STRENGTHENING FAMILIES
THROUGH BEHAVIORAL HEALTH

Frequently Asked Questions for Fiscal Year 2022

School-Based Mental Health Expansion Program

What is the budget ask and what will it cover?

We are asking for $6.4 million in recurring local dollars to expand the program to all remaining DC public schools (traditional and charter) – which is approximately 80 schools. This would ensure that every DC public school has at least one full-time behavioral health clinician available on-site to provide services at all three tiers.

Also, please consider the following recommendations for how to spend federal stimulus/pandemic relief dollars designated for K-12 education:

- $1.6 million to enhance SBMH grants to cover pandemic-related cost increases (DME did this last year and should do it again this year as pandemic conditions continue)
- Fund a one-time awareness/outreach campaign to ensure families returning to school in the fall know about SBMH and how to access services
- Fund a pilot program to explore the benefits of providing a stipend for SBMHCs
- Fund a pilot program to explore options for creating family support liaisons to connect families with SBMH services

Should we fund student mental/behavioral health supports through the Uniform Per Student Funding Formula (UPSFF)?

- UPSFF funding cannot be designated for specific uses. Local education agencies (LEAs) are able to allocate the funding how they see fit, meaning they can choose to spend money on mental health supports or not (outside of legal requirements for students with disabilities).
- School budgets can be and are used to support student mental health, including funding staff positions such as school social workers and school psychologists. These staff, however, are largely focused on students with 504s and IEPs, and their role is focused on helping students through an educational lens. In contrast, the behavioral health clinicians that are funded through the SBMH

expansion program serve an essential and distinct purpose. They are focused on the behavioral health of all staff and students and are uniquely positioned to provide services at all three tiers. Further, because they are connected to community-based organizations (CBOs), they can better connect students and families to services outside of the school.

- The behavioral health clinician provided to schools through the expansion is intended to complement, not replace existing school staff. These positions are not interchangeable.
- [note: Though we support an increase in the UPSFF, this is not the best way to specifically target behavioral health supports using education-specific funds because there is no way to guarantee the additional funds will be spent on additional behavioral health supports or staff. A more targeted way to get money to schools for this purpose through the education budget would be to increase investments in OSSE's School Safety and Positive School Climate Fund. The Climate Fund enables schools to pay for one-time programs, trainings, or services that promote healthy school climates (e.g., teacher development programs related to SEL).]

Why do some schools have clinicians from the Department of Behavioral Health and others have clinicians from CBOs? Why does the expansion only provide CBO clinicians?

- Prior to DBH's implementation of the comprehensive school-based behavioral health expansion, some schools were part of DBH's legacy program, which provided DBH employees to serve as clinicians in schools. The expansion under the new public health model involves DBH partnering with CBOs to bring CBO clinicians into schools to provide full-time behavioral health services. Both DBH clinicians and CBO clinicians are licensed professionals, closely supervised by DBH clinical supervisors, and are highly trained.
- CBO clinicians bill Medicaid and commercial insurance for some of the services that they provide, whereas DBH clinicians generally do not. Further, DBH splits the cost of the clinician with the CBO. This makes the expansion program more cost-effective than trying to hire all DBH clinicians, which in turn enables the city to put more clinicians in more schools more quickly.

    - Note: DBH clinicians tend to spend more time on Tier 1 and 2 services, which are generally not billable services.
- Further, they are connected to CBOs and, therefore, can better connect students and families to services outside of the school – i.e., in the community.

What is the goal of the expansion program?

The initial goal of the expansion program is to get at least one behavioral health clinician into every school because it is the only way to conduct an accurate needs assessment for behavioral health services in schools. Right now, the city relies on proxies (e.g., socioeconomic factors, number of at-risk, homeless, or foster students, etc.), which are not reliable metrics for determining the needs of schools, students, and families. Once every school has a clinician, the program is designed to enable the CBO clinician to work with the other members of the school behavioral health team to assess the behavioral health needs of the school community, identify existing resources, and determine whether there are gaps that need to be filled. Only then will the city know what is required for schools to successfully meet the behavioral health needs of their school communities.

Once we have at least one clinician in every school, we can then work to ensure all schools have sufficient resources to provide universal Tier 1 services. The public health approach encourages school clinicians to concentrate the largest portion of their efforts on prevention and promotion of mental health at the Tier 1 level. Providing universal Tier 1 services in the school enables schools to intervene early and change students' trajectory in terms of behavioral health, identify students that may need higher levels of care, and make the appropriate linkages to higher-tiered services and additional resources.

Note: The behavioral health needs of the school community includes the needs of teachers and school leaders, as well as students. Healthy teachers and healthy classrooms are necessary to have healthy students. For this reason, SBMH seeks to provide professional development and behavioral health supports for teachers as well.

Is one clinician per school enough? Isn't there a recommended national ratio of social workers-to-students? (1:250)

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THROUGH BEHAVIORAL HEALTH

Placing one clinician per-school is necessary to ensure that all students have some level of access to behavioral health services while attending a public school in the District. Still, we know that many schools in the District need more than one clinician per-school, particularly our larger schools and our schools that serve a high number of students living in poverty and facing other challenges.

The National Association of Social Workers (NASW) recommends a 1:250 social worker-to-student ratio per school.[1] However, NASW notes that this is a general ratio that depends on the characteristics and needs of the student population served.

In other words, ratios cannot be applied in a vacuum. Each school needs a complete behavioral health team, but different schools have different types of professionals working in the building. As a result, schools may require different combinations of licenses and staffing based on their unique needs.

Note: some professionals in the building (e.g., those tasked with assessments and evaluations) often don't have the bandwidth to address other behavioral health needs. In these instances, school-based clinicians would complement the services already offered to students and families in their schools in order to address the full continuum of behavioral health concerns in the school community.

Does every school need a full-time clinician?

Generally speaking, every school needs a full-time clinician integrated into the school community. Clinicians hold many essential responsibilities including assessing behavioral health needs of students, mapping out existing resources and gaps, and connecting students and families to services beyond school walls. Also, ensuring that clinicians have full-time positions helps to promote a higher quality delivery of services.

What is the total cost of the SBMH program? What is the cost per school and what does it include?

[1] National Association of Social Workers, "NASW Standards for School Social Work Services,"2012.

FY2021 budget line number: $21,796,000 (includes SBMH and other programs)

Total cost of CBO clinicians for all 234 schools + 39 supervisors: $18,778,500

Other costs include the DC Community of Practice, Evaluation, OSSE/DCPS FTEs (but we don't know how much each of these items cost)

What is the Department of Behavioral Health doing to make sure families and students can access these services?

This is an area where more work is needed. Each school is responsible for informing their community about the services offered by their school-based behavioral clinician and other members of the school's behavioral health team. In addition, DBH posts information about the expansion program on their website – including a regularly-updated master contact list for all CBO and DBH clinicians working in schools – and often develops communication materials such as flyers for school communities to use.

The Family and Youth Subcommittee of the Coordinating Council (which is tasked with implementing the SBMH program) is also working on several proposals to improve information-sharing with students and families regarding SBMH. However, we must take extensive steps to clearly communicate this work to families so that they know what supports are available at their school and how to access them. Furthermore, we also want families and students to be able to provide feedback on the services they receive so we can figure out what is working and what isn't. We need additional resources to conduct a strategic, citywide outreach campaign, as well as increased supports for schools to do this deeply important engagement work with their own communities.

Community-Based Behavioral Health Organizations (CBOs)

What is the budget ask and what will it cover?

We are asking for $4 million for community behavioral health services. This will return the budget for these services to FY 2020 levels.

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THROUGH BEHAVIORAL HEALTH

The FY 2021 budget cut $4 million from community behavioral health services, $2 million of which would have been matched by federal dollars (for every dollar that the District invests in behavioral health services covered by Medicaid, the federal government invests approximately $3.30). At minimum, we must return spending on community behavioral health services to FY 2020 levels and recover the $5 million in federal dollars left on the table. To truly meet the behavioral health needs of DC's residents, we need *more* spending on community behavioral health services, not less.

If the budget line for CBO behavioral health services is not restored to FY 2020 or there are further budget cuts, what is the anticipated impact? (Dr. Bazron has told the DC Council that the cut in the FY 2021 budget will not have an impact on services)

Failure to fully fund community behavioral health services will cause irreparable harm to DC residents. Community-based providers who were already operating on thin margins before the pandemic are now facing greater financial strain, making the behavioral health system more vulnerable during the worst possible time. Without additional funding, many providers may be forced to cut back care for the people they serve, and people with behavioral health challenges cannot afford a reduction in their care right now.

Ongoing financial strain could also lead provider organizations to withdraw from the District or close their businesses altogether. As a result, low-income residents who have been shouldering an unequal amount of stress and trauma for an indefinite amount of time will have fewer places to turn to for help. Even just a handful of provider organization closures could devastate our already fragile behavioral healthcare system, which also already suffers from a shortage of providers that serve children.

Note: a reduction in the number of community providers also threatens the stability of the School-Based Mental Health program – these are the same providers that partner with schools to place clinicians in our schools. In other words, without these community providers, the School-Based Mental Health program doesn't work.