**School-based Behavioral Health and Suicide Prevention subgroup meeting**

*August 28, 2020*

| Members |
|-------------------------|-------------------------------|--------------------------|
| Representative My-Linh Thai, Co-Chair (41st Legislative District) | David Crump (Spokane Public Schools) | Jeannie Nist (Communities in Schools of Washington) |
| Lee Collyer, sitting in for Camille Goldy, Co-Chair (Office of the Superintendent of Public Instruction [OSPI]) | Myra Hernandez (WA Commission on Hispanic Affairs) | Jill Patnode (Kaiser Permanente) |
| Tawni Barlow (Medical Lake School District) | Aveayl Jacobson (King County Behavioral Health and Recovery) | Elise Petosa (WA Association of School Social Workers) |
| Dr. Avanti Bergquist (WA State Council of Child and Adolescent Psychiatry) | Patti Jouper (Parent/Grandparent) | Kelcey Schmitz (UW SMART Center) [Alternate: Eric Bruns] |
| Antonette Blythe (Parent, Family Youth System Partner Roundtable) | Jeannie Larberg (Whole Child Sumner-Bonny Lake School District) | Susan Solstig (Parent, Family Youth System Partner Roundtable) |
| Harry Brown (Mercer Island Youth & Family Services, Forefront) [Alternate: Jennifer Stuber] | Sandy Lennon (WA School-based Health Alliance) | Jason Steege (Parent) |
| Brooklyn Brunette (Youth) | Molly Merkle (Parent) | Katrice Thabet Chapin (Vancouver Public Schools) |
| Jerri Clark (Washington PAVE) | Joe Neigel (Monroe School District) | Kathryn Yates (Chief Leschi School District) |

**Agenda Items**

**Summary Meeting Notes**

**Introductions, Group Norms, and Housekeeping**

*Rep. My-Linh Thai, 41st Legislative District; Lee Collyer and Mark McKechnie, OSPI*

- Adding: Request for person first language but, when in doubt, ask.

**Presentation: Safety Planning Intervention (SPI) Model**

*Harry Brown, Mercer Island Youth & Family Services*

*See page 23.*

- Consults with Forefront.
- Training objectives: 3 hrs, Understand, LEARN®, and Integrate.
- People die by suicide because of thwarted belongingness, perceived burdensomeness, acquired capability- experiences can reinforce suicide ideation.
- Within the LEARN model, they use the ASK steps.
- Screening and Assessment tools- teens have been shown to be more honest on questionnaires than when asked something in person.
- Screening tools help with long ER waits.
- Safety Planning is to be used in an ongoing intervention or plan, it is not meant to be a one time thing.
- Tools for students to use when in distress start with self/internal; then link to external resources.
- No Harm Contracts are not safety plans.
- Suicidality fluctuates over time.
- Write down what the experience that lead them to think about suicide was - track that.
- Ask them how they coped to not complete suicide.
- Resources: See page 37.

**Discussion:**

- **Q:** Parent and caregiver role?
  - **A:** They can be in a state of shock, cultural issues; we talk to them so they can know what to do/ what them to know warning signs.
- Unless a person is in danger, there is no help (speaking from personal experience).
- App for teens: Virtual Hope Box (originally designed for vets).
- **Q:** Can you explain this 10 min data to 1-12 months? (See page 32.)
  - **A:** Studies show that people may research or practice how to complete suicide for months, but of people that are admitted to the hospital after an attempt, 48% said they had been thinking about suicide for 10 minutes or less.
- Essential to ask parents: What meds are at home? Do you have a lockbox? Do you have weapons? Items may need to be removed from the house- belts, bleach, weapons, etc.
- This is ongoing work. It’s important we take care of the providers too.
- **Q:** Are there way for teachers and counselors to reach out to kids virtually?
  - **A:** Working on this – trying to create student check-ins, have telehealth programs, Zoom meetings w/ parent permission, create a virtual community and let them know that we are available; students have a virtual office now.
- System in place: If a kid mentions they will hurt themselves, the principal is immediately notified.
- These strategies require the individual to have problem-solving capacity. Is there a protocol for an individual with a serious brain-based disorder, such as schizophrenia, bipolar with psychosis, or severe autism? Those individuals often lose insight into their condition.

### Presentation:

**K-12 Funding for District Positions to Support Student Behavioral Health**

**Michelle Matakas**, Director, School Apportionment and Financial Services, OSPI

*See page 39.*

- Funding model; how it applies to the world as it exists now, how we hope to change it.
- Prototypical School? Fixed theoretical school size that is used for modeling purposes.
- House Bill 2776 established sizes.
- Base - Elementary: 400, Middle school: 432, High school: 600.
- Enrollment based on grade - if a 6th grader is in a middle school, the funding is based on elementary level, not the middle school level.
- Current funding for staff types (see page 43).
- There is no funding for Family Involvement Coordinators.
- Staffing Enrichment Workgroup proposed staffing increases (see page 45).

**Discussion:**

- **Q:** Clarify Initiative 1351?
  - **A:** Initiative 1351 (2013) directed Legislature to allocate funds to reduce class sizes and increase staffing support for students, with additional class-size reductions and staffing increases in high-poverty schools.
What research/recommendations were the ratios on 2276 build from?
If social workers are not part of district, then that portion of funding can be used in other staff?
Based on the students with IEP headcounts.
Is there a definition of "roles" for school staff in this model? in my district uses school social workers an school counselors for the same role in elementary?
Because they aren’t currently provided, it would also be helpful to have definitions for the family involvement coordinators and continuous improvement coaches
Did the workgroup explicitly define "safety"?
Q: What kind of funding is used for these positions?
A: General apportionment; school districts make decisions about how they address needs, spend funds.

Q: What funding do small school districts that do not meet the prototype model get?
A: Depends on the size of the district; there are regulations in place, most are based on certificated staff.

Q: Does our state Medicaid plan allow for Medicaid reimbursement (if a district is interested in applying) for school nurses, social workers and psychologists?

Q: Is there where the school safety officers are funded, i.e. law enforcement officers based in schools?
A: Yes, but not exclusively.

Q: Is Medicaid reimbursement only for students with an IEP?
A: Yes. That is the only group covered by the School-Based Health Centers program.

Info on staffing enrichment work group:

Districts can hire more or less faculty based on the funds and size of their district.
Other states have expanded SBHCS Medicaid funding beyond students with IEPs. The WA Healthy Schools, Promising Futures Learning Collaborative led by Anne Gray has info about this.
We see parents choosing to not put children in treatment because of costs, even with insurance.

Q: Is there a school that actually has adequate staffing to support emotional needs of students?
Recognize the need for school counselors, but the original focus of the work group was therapeutic – mental health.
I’ve spoken with staff at ESD 113 who expressed that some of these "related service" roles are hard to fill because of a shortage of qualified candidates. Anyone want to comment on that barrier to improving these services?
What assumption are used to derive these staffing recommendations? do districts find these staffing ratios to be adequate? are most schools taking up the state funding?
One big gap is appropriate services for students with private/commercial insurances to get Mental Health services.
The challenge I see is for funding adequate mental health support for higher need students who do not have Special Ed. support. In our district it is community based services that attempt to fill the gap.
We've heard about many effective practices but without the people to implement and systems to support we are going to be very challenged to help our kids and families.

how can we recommend a shift in resources and improve funding for the evidence-based practices that will save lives and support children where they are so underserved?

As a school psychologist our role is to be as comprehensive as we can within our educational community. I have been advocating with my psych team to be more than just a psychometrician. School Psychologist should have the opportunity to provide counseling services that meets the needs of our community.

**Recommendations**

<table>
<thead>
<tr>
<th>Member breakout groups</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mark McKechnie, OSPI</strong></td>
</tr>
<tr>
<td>- Focus on recommendations related to scope (see page 57).</td>
</tr>
<tr>
<td>- See page 58 for breakout group questions.</td>
</tr>
</tbody>
</table>

### Breakout Group – Summary of Recommendations

- **An integrated system of care through an identified statewide MTSS framework with ISF, along with clarified expectations and district data reports to OSPI.**
- **Expanded ability for behavioral health providers to work and bill in schools. Need health care providers in school buildings that can support all students (regardless of student/families’ insurance status/ability to pay/the health care exchange).**
- **Expansion of telehealth options – in building, to support more privacy, safety concerns**
- **Expanded LEA data reporting requirements to include behavioral health/equity/MTSS in the OSPI report card.**
- **PD for culturally responsive services as well as support and community development for BIPOC providers to provide services for BIPOC students.**
- **School based Medicaid expansion to non-IEP students.**
- **Dedicated funding for school based mental/behavioral health education/SEL in Tier 1**
- **Expansion of school-based health centers to provide more services in schools.**

### Issues and Ideas without recommendations:

**More Data Needed**

- What are our K12 and Higher Ed communities doing to support BIPOC providers?
- How many providers of school-based behavioral health services are there currently?
- How many students need behavioral health services, and how many are receiving them?
- What are the gaps in resources? What are the gaps in funding vs. workforce?

**Cross-agency collaboration**

- Legal issues: confidentiality laws (HIPAA/FERPA); liability concerns, telehealth
- Alignment of efforts: behavioral health providers & school staff
- CBO partnerships at state and district levels
- More prevention (more Tier 1 supports)

**Training**

- Using functional behavior approaches
- Culturally responsive and relevant behavioral health services for BIPOC communities
- Partnering with families to better understand student needs
- Understanding behavioral health needs across developmental stages: elementary age, early adolescence and adolescence
• Pre-service training on behavioral health and suicide prevention

Resources
• Increased and dedicated funding for social workers, school counselors, behavior support techs
• Dedicated funding to provide Tier II interventions
• Resources and PD for screening
• Integrated data systems
• Internet connectivity

Other Attendees
Molly Adrian
Marci Bloomquist
Elena Cusack
Logan Endres (Washington State School Directors Association)
Christine Kapral
Ailey Kato
Laurie Lippold (Partners for our Children)
Michelle Matakas (OSPI)
Liz Perez
Jennifer Stuber (Forefront Suicide Prevention)
Chasmon Tarimel (Pacific Islander Health Board)
Megan Veith (Building Changes)

Lucinda Young

Staff
Endalkachew Abebaw (Health Care Authority [HCA])
Rachel Burke (HCA)
Maria Flores (OSPI)
Kimberly Harris (HCA)
Robin Howe (OSPI)
Mark McKechnie (OSPI)
Justyn Poulous (OSPI)
Ashley Taylor (HCA)
School-based Behavioral Health and Suicide Prevention Subcommittee
Of the Child and Youth Behavioral Health Work Group
August 28, 2020
All students prepared for post-secondary pathways, careers, and civic engagement.

Transform K–12 education to a system that is centered on closing opportunity gaps and is characterized by high expectations for all students and educators. We achieve this by developing equity-based policies and supports that empower educators, families, and communities.

- Ensuring Equity
- Collaboration and Service
- Achieving Excellence through Continuous Improvement
- Focus on the Whole Child
Each student, family, and community possesses strengths and cultural knowledge that benefits their peers, educators, and schools.

Ensuring educational equity:

• Goes beyond equality; it requires education leaders to examine the ways current policies and practices result in disparate outcomes for our students of color, students living in poverty, students receiving special education and English Learner services, students who identify as LGBTQ+, and highly mobile student populations.

• Requires education leaders to develop an understanding of historical contexts; engage students, families, and community representatives as partners in decision-making; and actively dismantle systemic barriers, replacing them with policies and practices that ensure all students have access to the instruction and support they need to succeed in our schools.
Tribal Land Acknowledgment

- Squaxin Island Tribe
## Agenda:

**August 28, 2020**

<table>
<thead>
<tr>
<th>No.</th>
<th>Agenda Item</th>
<th>Leads</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Land Acknowledgement</td>
<td>Mark McKechnie, OSPI</td>
<td>9:00 – 9:05</td>
</tr>
<tr>
<td></td>
<td>Question and Answer</td>
<td>Members</td>
<td>9:50 – 10:00</td>
</tr>
<tr>
<td></td>
<td>Break</td>
<td></td>
<td>10:00 – 10:15</td>
</tr>
<tr>
<td>4.</td>
<td>K-12 Funding for District Positions to Support Student Behavioral Health</td>
<td><strong>Michelle Matakas</strong>, Director, School Apportionment and Financial Services, OSPI</td>
<td>10:15 – 10:40</td>
</tr>
<tr>
<td></td>
<td>Question and Answer</td>
<td>Members</td>
<td>10:40 – 10:50</td>
</tr>
<tr>
<td></td>
<td>Break</td>
<td></td>
<td>10:50 – 11:00</td>
</tr>
<tr>
<td>5.</td>
<td>Public Testimony</td>
<td>Mark McKechnie</td>
<td>11:00 – 11:10</td>
</tr>
<tr>
<td>6.</td>
<td>Second Brainstorm Session</td>
<td><strong>Maria Flores and Members</strong></td>
<td>11:10 – 11:45</td>
</tr>
<tr>
<td>7.</td>
<td>Report out</td>
<td>Members</td>
<td>11:45 – Noon</td>
</tr>
</tbody>
</table>
Welcome Members and Guests
Members

**Co-Chairs:** Rep. My-Linh Thai and Lee Collyer (alternate for Camille Goldy)

**Voices of Families and Young People:**
Brooklyn Brunette
Jason Steege
Kathryn Yates
Katrice Thabet-Chapin
Molly Merkle
Patti Jouper
Susan Stolsig
Members: Education and Behavioral Health Professionals and Advocates

Antonette Blythe, Family Tri Leader, Family YOUTH System Partners Round Table

Avanti Bergquist, Washington State Council of Child and Adolescent Psychiatry; Washington State Psychiatric Association; Eating Recovery Center/Insight Behavioral Health

Avreayl Jacobson, Children's Mental Health Planner, King County Behavioral Health and Recovery

David Crump, Clinical Director, Spokane Public Schools
Elise Petosa, Member/past president, WASSW

Erin Wick, Director of Behavioral Health and Student Support, ESD 113 (AESD Representative) [Designated alternate: Mick Miller, ESD 101]

Harry Brown, MIYFS - School Based Mental Health Counselor, Forefront in the Schools, consultant/trainer, Mercer Island Youth & Family Services, Forefront Suicide Prevention [alternate: Jennifer Stuber, Center Director, Forefront Suicide Prevention, UW School of Social Work]

Jeannie Larberg, Director: Whole Child, Sumner-Bonney Lake School District

Jeannie Nist, Associate Director, Communities In Schools of Washington
Jerri Clark, Parent Resource Coordinator, WA PAVE

Jill Patnode, Thriving Schools Program Manager, Kaiser Permanente

Joe Neigel, Prevention Services Manager, Monroe School District & Monroe Community Coalition

Kelcey Schmitz, MTSS/School Mental Health Training and TA Specialist [Alternate: Eric Bruns, Director of Training and Technical Assistance], UW SMART Ctr.

Myra Hernandez, Operations and Special Projects Manager, Commission on Hispanic Affairs
Robert Monton, Associate Director of Behavioral Health, Snoqualmie Valley School District

Sandy Lennon, Executive Director, Washington School-Based Health Alliance

Tawni Barlow, Director of Student Services, Medical Lake School District

William (Bill) Cheney, Director of Student Support and Prevention Systems, Mount Vernon School District
OSPI and HCA Staff Supporting the Subcommittee

OSPI Center for the Improvement of Student Learning:
Maria Flores
Justyn Poulos
Mark McKechnie
Robin Howe

OSPI Special Education:
Lee Collyer

Healthcare Authority:
Rachel Burke
Kimberly Harris
Ashley Taylor
Endalkachew Abebaw
Housekeeping: We’re all on the bus
Person first language

Person first language:
• Examples: Student with a disability; Student with behavioral health needs

Use the term preferred by the person or group whenever the preference is known or can be learned.

Don’t know? Ask.
Group Norms

• Share airtime; make sure all voices have the opportunity to be heard
• Stay engaged
• Speak your truth
• Expect and accept non-closure
• Listen with the intent to learn and understand
• Assume positive intentions
• Disagree respectfully
• Clarify and define acronyms
• Develop a definition for BH for the purpose of this group
• Take care of yourself and take care of others
• Ask for clarification
• Listen harder when you disagree
• Avoid using the phrase “committed suicide,” instead refer to it as a cause of death
Facilitator Requests

Audience/guests: please offer your comments during public testimony only.

Members: Please indicate that you want to speak by using the Chat to let us know. The chair or facilitator will recognize you to speak.

Everyone: please bear with us. Communication is more difficult via Zoom, but together we can use it productively.
Six Meetings to Develop Recommendations

1. Introductions, orientation, norms, identify potential priorities
2. Invited presentations; Decide about Deciding
3. Selected presentations; discuss remaining questions; discuss priorities
4. **Develop preliminary recommendations – may need to designate subgroup to draft**
5. Refine recommendations
6. Finalize recommendations
TRAINING OBJECTIVES

- Understand the public health issue of youth suicide
- LEARN® lifesaving skills to prevent youth suicide
- Integrate prevention approaches into your personal and professional life
WHY DO PEOPLE DIE BY SUICIDE?

Adapted from Thomas Joiner’s Interpersonal Theory of Suicide, 2007, and Van Orden, et al. 2010
Look for signs

Empathize & Listen

Ask & Assess

Reduce the Danger & Plan for Safety

Next Steps to Continuous Care
Sometimes when people are...

_________________,
_________________,
_________________,

they’re thinking about suicide. Are you thinking about suicide?

- Isolating from friends
- Feeling alone / pushed away
- Upset after a breakup
- Feeling numb / detached
- Hopeless about their future
- Feeling self-hatred
- Tired of pleasing everyone
- Feeling like giving up
SCREENING & ASSESSMENT TOOLS

- Ask Suicide Screening Questions - (asQ)
- Patient Health Questionnaire - (PHQ-9) modified for adolescents
- Columbia Suicide Severity Scale - (CSSR-S)
- Customized school checklist
1. In the past few weeks, have you wished you were dead?
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
3. In the past week, have you been having thoughts about killing yourself?
4. Have you ever tried to kill yourself?
5. If yes, how?
6. Are you having thoughts of killing yourself right now?
Look for signs

Empathize & Listen

Ask & Assess

Reduce the Danger & Plan for Safety

Next Steps to Continuous Care
SAFETY PLANNING

• A tool for students to use in distress; step-wise increase in level of intervention
  • Starts “within self” and builds to seeking help from external resources such as emergency services
• Plan is step-wise but individual can advance in steps without “completing” previous steps
• Safety planning can be done in one brief session and then, reviewed and revised over time
• NO HARM CONTRACTS are NOT safety plans
SUICIDAL CRISES ARE TIME LIMITED

People admitted to a hospital after an attempt were asked:
How long had you been thinking about suicide before the attempt?

48% said ten minutes or less.

Deisenhammer, et al., 2009
SUICIDALITY FLUCTUATES OVER TIME

Warning Signs & Triggers

Danger of acting on suicidal feelings
6 Step Process:

1. Warning signs
2. Individual, internal coping strategies
3. Positive distractions from the crisis
4. Reduce the danger make the environment safe
5. Reason(s) for living
6. Trusted adults, peers and professionals
Sometimes life can get pretty difficult - to the point where you may not care about things that used to matter. Remember, you are not alone. There are resources and people who want to help. Using these action steps can help keep you safe and more in charge of your emotional wellbeing. One step at a time, starting now.

**Step 1 – Recognizing Warning Signs**
Isolating, drug use, feeling hopeless, angry, exhausted...

1. ____________________________________
2. ____________________________________
3. ____________________________________
4. ____________________________________
5. ____________________________________

**Step 2 – Using Internal Coping Strategies**
Things I can do on my own like deep breathing, music...

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

**Step 3 – Using External Coping Strategies**
People and social settings that help distract me

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

**Step 4 – Contacting Family/Friends Who Can Help**
People I can be honest with about what’s bothering me

1. ____________________________________
2. ____________________________________
3. ____________________________________
4. ____________________________________
5. ____________________________________

**Step 5 – Turning to Professionals & Resources**
Trusted adults can help. Who could you add to this list?

<table>
<thead>
<tr>
<th>Name:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

More Resources for Teens

- Chat
- 24-Hr Suicide Lifeline: 1-800-273-8255
- 24-Hr Crisis Text Line: Text TEEN to 741741
- 24-Hr Crisis Connections: 1-866-427-4747
- Safe Place – First Shelter: Text “Safe” to 4HELPLINE
- Sexual Assault Hotline: 1-866-453-HOPE
- Teen Line: Text TEEN to 839839
- Teen Link: Call in 6-10 pm: 1-866-837-0546
- Trevor Project: LGTBQ: Text START to 678678
- Teen Lifeline: 1-877-555-4660
- LGBTQ+ Other resources: Call or go online

**Step 6 – Keeping My Personal Space Safe**
Trusted adults and my environment help keep me safe

- □ I let trusted adults help monitor my personal space
- □ I let trusted adults know about any harmful items
- □ I keep my personal environment safe

Form adapted from Stanley and Brown (2008). Safety plans are only one part of a comprehensive crisis response prevention plan. Rev. 7/27/20
Collaboratively developed by counselor and youth with caregiver notification

*Designed for youth who:*

- Are at increased risk for suicide but not requiring immediate rescue
- Do not have severe cognitive impairment
Resources

Forefront In The Schools

National Institute of Mental Health, ASQ Toolkit

SPRC Safety Planning Guide

Safety Planning Template

Stanley-Brown Safety Plan App

MY3 App
Break (mute/cameras off)
Funding for School Based Behavioral Health Services

Michelle Matakas
August 28, 2020
What is a Prototypical School?

• Prototypical school is a fixed theoretical school size that is used for modeling purposes.

• As adopted in 2776, it is a scalable model.

  • I.E., As enrollment increases or decreases from prototypical size, the staff units change proportionately.
2776: Prototype as a Basis

- Funding formula assumptions are based upon a prototypical school and an assumed prototypical class size.

<table>
<thead>
<tr>
<th>Category</th>
<th>Elementary (K-6)</th>
<th>Middle (7-8)</th>
<th>High (9-12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Enrollment</td>
<td>400</td>
<td>432</td>
<td>600</td>
</tr>
</tbody>
</table>

- In reality, school configurations vary widely and are not always consistent with the prototype.
How Enrollment is Used

• Funding is generated based on the student grade level rather than a school’s classification.
  • When 6th grade is part of the middle school, the 6th grade students generate staff at the elementary funding level.
  • When 9th grade is part of the middle school, the 9th grade students continue to generate staff at the high school funding level.

• Prototype allocations will be calculated based on districtwide grade level enrollment.
## School Based Behavioral Health Services: Current Funding

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>Elementary (K-6)</th>
<th>Middle (7-8)</th>
<th>High (9-12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Enrollment</td>
<td>400</td>
<td>500</td>
<td>600</td>
</tr>
<tr>
<td>Guidance Counselors</td>
<td>0.493</td>
<td>1.216</td>
<td>2.539</td>
</tr>
<tr>
<td>Health &amp; Social Services:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Nurses</td>
<td>0.076</td>
<td>0.060</td>
<td>0.096</td>
</tr>
<tr>
<td>Social Workers</td>
<td>0.042</td>
<td>0.006</td>
<td>0.015</td>
</tr>
<tr>
<td>Psychologists</td>
<td>0.017</td>
<td>0.002</td>
<td>0.007</td>
</tr>
<tr>
<td>Family Involvement Coordinators</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>Student and Staff Safety</td>
<td>0.079</td>
<td>0.092</td>
<td>0.141</td>
</tr>
<tr>
<td>Continuous Improvement Coaches</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
</tbody>
</table>

|                  | 500             | 1.407        | 2.116       |
|                  | 0.095           | 0.069        | 0.080       |
|                  | 0.053           | 0.007        | 0.013       |
|                  | 0.021           | 0.002        | 0.006       |
|                  | 0.000           | 0.000        | 0.000       |
|                  | 0.099           | 0.106        | 0.118       |
|                  | 0.000           | 0.000        | 0.000       |
Staffing Enrichment Workgroup

• In 2017, Legislature directed OSPI to convene technical workgroup to review definition of basic education program and needs of the students. The recommendations over six years of implementation:
  1. Modify current prototypical school level sizes.
  2. Meet students’ needs for safety as well as mental, social, emotional, and behavioral health.
  3. Provide impactful professional development to all staff.
  4. Increase flexibility with transparency and accountability.
  5. Raise staffing levels to meet those set in Initiative 1351 and provide additional funds for schools in the Capital Budget.
  6. Reconvene the Workgroup.
School Based Behavioral Health Services: Proposed Funding

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>Elementary (K-6)</th>
<th>Middle (7-8)</th>
<th>High (9-12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Enrollment</td>
<td>500</td>
<td>500</td>
<td>500</td>
</tr>
<tr>
<td>Guidance Counselors</td>
<td>0.625</td>
<td>2.315</td>
<td>2.917</td>
</tr>
<tr>
<td>Health &amp; Social Services:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Nurses</td>
<td>0.731</td>
<td>1.028</td>
<td>0.687</td>
</tr>
<tr>
<td>Social Workers</td>
<td>0.389</td>
<td>0.102</td>
<td>0.106</td>
</tr>
<tr>
<td>Psychologists</td>
<td>0.130</td>
<td>0.028</td>
<td>0.041</td>
</tr>
<tr>
<td>Family Involvement Coordinators</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
</tr>
<tr>
<td>Student and Staff Safety</td>
<td>0.988</td>
<td>0.810</td>
<td>1.083</td>
</tr>
<tr>
<td>Continuous Improvement Coaches</td>
<td>1.250</td>
<td>1.157</td>
<td>0.833</td>
</tr>
</tbody>
</table>
Questions

Michelle Matakas
Director
OSPI-School Apportionment and Financial Services
360-725-6019
michelle.matakas@k12.wa.us
Public Testimony
If you wish to provide public testimony

• Please notify the chairs and facilitators using the chat
• Please limit your testimony to no more than three minutes
Themes from last week’s breakouts
1. More Data Needed

• How many providers of school-based behavioral health services are there?
• How many students need behavioral health services, and how many are receiving them?
• What are the gaps?
2. Identifying examples: what works well?

• What are the ingredients for districts that have been successful in building the capacity to address student behavioral health needs?
• What is common among them?
• What are the differences based upon size, region, and other factors?
3. Cross-agency collaboration and barriers

- Legal issues: confidentiality laws (HIPAA/FERPA); liability concerns
- Alignment of efforts: behavioral health providers & school staff
- CBO partnerships at state and district levels
- More prevention (more Tier 1 supports)
- Agreements and memoranda of understanding between districts and CBOs
4. Statewide supports

- Multi-tiered Systems of Support (MTSS) across the state: universal screening and tiered supports
- Interconnected Systems Framework (ISF) in all schools
- Funding/resources to address diversity of district needs
- Dedicated staffing
- Data systems
5. Training

- Using functional behavior approaches
- Culturally competent and responsive behavioral health services for BIPOC communities
- Partnering with families to better understand student needs
- Understanding behavioral health needs across developmental stages: elementary age, early adolescence, and adolescence
- Pre-service/pre-certification training on behavioral health and suicide prevention
Next month

• Review information on other subcommittee recommendations or agency proposals that this group may wish to support
Scope -- HB 2737 (2020): School-based Behavioral Health and Suicide Prevention

“The advisory group shall advise the full work group on creating and maintaining an integrated system of care through a tiered support framework for kindergarten through twelfth grade school systems defined by the office of the superintendent of public instruction and behavioral health care systems that can rapidly identify students in need of care and effectively link these students to appropriate services, provide age appropriate education on behavioral health and other universal supports for social-emotional wellness for all students, and improve both education and behavioral health outcomes for students.” (Sec. 5)
Breakout Rooms

Recommendations related to scope:

• Integrated system of care through tiered support framework, K-12
• Identify students with behavioral health needs
• Education and prevention
• Link students with behavioral health supports
Begin Refining and Prioritizing

• Within scope?
• Need is clear?
• Who is responsible?
• What is the policy solution?
• What are the costs?
• Time to implement?

• Identify longer-term priorities for 2022 and beyond
Report back
Thank you!