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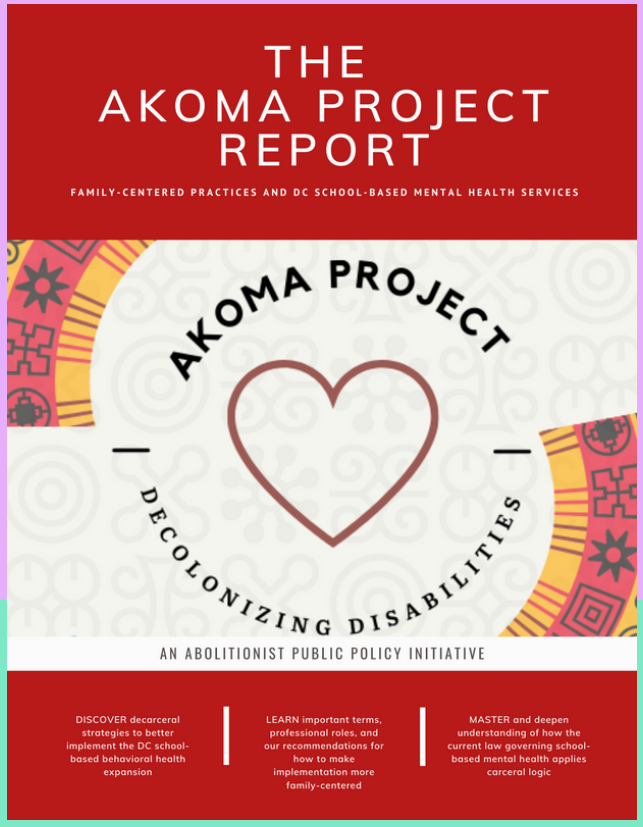

RECOMMENDATIONS TO DECOLONIZE& DECARCERATE SCHOOL MENTAL HEALTH

MAY 2023

DC Child Justice Coalition

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ACKNOWLEDGEMENTS

The Akoma Project would not be possible without our core team members, Fari Ghamina Tumpe and Renee Davis, both Native Washingtonians that are DC public school graduates, identify as Black and disabled/neurodivergent, and are family caregivers.. The backbone of our core team is Claudia Rojas, who helped keep us organized, motivated, and thinking strategically. Claudia is also an alum of DC public schools, a first-generation American, and a sibling caregiver.

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THE AKOMA PROJECT TEAM

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Chioma is the founding director of FixPat, Inc., a start up nonprofit in DC that initiated the DC Child Justice Coalition and is incubating NeuroMama cooperative. To learn more visit: fixpat.wordpress.com

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Renee is a 4th generation Washingtonian and DC public school graduate attending FW Ballou and the School Without Walls High School Programs. This legacy of having both environmental and healthcare justice and having to fight for our abilities to get educational services really guides my current volunteer work.

ABOUT THE AKOMA PROJECT

"...I'm human. I'm a mother. When one mother cries, every mother should cry because that's how I do..."
(Nardyn Jeffries said at a C-SPAN press conference on gun violence prevention on November 1, 2016)

Akoma is the indkra symbol for patience and tolerance in the Akan tradition of Ghana, West Africa. Akoma is the chosen name for this public policy research project because tolerance and patience are the human values we are attempting to uncover and nurture in efforts to reimagine public safety and appropriate interventions for disabled children, youth, and their families. The vision for this project is aspirational and, hopefully, inspirational. We align with the values of indigeneity that put people before knowledge, product, and profit, and most essentially, we aim for the process to be inclusive and welcoming. The Akoma Project purposefully blur the lines between subject and object because the core team members of the Akoma Project are also subject in the study. The objective utility of this study is to identify areas of improvement needed in the law to create safer navigation for students and families, particularly those with disabilities and intersecting marginalized identities.

Starting in October 2021, the Akoma Project core team began meeting on a monthly basis in the off times that we would meet weekly as a part of a larger cohort with the Black Future's Lab Public Policy Fellowship Program (Fellowship). The Fellowship concluded in May 2022, and the Akoma Project team continued meeting regularly to collect and analyze data until August 2022, after which we collectively debrief and plan ahead for the documentation of our findings and the need to engage elected officials in both the Executive and Legislative branches of government in Washington, DC. As this report continues to take shape, our core team along with other caregivers participating in the 2023 Caregiver Political Education Bootcamp meet regularly to revamp the recommendations based on our findings and feedback from different stages. Our goal is to host teach-ins and other decolonial pedagogies to continue to engage directly families to get their feedback on the recommendations, which will be in the final draft of the final report.

As a horizontal body of peers, the Akoma Project teaming practice is an important component of our data collection and processing efforts. During the first months of convening as a team, the function of our teaming practice was primarily in studying and understanding the content of the South Capitol Street Memorial Act of 2012 (Act). By January 2022, we had a credible understanding of not just the history of the Act, but we also got under its hood, so to speak, and developed an analysis of the content of the Act, reflecting on our experiences as family caregivers whom all three attended DC public schools as youth and engaging each other in dialogue in how we felt about different aspects of the Act with consideration that we all also have school-aged children in the home. By the end of the first month in 2022, we developed a list of seven aspects of the law we hoped to see significant improvement. These proposed changes strengthen to more directly impact the root causes of pathologies and disproportionalities, including:

#1 Expanding Community Care to involve partnerships with nontraditional family-centered organizations, violence disruptor programs, OST, culturally affirming community healers (reiki, yoga, mindfulness and meditation, etc.)

#2 Early Childhood and Transition Support from birth to 3 to pre-k to k-12 to secondary transition up to the age of 25, and other important transitions (i.e. grade level to grade level, in between schools, etc.)

#3 Improved Tiers 1 and 2 services to include evidence-based inclusion practices via the multitiered system of supports and services (MTSS)

#4 More consideration for students in more restrictive environments for Children and Youth (i.e., nonpublic, psychiatrically placed, incarcerated youth and home-based learning)

#5 Strengthening family-centered due process protections for accountability in the system navigation for the school-based behavioral health

#6 Include ABA therapy providers and other sensory-based behaviorists in the menu of providers

#7 Enhance participatory democratic opportunities for the family caregiver and youth Self-Advocate to participate in the development of the school strengthening tool and require schools to complete the form and process

We then presented these seven points to trusted advisors using a rank choice voting tool on slido.com. With more team meetings and extensive dialogue, plus input from others, we settled on one policy area of interest to explore: **#1 Expanding Community Care to involve partnerships with nontraditional family-centered, violence disruptor programs, out-of-school time (OST), culturally affirming community healers (reiki, yoga, mindfulness, and meditation, etc.).**

In February 2022, the Akoma Project Team began planning for the inaugural Caregiver Political Education Bootcamp. This project, funded by Diverse City Funds, gave us the opportunity to call together some organizations in the DC Child Justice Coalition (Coalition) which includes the Akoma Project team and other DC organizations committed to disability justice, racial justice, and reproductive justice. The Coalition would help with organizing a 7-week cohort of 10 family caregivers. We selected the 10 participants in the Caregiver Political Education Bootcamp from a pool of 25 applicants - many of whom would be the key invitees to participate in the Caregiver Political Education Bootcamp from the end of February to early April 2022. Each member of the cohort for the Bootcamp received $300 cash payments, a NeuroMama advocacy care package, which includes a Special Education 101 Manual produced in-house via Chi Bornfree, and the opportunity to engage with key system actors and advocates in the DC systems of care impacting the school-based behavioral health expansion.

Out of informal debrief sessions with the Bootcamp cohort members, the Akoma Project team presented the #1 policy area of improvement in the Act and the family caregivers offered important feedback that helped refine the policy agenda to be:

Make significant changes to the South Capitol Street Memorial Act of 2012 and strengthen existing language around systems integration of early childhood education, child welfare, court-involved youth, juvenile detention and other non-traditional school placements where the highest needs students navigate and increase access to network of community care to involve nontraditional family-centered, violence disruptor programs, out of school time (OST), culturally affirming community healers (reiki, yoga, mindfulness, and meditation, etc.).

The final step of the Akoma Project was the Caregiver Interview Night on April 12, 2022 (See Appendix VII: Images). Here's the Action plan for the event:

On Tuesday April 12, 2022, 8 student groups will be joined with DC family caregivers, who will be sharing their experiences in navigating the DC school-based behavioral health system and gauge their current level of understanding of key concepts like abolitionism, police brutality, disability justice, systems of care, and carceral systems.

SMARTIE Goal:
To host 8 group dialogue sessions on April 12, 2022, 5:30pm-7:30pm; and each group will consist of the following:

- Howard University students who will assume the roles of:
  - Notetaker(s) (someone or a few number people who keeps notes that will be used for your final reflection paper 3-5 pages)
  - Form Submission Lead(s) (someone or a few number people that will be responsible for completing the Google form and submitting it)
  - Spokesperson (someone or a few numbers of people who will be responsible for asking the questions)
  - Writer(s) (someone or a few number people responsible for writing the 3-5 pages, which could overlap with Notetaker(s))
  - ONE person selected to submit the final paper via email (Group Number must be in the title of the paper)

There were twenty-one DC family caregivers that RSVP-ed to attend the April 12th event, yet only eleven (including Akoma Project team members) DC family caregivers attended the interview night. There were eight student groups from those enrolled in the Race and Public Policy course, instructed by Chioma Oruh, principal of the Akoma Project. Each family caregiver that attended was invited to a Zoom virtual meeting room and each participant was sent to a breakout room to be interviewed by each student group. Because there were eleven family caregivers and eight student groups, three out of the eight student groups had two caregivers participate in the interview breakout group.

Each student group was provided training ahead of the April 12th event on trauma-informed motivational interviews and informed of the sensitivities of the questions they would pose to the family caregivers. Each of the eight student groups used the same interview questions imputed on a Google Form and further interrogated in their submitted written papers, which sha[illegible] analysis.

The recommendations of the Akoma Project target the South Capitol Street Memorial Act because, as Student Group 1 noted above: it is more beneficial to make use of pre-existing resources. The art and science of public policy must be informed by history and this history is not just the history of laws. The lived experiences have value beyond documentation and testimony. The Akoma Project seeks answers through the courage storytelling of the family caregivers that participated in this project, the advocates that offered insight to bring us to this point, and the Howard University undergraduate students in the Department of Political Science that offer analysis.

The truth is that higher ed is as flawed an education environment as the public school system. Engaging with Howard University students, many of whom are coming from recent public schools around the country experiences similar to those expressed in their research, offers this invaluable insight. The family caregivers, offering their lived experiences filled with equally valuable recommendations and insights, are transformative truths. No degree program alone can offer what the Akoma Project models and with this, one of the key recommendations of this report encourages DC City Council to invest in a peer workforce. The Substance Abuse and Mental Health Services Administration (SAMSHA) of the US Department of Health and Human Services notes,

Peer support workers are people who have been successful in the recovery process and help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process. (SAMSHA 2022)

The value of a peer support system is unfortunately underestimated within the vision of resolving the mental health crisis at hand. There is no static population in which peer support singularly benefits and can be offered to educators, administrators, legislators, students, caregivers, etc. And most critically, peer support offers decarceral benefits - including infringing on the problematic practice of mandated reporting required of clinical and school staff.

07

CARCERAL LOGIC

and why the South Capitol Street Memorial Act of 2012 must change.

Carceral logic references a punishment mindset or reasoning assessed according to strict principles and or beliefs about crimes, criminality, prisons, prisoners, and other institutions that also restrict human liberty with the stated intention of correcting behavior in some manner. (Strayhorn 2022, 599) Carceral logic is pervasive in government systems and is not limited to criminal justice functions. When it comes to schools, carceral logic targets multiple stakeholders - the most vulnerable being Black, Brown, poor, disabled, immigrant, and queer students and their families. The concept of the school-to-prison pipeline is the most notable aspect of how carceral logic applies within school culture and policymaking - which, in turn, speaks specifically to the interconnection between criminalizing functions in schools that involve a number of punishment-oriented functions (ex. detention, in-school, and out-of-school suspensions, truancy action steps, etc.) that model the types of treatment prisoners face within prison walls. Specific to addressing behavioral health challenges in schools, the Act was passed into law with a progressive vision to provide preventative and early intervention, yet does so without any intentionality to decarcerate or decolonize.

To be fair, the Act does not create the carceral web that historically exists within school functions. These functions are well explained as,

Carceral logic is enacted through carceral practices in schools and colleges, generally carried out by institutional agents (Runell, 2016). For instance, in broader society, it has been white, mostly male, police officers who carried out the state-sponsored assassination of the public execution of unarmed, school-aged boys like Trayvon [Martin], Mike [Brown], and Tamir [Rice], succumbing to implicitly biased and tragically flawed logics that posit difference as deficient, unfamiliar as out-of-place, toys as weapons, and dar as dangerous to the name just a few. Similarly, faulty logic of carcerality led to the emergence of school resource officers (SROs), part and parcel of a larger strategy to embed police officers in communities...

...Carceral logics, or punishment mindsets, also influence the formulation of educational policies in schools and colleges in the United States, in tacit and known ways (Himmelstein & Bruckner, 2011). For instance, 'zero tolerance disciplinary policies in schools have been formulated to address a range of behaviors some school leaders deem undesirable...Preoccupation with punishment criminalizes student behaviors, e.g. fighting, truancy, and reframes some students, especially [youth of color], as incorrigible, incompatible with schooling, and thus, in need of stiffer penalties. (Strayhorn 2022, 599-600)

The Logic of Extraction	The Logic of Captivity	The Logic of Surveillance
IN THIS WAY THE CARCERAL STATE SEES MASS INCARCERATION AS MORE THAN A MOMENT IN TIME, IT DEPENDS ON A THEORY OR A SET OF CONNECTED BELIEFS, OR LOGICS, THAT JUSTIFY TAKING BODIES AWAY FROM THEIR NATURAL SETTING OR SURROUNDING BY FORCE OR LAW INTO A RESTRICTIVE UNNATURAL, OR UNWELCOME PHYSICAL SPACE (DOLOVICH, 2011). (STRAYHORN 2022, 601)	**WHEREAS 'ZERO TOLERANCE' POLICIES MANDATE HARSH STUDENT PUNISHMENTS FOR RELATIVELY MINOR MISBEHAVIOR, E.G. LOITERING, IN SCHOOLS AND ACT AS A DIRECT MECHANISM BY WHICH MANY [VULNERABLE STUDENTS] ARE (RE)ROUTED FROM SCHOOLS TO PRISON; JAILS, PRIONS, MENTAL INSTITUTIONS, AND SCHOOL DETENTION ROOMS REFLECT THE LOGIC OF CAPTIVITY. (STRAYHORN 2022, 602)**	**WHILE CAPTIVITY OF AN EXTRACTED BEING HELD AS PROPERTY OF THE STATE... INTENTIONALLY EXPOSES THE REMOVAL OF PERSONAL PRIVACY, THE ERASURE OF PERSONAL IDENTITY, AND THE COLLATERAL CONSEQUENCES ASSOCIATED WITH THE LOGIC OF (HYPER) SURVEILLANCE. EXCESSIVE SURVEILLANCE AND POLICING OF FOREIGN ANIMALS, SINGING BIRDS, OR PEOPLE WRONGLY AND BLATANTLY JUDGED AS SUSPICIOUS, SUCH AS BLACK MALES, BY OTHERS WHO ARE DIFFERENT FROM THEM ACTS AS WEAPONS OF PUNISHMENT AND SOCIAL CONTROL (MARTENSEN, 2020). (STRAYHORN 2022, 603)**

Using these three categories to guide the Akoma Project team's study of identified five key themes in the Act that lend to carceral logic, the first area addressed in the Act mandates:

- Youth Behavioral Health Epidemiology Report

Title I, Section 103 of the Act states that By March 30, 2013, and every 5 years thereafter the Mayor shall submit a report to the Council on the behavioral health of District youth. At minimum shall include:

1. The type and prevalence of behavioral health conditions among youth broken down, if possible by age, gender, race, ward residence, and sexual orientation,
2. The level of utilization of behavioral health services by youth and the location of the services accessed, and
3. An analysis of any barriers or obstacles preventing youth from accessing behavioral health services and recommendations for making the services more accessible.

The Youth Behavioral Health Epidemiology Report is the least destructive mandate of the Act, and could potentially provide useful information to motivate a scientific approach to measuring the success of the project. Yet, depending on the mindset of the administrative functions responsible for producing the report and that of other government agencies invested in the implementation of a school-based behavioral health model, determines the degree of concern about how the logic of surveillance applies. Because its utility is not made clear in the report, it does flag some concerns.

Both federally and nationally, epidemiological data is used for policy setting and can be a positive tool for understanding unmet needs. For example, the White House issued a 2021 brief that cites the use of epidemiological data to understand the rising need for mental health services since the COVID-19 pandemic (See Bibliography). As useful as such data can be to inform important policy, for it to not be weaponized against the students and families examined by such in-depth data collection, it's important to adopt decolonial practices of requiring contractors hired to conduct such studies to do so respectfully and in partnership with the environments they study. In this, the obligation to reduce the risk of using this data as a tool of carceral surveillance, true partnership and engagement practices should be spelled out in the letter of the law and guidance should follow at the agency level that recognizes this risk.

- Early Childhood and School-based Mental Health Infrastructure

Title II, Section 203 of the Act states that by March 30, 20213, the Mayor shall submit a comprehensive plan to the Council for the expansion of early childhood and school-based behavioral health programs and services by the 2016-2017 school year. At minimum, the plan shall:

1. Establish a strategy to enhance behavioral health services in all public schools

and public charter schools, including:

1. The implementation of programs that:

(i) Include interventions for families of students with behavioral health

needs:

(ii) Reduce aggressive and impulsive behavior; and (iii) promote social and emotional competency in students...

1. Include an analysis of whether current health education standards align with actual behavioral health needs of youth and any recommendations for proposed changes; and
2. Provide recommendations for the expansion of behavioral health programs and services at child development services.

The Comprehensive Plan mandated in the Act was completed in October 2017 (see Bibliography). The mandates of the Comprehensive Plan required the Mayor to produce this document to guide the integration of early childhood in the implementation of expanding school-based behavioral health services. The Executive Summary of Comprehensive Plan notes,

The vision of this system change is to provide a comprehensive approach to prevention, screening, and matching resources to student needs, making the most of the District's rich investments in school-based behavioral health services and robust behavioral health services in the community. Despite the current investment of nearly $50 million overall in school-based health, there is not currently a strategy to provide prevention and screening services in 100% of the schools or ensure that all students who have behavioral health needs are connected to the appropriate services. Similarly, there is not currently the capacity for 100% Child Development Centers to have access to individualized early childhood mental health consultation. (DC Department of Behavioral Health 2017)

In 2022, this vision remains at a far distance and with the advent of the current workforce crisis impacting all levels and areas of care in both healthcare and education. The current applied carceral logic of captivity is the unnamed and unaddressed barrier to successfully expanding care opportunities in the widespread manner as is the vision of the law. Universal screening is at will and choice of the families. Consent to receive treatment also lends to authority of the families to allow for service delivery to happen. And the most nurtured space of parent power is in early childhood education, which for many integrated in school and clinical services find this level of authority by families illegitimate, so the low prioritization of providing school-based behavioral services centers the needs of their empowered from the start of the education journey.

- Truancy Intervention

Title III, Section 302 of the Act provides for compulsory school attendance, for the taking of a school census in the District of Columbia, and for other purposes, approved February 4, 1925…is amended to read as follows:
'(3A) 'School-based student support team' means a team formed to support the
individual student by developing and implementing action plans and strategies
that are school-based or community-based, depending on the availability, to enhance the student's success with services, incentives, intervention strategies, and consequences for dealing with absenteeism.'…
…(j) By August 1, 2012, the Mayor shall develop, through rulemaking, appropriate
enforcement mechanisms to ensure that each school, principal, and teacher is in full
compliance with the requirements of this act and any regulations issued pursuant to this act…

…(19) By October 1, 2013, create a truancy prevention resource guide for parents and legal guardians who have children who attend a District public school, which shall be updated and made available upon request, at minimum, include:

1. An explanation of the District's law and regulations related to absenteeism and truancy;
2. Information on: (i) What a parent or legal guardian can do to prevent truancy; (ii) The common causes of truancy; and (iii) Common consequences of truancy;
3. A comprehensive list of resources that are available to a parent or legal guardian, and the student, that address the common causes of truancy and the prevention of it such as (i) Hotlines that provide assistance to parents, and legal guardians, (ii) Counseling for parents (or legal guardian) of the youth, or (iii) Parenting classes, (iv) Parent-support groups, (v) family psycho-education programs, (vi) Parent resource libraries, (vii) Risk prevention education, (viii) Neighborhood family support organizations and collaboratives that provide assistance to families experiencing hardship; (ix) Behavioral health resources and programs in schools, (x) the Behavioral Health Ombudsman Program, and (xi) The resources at each public school at-risk students and their parents or legal guardians.

…(a) Students ages five (5) through thirteen (13) shall be referred by the LEA to the Child and Family Services Agency no longer than two (2) school days after the accrual of ten (1) unexcused absences within one (1) school year and/or completion of the procedures specified in section 2013.3 of this chapter, or immediately at any time that educational neglect is suspected;

(b) Until the 2014-2015 school year, students aged fourteen (14) and over shall be referred by the LEA to the Court Social Services Division of the Superior Court of the District of Columbia and to the Office of the Attorney General Juvenile Section no later than two (2) school year. Beginning with the 2014-2015 school year, such a referral shall be made after the accrual of twenty (20) or more unexcused absences.

Truancy processes, which in its most critical stage rallies the courts as the primary source for interventions, and triggers all three levels of carceral logic - extraction, captivity, and surveillance. Narratives and analyses of the school-to-prison pipeline provide extensive analysis of the problems with truancy laws and their punitive nature of them. The Act seems to expand the reach of court services and does so first by creating a line of defense in schools in the form of student support teams that tend to not include the input and partnership of family caregivers and youth self-advocates. And even in the mandate to provide a family resource guide on truancy (see Bibliography), there are other calls for family resource guides throughout the Act, which are not easily accessible to the most vulnerable families - and with the prevalence of low literacy amongst immigrant, disabled, and poor people, the call for these resource guides rarely address the need for adapted tools and services to ensure that these documents (however well or poorly these resource guides are constructed) are also not accessible to those that need them the most.

Investing in transition support and services is a missing ingredient in Catania's analysis, which could help to decarcerate and decolonize the Act. While well-intended, Catania's Act reinforces carceral processes by arming notable agencies such as the Department of Youth Rehabilitation Services (juvenile justice system) and the Children and Family Services Agency (child welfare system) as key point bureaus to address chronic absenteeism and school push out. Transition services reinforce early intervention strategies that dissuade and reduce interaction with the child welfare and juvenile justice systems in the first place.

- Department of Mental Health Behavioral Health Infrastructure

Title IV Section 402 defines (1) Behavioral health as a person's overall social, emotional, and psychological well-being and development., (1A) Behavioral health assessment means a more thorough and comprehensive examination by a mental health professional of the behavioral health issues and needs identified during an initial behavioral health screening by which the mental health professional shall identify the types and extent of the behavioral health program and make recommendations for treatment plan...

...(By March 30, 2013, the [Department of Behavioral Health] shall:

Create a behavioral health resource guide for parents and legal guardians [which is articulated several times in this section of the Act]

The carcerality within the stated behavioral health infrastructure within the DC Department of Behavioral Health (formerly the DC Department of Mental Health) is harder to uncover than in law enforcement agencies, or even in schools. The deinstitutionalization movement in the 1950s, 1960s, and 1970s led to the passage of special education laws because prior to the 1970s, young people with unmet behavioral needs were actively excluded from the education system and were rather wardens that utilize the carceral logic of extraction and the logic of captivity. This happened all over the country, and in DC the premiere institutions that housed children, youth, and those transitioning to adulthood were Forrest Haven and Saint Elizabeth's. These institutions are born out of the clinical model primarily staffed with some of the higher education disciplines that continue to inform behavioral health services in governments - DC is no exception.

The almost exclusive vision of activating a clinical workforce as the implementers of the expansion of school-based behavioral health services lend to this rigid understanding of who is the best fit to deliver services in the expansion of school-based behavioral health. The role that higher education plays in reinforcing the current paradigm of service delivery in an unstable, underqualified (in the real world), and undermotivated dwindling workforce of clinical and licensed social workers, psychologists, and other behavioral health therapists, should not be underscored. It is through institutions of higher education that many key actors in the implementation of school-based behavioral health learn and utilize the carceral logic of surveillance, the logic of extraction, and the logic of captivity to set deliverables for services. Well-meaning people that seek employment as clinical workers in both sectors as employed within the DC DBH or via grant-eligible community-based organizations are incentivized to provide crisis care more than prevention and early intervention services, which has a direct impact on the degrees of carceral reinforcement that can and does happen with individual school communities.

Besides the threats for reinforcing carceral logic, the crisis facing the DC DBH and other relevant health sector-impacted agencies specifically is that the workforce model is unsustainable.

- **Child Welfare and Juvenile Justice Infrastructure**

Title V Section 502 calls for the Mayor shall create a comprehensive resource guide for families who come in contact with the child welfare or juvenile justice systems by October 1, 2013. The guide shall include:

1. A clear explanation of the rights and responsibilities of children and families;
2. The role of District agencies, including the:
    a. Child and Family Services Agency
    b. Department of Youth Rehabilitation Services
    c. Department of Mental Health
    d. Department of Health Care Finance
3. The role of the courts;
4. District government and non-governmental resources related to behavioral health, including contact information
5. Websites for District government agencies and nongovernmental resources related to behavioral health.

The resource guide shall be:

1. Made publicly available on the Internet
2. Updated as necessary, along with updates of the information described...
3. Made available to other District agencies (DC City Council 2012)

The family policing system is synonymous with the child welfare system because the functions of this government sector is the central nerve of the carceral logic of surveillance,the logic of captivity, and the logic of extraction well examined by abolitionist lawyers and social workers that understand the deep harms of this agency's historic practices - particularly for Black and Brown poor and disabled families.

Section 503 of Title V of the Act calls for the Mayor to submit a report to the DC Council by March 30th of each year for the number of youth committed to the DC Department of Youth Rehabilitation Services (DYRS), also noting they should receive behavioral health screening, assessments, and referrals for appropriate services. Catania's rationale for enlisting DYRS and the DC child welfare agency, Child and Family Services Agency (CFSA) is explained in the 2012 op-ed, which states,

> The reforms require that children in the Department of Youth Rehabilitation Services and Child and Family Services Agency systems receive a comprehensive behavioral health screening within 30 days of their initial contact with those agencies. Within the Department of [Behavioral] Health, the act calls for the implementation of a program to inform teachers, principals, and staff at child development facilities of common signals exhibited by youth with unmet behavioral health needs. (HuffPost)

Throughout the Act, it reinforces not only DYRS yet also the child welfare system and the court systems. While the Act also prescribes resources to be publicly available to families to support greater access to behavioral health services, it is unclear if any of these documents are actually being provided to families in accessible ways. To this end, the Act not only does not challenge the carcerality of the agencies employed as key actors in the Act, it reinforces their dangerous utility for the historically traumatized families that seek to benefit the most from well and working mental health services and behavioral health systems.

INSIGHT FROM FAMILY CAREGIVERS

Our sample size was relatively small, yet we were able to probe deeply with the caregivers that joined for the Caregiver Night. There were 11 caregivers that interacted with 8 Howard University student groups. Due to the uneven distribution of caregivers, some student groups interviewed multiple people while others engaged with only one person. Each group was asked the same set of questions and the responses were coded.

The majority of the interviewees are the biological parents of the student experiences referenced in their interview and 44% of the respondents currently have a school-aged child in the home. Also, 44% of the family caregiver respondents self-identified as having a disability and 77% of them noted that the student referenced has either 504s or IEPs, with the same percentage of students referenced noted to have received mental health services - 75% of which reported to have received these services at school. With a 50% satisfaction rate with the school services encountered by the family caregiver, 22% percent of the students referenced are said to have had police interactions.

Removing personal identifiers, all interviewees are referenced in some variation of being a family caregiver respondent and more detailed information is offered in Appendix V of this report. In some cases, the family caregiver is assigned a general XX, which replaces any name reference in the coding of the data. The accounts offered by the family caregiver respondents are documented and, in some cases, analysed, by the student group interviewees - which are numbered from 1 to 8.

CAREGIVER INTERVIEWEE CONCERNS ABOUT RECEIVING SCHOOL MENTAL HEALTH SERVICES

The caregiver mentioned that they wished that there were methods of testing for mental illnesses earlier on in childhood available in order to better monitor the mental health of students today...

...They expressed that while there are mental health resources available within the district, they were often inaccessible to her family specifically. Most of the hours for these places included weekdays during school hours as well as working hours for her. They felt like the resources were not meant for working-class families because they would never have the opportunity to take off work or miss school to make such appointments.

CAREGIVER INTERVIEWEE CONCERNS ABOUT RACE AND ACCESS TO SCHOOL MENTAL HEALTH SERVICES

The caregiver believes race is a factor in how her sons were treated as they stated there was only “one way” for the black kids within the current system. This way is to either prescribe high doses of medication or pass them through school even if they have failing grades. They were told there would be training programs for their sons upon their graduation from high school, however, once they graduated, they were forgotten by the system.

NEGATIVE EXPERIENCES ACCESSING MENTAL HEALTH SERVICES

XX has been a fierce advocate for their daughter since she entered the D.C. Public When thinking about education and health policies, we shared similar ideas as to the urgency and importance of ensuring that policies regarding education and health are at the forefront of government attention. These policies are often neglected and leave wonderful people such as XX at a disadvantage. Specifically looking at education in this country, and taking an even closer look at education within the Black and Brown communities, there is absolutely a “school to prison pipeline”. Without policies in place to ensure that our children grow into well-educated adults, they will fall asunder.

It is also more beneficial to make use of pre-existing resources rather than outsourcing healthcare professionals, because children should have the opportunity to be cared for by trustworthy people from within their own communities.

CONCERNS ABOUT RACE AND ACCESS TO SCHOOL MENTAL HEALTH SERVICES

Student Group 2 interviewed a caregiver who believes race is a factor in how her sons were treated and emphasized there was only ‘one way’ for the black children in the education system: prescribe high doses of medication or pass them through school even if they have failing grades. The caregiver, whose children are now adults, was told there would be training programs post high school yet when they transitioned out of the school system, they had no prospects in the future available to the family.

CONCERNS ABOUT SCHOOL CULTURE

Student Group 4 interviewed a caregiver that noted that children can be gifted and also require special education services. Due to the misconceptions around the gifted education program, disabled students are easily overlooked and often treated as less capable than their able-bodied and able-minded peers.

AKOMA PROJECT RECOMMENDATIONS

01. TRANSITION SUPPORT

We propose that **transition supports** should be included in the letter of the law, requiring the mandated **Comprehensive Plan** to include family-centered activities as deliverables at the state level and reinforced at school-level practices reflected in the Work Plans submitted by Behavioral Health Coordinators employed at every school and child development center.

Transition support means strengthening access to a range of wellness services available to students and families throughout the education lifespan (i.e. transition in and out of public school, grade level to grade level, in between schools) and inclusive of community care providers beyond clinical support and in consideration of different disability category mental health needs.

02. THE ROLE OF THE BEHAVIORAL HEALTH COORDINATOR

We propose that the role of the **Behavioral Health Coordinator** not be limited to clinical staff, and believe that highly skilled peer supporters should be employed to lead the process of developing the Work Plan via identifying the community-based organizations from a menu provided by the **Office of the State Superintendent of Education and DC Department of Behavioral Health.**

The Behavioral Health Coordinator should be required to participate in and develop decarceral training modules to be provided to through the DC Community of Practice; make deliverables on the Work Plan, and offered to all members of the school-level Behavioral Health team.

03. THE EPIDEMIOLOGY REPORT

We propose that **the epidemiology report required every 5 years in the Act** be the responsibility of the interdisciplinary Coordinating Council to approve its contents, similar to how the Task Force report submitted in 2018 was approved by its members. We also prescribe that **the Coordinating Council be a Council-confirmed body** and its seating and term requirements be included in amendments to the South Capitol Street Memorial Act.

04. PLACEMENT & SCHOOL ENVIRONMENT

We propose that the **unmet needs of students in nontraditional settings such as child development centers, nonpublic schools, juvenile detention, and those in psychiatric placements** be accounted for in the monitoring of access to service delivery of school-based behavioral health services. And that **the workforce in these nontraditional settings also reflects peer workers and not just clinical staff.**

EARLY CHILDHOOD 05.

We propose that an amendment to the Act is needed to guide more concerted efforts to include child development centers via greater investments in the **Healthy Futures Program** and this progress be monitored officially by a Council-confirmed Coordinating Council.

The Healthy Futures Program, also known as the Parent Infant Early Childhood Enhancement Program is the DC Department on Behavioral Health's early childhood program & serves primarily children five years of age and younger. The program involves play and art therapy, infant observation, and Parent Child Interaction Therapies, and supports parenting groups.

DISRUPTING FAMILY POLICING SYSTEM FUNCTIONS 06.

We propose that the Act exclude any mention of strengthening the functions of **child welfare, truancy courts, or juvenile detention**. We further propose that significant budget allocations from these agencies to prepare and manage any family resource material be transferred to the DC Department of Behavioral Health, who should use the additional funding to hire a peer support workforce employed to build a central school-based behavioral health family resource center.

Carceral logic is pervasive in government systems, and is not limited to criminal justice functions. When it comes to schools, carceral logic targets multiple stakeholders - the most vulnerable being Black, Brown, poor, disabled, immigrant, and queer students and their families.

FAMILY-CENTERED ORGANIZATIONAL PARTNERSHIPS 07.

We propose that the central school-based behavioral health family resource center work in partnership with **family-run and family facing organizations to provide technical assistance to the school level Behavioral Health coordinators** and actively participate in the DC Community of Practice to strengthen the shared learning community for open to all practitioners for school wellness, not just the clinical staff.

WORKING PARTICIPATORY DEMOCRATIC PRACTICES 08.

We propose that **the council-confirmed Coordinating Council work collaboratively with the school-appointed or elected Behavioral Health team to partner on implementation practices and discover funding models that support the implementation of culturally affirming community healers (reiki, yoga, mindfulness, and meditation, etc.)** as part of the menu of offerings by grant-funded organizations eligible to provide school-based mental health services.

SCHOOL OPT OUT PROCESS 09.

We propose that the Act be amended to offer guidance to a school-community consensus model to support school leaders who may consider opting out of participating in the expansion of school mental health services. The Act requires that all DC public and public charter schools, and clarification in the law should prescribe an opt-out process that requires input from members of an established behavioral health team at each school.

DISRUPTING FAMILY POLICING SYSTEM FUNCTIONS 10.

We propose that the Act offer state guidance as to how to actively integrate students in special education programs that receive behavioral health services in their individualized education programs (IEP). We further propose that the Act specifically requires that no schools participating in the school-based behavioral health service delivery system should be allowed to not include students in self-contained environments and other environments that IEP are implemented in the MTSS, which should be requirements of developing annual Work Plans by the employed Behavioral Health Coordinators.

CREATING A MORE INCLUSIVE SCHOOL BASED MENTAL HEALTH SYSTEM 11.

We propose that the Act offer state guidance as to how to **actively integrate students in special education programs that receive behavioral health services in their individualized education programs (IEP)**. We further propose that the Act specifically requires that no schools participating in the school-based behavioral health service delivery system should be allowed to exclude students in self-contained environments and other environments that IEP are implemented in the MTSS, which should be requirements of developing annual Work Plans by the employed Behavioral Health Coordinators.

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