## Legislative Perspective

**Representatives My-Linh Thai and Tina Orwell:**
- 2021 session will be mostly remote. Only day we are scheduled in person is first day to suspend rules to allow remote voting.
- Education committees are intact.
- In House: Early Learning & Human Services is split into Early Learning; Human Services being combined with Housing.
- Priorities: Economic recovery, COVID-19 impacts.
- Very tight focus, much fewer bills.
- Behavioral health will be prominent.
- 988 operational in 7/20/22. New funding mechanism allows us to redesign these systems.
Impacts of COVID-19 pandemic on Child and Youth Behavioral Health

Dr. Kira Mauseth, Dept of Health Behavioral Health Strike Team:
See pages 21-35.
• Primary things we’re seeing – cognitive and learning issues, emotional regulation issues.
• Disasters shine a light on what is and isn’t working well.
• Address with community awareness and bolstering resources.
• Acting in and acting out are common responses.
• Let kids know what they are feeling is normal.
• On a neurological level, people are not able to learn as well during a disaster.
• Avoidance makes fear stronger.

Q&A:
• School districts feel they need some support. Should we take this info and package it for suicide prevention/resiliency info – how do we disseminate to school districts? Conversations are happening at OSPI on best approach.
• What is the capacity for monitoring and surveillance data in public response? We talk about that all the time. WA is very forward with what we do with predicting the data. Walking a fine line between that and responding. Suicide contagion depends on how info is presented. Giving kids accurate info and asking directly reduces risk quite a bit. Surveillance data is really helpful but it is not enough, a piece of the puzzle; have to be careful how we are using it.
• How to work with people’s high emotions/acting out around school closure and opening decisions? When people are angry, in general, it’s because there’s something they’re afraid of underneath. If you can listen and understand what they are feeling, that is helpful. Anger and fear connected – it’s easier for people to express anger. How to interact with individuals who are feeling this distress – it’s a bandwidth issue of whether you can listen to them. Parents are completely overwhelmed; looking for anything that will give them a sense of control. Engage with what the concerns are rather than the anger itself.
• These increased needs coming out of the disillusionment phase seem to correlate with dramatic reductions in services in many areas, i.e. Sound BH reducing staff and services radically in King Co. What can be done to reconcile this increase in demand as supply crashes at the same time? https://www.seattletimes.com/seattle-news/health/king-countys-largest-behavioral-health-contractor-to-lay-off-25-employees-cut-31-other-positions/
• I’ve had a significant increase in parents requesting assessments for ADHD.

Research overview: Where children and youth access behavioral health services

Eric Bruns, Ph.D., UW SMART Center:
Study Rates of mental health service utilization by children and youth across service settings: A meta-analysis
See slides 38-57.
• SMART: Brief intervention model for schools – 4 sessions and triage.
• Schools had the greatest proportion of setting for mental health services received, but were a virtual tie with outpatient providers.
• 9% of youth with symptoms receive residential/inpatient care – how to build up outpatient services and prevention to reduce these numbers?
• Very few studies had data on race.
• Website - https://depts.washington.edu/uwsmart/policycore/
• On website, the Case for School Mental Health. There is other research on site on how school-based mental health helps close the gap.
We need studies that show how kids travel across settings; this study did not do that.
There are ways to increase the rate at which kids get access to community-based services. Are there other studies that indicate how you can make that happen?
Working on another study on the composition of school mental health and MTSS teams.

**Representative Lisa Callan, Co-Chair of the Children and Youth Behavioral Health Work Group:**
- Recommendations from this subgroup are on the agenda for lots of groups – not just CYBHWG; there are many stakeholders.
- Elevating the behavioral health landscape for youth will be important – emergency department data, the DOH behavioral health forecast, etc.
- Stakeholders will need to show that we can’t afford cuts in behavioral health.
- Both chambers are requesting no companion bills; no high-controversy omnibus bills.
- CYBHWG legislators will be looking at targeted legislation; coordinating among legislative champions, being strategic about which bills and budget provisos move forward.
- Strategically look at integration – MTSS, with things like WISE and youth mobile crisis units – furthering racial equity, addressing pandemic impacts, economic recovery, etc.
- OSPI decision packages – Foundational to addressing behavioral health issues early and reducing impacts and costs in the long-term.
- There is political will in both chambers to support foundational public health.
- Will communicate out how people can participate in public testimony.
- Also there will be remote Legislative Days for various constituencies.

**Camille Goldy and Mark McKechnie (OSPI):**
*See slides 60-64.*
- Purpose of this subcommittee: To identify improvements for school-based behavioral health
- Please communicate back out with the people you represent, your peers, your legislators about the recommendations and the decision packages.
- Personal experience often wins the day. Personal stories.
- Context: The components of the staffing decision package the CYBHWG is supporting represent 7% of the K-12 budget; the MTSS decision package represents less than 1% of the K-12 budget.
- Larger work group meeting met yesterday to review and finalize recommendations from the subgroups:
  - Workforce and Rates
  - Prenatal to Five Relational Health
  - School-based Behavioral Health and Suicide Prevention
  - Youth and Young Adult Continuum of Care
- Prioritized recommendations (*slide 57*) - School-based recommendations aren’t included because they are in statements of support.
- Statements of support:
  - National 988 behavioral health crisis number and peer credential bill added.

**Public Testimony**
No requests
| Work plan for coming year | **See slide 68.**  
- Feb. meeting – Ann Gray (OSPI) and Enos Mbajah (HCA) will speak about suicide prevention efforts. |

**Discussion**  
Concern raised by members: We don’t have anything in our recommendations specific to suicide prevention.

- How do we ensure that schools are implementing suicide prevention work?  
- Families, schools, and community providers – nobody has a plan around suicide. Providing someone with a list of signs and symptoms, having a hot line, does not save live. If we’re going to save lives we need a very clear plan on how we’re going to do it that everyone agrees to that is not a huge list of links.  
- Someone has to define – Frontfront has done this – a very clear protocol of what to do. We do not have a suicide plan that is evidence-based that is implemented. Parents knowing their child is in danger doesn’t stop it.  
- Kids are under lots of pressure to keep their friends from killing themselves. And there are not adults they trust to help.  
- There are no requirements in the buildings to provide suicide prevention at all grade levels.  
- Piloting of ESA training really is helpful in providing parents and school staff with tools to do a safety plan.  
- Priority needs to be providing resources in schools and training those who are available to students on research-based strategies across the tiers of help – including research-based school-wide and aged suicide prevention and safety planning.  
- Navigators are now funded, but they are new; OSPI has a partnership with Forefront to provide training to those navigators.  
- We have an opportunity to examine over the next few months what’s happening and how it’s working.  
- Also bring in Social-emotional learning (SEL) advisory committee on their efforts around upstream prevention.  
- SMART Center – pilot work around school-based connections to PAL. |
School-based Behavioral Health and Suicide Prevention Subcommittee

Of the Child and Youth Behavioral Health Work Group

December 4, 2020
Vision

All students prepared for post-secondary pathways, careers, and civic engagement.

Mission

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.

Values

• 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:
**December 4, 2020**

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<tr>
<th>No.</th>
<th>Agenda Item</th>
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<th>Time</th>
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<tbody>
<tr>
<td>1.</td>
<td>Land Acknowledgement</td>
<td>Mark McKechnie, OSPI</td>
<td>9:00 – 9:05</td>
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<td>3.</td>
<td>Overview</td>
<td>Mark McKechnie, OSPI</td>
<td>9:20 – 9:25</td>
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| Break | 10:00 – 10:10 |

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<tbody>
<tr>
<td>1.</td>
<td>Research overview: Where children and youth access behavioral health services</td>
<td>Eric Bruns, Ph.D., UW SMART Center</td>
<td>10:15 – 10:40</td>
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<td>2.</td>
<td>Legislative Perspectives on 2021 Session</td>
<td>Rep. My-Linh Thai, Co-Chair of the SBBHSP Subcommittee and Rep. Lisa Callan, Co-Chair of the Children and Youth Behavioral Health Work Group</td>
<td>10:40 – 11:00</td>
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| Break | 11:00 – 11:10 |

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<tr>
<td>6.</td>
<td>Update on Recommendations for 2021</td>
<td>Camille Goldy and Mark McKechnie</td>
<td>11:10 – 11:25</td>
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<td>7.</td>
<td>Public Testimony</td>
<td>Members</td>
<td>11:25 – 11:35</td>
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<td>8.</td>
<td>Work plan for coming year</td>
<td>Mark McKechnie</td>
<td>11:35 – 11:50</td>
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<td>9.</td>
<td>Close</td>
<td>Co-chairs</td>
<td>11:50 – Noon</td>
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</table>
Welcome Members and Guests
Members

**Co-Chairs:** Rep. My-Linh Thai and 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:**
Justyn Poulos
Mark McKechnie
Robin Howe

**OSPI Special Education:**
Lee Collyer

**Healthcare Authority:**
Rachel Burke
Kimberly Harris
Endalkachew Abebaw
Group Norms
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
• Person first language
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.
Impacts of COVID-19 on Child and Youth Behavioral Health

Kira Mauseth, Ph.D., Co-Lead, Behavioral Health Strike Team
BEHAVIORAL HEALTH IMPACTS OF COVID-19 ON THE K-12 SYSTEM

Kira Mauseth, Ph.D.
Behavioral Health Strike Team
Behavioral Health in WA: General Content and Context

- Defining key terms
- What to expect from a behavioral health standpoint over the next few months
- Understanding impacts to school systems and students
- Recommendations for Behavioral Health Supports in schools
Key Things to Know

Upwards of three million Washingtonians will likely experience clinically significant behavioral health symptoms within the next 2-5 months.

• Depression, anxiety, and acute stress will likely be the most common
• This number may increase dramatically depending on disease spread
• Overlay of stressors: COVID, flu, holidays, Seasonal Affective Disorder, elections, etc.

Violence and aggression will likely increase due to pandemic impacts

• Extreme and/or chronic stressors can leave individuals feeling powerless/loss of control
• “Acting-in” or “Acting-out” will subsequently increase, including both self-harm and interpersonal violence
• Increase in domestic violence compared to 2019, child abuse also likely increasing
Psychological Distress—Under 18 and All Groups, 2019-2020

- Under 18 (+54 per 10k, weekly average)
- All groups (-76 per 10k, weekly average)
Suicidal Ideation—Under 18 and All Groups, 2019-2020

- Under 18 (+66 per 10k, weekly average)
- All groups (-111 per 10k, weekly average)
Suicide Attempt – Under 18 and All Groups, 2019-2020

- Under 18 (+84 per 10k, weekly avg)

Number of Suicide Attempt Related Visits per 10,000 ED Visits (limited to patients under 18 years of age)

- All groups (-13 per 10k, weekly avg)

Number of Suicide Attempt Related Visits per 10,000 ED Visits
Intentional self-harm/suicidal intent up by 5%
  o Over-the-counter medications
  o Misuse of prescribed medications (e.g., atypical antipsychotics)

Substance abuse (wanting to get “high”)
  o Over-the-counter medications, such as antihistamines, cough medicine
  o Illegal substances, such as alcohol and cannabis, up by 34%
Common Responses to Disaster for Children and Teens

Physical Symptoms
• Headaches
• Stomachaches
• Trouble sleeping
• Appetite changes

Changes in Behavior
• Substance abuse
• Increased risk taking
• Acting like there is nothing good in the future
• Acting immature or younger than their age
• Increased tantrums
• Increased clinginess
Common Responses to Disaster for Children and Teens (Cont.)

Changes in Mood
- Worried for the safety of others
- Cranky
- Worried the disaster will happen again
- Too agitated or hyper
- Feeling angry, sad, or fearful

Changes in Thinking
- Trouble concentrating
- Difficulty learning new things
- False belief that it is their fault
- Loss of trust that adults can protect them
Impact of COVID-19 on Education And Learning

• Difficulty paying attention, having a hard time focusing on schoolwork
• Trouble remembering what was learned and remembering to complete tasks
• Having too much energy, acting too silly
• Feeling really tired all the time
• Sleep and appetite disturbances
• Having headaches or stomachaches
• Being cranky, having outbursts, or crying often
• Impulsiveness or having a hard time thinking before speaking or taking action
Priorities For Dealing With The Impact of COVID-19

1. Helping with behavioral symptoms of regression, isolation, \textit{acting out or acting in}
2. Educational deficits which need to be addressed
3. Need for structure and support (e.g., help contain negative behaviors, practice positive behaviors, and increase resiliency)
4. Recognizing that the ability to learn and retain new information is impacted by emotional state
5. Teaching tools for calming and emotional regulation for both parent and child
6. Help children and teens face fears and master them versus anxious avoidance
7. Parental self care is essential for the wellbeing of their children
1. Behavioral Health related professional development for teachers and staff:
   - Not turning teachers into psychologists or counselors.
   - Providing education and information about how people respond to adverse circumstances (what is normal in an abnormal situation).
   - Providing a “toolbox” of resources.

2. Supporting Behavioral Health resources (training, staff etc) as part of a cultural shift.
   - Prioritizing faculty and staff wellness and resilience has double the impact due to social learning theory.
Resources

Training:
Health Support Team (including train-the-trainer)
PsySTART-Responder (frontline healthcare only)

Specific Resources:
Behavioral Health Group Impact Reference Guide
- Healthcare, behavioral health, outreach teams, post-vent
- Unique challenges/considerations
- Support strategies (organizational, supervisory, personal)

Family toolbox:
Supporting Children and Teens During the COVID-19 Pandemic

Emergency and healthcare workers:
Coping During COVID-19 for Emergency and Healthcare Professionals

Businesses and workers:
COVID-19 Guidance for building resilience in the workplace
Resources:

DOH - Forecast and situation reports, guidance, and resources:

State – General mental health resources:

Looking for support?
Call Washington Listens at 1-833-681-0211

Washington State Department of Health | 31
Break (mute/cameras off)
Research overview: Where children and youth access behavioral health services

Eric Bruns, Ph.D., UW SMART Center
Rates of mental health service utilization by children and youth across service settings: A meta-analysis

Mylien T. Duong, Ph.D., Committee for Children
Eric J. Bruns, Ph.D., University of Washington School of Medicine
Seattle, WA, USA

UNIVERSITY of WASHINGTON
Mission: To promote high-quality, culturally-responsive programming to meet the full range of social, emotional, and behavioral (SEB) needs of all students through research, training, technical assistance, and support to policy-making.

https://depts.washington.edu/uwsmart/

Twitter: @SMARTCtr
Co-Authors

> Kristine Lee
> Shanon Cox
> Jessica Coifman
> Aaron R. Lyon
  – University of Washington

> Ashley Mayworm
  – Loyola University Chicago
A need for action

- Rates of mental health disorders in children and adolescents are at historically high rates and rising
- A minority of children and youth in need actually access treatment
- There is a need for national, state, and local strategies that guide how to finance, manage, and support provision of accessible, effective mental health services
Youth access mental health treatment in many settings beyond specialty mental health (e.g., outpatient clinics, community mental health):

- Primary care
- Schools
- Juvenile Justice
- Child protective services
- Other human service agencies
Knowing where youth get MH services is critical to decision-making

- Where to invest our resources
- Which segments of the workforce to target
- Specific prevention and treatment strategies
- Collaboration required across sectors
- Information sharing and management
Research exists, but has yielded a range of conclusions

- That certain systems serve as the “de facto” MH service system for youths
- That services are distributed equitably across sectors
- Variation can be explained by methodological differences
- Results of studies may also be influenced by national/local trends
  - Introduction of SCHIP, expansion of Medicaid
  - Recession of 2008 and subsequent cuts to MH funding
A Systematic review and meta-analysis of U.S. studies of service utilization rates across settings

Primary aim was to estimate proportions of youth receiving services across sectors for samples drawn from:

- General population (“universal”)
- Youth with clinical diagnoses or elevated symptoms
METHOD

• Electronic searches in Ovid Medline, PsycInfo, and CINAHL
• Years: 2000 to present
• Examples of Search terms:
  • Mental health
  • Health services
  • Pediatric populations
  • Service settings
Eligibility criteria:

- Empirical article
- Peer reviewed + grey literature
- Conducted in U.S.
- Study sample included children (5-18 years old or grades K-12)
- Results provided estimates of mental health service utilization in at least two settings.

Search yielded 1452 titles
• This screening process yielded
  • 23 distinct samples drawn from 23 papers
  • 9 samples from general population (151,360 youth total)
  • 14 samples of youth with diagnoses / elevated symptoms (18,614 youth total)
• Settings coded:
  • Outpatient, inpatient, primary care, school, juvenile justice, child welfare, “other”
• Four trained coders coded all studies
• Reliability of coding:
  • ICCs (continuous variables) ranged from .83 to 1.00 (M = .96).
  • Kappas (categorical variables) ranged from .74 to .83 (M = .78)
Proportions of youth receiving MH services across care settings from 9 general population samples (151,360 youth total)
Proportions of youth receiving MH services across care settings from **14 samples of symptomatic youth** (18,614 youth total)
Is there really a *de facto* service system for children and youth?

- Schools and outpatient settings were practically equivalent for both:
  - The general population (7.28% versus 7.26%)
  - Youth with diagnoses / elevated symptoms (22.1%, 20.6%)
- Primary Care and Inpatient rates were lower but not inconsiderable
- JJ and CW rates lower (and hard to interpret)
Youth receive MH care across a wide range of settings

- School and outpatient settings clearly most prominent
  - Smaller but substantial rates of youth with identified need are served in JJ and CW
- Estimated 9% of youth with symptoms receive care in residential/inpatient
Implications

> Build connections across the school and community MH sectors
  - Enhance the capacity of schools to do early identification, service accessibility, and impact
  - Purposeful strategies such as MTSS and the Interconnected Systems Framework (ISF)

> Clear need to invest in prevention / early intervention.
  - Meaningful rates of MH care received in hospitals, JJ and CW
  - Hospitalization has increased 50% in last decade

UNIVERSITY of WASHINGTON
Increasing Access to Care Is Not Enough

> The SMART Center continues to conduct research on, and advocate for, higher quality School Mental Health

- **Accountability framework** for multi-tiered systems of school mental health support (MTSS)
- High-quality, accessible **professional development for school professionals** and **technical assistance for districts** on MTSS and effective SMH
- **Funding for districts and schools** to improve their MTSS and fill gaps in their continuum of SMH services
The Case for School Mental Health

- One in five children and adolescents have a diagnosable mental health disorder, such as depression, anxiety, or attention deficit disorder (NAMI, 2015).
- National surveillance data show that 30% of adolescents have felt so sad or hopeless that they stopped doing usual activities. 33% more Washington students report feeling hopeless in 2018 than in 2008 (HYS, 2018).
- Suicidal thoughts among Washington students have increased 35% from 2008 to 2018 and the number of youth planning suicide has increased by 39% (HYS, 2018).

The Covid-19 pandemic has only increased the crisis in children’s mental health. Over 50% of young people say COVID has negatively impacted their mental health, due to decreased social connections, missed rituals of childhood and adolescence, economic stress on families, and the strains of virtual learning. These impacts are likely to endure long after current COVID restrictions are lifted (Am. Society for Suicide Prevention, 2020).

Providing comprehensive mental health services is critical to student academic success, school safety, and the well-being of our young people.

School mental health is associated with positive mental health outcomes for children and youth. A review of 43 studies found that school-based services are effective at decreasing mental health problems, with targeted services (for individual students with mental health needs) showing particularly strong effects (Sanchez et al., 2017).
For more information

> Eric J. Bruns – ebruns@uw.edu
> Mylien T. Duong – mduong@cfchildren.org
> UW SMART Center -- http://depts.washington.edu/uwsmart
Legislative Preview:
Break (mute/cameras off)
Update on Work Group Recommendations
Prioritized recommendations

Priority 1:
- Inclusion of the 2020 budget proviso [SB 6168, Sec. 211(78), 2020] to increase Medicaid rates for behavioral health services to retain workforce and ensure access. (Passed in 2020 legislative session for 2021 fiscal year; then vetoed as part of pandemic response.) All of the recommendations for improving access and quality of services rely on the ability to recruit and retain a skilled workforce. An increase in existing Medicaid rates for behavioral health services is critical to achieving this goal.
- Continue funding the “Washington State Mental Health Referral Service for Children and Teens” which helps families find providers that accept their insurance. Current funding ends July 1, 2021.

Priority 2: Expand youth mobile crisis services statewide and ensure existing teams can meet increased demand.

Priority 3: Change Medicaid policy to match best practices for mental health assessment and diagnosis of children 0-5, including allowing 3-5 sessions for intake/assessment, in children’s homes and other natural settings.

Priority 4: Establish a workgroup to develop a behavioral health teaching clinic enhancement rate.
[The rate would apply to Behavioral Health Agencies that are training and supervising students and those seeking their certification or license.]

Priority 5:
- Expand the Student Loan Repayment Program to serve 100 additional individuals and reduce existing barriers within the program.
- Preserve existing investments in infant and early childhood mental health consultation
  
  Establish a complex needs fund to address the behavioral health challenges of children ages 0-5.

Priority 6: Direct HCA to explore Medicaid waiver options for respite care for youth with behavioral health challenges, without adversely impacting the DDA and DCYF respite waivers.

Priority 7: Expand availability of youth and family peer services across the continuum of care, reduce barriers to entry and retention, enhance diversity, and ensure peers are supported in their recovery.
Statements of support
The CYBHWG focuses its efforts on behavioral health needs of and services for infants, children, youth and young adults, and their families. To that end, the work group and its subgroups work with and support other groups’ efforts whenever possible, ensuring that the needs of children and youth are considered.

The CYBHWG and its subgroups found that these initiatives, which are beyond the scope of the work group, would help address the issues children, youth, and families experience when trying to access behavioral health services. These recommendations are not prioritized.

CYBHWG activities
- *School-based Behavioral Health & Suicide Prevention subgroup:*
The subgroup will examine funding streams that contribute or could contribute to supporting K-12 students’ emotional well-being and behavioral health (OSPI, HCA, others).
Recommendations presented to Legislature (Support of existing decision packages)

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<td>Provide support for districts to implement equity-based Multi-tiered Systems of Support (MTSS), including the Interconnected Systems Framework (ISF) for behavioral health, through training, coaching, and technical assistance using a consistent, statewide framework. MTSS uses data-based decision making to support improved student outcomes and accountability at each level of the system (state, district, school, classroom, and student). A multi-tiered system of supports (MTSS) is a framework for enhancing the adoption and implementation of a continuum of evidence-based practices to improve important outcomes for all students and decrease adverse outcomes for student groups who experience opportunity gaps. MTSS integrates both academic and non-academic supports to meet the needs of the whole child. By integrating these supports, schools may also increase the efficiency, effectiveness, and sustainability of their services (McIntosh, K., &amp; Goodman, S. 2016). As students (and adults) are experiencing the additional traumatic effects of a global pandemic, MTSS also provides a framework for more effectively integrating behavioral health supports into the school setting. For the purposes of this recommendation, the School-Based Behavioral Health and Suicide Prevention Subcommittee recommends the CYBHWG support the MTSS Decision Package submitted to the 2021 Legislature by the Office of Superintendent of Public Instruction. The package funds 12 regional implementation specialists to train, coach and support districts in order to align policies, personnel, and other resources so that their schools can implement and sustain MTSS with fidelity.</td>
<td>Yes</td>
<td>$4.47 million for the biennium</td>
<td>Supporting Students through Multi-Tiered Systems of Support 2021-2023 Biennial Operating Budget Decision Package</td>
<td>No</td>
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*Lead: Office of the Superintendent of Public Instruction*
Increase staffing levels in schools to support the social/emotional/behavioral health of students.

Increasing staffing will improve Tier 1 universal supports for students, as well as provide increased staffing to provide individual and targeted supports to students with more significant behavioral health needs.

The subcommittee recommends that the Work Group endorse the staffing enhancements proposed by the Office of Superintendent of Public Instruction (OSPI) to support the social/emotional/behavioral well-being of students. The OSPI decision package, “Building Staffing Capacity to Support Student Well-Being,” requests increased staff allocations in the prototypical school funding model for school counselors, school nurses, social workers, psychologists, family engagement coordinators, and student, and staff safety personnel no later than the 2024-25 school year.

The subcommittee recommends support for Components 1 and 2:

- Component 1 of the Decision Package includes more appropriate staffing allocations to help ensure students are in healthy, safe, and productive learning environments.
- Component 2 includes additional days of professional development for certificated and classified staff. This increase phases in over three years, with the end result of six days for certificated instructional staff and classified staff, and three days for certificated administrative staff. The professional development would include, in part, mandatory learning focused on racial literacy and cultural responsiveness. This focus is necessary to accelerate the closure of persistent opportunity gaps. Training on these topics is critical for serving all students, regardless of race. Professional development for racial literacy will be expected of all district personnel statewide on an ongoing basis.

The subcommittee did not discuss and did not make a recommendation on components three or four of the decision package.

Lead: Office of the Superintendent of Public Instruction

| Yes | $194,831,000 for the 2022-23 school and fiscal year |
| No | Building Staffing Capacity to Support Student Well-Being |
Public Comment
If you wish to provide public comment

• Please notify the chairs or facilitator using the chat
• Please limit your comments to no more than three minutes
Future Meetings
Topics/Priorities for 2021

• Education Service District Navigators and HCA on service coordination and capacity around the state
• Resources that support student behavioral health: Medicaid, K-12, private insurance, etc.
• Student assistance programs
• Moving beyond grants and demonstration projects to support student behavioral health
• State Auditor's report
• Tracking progress of recommendations in 2021 Legislative session