CYBHWG School-based Behavioral Health and Suicide Prevention (SBBHSP) subgroup

Date: July 17, 2024
Time: 3:00 – 5:00 PM

Leads: Representative My-Linh Thai (41st Legislative District)
Christian Stark, OSPI

Professional Members					
☒	Devyna Aguon Renton School District	☒	Sinuon Hem Asia Pacific Cultural Center	☐	Daniel Smith Community Health Plan of WA
☒	Alice Amaya Pasco School District	☐	Megan Howard OESD 114	☐	Joseph Soliz Granger School District
☒	Gina Cabiddu Kids Mental Health WA	☒	Delaney Knotterus King County	☐	Chetan Soni WA Youth Alliance
☒	Phyllis M. Cavens, MD Child & Adolescent Clinic	☐	Joe Neigel Monroe School District	☒	Michelle Sorensen Richland School District
☒	David Crump Spokane Public Schools	☒	Jill Patnode Kaiser Permanente	☐	Tabby Stokes Vancouver Public Schools
☒	Jodie DesBiens NWESD 189	☐	Elise Petosa WA Association of School Social Workers	☐	Nigar Suleman WA State PTA
☐	Jeanne Dodd Burlington School District	☒	Megan Reibel & Rafaela Steen UW Forefront Suicide Prevention	☐	Mabel Thackeray North Thurston Public Schools
☒	Erin Drury WA School-based Health Alliance	☒	Nolita Reynolds Catholic Community Services	☒	Brook Vejo Carelon Behavioral Health
☐	Brooke Fox Frank Wagner Elementary School	☐	Renee Schoening Whitworth University	☐	
☐	Britnee Harvey Shine Light on Depression	☐	Rayann Silva UW SMART Center	☐	

Youth Members					
☐	Eliasib Alvarado	☐	Zoe (Crow) Barnett	☐	Rowan Guerrero
☒	Taanvi Arekapudi	☐	Payton Frank	☒	Pradyu Kandala
☒	Hanna Baker	☒	Kei Gregson (Lead)	☐	

Parent/Guardian/Family Members					
☒	Valerie Denney	☐	Arnie Martinez	☒	Byron Smith
☒	Shawnda Hicks (Lead)	☐	Yahaira Nava	☐	Marcella Taylor
☐	Richelle Madigan	☐	Danielle Ouellette	☐	

Meeting notes

Youth & Family Lead Introductions

Kei Gregson — Youth Lead
Shawnda Hicks — Family Lead

Bloom Works K–12 Discovery Sprint Overview:
Presented by Angel Zhou

Examining 4 topics over 20 weeks

Sprint 1: K-12
How might we better connect middle and high school students with Tier 2 behavioral health services through school?

Sprint 2: Behavioral Health During pregnancy
How might we better connect pregnant people who have behavioral health needs to services during their pregnancy?

Sprint 3: Complex Hospital Discharge
How might we improve supports for reintegration of youth with complex needs in preparation for a behavioral health-related hospital discharge?

Sprint 4: Transition Age Youth
How might we better help transition age youth with BH needs more successfully access services and supports that meet their needs?

Key Objectives:

Understand the current state of systems and services, which could include:

- Challenges that exist
- Areas of opportunity
- Connectedness of systems and impact across stages

Provide actionable recommendations for a path forward, which could include:

- Short- and long-term goals
- Proposed policy
- A plan for incremental service improvements
- Suggested feedback loops needed to measure the effectiveness of proposed changes

We will use co-design methodology to achieve what we can accomplish in the 10-week timeframes.

Insights and recommendations might include:

Insights about challenges and successes accessing BH services

- Stories and first-hand perspectives from people with lived experience
- Challenges and opportunities from districts and school perspectives (principals, school counselors, teacher, clinicians, etc.)

Potential types of recommendations

- Tactical opportunities to streamline processes, guidance or technology
- Piloting or expanding successful services and supports
- Larger scale insights and opportunities for the system (example: resource needs, experiments, policy)

Scoping phase:

Broad starter question: How might we help schools more successfully connect students with behavioral health services through school?

Spoke with 20 stakeholders and experts to scope the discovery sprint.

Challenges identified in scoping:

- Tier 2 in Multi-Tiered System of Supports
- Funding
- Variation in delivery of services
- Need for common language and training
- Logistics
- Stigma

How students get identified and connected to services

- Identify a potential behavioral health need
- Determine what behavioral health support might be needed
- Connects student with behavioral health support

Narrowed into Tier 2 and middle and high school. Behavioral health needs exist in all grades, but Tier 2 is more prevalent in middle and high school.

Target Perspectives

- Students
- Families and caretakers (of the students)
- Faculty in schools who support this process:
    - School counselors and nurses
    - Teachers
    - Administrators
    - Mental Health Counselors
- District and Educational Service District and School District behavioral health roles
- Additional perspectives: Student Assistance Professionals, providers, etc.

Target Demographics

- Communities of color
- LGBTQ2SIA+
- Rural
- Non-native English speakers
- Various academic proxies for behavioral health:
    - Students affected by opportunity gap
    - Students with lower graduation rates, attendance rates and retention rates
- Geographical location within the state

Interviews completed:

- 5 ESDs
- 11 Districts
- 5 Principals
- 2 School/MH counselors
- 3 Student Assistant Professionals
- 1 BH provider

Sharing early insights:

- Factors that influence delivery of BH
    - Non-clinical needs (Tiers 1–2)
    - Non-Clinical Supports & Interventions
    - Physical, Social & Emotional Support Staff in Schools
- Staff Training & Resources for Families
- Clinical Needs (Tiers 2–3)

  - Access to Clinicians in Schools
  - Community Provider Capacity
- 5 minutes for questions

Factors that Influence Delivery of Behavioral Health Supports

- Top-down support/expertise at the district and school level
- Maturity and consistency of MTSS per district/school
- Scale of districts/schools
- Elementary vs. secondary — they treat these topics differently
- ESD/district behavioral health supports — how they do/do not provide supports and the ease with which they provide them.
- Master schedules accommodating behavioral health supports — have heard from a number of perspectives. The biggest challenge is making them happen during the school day.
- Sustainable funding — pulling from multiple grant strings
- Provider availability/geographic access — access challenges are stark for the most remote districts, especially clinician access in schools.

Non-clinical supports

- Thinking about effectively working with students, maturity of MTSS is crucial factor
  - Training, professional development, coaching – a lot are using school counseling team for these supports
- Schools moving to leverage small group intervention
- Accountability – what is required and/or evaluated is what is worked on
- Focus on wellness, not just behavioral health, making connections between physical well-being and mental well-being
- Staff training & resources for families — family wellness is student wellness
- Physical, Social and Emotional Support staff in schools
- "All comes down to MTSS"
- Districts trying to leverage the roles, expertise and touch points they have in the school (school counselors, nurses, teachers, etc.)
- What it takes for these roles to be successful in supporting behavioral health
  - Training
  - Accountability: what is required, evaluated, etc.
  - Many effective tools for screening and Tier 2: check and connect, Trails to Wellness, Character Strong

Clinical Support: Community Provider Capacity

- Strengths/Benefits
  - Community partners can help support schools lacking in resources or personnel and help better provide for students
  - When the whole community is invested in supporting BH of students and families, we see better results.
  - Having interns available to provide support in schools has been extremely helpful for those who have access to them.
- Challenges/Barriers
  - Transportation for students to and from community providers is a huge barrier.
  - Logistics of telehealth is a barrier (quiet/private space, internet access, etc.).
  - Hard to connect non-English speaking families to services.
  - Many students don't qualify for private insurance and thus can't be seen by community providers.
  - A lot of community providers are also overrun (especially in rural areas), which means students are still left without care.
  - It is difficult to vet community providers and they often aren't focused on Tier 2.

Clinical Supports: Access to Clinicians in Schools

- Strengths/Benefits
  - Certified providers with training that meets the needs of students in schools
  - Having clinicians on-site mitigates transportation/logistics challenges
  - Helps support schools that have a lack of community providers (rural areas)
- Challenges/Barriers
  - Large caseload result in stressed-out providers and students with unmet needs.
  - Requires a clear referral system to ensure caseload is appropriate and manageable.

Questions/Discussion:

- MTSS is just a framework. It's how people implement that is actionable. When doing research, what did that mean to you?
  - We understand that MTSS is widely varied in interpretation. When we start these conversations regarding approach, we tell them if they don't have specific systems in place, it's harder to do this work with fidelity. We're hearing folks want to talk about stages for earlier interventions. Tier 1 would get all support, Tier 2 would get some support, Tier 3 is greater support. We are more interested in the process than the tier.
- The tier definitions are critical and why Tier 2 access is being emphasized is problematic. Needs assessments and cognitive assessments are a large caseload for professionals. We have higher levels of services that aren't included.
- School-based health centers: were they involved in definition of solutions?
- Waiting to talk to people with a range of approaches. Some are school-based, and some districts have mental health providers coming in from outside.
- Why did you look specifically at tier 2 access instead of any higher tier support needed?
  - There was an interest in looking at connecting students to services, our sense is that that's beyond Tier 1. When we spoke with folks during scoping, there was a sense that while there are significant needs around Tier 3, there were more unknowns around Tier 2 and it was a level of support that schools were struggling with.
  - Yet Tier 3 is difficult to access. And Tier 2 might include WISe at one school, but might not in another... and children with private insurance don't qualify for WISe.
- How do schools address kids with fire setting, school refusal, 504 plans, vandalism, but aren't "qualified" for the severe emotional disability category... and they don't in fact offer services in that area.

For more information:

Email: bloom-wa-k12@bloomworks.digital
a.zhou@bloomworks.digital

Comment Form: https://tinyurl.com/WABH-discovery

Workforce Workshop Focus Areas Breakout Session 1

Breakout Prompts:

- *Does the information characterize the problem? If not, what's missing?*
- *How would we judge a successful intervention to address the problem?*

Access to Clinical Supports (Tier 3)

Issue: There is a lack of staff who can provide clinical supports (Tier 3) in the school setting.

- No dedicated state funding for behavioral health services & lack of state funding to school districts for staffing behavioral health
  - Most districts must use grants and/or local tax revenue to fund staff & services
- School Medicaid billing options do not support sustained funding for licensed staff.
- In current Severe Discrepancy Model for SPED identification, school psychologists spend most of their time in the 'psychometrician role' focused on evaluations for IEPs, instead of broader supports across the BH continuum in a Multi-Tiered Systems of Support model.

- There is no ESA Certification for DOH LMHCs, LMFTs, or LCSWs (unless they also get a SSW cert)
- When districts do have funding:
    - Inadequate candidate pipeline – lack of candidates interested in positions
    - Often no other licensed staff available to provide clinical supervision for candidates working toward licensure

Does the information characterize the problem? If not, what's missing?

- This is just in schools, not community partners. (School based centers are my lens). Does all of this need to go to public schools or is this partnerships and money can come from other areas as well?
- It does capture a lot of what we're experiencing. If we are going to contract with a community health provider, if our school based center doesn't have enough, often we have to contract with the provider to be able to have those services come into our school. Want consistency, not just interns. Continuity is important and has been a struggle. Interns leave after a certain point of time and kids need ongoing support.
- Agree with a lot of what's written. Might be unique to Pasco SD, districts are not typically licensed organizations for providing clinical services to students. We lean heavily on community partners. We want people to come into the building. Our district as an organization is not a licensed provider of clinical services.
- Grants come up, there's a lot of expectations for what feels like not a lot of money compared to other services out there. Can there be more direct funding rather than grants? There's a push to license schools as BHAs, I do wonder what happens after hours. Can we get funds without tons of administrative overhead. Also BH needs don't stop after the school day.
- We have three different programs schools can receive Medicaid dollars through. We did receive CMS school-based services federal grant. We're going to be doing a lot of work over the next year. Want to decrease the administrative burden, want to license school counselors/psychologists to bill Medicaid.

Non-Clinical Supports & Interventions

<u>Issue:</u> Schools (and teaching staff specifically) need staff support for behavior management, 1:1 connection with students, and other tier 2 supports.

- There are not enough staff in schools to prioritize these non-clinical supports for students.
    - There are few behavioral health Student Assistance Professionals embedded in school buildings.
- High turnover/inconsistent funding for staffing paraeducators, family engagement coordinators, Student Assistant Professionals, Behavioral Interventionalists, community-based non-licensed staff, etc.
- Teachers do not have enough support and communication between families and school staff is too often negatively coded.

Share Out:

- It takes too long to get support i.e. 504, IEP
- Parent education—thinking along the lines that kids are the problem
- Need to flesh out what does Tier 2 mean?
- When a student is reacting or acting out in class and the teacher responds to the student and the student goes home and tells parent, the teacher is required to go into a meeting with parent/admin.
- Teacher Prep programs don't include training on "customer service" skills.
- "Negatively coded" is a statement that is confusing depending upon who is reading it.
- Peer support workers in schools is really important and addresses the issue. How can we help schools be more welcoming to this type of support?

Care Coordination

<u>Issue:</u> School staff do not have the time and capacity to connect students with existing community care options (inadequate and/or unrealized referral pathways).

- Lack of formalized care coordination between primary care (community health worker role) and schools
- School and health care providers 'speak different languages' making coordination difficult.

- The no-show rate for intensive services (outside of a school setting) is 40%, resulting in a lot of unused clinical time.

Share Out:

- The workforce health shortage makes it difficult for students to be seen. Some students need to be in a clinical setting.
- When you're doing care coordination is meetings and billing. Conversations RE HIPAA and FRPPA and how it can be working with the young person and their parents.
- Different levels of services, needs have a disconnect on the communication and partnership piece.
- The employment gap/shortage is having a huge impact. Can't fulfill referrals due to capacity.
- Challenge of funding coordination of services in the appropriate locations. That partnership has to come from both sides.
- Teachers can feel attacked by parents when they try to discipline a child.
- HIPAA and confidentiality is part of the problem... parents of struggling children get the message that it is shameful to talk about. Families need support instead of isolation. Special education PTAs can provide some of that, but what about parents who are in recovery or who have had their children removed by CPS? Lots of times we have to seek help outside of our community instead of in the school community where all of the parents connect.

Workforce Workshop Focus Areas Breakout Session 2

Breakout Prompts:

- *Does the information characterize the problem? If no, what's missing?*
- *How would we judge a successful intervention to address the problem?*

Community Provider Capacity

Issue: Community provider capacity is inadequate for fulfilling student referrals.

- Many districts across the state are in health care and resource deserts, especially those in rural communities. Can't make referrals to community services when there are none.
- Workforce shortages mean that community providers have no one pool to hire from.
- Schools can pay providers better than community agencies can, assuming there are candidates available for either sector to hire.
- Especially in rural areas, there is a high turnover in mental health providers. In-patient facilities have closed for state medical and youth and are only available for those with private insurance. Many of the available services are very costly, and there are not enough accessible service options that work for families enrolled in Medicaid or without insurance at all.
- Many community providers are at capacity and/or have long waitlists for services.

Share Out:

- Concurrence is that it is a true struggle. Some baseline services may not even be available.
- We won't get better until we have a team approach. Mental health workers, providers and professionals teaming together. Outside of WYSE there are no peers for other areas.
- Salaries and cost of housing are a barrier.
- What can be done to lower the barriers?
- Some of the impacts on school employees: There's been a lot of staff shuffling, many staff shortages.
- If we could bring in peer workers to the schools, such as parents, it's a great opportunity to lean into that. We have a great statewide student network. They can help ease the load.

Prevention Supports

Issue: There is a lack of staff who can provide clinical supports (Tier 3) in the school setting.

- Lack of dedicated state funding for prevention activities in schools.
- Prevention (tier 1) supports are very vulnerable to budget cuts.
- Gap in building leadership buy-in on the benefits of these programs.

    - Prevention supports show impacts when there is sustained investment in them and sustained focus prioritization of them by district leadership.
- Inconsistent availability of Social Emotional Learning (SEL) and mental health literacy instruction for students in WA schools.
    - Schools are not required to provide SEL or MHL instruction to students.
    - Health classes are not the most effective intervention for prevention topics and the health curriculums that are taught in many schools are outdated & sometimes harmful.
    - Goals for prevention efforts in schools are often not well defined.
- Not enough staff and/or staff capacity to focus on prevention consistently and comprehensively.
- Paraeducator and counselor shortage is a barrier for schools working to identify and validly assess SEL levels as well as physical development in schools.

Share Out:

- Short convo RE the list that was provided was pretty comprehensive.
- Peer support and SEL were mentioned.
- Supports and resources for training are needed, as is a curriculum.
- SEL is getting politicized, making discussion difficult. OSPI needs more authority to hold the schools accountable.

PSES Staff – Funding + Workforce Pipeline

Issue: There is not enough Physical, Social, and Emotional Support (PSES) employed in WA schools. Statewide staffing ratios for counselors, social workers, psychologists, and nurses are all under nationwide recommended ratios, and ratios for school social workers and school psychologists are far below nationally recommended ratios.

- Despite funding increases from HB 1664 (2022) phasing in over a three-year period (SY '22-23 through '24-25), the state's prototypical funding formula does not fund PSES staff at level required for nationally recommended ratios.
- High reliance on levy funding and other non-state funding sources (i.e. local funding, grants, etc.) to supplement state allocations to fund PSES staff positions.
- There is no funding floor in the state funding formula for PSES staff – many districts have less students than the prototypical funding formula presumes.
    - 118 LEAs out of the 325 LEAs in the state had a student population lower than lower than 400 students in the '20-21 school year.
- Many districts don't have enough funding to hire PSES staff, even if they have candidates available in the community and want to hire specific PSES staff types.

Share out:

- Would like to see added to description:
    - How far are we from the nationally recommended ratios? How does this vary across districts of different sizes and regionally?
    - Clarity around rural schools?
    - Which schools have less than the # of students that the prototypical formula is based on (elementary – 400; middle – 432; high – 600)
- Big topic: With more information we will be better able to evaluate progress.
- Internships in collaboration with school districts to better educate providers to be prepared in the school system. The language is not the same and can affect capacity.
- Supporting the education of already educated people to work with the school system
- Clarification of where funds are going, especially with staff and in-school training. There are groups that are being trained but are unable to get placed in schools. We need to connect people and the need.

Workforce Workshop Focus Areas Breakout Session 3 (Deferred)

Breakout Prompts:

- *Does the information characterize the problem? If not, what's missing?*
- *How would we judge a successful intervention to address the problem?*

PSES Staff – Role Definition

Issue: School leaders don't understand all the things the different ESA roles can do to serve students in the school setting.

- Districts may choose not to hire a specific ESA role even if state allocation provides enough funding an FTE if district administration don't understand the value of that ESA role.
- There is a lack of knowledge about what **social workers** can do in the school setting, especially in support student mental health.
- Lack of clarity on the role of **school counselors**. Most think they should be only academic. And there is tension there.
    - ASCA model puts a lot of demands on what school counselors should do- and then each district interprets that differently.
    - Some are pushing focus on ONLY career/college readiness and advocating for dropping social emotional learning
    - For school counselors, I hear a lot about "liability" and there's fear there when it comes to screening and meeting with students outside their scope of practice.
- In current Severe Discrepancy Model for SPED identification, **school psychologists** spend a majority of their time in the 'psychometrician role' focused on evaluations for IEPs, instead of broader supports across the continuum in a Multi-Tiered Systems of Support model.

Therapeutic Residential Schools

Issue: Many WA youth that need intensive services must leave the state to access vital residential services.

- There are no public therapeutic residential school options in WA.
- There are few non-public agency options in WA.

Staff Training & Resources for Families

Issue: School staff need more training on how best to support student mental health and prevention.

- Staff need more training on how to recognize if a student is in distress and how to connect students with further supports when they are in distress.
- Many schools still do not have enough understanding about how tiered services work. There's a rush to exclude students from class and lifelines supports when they show signs of mental health and/or suicidality.
- Many staff struggle with how to support students' social-emotional well-being without defaulting to setting low expectations for students.

Issue: School staff need more training on trauma-informed practices and behavior management.

- Students are still showing the significant impacts of the loss of instruction and socialization during COVID, chaotic classrooms
- The school environment itself is causing trauma for some students.
- Communication between families and teachers/school staff is often negatively coded.
- Adults in the school setting are the first line of defense for the kids, and they need to learn to deal with conflict in the best way.

Issue: Many families do not have access to accessible, effective, and culturally relevant resources to support their children' mental health and behavioral development.

- Need to expand availability of resources and training opportunities for parents and other community members on trauma-informed skills for working with youth.
- When a family is in crisis mode, families need to know there's a light at the end of the tunnel.

Feedback:

- HIPAA and confidentiality is part of the problem... parents of struggling children get the message that it is shameful to talk about. Families need support instead of isolation. Special education PTAs can provide some of that, but what about parents who are in recovery or who have had their children removed by CPS? Lots of times we have to seek help outside of our community instead of in the school community where all of the parents connect.
- Parent support within their school community could help to reduce stigma.

Group Shareout:

Feedback on Criteria Development:

- qualitative data is critical to understanding the children most at need and how the system can be broken... and fixed
- setting key performance indicator (KPI) around things like caseloads... a caseload of 100 students for a counselors is too high. A KPI can be a goal to strive towards, and measuring how close or far we have to go in which area.
- another KPI could be how much a private practitioner is being paid v. how much a school-based counselor is paid. (huge gap!). I'd also add measures that look at career pathways... what does the pipeline for new providers look like? How much education is needed? How long does it take to bring people onboard? What is retention levels of existing staff?
- Point about criteria – what can be done to lower the barriers? How does this impact schools, specifically? Bring in Peer workers into the school – Parent & Youth Peer workers. How will new certification/training create an opportunity to add Peers to schools?
- ability to increase BH staff in schools
- impact on equity of services available

Are there other topics that should be added for consideration?

- Does the group agree that workforce capacity is a problem as outlined? Rural provider noted it was a huge struggle. Even baseline services (dial a ride) may not be available regardless of capacity).
- One individual expressed concern about the lack of primary care physicians. One PCP commented that a team approach would be the way to get to better.
- Utilizing more peer workers so mental health providers/professionals do not have as much time taken. Is it more of an issue for rural areas? Outside of WYSE, one commenter stated that there were not peers at all.
- Salaries – cost of housing as a barrier.
- Lived experience piece: also looking at peer support for students and families. Need to look at it as a paid position for school supports. Help from peers is so important to the students.
- Getting precise recommendations is needed.

Public Comment & Announcements

<u>New Cooperative Agreement Funding:</u>

The Health Care Authority (HCA) in cooperation with OSPI was awarded 3 year Cooperative Agreement funding from the Federal Centers for Medicare and Medicaid Services (CMS) with the goal of improving Medicaid School-based Services (SBS) in Washington.

1st Year: $500,000

2nd Year: $1,000,000

3rd Year: $1,000,000

<u>New dates for SBBHSP meetings</u>

Wednesday, September 18, 3 – 5:00 PM
Wednesday, October 23, 3 – 5:00 PM
Wednesday, November 20, 3 – 5:00 PM

Additional Resources:
Feedback survey for attendees

Attendees:

Member Alternates:
Peggy Dolane
Brandi Kingston

State Agency & CYBHWG Staff:
Brisa Sanchez Cornejo, OSPI
Candis Coble, OSPI
Cindi Wiek, HCA
DeeSha Connor, DOH
Delika Steele, OIC
Diane Stead, OSPI
Ella DeVerse, DCYF
Enos Mbajah, he/him, HCA-DBHR
Erika Rodriguez, OSPI
Francesca Matias, OSPI
Julia Kemner, Behavioral Health Catalyst
Katie Shaler, HCA
Kerry Bloomquist, OSPI
Larry Kinread, OSPI
Meghan Hopkins, DSHS DDA
Mikhail Cherniske, OSPI
Renee Tinder, DOH
Todd Slettvet, HCA-Medicaid

State Legislators & Staff:
Rep. Callan | Dist. 05
Rep. Eslick | Dist. 39

Public Attendees:
Colleen McCarty (she/her)
Karen Kelly - WA State Community Connectors# Project Director (Karen Kelly)
Max Lau# Children's Alliance (Children's Alliance)
Michelle Wilright
Renee Fullerton
Shelley Seslar NCESD (she/her)
Siddharth Baasri
Tessa Gooding (Newport Healthcare)