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

Date: August 21, 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 Knottnerus 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 [Alternate: Gwen Loosmore] 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	☐	Richelle Madigan	☐	Danielle Ouellette
☒	Peggy Dolane	☐	Arnie Martinez	☒	Byron Smith
☐	Shawnda Hicks (Lead)	☐	Yahaira Nava	☒	Marcella Taylor
☐	Brandi Kingston				

Staff: Diane Stead, OSPI

Meeting notes

Multi-Tiered System of Supports (MTSS) — Re-grounding in the Tiers
RJ Monton, Director of MTSS, OSPI

One of the goals is to do some re-grounding on MTSS principles. We are looking at the sustainability of policy statewide.

MTSS — what it is

An MTSS is a framework that helps the educators organize themselves. It is for adults to effectively collaborate within a P–12 system.

Some key components include:

- Universal Screening/progress monitoring
- Data collection/Data driven decisions
- Continuum of supports made up of evidence-based practices.

We want educators to work together to make the system as equitable as possible.

Our MTSS indicates what locally determined framework is. It looks different depending on our role and sphere of influence. A MTSS often shows up in context. Any system that combines pieces of practices in the data collection. RTI is response to intervention. A student who is receiving skills development is in addition to the universal supports they receive.
PBIS Positive Behavior Interventions and Supports. How are we developing our schools, what are our expectations, how can we work with our environments? How can the data inform us within the framework?

Interconnected systems framework: PBIS that pulls in some community resources, breaks down the school wall and includes the community/community-based organizations.

All of these are multi-tiered frameworks. At a district or building level we need to look at the interconnectedness of these principles.

What are the priorities for Washington? How do we parse it into digestible pieces? We do professional development, technical assistance, etc. We cannot do this, especially looping in community without including families and students. We are looking at evidence-based practices for guidance.

Continuum of Supports in Action — Based on a public health model.

Tier 1 – basic supports that everyone does (accessible to 100% of students, effective for 80% of all students)

Tier 2 – more individualized intervention (applies to 20% of students, includes targeted smaller group of interventions and supports. It should consist of 15% of the student population. From an economic and resource standpoint, not possible to apply to all students.

Tier 3 – requires immediate treatment/intervention. 5% of students who have a completely individualized need, something that is infrequently used and unique to the student. Coordinated by the schools and many are site-dependent. If you get to more than 5%, resources will be limited and will make intervention more difficult.

DBI – Data Based Individualization
DBI is a research-based process for individualizing and intensifying interventions through the systematic use of assessment data, validated interventions, and research-based adaption strategies.

DBI is a process, not a specific program or product.
Are we doing what we said we were going to do? If we are creeping off-label, we can know if we are doing effective work.

Intensity and Investment
The tiers are not siloed. There will be gray areas. The individual and group staff behavior has to change to help these students. This is more effective than one person responding completely.

Why is it so important to look at your system again and again? If we see students with needs and we intervene, then we also need to look at the environment that they are returning to. We need to look at the core supports and see how we can change them to help the students who need this help. It requires a lot of initial adult behavior change.

We know we will have students who will have advanced needs, especially post-pandemic. We need to address tier 1, but we can think about this a little differently. We don't need to coordinate care for one student. Needs, intensity and quantity will be different. Student populations are always changing. People don't have to live where they work anymore, so demographics are changing. Community supports within a multi-tiered framework needs to be established.
Tier 1 – Lending expertise to school-wide decisions. Does not violate HIPAA laws.
Tier 2. – Teaming to provide targeted supports. Some student information may be provided, and assistance will be more coordinated for the individual.
Tier 3 – In or out of school direct support. Response at this tier is a localized issue.

Implementation teams
State Implementation Team

Regional Implementation Team

District Implementation Team

Building Implementation Team

Are we using individual based practices? Is this a systems issue? Should we provide more training? How do we continue to fund implementation? We can't ignore the practices that show promise with the population. If you're on a district or building team, you're looking at the role everyone plays. How do we take the individual support and make it school-wide? Implementation is messy. We're trying to make the system more effective and equitable. Washington has had a few fits and starts with MTSS implementation. We have a personnel development grant for coaching districts.

Started in 2021 - $5M over 5 years
Funds most of the implementation efforts

State Personnel Development Grant (SPDG) Objectives
Use evidence-based PD to support attainment of identified competencies
Demonstrate improvement in implementation of practices over time
Establish technical assistance and develop enduring

Average DCA Drivers Scores – All State
We're seeing growth in the capacity of implementation teams. They are measured by drivers score. Teams ensure that the work will continue despite staff turnover and maintain fidelity.

Qualitative data:

District teams
They are actively engaging

The are actively (with coaching) shifting
The PD and technical assistance conversation has shifted from 'what is MTSS' t 'what's my role…how do

Biggest barriers
Financial security – reaching the end of the grant.
Frequent changes at the district leadership level
Fatigued workforce – le

Q: in chat
We need to have a way to look at where the disproportionality is. How do we look at screening tools and adjust any biases? Can we re-visit cultural needs? Can we address our individual bias while doing this work? We need to look at disproportionate data to improve our actions for all students.

Q: Implementation data: have you started to look at data on what is working in the programs that have been implemented. Have you looked at the data from successful schools?

Are we seeing any student-level changes? Are we seeing improvement at that level? How about staff retention? What pieces lead to student success? We're learning a great deal at three years of our cohort. We are seeing some correlations in some areas. We can't verify causation due to lack of substantive data.

Recommendation Priority Areas — Group Discussion

Two sub-breakout groups (~35 minutes)

Youth/young adults with lived experience: Francesca Matias, OSPI & Kei Gregson, Youth Lead

Parents, guardians and family members with lived experience: Kerry Bloomquist + Brisa Sanchez Cornejo, OSPI

Main Room: Non-Family or Youth:

Care Coordination:

Goal: Improve capacity for schools to connect students with existing community care options.

Where should the focus be? Survey says:

- Provide funding to schools to support implementing.

Deyvna from Renton schools discussed their database for healthcare needs.

Hard to commingle schools and pediatric primary care. Students with behavioral health concerns (50%). Pediatric primary care provides 75% of behavioral health care, leaving 25% to go elsewhere.

To integrate behavioral health qualified professionals into school staff is an expensive way of delivering care.

The only way to provide 75% of behavioral health to students is to coordinate. This is not to negate the work schools are doing.

The 50% who are also student pediatricians are responsible for drive them toward different resources. Co-management, whole child care is driving us to make care coordination our biggest priority for students who are getting 6 hours per day in the school facility.

Q. Is this system of service, currently available in practice? Two pieces of things that have

Integrated mental health, what are we talking about?

Schools that have a school-based clinic – is that a form of coordination.

They really serve a need, 95% of students have some form of health insurance. 85% of our children have seen a primary care physician in the previous year. The site of care is important. School-based clinics work best if they are staffed by physicians who are there on site but are getting federal funding. The thrust of the federal funding is the need of adults. Teachers and doctors are both meeting students' needs and coordinate to help the whole child. We have numerous models for care coordination. How can we coordinate their supports and services?

We've developed a model with Medical Lake SD to coordinate help and have presented data to WSSDA. There are many models, and we are working within schools. We are working with master-level clinicians. MLSD has 85% of mental health. Working on Tier 1 works because you're not putting out fires constantly.

Physicians try to screen kids. If we could provide coordinated care based upon those screenings, we could effectively provide support.

If this made a top priority, should Rep. Thai work with Dr. Cavens and Mabel Thackeray to build the infrastructure that can be supported by the legislature?

Students & Youth Breakout Notes:

Thoughts on staffing in schools:

- All teachers have suicide prevention training. All schools should have this training, including medical & mental health first-aid. Having these resources should be shared more with students and families. It would be helpful to have more mental health staff in the schools. Youth should be more involved in creating the SEL curriculum.
- I think what's really important about building trust with mental health staff and youth is setting up check ins for students, I think that seems to help with the school college counselors, or even spreading the word with parents/families about them being available!
- Has school psychologist that only knew of because found them in a room. The school never disclosed one was available. Large student body for small town. Hard to find time to schedule time with school psychologist because they are serving a large population of students.

School staffing: overworked and few counselors and no one knows who they are. Teachers need required mental health training. They get only brief MH training and can do more to support students. The possibility of on-site/on-campus counseling, rather than online to improve interaction. Main counselors and staff are unknown. The school psychologist can't handle the workload, since they have multiple roles in the school. Having a place where kids can connect with other kids who are not in crisis that is free would help.

How can we build trust when we add more staff? Having check-ins with students can get the word out to the student population. Safe space in schools has proven to be valuable to students.

Big funding piece for these efforts: should it be at the local level, state level or somewhere in-between

Parents & Families Breakout Notes:

Training priorities:

- Recognizing behavioral health need and connecting students to support
- Trauma-informed practices

Other notes on training:

- Groups wanted to see the list.
- Looking at the model of MTSS – Training/Training/Training
- No restraint and isolation – happening in 2024? Means it's a training issue. Speaks to classroom management.

- Teachers have classrooms that had what she needed.
- What are the professional levels needed to support the models.
- How are we training teachers who are older to adapt to new models.
- Systems in place to support good classroom management.
- Training for staff, more resources
- More education, property trained individuals who are agency affiliated as support staff(counselor). More $$ to hire.

Resources priorities:

- Resources for navigating a behavioral health crisis within your family

Other notes on resources:

- DARE was a horrible drug-prevention program. More information regarding drugs for prevention, MH higher priority than drug prevention.
- Natural Helpers, peer to peer youth supports.

Staffing in Schools – priorities:

- Require schools to have a ratio of specific staff (i.e. counselors, social workers, psychologists, nurses) to students. (Gwen: A little nervous about this language – would like to see increased $$ to increase supports that way)
- Standard of staffing and how do we get to them? What is normal?

Prevention supports – priorities:

- **Adequate staffing is needed** - staffing for assistant teachers/paraeducators to support students, especially around social emotional learning (Gwen)
- Need more staff!

Access to clinical behavioral health supports – priories:

- Colorado IMatter program of offering 6 free therapy sessions to any youth that needs it (Gwen), impressed by their program, if they can do it, we can do it.

Group share-out:

We have problems with turnover, especially for students who are trying to establish trusting relationships. We need to educate staff across the board to give the students more resources. Students reach out to staff such as bus drivers, which reinforces the need for students to have the right person to contact when they are in crisis.

Youth mental health first aid.

Is there an approach that we can take on the training piece? Is it funding?

We should ask the state for more resources for more staff in the schools, especially when training. Teachers are already at capacity. They can recognize the need for support, but then we have to provide support.

Standards – should there be one person per building? We have been under-staffing since 2008 and haven't had the will to tackle the issue. We should ask the legislature to provide funding to make that happen.

The DOH pays pediatricians as well as insurance. You have at your disposal free staff that don't require educational dollars. Change some mandates for attending public school. SpEd students should need a physical every two years. Insurance information should be provided to the schools. Children with poor attendance or poor grades should also need a comprehensive physical exam. By signing a release, you could get a care plan from the primary care provider that will start coordination of care. The

legislature has directed the medical community to do that work. Preventive early intervention or behavioral health is 50% of directive to medical field in Washington.

Colorado iMatter Presentation Discussion:

Any student within the state of Colorado is eligible for the service and it is free. They were able to fund an option so that young people who needed someone to talk to and work through a few things could get that help.

This can be done in Washington. If we could do 5–6 sessions for each student, it would be a great way for students to get help. This takes some pressure from the schools and providers. Doing clinical work in schools is expensive. Rural areas have difficulty with getting staff at all in the schools.

The legislature has funded work specifically about essential health. What we identify at the state level is what to fund, where and how much. Hopefully Washington can move this up in our priorities. Mental health is definitely on the list of priorities to discuss. iMatter was started a few years ago. The question is how do you do the outreach? What are the barriers? What can be done to overcome them? There are districts who have licensed clinicians, so that could augment the care currently being received.

One of the key points is that they paid a rate for the providers that was significantly above the Medicaid rate. Having matching funds drew enough BH providers into the program. The dollar amount was not tied to insurance rates. BH administration and contacting source provided deeper penetration into the rural areas. It was independent of the school system. You could schedule a telehealth visit. How do we connect education outcomes and BH aspects? We need to tie the free sessions into the Tier 2 space. Students getting care during the school day is more conducive to getting care.

We need to see if we can bring some tangible work to the issue.

Public Comment & Announcements

Fall Community Engagement Forums:

Will announce these in later communications

Fall Schedule Changes

Welcome to Josh Kent, new OSPI employee.

Additional Resources:
Feedback survey for attendees

Attendees:

State Agency & CYBHWG Staff:
Bridget Underdahl, OSPI
Brisa Sanchez Cornejo, OSPI
Candis Coble, OSPI
Cindi Wiek, HCA
Debra Parker, OSPI
DeeSha Connor, DOH
Delika Steele, OIC
Enos Mbajah, HCA
Francesca Matias, OSPI
Garaline Tom, OSPI
Jason McGill, HCA
Jennifer Price, HCA

Joshua Kent, OSPI
Kerry Bloomquist, OSPI
Lindsay Martin, DOH
Michelle Curry, OSPI
Misha Cherniske, OSPI
RJ Monton, OSPI
Stacey Bushaw, HCA
Tammy Bolen, OSPI

State Legislators & Staff:
Rep. Callan | 5th District
Rep. Davis | 32nd District

Public Attendees:
Chelsea Stone, CHPW/CHNW
Colleen McCarty
Dontae Brown Jr.
Jackie Yee, SUDP Clinical Supervisor
Josh Henderson, CSD REACh/CLIP)
Katie Shaler
Lula S. Sloans
Margaret Soukup
Max Lau, Children's Alliance
Meredith Piehowski
Roz Thompson, AWSP
Tessa McIlraith
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