DC Health Matters Collaborative

October 2021

Improvements to Behavioral Health Integration and Service Provision in D.C.

Listening to our Behavioral Health Workforce and Youth

DC Health Matters Collaborative

Introduction

In recent years, the District of Columbia has maintained multiple behavioral health programs for youth and adults and sought to integrate behavioral healthcare[1] into settings beyond doctors' and therapists' offices, going beyond the collaborative care model of treating depression and anxiety in primary care settings through the involvement of behavioral health clinicians.[2] This put D.C. in line with best practices in public health and medicine to expand access to services like individual and group counseling, substance use recovery and harm reduction, and crisis intervention. Yet, D.C. also regularly experiences workforce shortages across all types of behavioral health providers, such as Peer Support Workers, Licensed Independent Clinical Social Workers, and child psychiatrists. Although the District implemented temporary credentialing and licensure changes to ensure provider availability met demand during the COVID-19 Public Health Emergency, extended to August 10, 2022[3], the behavioral health[4] workforce remains stretched thin, both in terms of organizational personnel and personal bandwidth.

The need for increased attention on behavioral health and the attendant workforce is clear: an estimated 19% of Americans have a mental health condition.[5] Indicators of adverse mental health in the District are on the rise, such as death rate by suicide, prevalence of depression, and frequent mental distress.[6] The federal Substance Abuse and Mental Health Services Administration (SAMHSA) notes that only 42% of District residents with a mental health condition currently receive treatment.[7] If not attended to, mental health challenges can inhibit our ability to care for others, succeed in school or employment, or maintain our physical health.

The DC Health Matters Collaborative is a coalition of hospitals and health centers that combine efforts to assess and address community needs in the District of Columbia. Every three years the Collaborative completes a Community Health Needs Assessment (CHNA). Based on our 2016 and

[1] "Behavioral health integration" means to foster integration between behavioral health care and public health system to include government, private, nonprofit and faith-based entities providing health, behavioral health and social services, and collaborating on developing a comprehensive strategy to effectively finance behavioral health services and other social services that contribute to the overall health of the individual and of communities (see samhsa-behavioral-health-integration.pdf.)

[2] Eghaneyan, B. H., Sanchez, K., & Mitschke, D. B. (2014). Implementation of a collaborative care model for the treatment of depression and anxiety in a community health center: results from a qualitative case study. Journal of multidisciplinary healthcare, 7, 503–513. https://doi.org/10.2147/JMDH.S69821

[3] B24-399: Preserve Our Healthcare Workforce Emergency Amendment Act of 2021, passed October 5, 2021.

[4] "Mental health" and "behavioral health" will be used interchangeably throughout this report.

[5] Reinert, M, Fritze, D. & Nguyen, T. (October 2021). The State of Mental Health in America 2022, Mental Health America, Alexandria VA, page 18. https://mhanational.org/issues/state-mental-health-america

[6] DC Health Matters Data Dashboard: All Data, District of Columbia. https://www.dchealthmatters.org/indicators/index/dashboard?alias=alldata

[7] Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: District of Columbia, 2015. HHS Publication No. SMA–16–Baro–2015–DC. Rockville, MD: Substance Abuse and Mental Health Services Administration, page 11 . https://www.samhsa.gov/data/sites/default/files/2015_District-of-Columbia_BHBarometer.pdf

2019 needs assessment findings, the Collaborative's work is organized around four key priority needs: mental health, care coordination, health literacy, and access to place-based care.

In implementing the Collaborative's 2019-2022 Community Health Improvement Plan (CHIP), our mental health work focuses on advocating for policy and systems-change strategies to improve access to and equity within the publicly-funded D.C. behavioral healthcare system, Recent policy advocacy included testifying before the DC Council's Committee on Health in support of Bill 24-65, the "Interagency Council on Behavioral Health Establishment Amendment Act of 2021", noting how many non-health systems and sectors already experience behavioral health needs, such as schools, jails, and the foster care system, and how a Mayoral cabinet-level entity coordinating behavioral health services across the government would facilitate the relationships, integration, and trust-building that is necessary to achieve systemic improvements. A current system-change effort we are undertaking is to name and address workforce needs impacting efforts to increase behavioral healthcare integration into non-traditional settings (such as outside of primary care) and identify additional integration approaches to improve access to care.

Behavioral Health Workforce Listening Sessions

Behavioral Health System Improvement Themes

Over the summer of 2021, the Collaborative convened listening sessions to contribute to the health systems improvements and workforce conversations already underway in the District. The first session included D.C. high school students interning within healthcare settings about their career aspirations and thoughts on the behavioral health system, including their impressions of behavioral health professions and services and how they could be better integrated into their lives and communities. The second session invited behavioral health professionals and organizational leadership to discuss their and their patients' and clients' experiences with behavioral health care services. Specifically, the Collaborative spoke with psychiatrists, social workers, peer support and community support workers, community-based providers, advocates, and executives in primary and specialty care, emergency departments, and publicly funded services on how the system could be improved, including through increased and innovative integrated behavioral health efforts.

The Collaborative used these listening sessions to identify several workforce-related themes to improve the D.C. behavioral health system by better supporting direct service providers, patients, organizations, and the public. We note that Bill 24-65 to establish an Interagency Council remains pending, although the issues and recommendations below offer rich opportunities for multi-agency collaboration. One important and consistent thread through all themes is the need for increased pay and/or billing and improved reimbursement options.

1. Reduce obstacles to entering behavioral health fields: costs to pursue formalized clinical education; lack of awareness of non-clinical roles and/or different types of behavioral health roles, including in harm reduction; credentialing timelines, requirements, and processes; and inadequate pay;
2. Make targeted improvements to reimbursements, billing, contract and grant opportunities, and insurance structures: increase opportunities for behavioral health coverage, to provide sufficient pay for behavioral health workers, including peer support roles and community health workers;
3. Address existing and emerging challenges for organizational recruitment and behavioral health provider retention: provider satisfaction, incentives and pay; address credentialing, competition, diversity and inclusion, and turnover issues; and the need for a provider pipeline[8] in coordination with local colleges and universities;
4. Increase attention from policymakers and D.C. government agencies to behavioral health providers and organizations: increasing reimbursement rates and billing opportunities, funding mutual aid systems, and citywide collaboration and investment into cohesively integrated referral systems, care coordination, and consultation.

Youth Perspective on Behavioral Health Services and Integration

We asked our listening session participants where they currently see positive examples of behavioral health integration, and further, where they would *like* to see behavioral health services offered or improved, including any settings where access to behavioral health services are needed but not currently accessible.

Youth noted they have counseling options at school (through Department of Behavioral Health school-based clinicians, D.C. Public School counselors, and/or community-based clinicians serving in the schools), but that schools may "ignore" some of the relevant and impactful issues happening in the community or world. They told the Collaborative that appointments are difficult to get, and increased information about behavioral health (such as mental health first aid), would be helpful. They noted, for example, that it is not always clear what "depressed" looks like or what it actually means to "suffer from depression."

Youth also noted they may turn to online apps to assess their behavioral health, particularly if unsure about attending therapy, noting they lack access to physical spaces that feel "open" and comfortable and where they are not shamed for asking for help. For youth, integrating care into safe spaces or youth-focused events may increase their interest in accessing services and/or their awareness of different types of fields within the broader system of behavioral health.

Professional Perspective on Behavioral Health System and Integration

Our professional participants noted a variety of services where behavioral health integration is already useful, including:

[8] Supported career pathways for individuals as part of a larger workforce development program.

Within emergency rooms for patients who are seen frequently for "repeat admissions";

1. "Healthy Futures"-type programs where behavioral health professionals work with early childhood educators and their students on behaviors and socio-emotional learning;
2. "HealthySteps"-type programs, and the DC MAP program (Mental Health Access in Pediatrics at both Children's National Hospital and Georgetown University Hospital), that integrate pediatric primary care with an interdisciplinary behavioral health team and/or parenting supports;
3. Department of Behavioral Health-led school-based behavioral health expansion program within DCPS and the D.C. public charter schools; and
4. Use of warm lines and referral services, such as the Access Helpline.[9]

Additional integration efforts would be beneficial, even as we must consider the limited availability of the relevant workforce. According to the providers, the District currently lacks sufficient substance use disorder (SUD) and residential treatment services for adolescents, as well as sufficient autism-related services. They further noted a lack of low-barrier harm reduction and crisis intervention services available for residents living in Wards 7 & 8. The District should consider how to utilize existing services, providers, organizations, and systems to further embed SUD, crisis, harm reduction, and other therapeutic services, particularly if an existing credential or certification may be required.

> "The utilization of consistent mental health services is a little lower now due to COVID, although there are increases in generalized anxiety, irritability, and hopelessness. When school-based behavioral health clinicians are available within schools, there are opportunities for micro-interactions with students and their teachers, the whole school community, so that we can be aware of a need and address it on the spot. We are currently using targeted Zoom appointments because telehealth is extremely effective to support families and give them greater access to services."
>
> - School-based behavioral health expansion clinician, Mary's Center

One example our participants noted includes the need for a sobering center in the District. These could be modeled off centers in California, which are open 24 hours a day, seven days a week, 365 days a year, with an average length of stay of twelve hours. They are staffed in part with licensed staff (usually nurses) and in part with non-clinical staff (conducting intake and assessments and providing peer-level support or motivational interviewing). However, should D.C. pursue this intervention, a sustainable model of funding will be critical; California notes that *none* of its sobering facilities bill either the patients or commercial payors, relying instead on state or local funding or philanthropy, which can lack consistency.[10]

[9] The Access HelpLine, 1(888)7WE-HELP (1-888-793-4357), https://dbh.dc.gov/service/access-helpline

[10] Smith-Bernardin, S, Menninger B, Sobering Centers Explained: An Innovative Solution for Care of Acute Intoxication (July 2021) California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2021/07/SoberingCentersExplainedInnovativeSolutionAcuteIntoxication.pdf

The participants also noted potential areas to increase integration, such as stationing behavioral health personnel at COVID-19 testing and vaccination sites, as peers or clinicians would be more readily able to address vaccine hesitancy concerns. Our professionals also noted the stress caused by the high costs of living in the District, suggesting that rental housing offices and housing communities should have case managers and/or social workers available for residents who need to address financial or other life stressors.[11] Resident Services Coordinators in senior buildings could focus on health and wellness services, whereas that same role in a multi-family property could coordinate programming focuses on finances, youth, or employment.[12] This partially mirrors D.C. legislation introduced in 2019[13] to provide on-site services to residents in apartment buildings where a certain percentage of units were rented by recipients of housing subsidies. The providers suggest expanding this type of concept to housing providers regardless of tenant income, as behavioral health concerns impact people of all walks of life, income, and education level, and having services available "where you are" is a prime recommendation of many of the participants with whom we spoke.

Overall, the provider participants expressed the significant need for (non-clinical) social workers, among other types of coordinating and navigating personnel, to provide "wrap-around" services for the whole family and increased case management availability "across the board." Community-based organizations may be well-suited to meet this need, as these organizations may tend to be more flexible, family or person-centered, and may offer a wide range of services that provides a safety-net for clients and patients.

The participants also focused on the need for an increased public understanding of the mental health crisis response system, including which first responders may respond to a call and their level of behavioral health training, how to access appropriate services, and the provision of mental health first aid for the general population. Participants shared a suggestion that District social workers and/or peers have the authority and reimbursement structure to provide follow-up care after EMS interactions for persons who were in crisis or overdosed, modeled in other jurisdictions. They also shared the need for "warm lines"[14] for parents in times of crisis.

The recommendations for more case managers, social workers, and/or care coordinators and system navigators resonated across the listening sessions, suggesting a gap where non-clinicians can further connect people to resources and provide general, non-therapeutic assistance. With DC Council expected to consider proposed amendments to the Health Occupations Reform Act (HORA) in the next several months, the District's Health Licensing Boards are reviewing their specific scopes of practice and licensing requirements. The need for these non-clinical

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[11] Blake, A. (2011) Beyond Housing: New Approaches in Community Services Are an Opportunity for Social Workers, The New Social Worker. https://www.socialworker.com/feature-articles/practice/Beyond_Housing%3A_New_Approaches_in_Community_Services_Are_an_Opportunity_for_Social_Workers/

[12] *Id.*

[13] Bill 23-180: the On-Site Services Act of 2019

[14] Alternative to a crisis line that is run by "peers," generally those who have had their own experiences of trauma that they are willing to speak of and acknowledge.

services should be considered by all the relevant boards and determinations made regarding the necessity of credentials to provide referral, coordination, and navigation assistance. The number of licensed social workers or similarly-skilled providers would need to dramatically increase in order to effectively meet the integration needs of our providers' suggestions.

We note concerns of community-based organizations that certain Boards, when reviewing candidates' applications for licensure, have claimed previous work experience could be viewed as having "practiced out of scope" of their chosen profession. Imputing prior experience, appropriately performed yet under no expectation of Board oversight at the time of performance, negatively impacts licensure applications. For example, "referral" is one activity within the DC Board of Social Work's scope of practice definition.[15] The Collaborative has heard reports of employees, such as in Community Support Worker roles, without an applicable college degree, completing service referrals on behalf of organizational clients, as per their job description. These employees, due to the enjoyment and satisfaction gained in that work, subsequently attended college and received a Bachelor's degree in Social Work. However, in some cases, the employee's previous job duties, before becoming qualified to apply for a license, are being adversely used against them, potentially resulting in fines and delays to licensure.

Given the expressed need to increase the availability of social workers in a variety of locations and service sectors, the Collaborative wants to emphasize the importance of clearly delineating clinical and non-clinical roles and ensuring broad terms such as "advocacy" and "referral" cannot be the sole domain of any one field's scope of practice.[16] Further, it is critical to ensure that work designed to assist patients and clients, such a care coordination, does not fall under the purview of any one Health Licensing Board or field, so that someone who previously provided care coordination, navigation, or referral services would not later be penalized for doing that work when considered otherwise appropriate within the scope of their employment.

Leadership Perspective on Behavioral Health System and Integration

Representatives of organizational leadership who participated in our session noted that they may not, in fact, provide integrated care, to the extent necessary. A government representative noted that integrated healthcare is the goal but "happens more on paper than in actuality", specifically noting that young adults (aged 16-25) have fewer integrated options. In some cases, it may simply be a matter of time before integrated services are provided, but the organization is either too new or is actively working to build up its workforce and capacity to provide integrated care.

A. Challenges to Recruitment, Capacity-Building, and Retention

In terms of organizational capacity-building, leaders note three main challenges with respect to

[15] DC Code 3-1201.02(18)(A). Definitions of health occupations – practice of social work.
[16] *Id.*

recruitment and retention of providers: 1) credentialing processes and requirements, 2) the high cost of living in the District, and 3) staff turnover.

> "Mary's Center offers behavioral health and social services in programs staffed by graduates and undergraduates, often as Family Support Worker or Community Support Worker. These roles provide education, care coordination and case management to our home visiting, social service, and behavioral health programming. Some individuals studied social work as an undergraduate, while many studied in related fields, such as psychology, sociology, or human development.
>
> While working in their roles at the undergraduate level we provide on-going training, weekly supervision, and mentor these staff in the hopes that as they continue their education, they will continue to work with us in support of our shared communities. Many staff continue to work with us in the field as they put themselves through school. Their presence benefits community members and their pursuit of a higher degree can only bring more benefit to themselves and the residents of DC. These individuals are representative of the communities we work with and engage in care.
>
> After earning their MSW and preparing to sit for their first licensing exam, these individuals face uncertainty and fear. They know that coworkers, Community Support Workers, or Home Visitors, have been fined by the Board for practicing social work without a license at Mary's Center.
>
> We offer high quality supervision by experienced, independently licensed clinicians who follow the ethical guidelines of their licensing boards. We closely supervise the functions of our community and family support workers to ensure their practice is within the parameters of their training, and not beyond what they are qualified to provide. The work they are engaged in is necessary to be decisive and prepared to pursue a career in social work. While there may be students who can complete a bachelor's degree and immediately enter a masters' degree program, we can't assume that all students have that opportunity, nor want it. Encouraging the type of work outlined here increases the capacity of diverse communities to access social work as a viable field of practice."
>
> - Maria Gomez, President and CEO, Mary's Center

B. Credentialing

One leader shared how difficult it is to hire, specifically disclosing, "I can't find enough people to hire" as there are not enough qualified applicants to fill available positions. One health center who employs Community Support Workers noted that while they are budgeted for five CSWs, they have *never* had more than four on staff at any given time, and currently only have two on staff while recruiting for a third. These workers are credentialed through DBH through mandatory trainings (although there is *not* an official CSW training program) but must have a high school degree or GED in order to bill and must work under clinical oversight of an LICSW or

an LPC; these credentialed workers are *also* difficult to find and retain. Further, credentialing processes and timelines make it even more difficult to identify, hire, and start a new employee. A leader shared, "By the time we've hired them and then it's another 90 days to getting them credentialed and contracted, it's hard to hang onto them for that period. They're eager and anxious to help and get started, but they can't wait 90 days, and sometimes 120 days, for the licensing and contracting and credentialing."

The Collaborative notes that several of its members in September 2020 requested the DC Board of Social Work allow periods of supervised practice for recent but unlicensed graduates who have yet to take and pass their exam. In June 2021, the Board agreed to amend its regulations to allow for a 90-day supervised practice period. The provider coalition is particularly interested in being able to hire, and have candidates begin working, prior to licensure in part due to workforce needs, in part due to community needs, and in part to support the candidates themselves, both financially and professionally. The revised regime is not yet in effect.

C. Salary Constraints

Leadership also noted that health and human services providers are often competing against each other and against the government for a limited pool of available professionals, and the pay scale that some community-based organizations can offer is too low. The pay is often based on underlying government contract or grant funding, which can functionally act as a hiring disincentive, allowing for other providers or government to effectively poach a promising candidate. One leader noted that between employee turnover due to higher wages elsewhere and desire for career development, "we end up with not always the cream of the crop." Please see Appendices A and B for national average wage and District government salary information for specific behavioral health positions.[17]

With respect to D.C. contracts, community-based providers must meet D.C. resident hiring requirements on all awards over $300,000[18], impacting much of the contract funding received by community-based organizations. The underlying First Source law mandates that at least 51% of all new positions created with contract funding be filled by District residents. Due to workforce constraints limiting provider availability, and reimbursement levels potentially insufficient to meet D.C. rental or home buying costs, organizations struggle. They find it difficult to find the *type* of provider(s) necessary, but also providers who either already live in the District or can afford to relocate on the pay the contract or grant will offer. According to the National Low Income Housing Coalition's 2021 Out of Reach report on the cost of housing across America, the District's "housing wage", or the amount necessary to earn to afford a two-bedroom apartment (meeting US Department of Housing and Urban Development guidelines to spend

[17] National average salary for Social Workers in 2020 = $56,000; DC government (DBH) Social Workers FY21 = $73,000-$105,000.

[18] Workforce Intermediary Establishment and Reform of the First Source Amendment Act of 2011, effective February 24, 2012 (D.C. Law 19-84).

30% or less of your income on housing costs), is $33.94/hour.[19] For a studio apartment, the wage is still over $29/hour.[20]

For fee-for-service positions which provide billable services, such as Community Support Workers, the billable rate is often not enough to fully sustain an employee and/or a program. For example, a CSW's reimbursable rate is $24.27/15-minute service, which annually will tend to support an employee salary from a low of approximately $31,000 to a high of $48,000, based on experience and longevity. But in billing terms, CSWs are prohibited from billing for activities such as assisting clients with transportation or while waiting on site with the client for provision of services, which prevents a CSW from billing for a full 40-hour week. Providers of Community Support work note that it is a "tremendous service with very low reimbursement rate."

> "Every single person in health department makes significantly more than peer support workers, but know less than I do. When I started, I needed another part-time job because pay was so low and only for short durations (six months). This is still common and makes it hard to get a committed workforce. People without the advanced degree will find other work that pays more, may try to work in different area of the field (not direct services). They last a year or two. Organizations "shoe-string" grants together to pay positions enough; if peers are involved in a program, it is always the least funded grant. There is room for people with credentials and without. DBH requires a high school diploma or GED. For substance use peers, the standard requirement is two years in recovery, defined as abstinent, which is also a barrier (and counterproductive)."
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> - Peer Support Worker listening session participant

D. Turnover due to Employee Preference and Advancement

Other hiring challenges include whether the newly hired staff member prefers to serve the organization's target population (youth versus adults, for example) or desires to quickly advance into a higher-level position. We also heard from organizational leadership that some positions, like Community Support, may initially attract graduates with a social work or similar degree but many of those hires do not remain beyond the probationary period. The demands and requirements of the job, including addressing the behavioral health or housing needs of residents may be more than expected. Further, some clients receiving community support services may lack ongoing clinical support and treatment, increasing challenges to the paraprofessionals trying to provide appropriate levels of care for persons who may suffer from more serious mental illness or conditions. Leaders also mentioned COVID-19, telehealth, and the need for a more expansive view of "diversity and inclusion" impacting hiring, noting that

[19] Out of Reach 2021: District of Columbia, National Low Income Housing Coalition (2021). https://reports.nlihc.org/oor/district-columbia
[20] *Id.*

providers' expectations have changed regarding a need for greater flexibility and understanding from their workplace.

The District also announced vaccine mandates for its contractors and health workers, which may further impact organizational workforces. While many health workers and those completing contract work on behalf of the government have or plan to receive the vaccine, there is vaccine hesitancy even amongst health professionals, and some turnover in those positions is likely. To analogize, one participant noted during a discussion on credentialing that people can often find better paying work slightly outside of their initial chosen profession *and* that does not require a credential, such as becoming a health or policy advocate. It is possible that health workers who choose to remain unvaccinated may leave the direct health workforce while still remaining hirable in other sectors, further reducing the availability of direct care staff.

Retention Recommendations

We asked our participants to share: 1) how to attract more people to behavioral health professions, 2) ways to increase provider satisfaction in the field, and 3) what system improvements would make life as a provider easier?

Build the Behavioral Health Workforce

To attract more people into behavioral health fields, our listening session participants recommended that the District and/or individual organizations provide both better incentives and higher pay. One provider noted that a *barrier* to entry into the behavioral health field is the high cost of a formalized, clinical education, so our participants were keen to note the need for student loan repayment options. However, not all fields or levels of licensure seem to qualify for loan forgiveness or reduction. One leader noted "We're an FQHC and people can qualify for loan repayment under several programs which is an amazing benefit, but I recently learned that you have to have your LICSW [Licensed Independent Clinical Social Worker] or your LPC [Licensed Professional Counselor] to qualify for loan repayment programs, which I kind of understand. But on the other hand, when people really need loan repayments is when they come out of graduate school and they have the loans and they're in their first jobs. So, if LGSWs [Licensed Graduate Social Worker] could qualify for that, it's a great benefit but people can't get it until they're in their LICSWs."

Similarly, there was discussion about whether organizations should pay for certain certifications, so as not to place additional financial burdens on their workers. From a participant, "I don't see a lot of incentives that go with certifications [in different modalities]. So maybe I paid off my loan, and I'm at a point where I want to get a certification but don't want to put myself in additional debt. Are employers able to pay for certifications in specialized treatments? Those things would incentivize people to stay on or at least come on board." The Collaborative also heard an interest in additional in-service training and professional development opportunities.

As mentioned, a common thread through all themes and discussions relates to pay. Providers and organizational leaders noted the need for increased reimbursement levels on contracts (particularly to meet the District's First Source law mandating D.C. resident hiring obligations) and grants, as well as increased funding for roles, such as peer support and community support workers. Further, Medicaid and private insurance covers behavioral health services differently, if at all, and increasing consistency of coverage, billing, and rates for services was key for our participants. We will note, however, that due to a rebidding of the District's Medicaid managed care (MCO) contracts, behavioral health coverage will be included starting in 2022.

Leaders also noted that organizations need to have a wider view of "diversity and inclusion". Certainly, such initiatives tend to focus on equity with respect to race, ethnicity, and gender, but our leaders shared that to find and keep the right employees, there needs to be an across-the-board strategy. This includes placement of the job advertisement, determining in advance the type of desired individual, and how to retain that person, including whether the employee can or needs to work from home, work nights or weekends, needs childcare or tuition assistance, etc. In this vein, requirements for drug testing or abstinence from substances may limit the available pool of behavioral health providers, including those who have pertinent life experience best suited for peer support work.

One specific recommendation focused on the District's school-based behavioral health expansion program. Noted above was a general desire to see a provider "pipeline", a collaborative effort with schools, colleges, and universities to inform students about behavioral health opportunities and prepare them for those roles. An organizational leader recommended that having school-based behavioral health recognized as its own specialty, such that colleges and universities create specific school-based mental health tracks, could be a useful way to engage students and create future school-based clinicians. The District's expansion program, servicing both D.C. public schools and public charter schools, has placed Department of Behavioral Health and community-based clinicians in more than 200 schools in just a few years. As our focus group participants noted, the clinicians are a successful example of behavioral health integration and can further serve as way to educate future providers about the types of positions and opportunities available within the behavioral health field.

Increase Provider Satisfaction

We asked our professionals what would increase their satisfaction with their job or with the behavioral health system. They answered:

1. Increased collaboration between patients and providers; better referral coordination for the growing number of referrals, meaning substantive feedback or "loop-closing" to inform the referring provider whether/how services were performed;
2. Additional case management and/or care coordination; additional training for care coordinators and peer support workers to better assist patients, potentially to cover motivational interviewing and mental health literacy;

3. Improvements to the behavioral health insurance pre-authorization system; reducing the amount of necessary paperwork;
4. Increased availability of mid-level services; partial hospitalization (PHPs) and intensive outpatient programs (IOPs) to support children needing more intensive services;
5. Lower caseloads; limiting the number of clients/patients on which to focus;
6. Better pay, commensurate with workload and difficulty of work; student loan reimbursements and/or other incentives to work in low-income areas; and
7. Improvements to credentialing; described as "a nightmare" by one leader (specifically noting challenges with the Board of Social Work), and logistical challenges of varying requirements by jurisdiction in the region.

Providers also noted improvements outside the behavioral health system that would increase their satisfaction, including increased behavioral health literacy amongst all health professionals and families/patients, as well as stronger lines of communication with policymakers. One participant noted that government websites are often not up-to-date and are hard to navigate.

Make System Improvements

There was a strong desire expressed across the participant groups for increased compensation and changes to payment structures. Participants wanted to see increased coverage for behavioral health from both Medicaid and private insurance, to include an increase in providers who *accept* Medicaid and/or private insurance. Participants also want to see improvements to billing (including *whose* services can be billed), and increases in reimbursement rates, particularly on District contracts and grants. Increases to grants and contracts also need to ensure funding for an organization's indirect cost rate, as well as to ensure organizations are better able to meet First Source requirements for resident hiring. They also noted the need for inclusion of certain types of providers, such as Peer Support Workers, into billing methodologies. As discussed above, participants want to see compensation for care coordination, noting how important and necessary those services are when working within the District's fragmented behavioral health system.

Regarding services, providers told the Collaborative that there's a lack of availability of:

1. Evidence-based treatments, like Parent-Child Interactive Therapy (PCIT) and trauma-informed Cognitive Behavioral Therapy (CBT), which have long wait lists (2-3 months);
2. Comprehensive neuro-development assessments have a wait list of 6-12 months, resulting in families getting discouraged by the process;
3. Meaningful follow-up after a behavioral health crisis or drug overdose; and
4. Timely access to treatment (even where it already exists).

Organizational Integration Efforts

The leadership group, similar to the professional group, noted a need for increased behavioral health integration within housing providers and communities, including at homeless shelters.

They emphasized the importance of accessible spaces within neighborhoods and the need to meet people where they are – literally and figuratively. One organization noted they try to use non-behavioral health-focused activities with youth, for example, fishing, racecar driving, or sailboat racing, to decrease behavioral health-associated pressures. The organization said they "applied those activities to behavioral health needs and were able to connect those individuals to behavioral health services" further noting that they find a lot of importance in "being innovative enough to do things differently."

One organizational representative noted that people "aren't as comfortable with stepping outside of their neighborhood for behavioral health services, so bringing those services to them in a trusted place would be the best way." A second organization echoed this in its suggestion that behavioral health services be provided in barber shops and salons, and/or places where people not only go frequently but tend to feel comfortable and share with others. This also mirrors recent DC Council legislation, Bill 24-242: the Beautician and Barber Behavioral Health Training Act of 2021, which would create and govern a program to provide beauticians and barbers with behavioral health support training for the benefit of their clientele[21]. However, as workforce and treatment availability is *already* stretched, we would urge the Council to consider the need to bolster the behavioral health workforce in order to support receipt of referrals for services from the trained barbers and beauticians, to continue to provide support and training to the barbers and beauticians, and to develop strong pathways to connect their clients with services. We also recommend the Council consider potential liability concerns in the event a barber or beautician recognizes that a client is a threat to themselves or others but no action or insufficient action is taken to reduce the threat.

Additional Professional Suggestions

The providers were keen to call out trauma and the need for trauma-informed care throughout provision of services (social and medical), as trauma crosses generations and may never be successfully or thoroughly addressed, negatively impacting a multi-generational household. They further noted that at times, seeking to get help *from* the behavioral health system may in fact cause *additional trauma*, or "re-traumatization," as in instances where police are called for mental health emergencies or sexual assaults, or in instances where parents, seeking help for their children, are re-traumatized by a behavioral health system that fails to provide local and appropriate services, or be sufficiently sensitive to and supportive of parents' efforts. There is a reported lack of appropriate understanding within services for persons living with disabilities. The concept of "teaming" providers within an integrated approach is common, but it is important to ensure the team members are truly interdisciplinary, including *not only* healthcare providers, but education, criminal justice, advocates, and others working collectively to address all the individuals' specific needs.

[21] DC Council Committee on Health hearing scheduled for November 15, 2021.

At the heart of an integrated healthcare system is the community and its providers. Our participants specifically shared that "community" needs to be reinserted into community behavioral health efforts. They further warn not to "put professionals on a pedestal" as they may carry professional bias that could negatively impact their provision of services and/or their connection with their patients and community members. To counteract such bias, providers requested organizations support their workforce by offering more in-person service training and professional development opportunities, which could result in decreased provider burnout, as well as increase the likelihood of provider retention, both large challenges faced by the District's behavioral health providers and their organizations.

Conclusion

After listening to community providers, the Collaborative believes that our nascent integrated behavioral health system and workforce can – and must – be strengthened and expanded. This will require many urgent policy considerations, such as reducing qualifications obstacles to entering into and remaining in the behavioral health workforce in the District, targeting improvements to reimbursement and provider pay, addressing issues at the heart of organizational recruitment and retention of providers, and involving policymakers and DC government leaders in developing solutions.

APPENDIX A: National Position/Salary Examples

Bureau of Labor Statistics Information – Community and Social Service Occupations/Behavioral Health Careers (21-1000)
Overall Wages for the US (*not* specific to DC)

See May 2020 National Occupational Employment and Wage Estimates (bls.gov):

Type of Career/Field	Median Hourly Wage	Mean Hourly Wage	Annual Mean Wage
Community and Social Service Occupations (group 21-1000)	$22.85	$25.09	$52,180
Counselors/social workers, other counselors/social services (21-1000)	$22.83	$25.06	$52,120
Counselors (21-1010)	$24.17	$26.34	$54,780
Educational, guidance, and career counselors and advisors (21-1012)	$27.94	$29.96	$62,320
Marriage and Family Therapists (21-1013)	$24.69	$27.35	$56,890
Rehab counselors (21-1015)	$18.05	$20.23	$42,080
SUD, BH/MH disorder, counselors (21-1018)	$22.91	$24.78	$51,550
Counselors, all other (21-1019)	$22.00	$24.42	$50,880
Social Workers (21-1020)	$24.88	$26.90	$55,950
Child, Family, and School social workers (21-1021)	$23.28	$25.18	$52,370
Healthcare social workers (21-1022)	$27.71	$29.07	$60,470
MH and SUD social workers (21-1023)	$23.42	$26.22	$54,540
Social Workers, all other (21-1029)	$30.87	$31.22	$64,940
Misc. Community and Social Service specialists (21-1090)	$19.39	$21.82	$45,390
Health Education specialists (21-1091)	$27.16	$29.86	$62,120
Probation Officers and Correctional Treatment specialists (21-1093)	$26.77	$29.76	$61,900
Social and Human Service assistants (21-1093)	$17.29	$18.38	$38,230
Community Health Workers (21-1094)	$20.19	$22.12	$46,000
Community and Social Service specialists, all other (21-1099)	$22.48	$23.85	$49,600

21-1012 Educational, Guidance, and Career Counselors and Advisors

Advise and assist students and provide educational and vocational guidance services.

21-1013 Marriage and Family Therapists

Diagnose and treat mental and emotional disorders, whether cognitive, affective, or behavioral, within the context of marriage and family systems. Apply psychotherapeutic and family systems theories and techniques in the delivery of services to individuals, couples, and families for the purpose of treating such diagnosed nervous and mental disorders. Excludes "Psychologists" (19-3032 through 19-3039) and "Social Workers" (21-1020).

21-1015 Rehabilitation Counselors

Counsel individuals to maximize the independence and employability of persons coping with personal, social, and vocational difficulties that result from birth defects, illness, disease, accidents, aging, or the stress of daily life. Coordinate activities for residents of care and treatment facilities. Assess client needs and design and implement rehabilitation programs that may include personal and vocational counseling, training, and job placement. Excludes "Occupational Therapists" (29-1122).

21-1018 Substance Abuse, Behavioral Disorder, and Mental Health Counselors

This occupation includes the 2018 and 2010 SOC occupations 21-1011 Substance Abuse and Behavioral Disorder Counselors and 21-1014 Mental Health Counselors.

21-1019 Counselors, All Other

All counselors not listed separately.

21-1021 Child, Family, and School Social Workers

Provide social services and assistance to improve the social and psychological functioning of children and their families and to maximize the family well-being and the academic functioning of children. May assist parents, arrange adoptions, and find foster homes for abandoned or abused children. In schools, they address such problems as teenage pregnancy, misbehavior, and truancy. May also advise teachers.

21-1022 Healthcare Social Workers

Provide individuals, families, and groups with the psychosocial support needed to cope with chronic, acute, or terminal illnesses. Services include advising family caregivers. Provide patients with information and counseling, and make referrals for other services. May also provide case and care management or interventions designed to promote health, prevent disease, and address barriers to access to healthcare.

21-1023 Mental Health and Substance Abuse Social Workers

Assess and treat individuals with mental, emotional, or substance abuse problems, including abuse of alcohol, tobacco, and/or other drugs. Activities may include individual and group therapy, crisis intervention, case management, client advocacy, prevention, and education.

21-1029 Social Workers, All Other

All social workers not listed separately.

21-1091 Health Education Specialists

Provide and manage health education programs that help individuals, families, and their communities maximize and maintain healthy lifestyles. Use data to identify community needs prior to planning, implementing, monitoring, and evaluating programs designed to encourage healthy lifestyles, policies, and environments. May link health systems, health providers, insurers, and patients to address individual and population health needs. May serve as a resource to assist individuals, other health professionals, or the community, and may administer fiscal resources for health education programs. Excludes "Community Health Workers" (21-1094).

21-1092 Probation Officers and Correctional Treatment Specialists

Provide social services to assist in rehabilitation of law offenders in custody or on probation or parole. Make recommendations for actions involving formulation of rehabilitation plan and treatment of offender, including conditional release and education and employment stipulations.

21-1093 Social and Human Service Assistants

Assist other social and human service providers in providing client services in a wide variety of fields, such as psychology, rehabilitation, or social work, including support for families. May assist clients in identifying and obtaining available benefits and social and community services. May assist social workers with developing, organizing, and conducting programs to prevent and resolve problems relevant to substance abuse, human relationships, rehabilitation, or dependent care. Excludes "Rehabilitation Counselors" (21-1015), "Psychiatric Technicians" (29-2053), "Personal Care Aides" (31-1122), and "Eligibility Interviewers, Government Programs" (43-4061).

21-1094 Community Health Workers

Promote health within a community by assisting individuals to adopt healthy behaviors. Serve as an advocate for the health needs of individuals by assisting community residents in effectively communicating with healthcare providers or social service agencies. Act as liaison or advocate and implement programs that promote, maintain, and improve individual and overall community health. May deliver health-related preventive services such as blood pressure, glaucoma, and hearing screenings. May collect data to help identify community health needs. Excludes "Health Education Specialists" (21-1091).

21-1099 Community and Social Service Specialists, All Other

All community and social service specialists not listed separately.

APPENDIX B: D.C. Government Position/Salary Examples

Department of Behavioral Health Fiscal Year 2021 Position Salaries – Behavioral Health Positions (Specific Examples)

See RM0 FY21 Position Listing (dccouncil.us):

Position Name/Type	Salary/Salary Range (among various staff)
Peer Counselor	$45,718 - $56,841
Peer Program Coordinator	$72,956
Social Worker	$72,953 - $105,339 (representing more than 100 listings)
Supervisory Social Worker	$100,000 - $113,052
Behavioral Technician	$45,718 - $64,607
Recovery Advocate	$45,718 - $52,074
Addictions Counselor	$56,994 - $64,050
Access Counselor	$60,019
Community Behavioral Health Specialist	$56,994 - $85,784
Care Coordinator	$70,818 - $85,784
Community Support Worker	$85,784 (only one example; long history of employment)
Mental Health Counselor	$51,807 - $64,607
Mental Health Clinical Specialist	$82,326
Psychiatric Resident	$58,805 - $70,760
Licensed Professional Counselor	$72,956 - $77,232
Clinical Psychologist	$94,858 - $122,227
Psychiatrist	$122,066 - $267,880

DC Health Fiscal Year 2021 Position Salaries – Behavioral Health Positions (Specific Examples)

See HC0 FY21 Schedule-A.pdf (dccouncil.us):

Position Name/Type	Salary/Salary Range (among various staff)
Lead Rapid Peer Responder	$52,080 (federal funding; 2 positions listed in FY21 as vacant)
Behavioral Health Coordinator	$110,705 (federal funding; position listed in FY21 as vacant)

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