healthcare should play more of a role in upstream prevention:

- Requires insurance reimbursement –1115 waivers and renegotiation of MCO contracts are good opportunities
- Need to leverage community benefit/anchor institution roles – key opportunities include Community Health Investment Act; St. Elizabeth site (create a health hub); and a larger role for health centers in school behavioral health, including via holistic models (e.g., Mary's Center) and effective strategies (e.g., meet families during intake)

Better communication between DC agencies and MCOs:

- Requires better information and data sharing, including Health Information Exchange
- DC on path to integrating behavioral health as part of managed care services under DC Medicaid
- Health systems and MCOs with integrated system where they are both payor and provider (e.g., Kaiser) are more efficient in implementing QI/improving outcomes



Implementation Factors

CBOs bringing schools into their scope of services facilitates billing

Need to expand what Medicaid will reimburse for

- Telehealth services, case management, phone calls now reimbursed
- State Plan Amendment (Behavioral Health Transformation Medicaid waiver) is a positive step

Align reimbursement with effective approaches

- Providers paid more for individual therapy session than for working with families
- Billing for crisis services and trauma specific interventions difficult

Different provider types paid at different rates for same interventions

- Creates big discrepancies across schools (depending on provider type)
- FQHCs must add each school as a separate free-standing mental health clinic

Requirements around billing (e.g., wait for intake no longer than 7 business days) often not enforced

Value-based payment has potential to enhance provision of behavioral health services but requires:

- Agreeing upon common measures tracking meaningful outcomes;
- Greater use of health information exchange technology;
- Better incident management tools

APPENDIX D: KEY CONSIDERATIONS FOR PRIORITY ACTION ITEMS

Expanding Tier 1 & Tier 2 Services

- There is a need to develop shared understanding of what Tier 1 and 2 services are; what services are available in a school, who is making decisions about what services are offered, who is implementing them, and which services are effective.
- Licensed clinicians have limited time available to deliver Tier 1 and Tier 2 services once Tier 3 services/billing/administration are completed. In addition, delivery of Tier 1 and 2 services does not make the best use of the skills of these clinicians, when bachelor-level or other workforce could effectively deliver these services at lower cost (though not reimbursed by Medicaid currently).
- Strengthening school and classroom-level climate cannot be done sufficiently with external personnel (e.g., leading SEL lessons for students); teacher workforce development in this area is key.
- Lack of coordination between clinical providers and schools limits clinical provider ability to refer to available school-based resources, including Tier 2. There is also a need for more flexible referrals from community stakeholders.
- Many competing Tier 1 initiatives (e.g., trauma-informed, restorative, etc.) being supported District-wide and within schools poses challenges with integration, alignment, and prioritization.
- There is a need for clear, regular, dedicated funding for schools to offer Tier 1 and 2 services (and a better balance of resources between Tier 3 and Tier 2/Tier 1) as well as buy in and leadership from the school.

Strengthening School Behavioral Health (SBH) Coordinator Position

- There is an [existing description of this role in the Primary Guide](#), as well as information from surveys of those in this role (e.g., via Community of Practice, Child Trends' evaluation data collection). DCPS is currently working to clarify and strengthen the role of the coordinator.
- There is some funding for these positions, but not enough to cover the entire role. Strengthening quality of the role increases time commitment and capacity building required. Even with funding, people do not want this role. How can workload and other factors be adjusted to rectify that? What is the role of distributed leadership and rotating functions to minimize overwhelm?
- How should the role be structured and do expectations around the role need to be tightened – considering whether it is one position per school, more than one position per school, or one person serving this function for multiple schools; whether it is a 12 month or 9 month position; qualifications of the person filling this role; etc? How best to deal with the difference in workload for this position across schools (e.g., large high school vs small elementary school)?
- Is the goal to make sure the *function* this role serves happens or is the goal to make sure this particular position is filled and executed effectively? If it is about the function, how can we assess whether we are getting the outcomes we need and whether the coordinator function is/isn't contributing to that?
- Need same level of attention to the importance of this role in charter schools but decentralization makes that difficult.
- How expansive should the "coordination" function of this role be, both at the level of a school (consider Community Schools model, with designated coordinator and budget for supports/services) and more broadly (consider shift in Mayor's budget moving resources to mental health supports and lack of clarity around coordination across these roles).

Creating Family Liaison Role

Position logistics

- o Is this a formal position?
- o Should this position be housed in the school or should this be an external role given the structure/politics in schools?
- o Where does this role fit within context of varying roles for support professionals in schools?
- o Who will support/supervise the liaison? What type of experience would the supervisor have in order to truly support the development and success of this role?

Position responsibilities

- o Would this role connect only to behavioral health services or all services?
- o Peer support and warm hand offs to other agencies will be key to this position.
- o The priority around menu of services/supports is relevant to consider here.

Qualifications for the role

- o Consider previous relationship with school staff and families.
- o Personal lived experience should be valued and individuals provided opportunities to professionalize their experience (important from an equity perspective). We need to look at the process of identification through CBO partners; who can identify parents that are ready to take their advocacy to the next level?

Current barriers to credentialing and if there may be pathways to certification and credentialing as this position is established

- o Note that some families express concerns around credentialing and whether differences indicate some families are getting better/worse services while others prefer someone they know and have a relationship with over credentials.

Buy in:

- o Are schools interested in this role?
- o Is there a way to provide families some say in the type of person selected for this role, and could that potentially increase inequity if there are not centralized policies guiding selection of family liaisons?



Developing Menu of Mental Health Supports at Each School

There are existing information gathering efforts that are related to this:

- OSSE and Child Trends are working on a Beta test for an online database with information from School Health Profiles (partnerships, programs, clinicians, etc), searchable by ward, sector, school, and so on. Other data sources may be folded in later on. It will be available to DC Agency personnel first (to inform distribution of resources across the city, what schools might be good candidates to partner on a particular grant, etc.).
- CHHCS has pulled together a spreadsheet of existing school-level information on resources, programs, and staffing but it was difficult to utilize, analyze or manage.

What data should be included?

- If data collected means something to a school, then that incentivizes better data collection.
- [School Health Profiles](#), SBHE List of SBHCs and CBO clinician points of contact, DBH Clinician list, and lists of outside providers all include relevant data.
- There may be value in connecting this information to the school work plan and [school strengthening plan](#) process, The work plan reflects what schools aim to do (vs currently done) and is required to address all tiers but does not capture the whole school health index. Also, the plan goals are not captured in an aggregate way to see patterns across schools. There is a question of who enforces the requirement (DBH can enforce with its clinicians/CBOs, but DCPS needs to with its personnel). There are also timeline challenges (DCPS announced they will not get to School Strengthening Work Plans until October, making it impossible to integrate into whole school plan and associated accountability; also unclear what time of year to work on this, given staff gone over the summer and how busy the first week back is).

How should the data be collected and synthesized?

- Should a menu of services be a citywide map/endeavor or something accomplished at school level with some guidance provided?
- Who is providing information on resources available? Who is accountable for ensuring people come to the table?
- There is a need for an accessible/family-facing format that makes it clear how the school is doing with respect to meeting behavioral health needs (just as there are indicators for how the school is doing with math and English), and what expectations they can have of the school. Linking to MySchoolDC or app could be useful.

A written menu of services can only go so far –consistent, face-to-face communication is important to convey how this looks in a child’s classroom and share resources to extend supports into their home.

- Need incentives/resources/supports to continue these conversations. Parent-facing organizations can help but hard for them to be school-specific in the way that is needed.

Re-envisioning Family Engagement

- **Family engagement should be embedded** in each part of planning process from the very beginning.
- **A number of organizations/groups are involved with/lead family engagement related activities**, including PAVE, Mary’s Center, Flamboyant Foundation, family-run organizations in DC, DC School Behavioral Health Coordinating Council Family and Youth Committee, DBH (hosted listening sessions with families), SLC (caregiver group model building), Family and Youth Engagement Practice Group of the DC CoP (working to understand barriers to family engagement).
- **Schools with promising family engagement approaches include:**
 - Eagle Academy planning to start a food patty in wake of COVID
 - DC Prep surveys families at multiple times in the year to gather their input
 - DC Bilingual (and other schools) had every staff from top to bottom check in on a group of families during COVID; some schools planning to continue this moving forward.
 - Leaders modeled calls initially
 - Schools who did this are seeing better re-enrollment and more willingness to return in-person
 - Question of how to sustain this if school personnel feel overwhelmed by it; tracking can be cumbersome.
- **1:1 contact has made a difference in clinical sessions as well.** Numerous clinicians say they will keep the effort to connect with parents/caregivers during every session with the child. Although it is a best practice, many clinicians didn’t do it regularly. Now they plan to adhere more to that practice.
- **We need leaders in the system and a pipeline of future leaders** that are willing to act on family concerns.
- **Need resources, time, accountability, data/information sharing.** But money alone won’t improve the system. A culture shift is needed.
- **If families are asked for their opinions, their requests need to be acted upon/addressed.** More power needs to be placed in their hands.
- **Families know when they are coming into an organic space** where their ideas and experiences are recognized. There is a need for more spaces for authentic relationships.
- **People in power need to self-reflect on how their policies are operationalized/ implemented.** There are no guides or incentives for people to do good family engagement work.
- **Individuals with Disabilities Act is a good example** of what effective family engagement looks like.
- **South Capitol Street Memorial Act is the foundation of school behavioral health efforts in DC**, but it is not utilized or reviewed in a way that demonstrates a desire to transform the system.

Who makes up the SLC?



The Center for
Health and Health Care
in Schools



Children's National
Health System



Premnas
Partners



DISTRICT OF COLUMBIA
BEHAVIORAL HEALTH ASSOCIATION



Rekindling hope. Rebuilding lives.



GEORGETOWN UNIVERSITY
Georgetown University Medical Center



MedStar Health



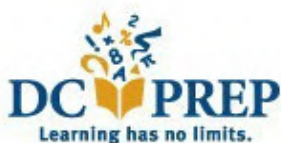
SchoolTalk
VOICES OF CHANGE



EAGLE ACADEMY PCS
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Mary's Center
Quality healthcare. Stronger communities.



Advocates for Justice and Education, Inc.
Children with Special Needs, Need Parents with Special Skills



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