# School-based Behavioral Health and Suicide Prevention Subcommittee
*June 4, 2021*

| Members | | | | | |
|---|---|---|---|---|---|
| ☒ | Representative My-Linh Thai, Co-Chair (41st Legislative District) | ☒ | David Crump (Spokane Public Schools) | ☒ | Jeannie Nist (Communities in Schools of Washington) |
| ☒ | Camille Goldy, Co-Chair (Office of the Superintendent of Public Instruction) | ☒ | Myra Hernandez (WA Commission on Hispanic Affairs) | ☐ | Jill Patnode (Kaiser Permanente) |
| ☒ | Tawni Barlow (Medical Lake School District) | ☒ | Avreayl 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) | ☐ | Vacant | ☒ | 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) |
| ☒ | William (Bill) Cheney (Mount Vernon School District) | ☐ | Vacant | ☒ | Erin Wick (AESD) [Alternate: Mick Miller] |
| ☒ | Jerri Clark (Washington PAVE) | ☒ | Joe Neigel (Monroe School District) | ☐ | Kathryn Yates (Chief Leschi School District) |

Staff: Lee Collyer, Mark McKechnie, RJ Monton, and Justyn Poulos (OSPI); Rachel Burke and Kimberly Harris (HCA)

| Agenda Item | Notes |
|---|---|
| Office of the State Auditor (SAO) Performance Audit **K-12 Student behavioral health in Washington: Opportunities to improve access to needed supports and services** | **Carolyn Cato and Nancy Patiño,** Office of the State Auditor *See pages 17-37.*<br>• Key findings – *see page 18.*<br>• Key recommendations – *see page 19.*<br>• Challenges to providing Medicaid services in schools; only two LEAs currently do so – ESD 113 and Spokane Public Schools.<br>• Compared to two model states: Michigan (school districts provide Medicaid services) and South Carolina (school districts contract with MCOs).<br>• South Carolina has a goal of full time MH provider in every public school by 2023. They are already at 60%.<br>• Audit did not include barriers related to private insurance; every SD mentioned this as a problem.<br>• Report to be published on 6/22. View on SAO website: https://sao.wa.gov/performance-audits/featured-performance-audit-report/<br><br>**Discussion**<br>• Issue: fiscal and legal liability at local level rather than state.<br>• Districts are doing what they can within their means – staff care deeply. |

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| | <ul><li>Individuals with Disabilities Education Act (IDEA) requires all student needs be met. But the programs to meet those needs aren't there in all districts because of lack of funding. (examples of students not receiving services raised)</li><li>State model plan for recognition, screening, and response to emotional or behavioral distress in students – RCW 28A.320.127</li><li>Use this report to leverage where we want to go and where we want to be. Adds weight to what we already want to accomplish.</li><li>How much behavioral health should be happening in schools and how much in integrating supports in community? Plus disaster response planning.</li></ul> |
| **Commercial carrier perspective – School-based health care** | **Sarah Kwiatkowski**, Premera Blue Cross, Association of Washington Health Plans<br>*See pages 38-48.*<br><ul><li>51.5% of children in Washington State are covered by employer sponsored insurance (2018 data); 38.7% by Medicaid; 4.0% by non-group insurance; 2.7-other public; 3.1% uninsured (KFF State health facts, 2019).</li><li>There is not a universal case management benefit, or state or federal requirements to provide case management for individuals with high medical/BH needs.<br>*Different for different insurers. Premera – individuals identified/ determined by claims data.*</li><li>Self funded are plans not required to cover mental health benefits. Just requires that if they do cover them, there should be parity with medical surgical benefits. But it is the norm that they are covered. And, in general, benefits in employer-based plans tend to be richer than the minimum.</li></ul><br>*Action item:* Sarah will get information on state/federal rules for commercial insurers to Mark to share with the group.<br><br>**Discussion**<br><ul><li>Parents must consent and youth must sign a release to parent and insurance provider to coordinate insurance billing. As a school based health provider we have multiple students a year that seek out services, and their parents refuse to allow them to participate under the insurance.That is not a barrier that we run into with state funded insurance.</li><li>Confusion for schools:<ul><li>According to HCA, Medicaid-reimbursable School-Based Health Services MUST be included in the IEP. https://www.hca.wa.gov/billers-providers-partners/programs-and-services/school-based-health-care-services-sbhs</li><li>Medicaid rules don't apply to commercial carriers; for them, billable school health service cannot be on the IEP as a related service.</li></ul></li><li>ESD 113: 15-20% of our students receiving behavioral health services have commercial insurance; billing to commercial. Insurers takes up 100% of billing time.</li><li>The School-based Health Care Services Program offered by HCA is a separate fee-for-service program that covers services (for Medicaid eligible students) written into an IEP or IFSP. Districts can contract directly with HCA for this program. And School-based Health Care Services Program is only for those services.</li><li>Useful visual on the ways schools have to navigate payers for Medicaid – page 30 of the report, Children's Regional Behavioral Health Pilot Program (2020).</li><li>Is it time to rethink the full funding model for school-based behavioral health – to one that allows providers to provide quality care to students in the unique environment that occurs being embedded in schools?</li></ul> |

| Updates on Legislative Session | **Representative Lisa Callan; Katherine Mahoney, Camille Goldy, and Mark McKechnie**, OSPI<br>*See pages 49-60.*<br><ul><li>Additional legislation (not in slides):<ul><li>Early childhood consultants and complex needs funds</li><li>Exploration of respite care waiver</li><li>Teaching clinic enhancements.</li><li>Expand scholarships</li><li>Telehealth eval / best practices for children and youth</li><li>Funding for a 12-bed children's long-term facility (CLIP)</li><li>$1M for grants to schools for social-emotional learning and $500,000 for technical assistance on implementation.</li></ul></li><li>Ongoing conversations/strategizing across state agencies around surge – addressing children and youth's critical BH needs.</li><li>Significant federal investments – distribution based on Title I data. Districts have just completed recovery plans for next year.</li><li>For districts interested in applying for support with MTSS implementation, see: https://www.k12.wa.us/student-success/support-programs/multi-tiered-system-supports-mtss</li></ul> |
|---|---|
| **Reflections on the presentations and updates**<br>*Breakout groups* | *See pages 59-60.*<br><br>Resource shared: *Healing the hidden wounds of racial trauma (Kenneth V. Hardy, 2013)*<br>*See page 61.* |
| **Public comment** | *No requests.* |

## Other attendees

Elizabeth Allen, *Tacoma-Pierce County Health Department*
Emily Contreras, *ESD 105*
Tania Fleming
Michelle Karnath, *Clark County Juvenile Justice*
Laurie Lippold, *Partners for Our Children*
Cameron Long, *Legislative staff*
Gwen Loosmore
Alice MacLean, *Legislative staff*
Lorell Noahr, *Washington Education Association*
Melanie Smith, *NAMI Washington*
Scott Swan
Roz Thompson, *Association of Washington Principals*
Jessica Vavrus
Liz Venuto, *Health Care Authority, Division of Behavioral Health & Recovery*
Jackie Yee, *ESD 113*

# School-based Behavioral Health and Suicide Prevention Subcommittee

Of the Child and Youth Behavioral Health Work Group

June 4, 2021

Washington Office of Superintendent of
**PUBLIC INSTRUCTION**

**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

Washington Office of Superintendent of
**PUBLIC INSTRUCTION**

# Equity Statement

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.

Washington Office of Superintendent of
**PUBLIC INSTRUCTION**

# Tribal Land Acknowledgment

For those of us in the Olympia area, we acknowledge that this meeting is being held on the traditional lands of the Squaxin Island Tribe. Descendants of the maritime people who lived and prospered along the shores of the southern-most inlets of the Salish Sea for untold centuries.

We ask that the participants of this meeting honor the Tribal lands on which each of you are located today. On the lands of Tribes located on the coast, to the Tribes on the central plateau, to those along the Columbia, Spokane and other rivers, and to those living in the foothills of the Cascade Mountains.

We acknowledge the commitment of all Pacific Northwest Tribes to the resurgence of their traditional ways and their respect and protection of all people, not only those who are living, but also those who have gone before and who are yet to be born. We pay our respect to the elders both past and present and to a valued resource the Tribes have defined as their children. They are the Tribes' future.

# Agenda:
# June 4, 2021

| No. | Agenda Item | Leads | Time |
|-----|-------------|-------|------|
| **1.** | Introductions, Group Agreements, and Housekeeping | Rep. Thai and Camille Goldy | 9:00 – 9:15 |
| **2.** | Secretary of State Performance Audit: "K-12 Student Behavioral Health in Washington: Opportunities to improve access to needed supports and services" | Carolyn Cato, Senior Performance Auditor, Office of the Washington State Auditor | 9:15 – 9:45 |
| **3.** | Private/Group Insurance Coverage of School-based Behavioral Health Services | Sarah Kwiatkowski, Senior Manager for Legislative Policy, Premera Blue Cross | 9:45 – 10:15 |

| | | | |
|-----|-------------|-------|------|
| | Break | | 10:15 – 10:30 |
| 1. | Updates on Legislative Session | Rep. Thai and Camille Goldy | 10:30 – 11:00 |
| 5. | Time to reflect on the presentations and updates | Breakout groups | 11:00 – 11:25 |
| | Stretch Break | | 11:25 – 11:30 |
| 6. | Breakout report back | Large Group | 11:30 – 11:45 |
| 7. | Public comment | | 11:45 – 11:55 |
| 8. | Close | Co-chair | 11:55 – Noon |

# Welcome Members and Guests

# Members

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

**Voices of Families and Young People:**
Brooklyn Brunette
Jason Steege
Kathryn Yates
Katrice Thabet-Chapin
Molly Merkle
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

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:**

Mark McKechnie

Justyn Poulos

RJ Monton

**OSPI Special Education:**

Lee Collyer

**Healthcare Authority:**

Rachel Burke

Kimberly Harris

Endalkachew Abebaw

# Group Agreements

- 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

# K-12 Student Behavioral Health in Washington:

## Opportunities to improve access to needed supports and services

Carolyn Cato, *Senior Performance Auditor*
Nancy Patiño, *Performance Auditor*

School-based Behavioral Health and
Suicide Prevention Subcommittee
June 4, 2021

Office of the
Washington
State Auditor
Pat McCarthy

# Key audit findings

- Student access to behavioral health supports depends significantly on what schools are able to provide to them.

- The state's approach to student behavioral health is fragmented and lacks sufficient resources.

- Fundamental changes are needed to address issues in the current structure. State and local agencies can also make incremental changes to help improve student access to services.

# Key audit recommendations

To the Legislature:

- Address fragmentation in the existing structure to provide greater state-level coordination and direction.

To the Health Care Authority:

- Improve the existing state system's ability to connect students with behavioral health prevention and early intervention services.

To the Office of Superintendent of Public Instruction:

- Address shortcomings in its model plan for recognizing and responding to students in emotional distress.

# The audit asked…
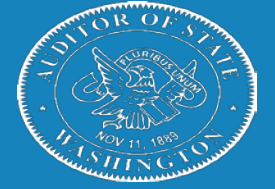
1.  Are there opportunities for state agencies, educational service districts and school districts to better identify and connect Washington students to needed services?

2.  Can state agencies, educational service districts, and school districts reduce barriers to accessing these services and improve coordination of them?

Work conducted during the audit:
1.  Met with state, regional and local agencies
2.  Researched leading practices and issues on student behavioral health
3.  Surveyed 499 schools in 50 districts; received nearly 400 responses
4.  Interviewed school and district officials from 17 districts

# Most schools have not implemented a full continuum of supports

Only 42 percent of schools provide in-school supports that cover the full continuum of prevention and early intervention activities

| Tier 1: Prevention | Promotion of positive social, emotional and behavioral wellness for **all students** |
| Tier 2: Early Intervention | Supports for students identified for being **at risk** for behavioral health concerns |
| Tier 3: Referrals for treatment | **Targeted intervention** and services for students with serious concerns |
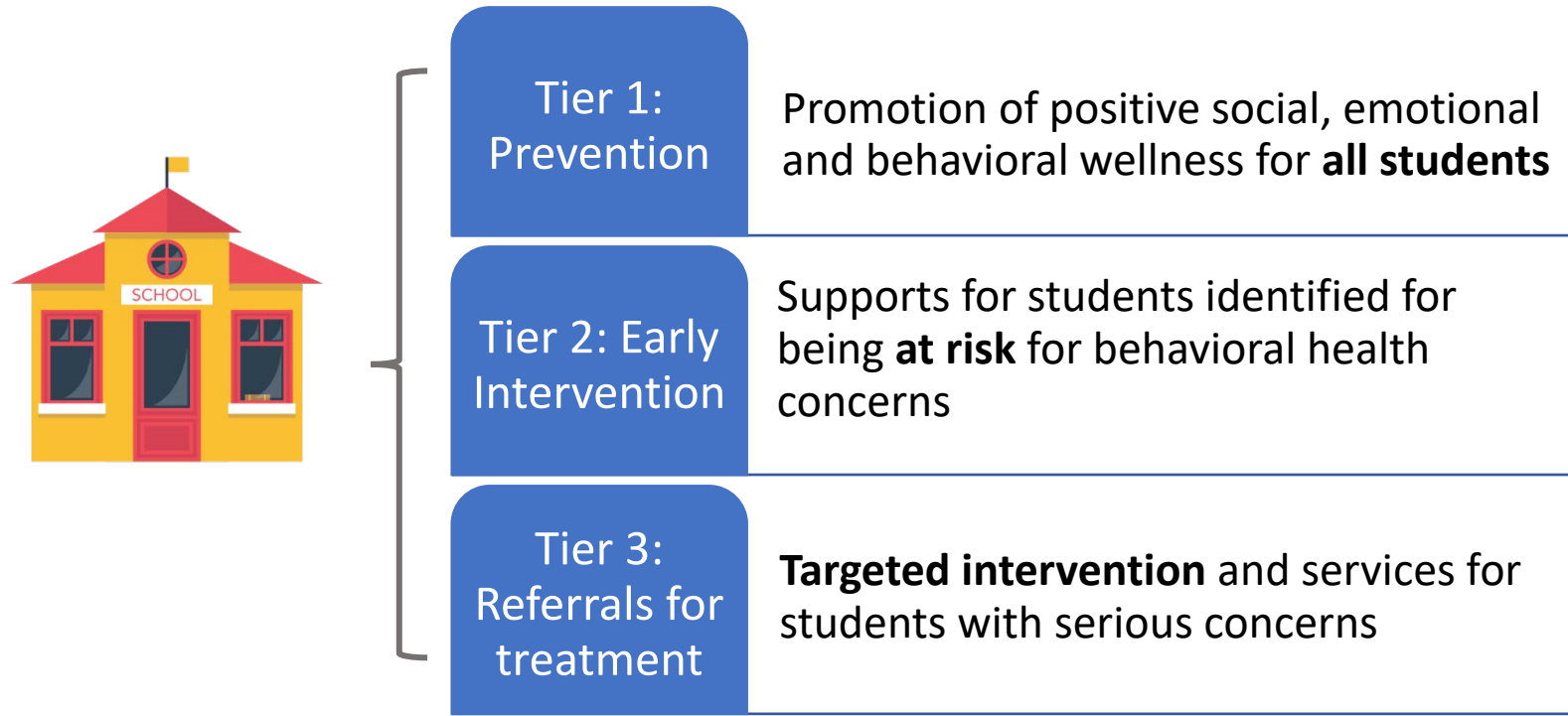
# Few schools screened students systematically



40%
No screening;
Don't know;
Other

18%
Screen all students

14%
Screen some subset of students
(for example, by grade or at-risk)

28%
Screen on
individual
basis
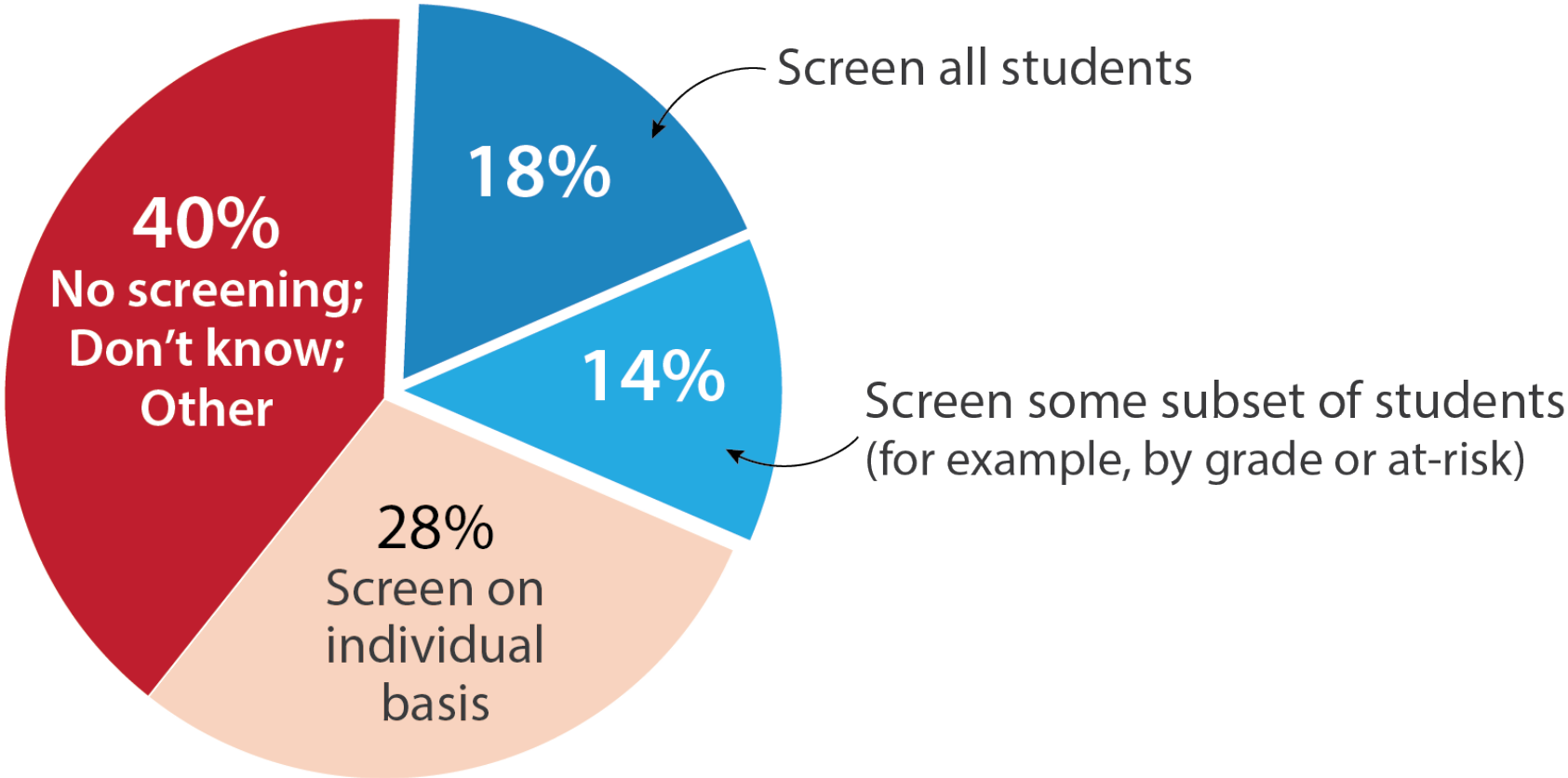
# Most schools have trained staff and dedicated person to respond to concerns

Well-trained staff who can support behavioral health needs

| | |
|---|---|
| Trained some staff | 71% |
| Trained all staff | 19% |
| Don't train staff/Don't know | 10% |
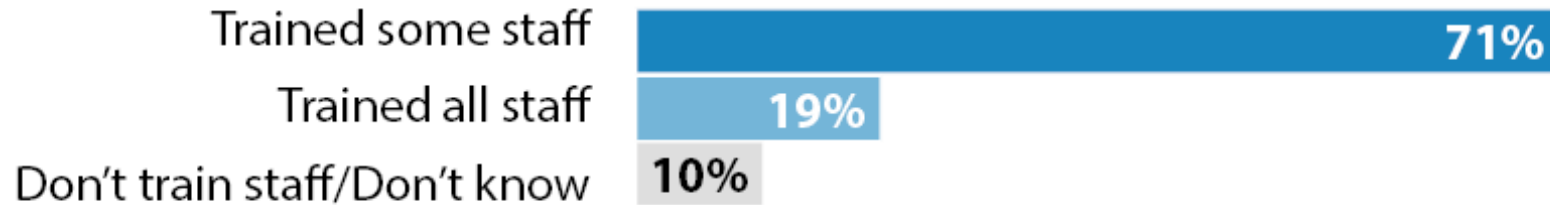
Almost 7 out of 10 reported having either a dedicated staff person or team to respond to concerns

Tracked data on behavioral health outcomes and needs

| | |
|---|---|
| Monitor data for all students | 54% |
| Monitor data for at-risk students | 28% |
| Don't monitor data/Don't know | 18% |

# The state's approach to K-12 student behavioral health is fragmented

Roles and responsibilities assigned across several local and state agencies, resulting in:

- No oversight for school districts to develop behavioral health plans

- Limited ability to provide support to school districts

- Lack of strategic and comprehensive direction, with no state level oversight or guidance

# Current approach has relied on districts to develop plans on their own
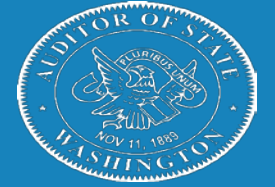
School districts are required to develop district plans to recognize and respond to student emotional distress

**District plans must:**

1. Identify training opportunities
2. Address how to use trained staff
3. Detail how staff should respond to concerns
4. Develop partnerships with community organizations

*RCW 28A.320.127*

- Only 3 of 20 district plans reviewed fully met requirements



- OSPI's model plan to support school districts does not fully meet requirements

- OSPI will begin monitoring plans during 2021-22 school year

# Educational Service Districts can only provide limited support

Educational Service Districts provide behavioral health supports through regional school safety centers.

Centers were intended to:

- Help districts develop and implement required plans

- Offer training opportunities for district staff

- Facilitate partnerships with community providers

But, ESDs have had limited capacity to fully meet requirements

- Legislative bill for regional safety centers was not fully funded

- In July 2020, the Legislature funded nine staff positions to support ESDs

# Gaps in the current structure require improved state-level coordination

- State laws direct local and state agencies to implement a patchwork of behavioral health requirements.

  They do not designate a state agency to oversee behavioral health services in K-12 education.

- Neither HCA nor OSPI are able to provide state-level programs and resources sufficient to help districts implement comprehensive behavioral health systems.

This results in a lack of strategic direction, with no state-level oversight or guidance for school districts.

# Current approach lacks needed resources

Funding and restrictions hinder the state's main prevention program: Community Prevention and Wellness Initiative

Program funding was $32 million during the 2019-21 biennium

- Serves only 6% of public schools
- Focused on substance use prevention

# Leading practices suggest benefits to greater state-level direction, coordination

**State-level leading practices**

- Support schools, to help them establish a behavioral health system

- Coordination, to promote goal setting across education and health agencies

- Establish an advisory council:
  - Develop strategic direction
  - Provide guidance and funding to school districts
  - Monitor activities
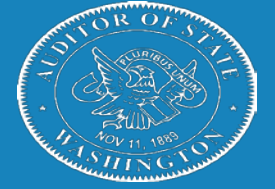
# Legislature can promote greater state-level direction

**Designate a lead agency**

- Coordinate strategic direction and local activities with key partners
- Provide technical support to school districts
- Facilitate the advisory council's meetings

# HCA can help educational agencies better access Medicaid services

Medicaid allows ESDs and districts to become providers and deliver behavioral health services in schools

But, educational agencies noted challenges with doing so:

1.  Lack of expertise to navigate the medical field
2.  Time and costs involved in billing multiple managed care organizations
3.  Lack of resources to complete the process

# Other states help educational agencies provide Medicaid services

## Michigan

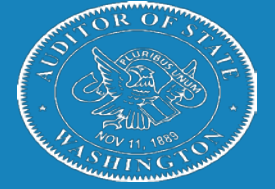- Received federal approval to streamline billing process

- Developed program guide for school-based services

- Created advisory council to support program implementation – Legislature allocated $17 million

## South Carolina

- Facilitated collaboration before transition to managed care

- Standardized contract and forms with managed care organizations

- Prepared school districts to bill managed care organizations

# HCA could seek a federal waiver to expand student eligibility for Medicaid

More than 40 percent of surveyed schools identified parental reluctance to access services for their students as a barrier

- HCA's 1115 Medicaid Waiver, the Family Planning Only Program, addresses this barrier in reproductive health services
  - Covers all youth: private insured, uninsured, Medicaid-enrolled

A similar waiver for behavioral health services could expand student eligibility

# HCA should monitor providers to ensure screenings occur

HCA lacks full assurance that Medicaid-eligible children are receiving the behavioral health screenings they are entitled to.

Screenings can be conducted by:

- Standardized screening tool (separate billing code)
- Interview screening (only recorded in patient's medical records)

HCA's contractor does not currently review the medical records to determine if screenings took place

Well-child checkups (2018-19)

**55%**
No documented screening

**45%**
Documented screening or treatment
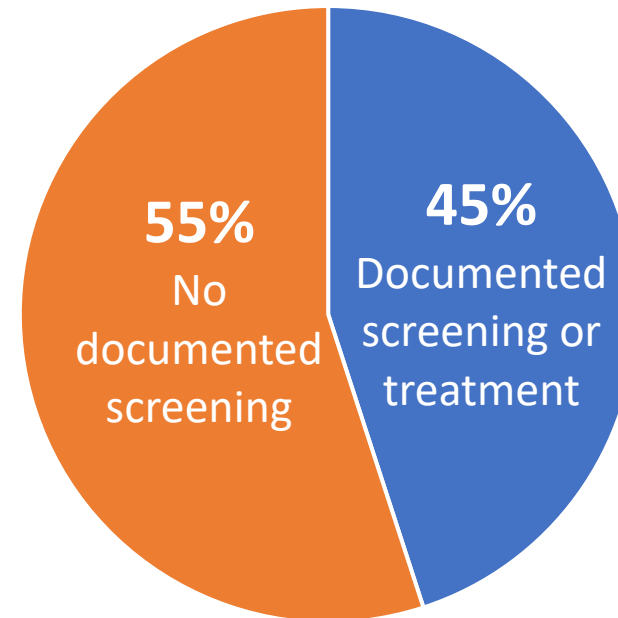
# To view a copy of the published report

- Audit report due to publish on June 22, 2021

- After publication, view on our website at: sao.wa.gov/performance-audits/featured-performance-audit-report/

# Questions

# Contact Information

**Pat McCarthy**

State Auditor

Pat.McCarthy@sao.wa.gov

(564) 999-0801

**Scott Frank**

Director of Performance & IT Audit

Scott.Frank@sao.wa.gov

(564) 999-0809

**Carolyn Cato**

Senior Performance Auditor

Carolyn.Cato@sao.wa.gov

(564) 999-0848

Website: www.sao.wa.gov
Twitter: @WAStateAuditor
Facebook: WAStateAuditorsOffice
LinkedIn: Washington State Auditor's Office

# Commercial Carrier Perspective – School Based Health Care

Sarah Kwiatkowski, Premera Blue Cross

AWHP Commercial Carrier Representative

June 4, 2021

# What is commercial insurance?

# Let's level set – what are we talking about when we say "commercial"

- Self-Funded employer plans
  - Large employers
  - Employer as the risk
  - Benefits and coverage governed by federal requirements, not state

Regulated by federal government (ERISA law and other federal laws)

- Fully Insured plans
  - Individual plans (on & off Exchange)
  - Small group employer plans
  - Large group employer plans (+50 employees)

Regulated by the state

# Who are the commercial carriers in our state?

- Aetna
- Asuris Northwest Health
- Cigna
- Community Health Network of Washington
- Coordinated Care
- Bridgespan
- Kaiser Foundation Health Plan of Washington
- Kaiser Foundation Health Plan of the NW
- Kaiser Permanente
- LifeWise
- Molina
- PacificSource Health Plan
- Premera Blue Cross
- Providence Health Plan
- Regence BlueShield of Oregon
- Regence BlueShield
- United Health Care

# Covered benefits + Provider relationships

# Benefits differ depending on type of health plan

## Fully insured small and Individual market plans

- **Essential Health Benefits**
  - Includes both mental health & substance use disorder services
  - States set the "benchmark" for the EHB.
  - WA's benchmark can be found [here](#).

- Health plans may design different plan designs and benefit structures, including cost-sharing, virtual provider access, and other designs

- Mental Health Parity Applies

## Large group fully insured & Self–funded group plans

- EHB requirement does *not* apply

- **Federal Mental Health Parity** law does apply
  - MHPAEA does not require large group health plans or health insurance issuers to cover MH/SUD benefits
  - Requires general equivalence in the way MH/SUD and Med/Surg benefits are treated

- **WA law** – fully insured group
  - [RCW 48.44.240](#) – chemical dependency
  - [RCW 48.44.341](#) – mental health services
  - [RCW 48.43.093](#) – emergency services, includes MH/SUD

# Access to Care

## Networks

- Most health plans contract with providers & hospitals to deliver care to members.

- In-network providers can't charge more than the members' cost-sharing.

- Provider follow contract terms, including how to bill and ensuring "clean claims" are submitted

## Out of Network

- Some providers don't contract, they may still bill insurance. The health plan may pay depending on plan design.

- What isn't covered by insurance may be a balance bill. See more here.

# What does this mean for school- based health clinics?

**This is driven primarily by benefits**.

✓If covered (i.e. licensed) BH clinicians provide services in school settings, those will be covered as long as the usual benefit parameters are met, e.g. the member is on the plan, the diagnosis is not an exclusion, the service is not an exclusion or investigational, the clinician is practicing within her/his legal scope of licensure

✓The service is medically necessary.

✓The service is not a service that the school system is required to provide; for example, if a service is specified in an IEP or a 504 plan, then the school system is required to provide it.

# What does this mean for school- based health clinics?

AWHP member survey

**Contract status:**

- Some commercial carriers contract directly with School Based Health clinics.

- Some clinics are staffed by providers with whom the carrier has a contractual relationship and claims from those providers would be reimbursed, though the school clinic is not under contract.

- Carriers who do not contract with school-based health centers reimburse covered claims at the out-of-network level if the enrollee's health plan includes OON coverage.

# What does this mean for school- based health clinics?

AWHP member survey

**Identified Barriers:**

- Lack of providers in schools, lack of contractual relationships with SBHCs, limited claims received from providers

- Stigma young people may feel in getting services during school

**Issues to work on**:

- Increasing the number of BH providers in school settings requires:
  - competitive pay,
  - adequate dedicated space, and
  - for some schools or school districts, an evolution in perspective on integrating BH clinicians into the school setting.

# Questions?

Contact information: Sarah Kwiatkowski,
sarah.kwiatkowski@premera.com

# Legislative Updates

# Funding for Behavioral health

- *$6.5M General Funds-State (GFS)/$17.509M total (includes federal funding through Medicaid).*
  *For children and adults, increases provider rates for behavioral health services by 15% (not to exceed the Medicaid rate) for individual, family and group therapy related to a primary medical diagnosis; assessment, and other behavioral health supports, effective October 1, 2021.*

- Continue funding the "Washington State Mental Health Referral Service for Children and Teens" which helps families find providers that accept their insurance, and PAL for Moms, which supports physicians treating post-partum depression.

# Funding for Behavioral Health, continued

- Expand youth mobile crisis services statewide and ensure existing teams can meet increased demand.
  *Senate Bill 5092: $25.848M GFS/$38.579M total\* for adult and youth mobile crisis services.*

- Expand the Student Loan Repayment Program and reduce existing barriers within the program.
  *Senate Bill 5092: $8.25M GFS/Total. Provides additional funds for behavioral health students.*

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# MTSS Implementation

- OSPI received a portion of the funds requested through a proviso (SB 5092.
- Focus:
  - Adding MTSS Implementation Coordinator Positions in two ESDs: 105 and 114
  - Adding a OSPI MTSS Data Manager to help design, collect, analyze and report data related to MTSS implementation and impacts on student outcomes
- Planning for the 2021-2023 funds is underway

- Existing federal grants fund MTSS Implementation Coordinator positions in ESDs 101, 112, 113, 121, 123, 171, and 189

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# School Counselors

Starting in the 2022-23 school year, high poverty schools in each grade band will be funded with an additional .5 FTE for school counselors.

# Bills of Interest

- HB 1373: Promoting student access to information about behavioral health resources.
- HB 1477: Implementing the national 988 system to enhance and expand behavioral health crisis response and suicide prevention services.
- HB 1225: Concerning school-based health centers
- 1325: recommendations from the Children & Youth Behavioral Health Workgroup (Extending the PAL for mom's program, the mental health referral assist program, and expanding birth to 5 mental health services)
- 1363: Addressing secondary traumatic stress (resource page on OSPI's website and WSSDA model policy)
- Funding to Attorney General's office for Youth Tip Line

# Breakouts

# Breakout Room Discussions

- What are your takeaways from presentations we've heard in 2021:
  - Medicaid and other public behavioral health programs
  - Private insurance coverage
  - Audit

- What are some ideas you would like the group to consider for recommendations in 2022? (We will be submitting them to the full work group in October.)

Washington Office of Superintendent of
**PUBLIC INSTRUCTION**

# Padlet

https://padlet.com/markmckechnie/ermqgk8omfjvp83y

# Next meeting

Friday, August 6, 2021

9:00 am - Noon

**padlet**

# School-based Behavioral Health and Suicide Prevention, 6/4/21

Breakout rooms

**MARK MCKECHNIE**   JUN 04, 2021 12:05AM

## Column 1

**ANONYMOUS**   JUN 04, 2021 06:27PM

### Ideas:

State Medicaid plan change to cover all school-based behavioral health services. HCA apply for a waiver for pilot to demonstrate cost-benefit of this model.
Population-based services (tier 1& 2 services & supports, staff training)
Identify areas to be proactive. Specifically around trauma (!!). Racial trauma.
Providers/teachers getting training in responding to racial trauma.
Culturally inclusive services. (How will districts recruit BIPOC counselors with their new FTE).
Are districts prepared to talk about race/racism?

**ANONYMOUS**   JUN 04, 2021 06:17PM

### Takeaways: why are we continuing to try and force systems to adapt to what we need rather than create systems to respond to what we need.

Benefits of the last year--reduction of stigma around mental health. Brings opportunities.

**MARK MCKECHNIE**   JUN 04, 2021 12:08AM

### BR 1 Reflections

**MARK MCKECHNIE**   JUN 04, 2021 12:08AM

### BR 1 Recommendations

## BR 2

**MARK MCKECHNIE**   JUN 04, 2021 12:10AM

### BR 2 Reflections

*It has been a long year. Appreciated the conversation today and audit report. Surprised by fact tht 41% schools were providing BH across a continuum. (BC) – Take this statistic cautiously. (TB) Variability, local control, need accountabilit for MTSS. Confusing when we have law and no funding to support adherence and improvement. Concerned that what we want to do does not match up with values. (Rep - Callan) - seeing lack of Parity across state. Seeing emerging workload burden for school districts to figure out BH funding/reimbursement.*

— ANONYMOUS

**MARK MCKECHNIE**   JUN 04, 2021 12:10AM

### BR 2 Recommendations

*need to spell out for legislators what Tier 1/2/3 are.*
— ANONYMOUS

*BC - reccommendations to support and development of comprehensive and aligned school based mental health support systems (w/ MTSS), agreed upon strategy, policy and funding.*
— ANONYMOUS

*TB - very small district doing work and trying to create ripple effect for the state (Medical Lake) - small district big effect?*
— ANONYMOUS

*Need for superintendents to be trained up in MTSS implementation - and how to lead that change.* — ANONYMOUS

*who needs to be at the table to create balance and movement around MTSS implementation. Break down silos.*
— ANONYMOUS

## BR 3

**MARK MCKECHNIE**   JUN 04, 2021 12:10AM

### BR 3 Reflections

*Expanding Medicaid appears to have been pushed back on the school districts to partner with MCOs.* — **LEE COLLYER**

*How would this work if schools do not have the infrastructure to do this?* — **LEE COLLYER**

*How do we get professionals embedded in schools?* — **LEE COLLYER**

*Need to support districts to build functioning MTSS systems.* — **LEE COLLYER**

*Expand family planning only program to support confidential behavioral health services* — **LEE COLLYER**

*Integrating SEL effectively into all curriculum.* — **LEE COLLYER**

**MARK MCKECHNIE**  JUN 04, 2021 12:10AM

## BR 3 Recommendations

*The whole community surrounding a student needs to be able to access care.* — **LEE COLLYER**

*All Students served no matter what.* — **LEE COLLYER**

*Effective suicide prevention and safety planning* — **LEE COLLYER**

# BR 4

**JUSTYN POULOS**  JUN 04, 2021 06:28PM

## Reflections

disconnect between IEP and school provided services for school-based health services. - what influence does this group have for school-district buy-in and engagement?

We continue to have disconnect and inconsistencies in services and organizations.  How do we break down barriers?

unclear of reporting and accountability mechanisms for RCW 28A.320.127

How do we procure services and allow for flexible and direct funding?

Training and technical assistance to districts is necessary - funding, staffing, workforce support.

how do we track strengths-based outcomes for SEL?

What's the role of community based organizations and how are they built into our measures and systems?

How are we embedding equity/CR practices into our recommendations of this group?

How do we disrupt school to prison pipeline - less punitive for unmet needs, disability conditions, etc.?

**JUSTYN POULOS**  JUN 04, 2021 06:27PM

## Group 4:

Jerri Clark, Jeannie Nist, Eric Bruns, Rachel Burke, Justyn Poulos, Michelle Karnath

**MARK MCKECHNIE**  JUN 04, 2021 03:20PM

## BR 4 Reflections

**MARK MCKECHNIE**  JUN 04, 2021 03:20PM

## BR 4 Recommendations

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# Healing the Hidden Wounds of Racial Trauma

*Kenneth V. Hardy*

A disproportionate number of children and youth of color fail in school and become trapped in the pipelines of treatment, social service, and justice systems. This article examines racial trauma and highlights strategies for healing and transformation.

All service systems for youth encounter young people of color who can be challenging to treat, reach, and teach. Our difficulty in meeting their needs is not just because of greater "pathology" or "resistance" as some assert. Rather, we fail to appreciate the ways in which race is entangled with their suffering.

### Race-Related Trauma Wounds

Racial oppression is a traumatic form of interpersonal violence which can lacerate the spirit, scar the soul, and puncture the psyche. Without a clear and descriptive language to describe this experience, those who suffer cannot coherently convey their pain, let alone heal. The source of their hurt is often confused with distracting secondary symptoms ranging from hopelessness to acting out behavior. Racial oppression is seldom seen as contributing to these difficulties, and discussions of race are dismissed as manufacturing excuses, justifying bad behavior. As with other forms of trauma, we ask the wrong question about struggling youth of color. Instead of asking "What is wrong with them?" we need to ask the trauma-informed question, "What has happened to them?"

Rarely is unmasking and treating the hidden wounds of racial trauma a focal point of intervention. Instead, conventional approaches attend to family problems, individual psychological issues, behavioral problems, affect disorders, and substance misuse (Hardy & Qureshi, 2012). These are salient factors but skirt issues of race which are powerful dynamics in the lives of youth of color. These are insidious, mostly invisible, and virtually inextricable from the other difficulties that youth are experiencing. To work effectively with youth of color, we must understand, address, and ultimately heal the hidden wounds of racial oppression.

### Internalized Devaluation

A toxic human mold, hard to see yet ever spreading, gnaws at the dignity of youth of color. They are oblivious to this infection but emotionally reactive to its effects (Hardy & Qureshi, 2012). *Internalized devaluation* is a direct by-product of racism, inextricably linked to the deification of whiteness and the demonization of non-white hues. It is perpetrated throughout society, including in the very systems with the stated mission of serving youth. For example, when youth of color are removed from their families and placed in a residential setting, they observe that most of their peers in care look like them. This reinforces a powerful message internalized since childhood—"I am bad and unworthy." Racial devaluation is intertwined with other affronts to dignity such as neglect, abuse, and rejection. While

> *Racial oppression is a traumatic form of interpersonal violence which can lacerate the spirit, scar the soul, and puncture the psyche.*

treatment protocols may be designed to address familial dynamics, scant or no attention is given to underlying racial wounds.

Profoundly devalued youth become hypervigilant about gaining respect (Hardy & Laszloffy, 2005). They intuitively understand that respect is the perfect elixir for devaluation. While they would be hard-pressed to explain why respect is so important, they seem to *know* experientially that respect reduces the intensity of the uneasiness of devaluation. To some of these youth, death is preferable to disrespect.

### Assaulted Sense of Self

There is a second hidden trauma wound that is closely tied to internalized devaluation and ultimately racial oppression. The *assaulted sense of self* is the culmination of recurring experiences with internalized devaluation. Continual exposure to devaluation shapes how youth of color see themselves. It becomes very challenging to develop a healthy sense of self when one's emotional-psychological milieu is inundated with the repeated race-related messages such as: *you are not as attractive as...not as smart as... too dumb to...not intelligent enough to... ain't ever going to be anything...not college material...not welcomed here...*and so forth. The onslaught of devaluing messages makes it hard for youth to know who they really are—and easy to believe they are what others say. This is the essence of the assaulted sense of self. Unfortunately, it strikes at one of the most vulnerable stages of the life cycle: adolescence, when youth are forming their identities.

### Internalized Voicelessness

The third hidden wound of *internalized voicelessness* erodes the ability to defend against a barrage of unwelcomed and unjustified negative, debilitating messages. While these wounds are described here in a linear and distinct fashion, they are experienced in a systemic, inter-tangled way. For example, voicelessness both results from and fuels internalized devaluation and an assaulted sense of self. While voicelessness does not literally render the youth silent, it impairs the ability to advocate for oneself. Angel, a seventeen-year-old Latino, shared this example with his therapist:

"Dog, it's crazy out there as a Latino...; everybody looks at you all the time like something is getting ready to go down. I mean, I get on the E Train (subway) and suddenly all eyes are on you like you are a thief, rapist, or burglar. I see the looks.... I know the looks cuz they happen all the time. At times, I want to go over to them, you know, mostly white people, and say 'hey, I know what you're thinking and I ain't no robber'. But I ain't stupid. I know I can't say s--- cuz the minute I try to say something like that, the next thing you know, the person start screaming and yelling, I am dead! You and I know what happens next...here comes the Po-Po and the next thing you know I'm on lock down for just trying to tell some racist M----- F-----, I ain't trying to rob them. Man, it's messed up out there!"

## *Many youth of color, like their adult counterparts, suffer from the race-related trauma wound of rage.*

Angel never mentions the word *voicelessness* but his experience on the subway describes it perfectly. He is both a victim and a prisoner of others' perceptions of him. His options are severely limited, especially his ability to advocate for himself. From his perspective, he either speaks up and risks appearing to be threatening or remains silent and has his sense of self further assaulted. No matter how much he repudiates the views others have of him, he has little to no ability to effectively address or alter them. Consequently, he suppresses his feelings while planting the seeds of rage.

### The Wound of Rage

Many youth of color, like their adult counterparts, suffer from the race-related trauma wound of rage. It is virtually impossible to be the depository of perpetual negative and debilitating messages and have one's sense of self assaulted without experiencing rage. Rage can be a deep-seated emotional response to experiences of degradation and devaluation. Rage builds over time as a result of cumulative suppressed emotions precipitated by voicelessness. It is distinguishable from anger, which is an emotion connected to immediate experiences. Rage is a very complex emotion that can appear as anger, explosiveness, sadness, and depression. Youth of color are often prescribed anger management interventions, while rage from the hidden wound of racial oppression remains unaddressed.

### The Case of a Nobody

Fourteen-year-old Assad sat nervously shaking his left leg while staring off to a far-off place. He appeared disengaged and verbally unresponsive to questions posed by his therapist while passively expressing disdain for having to be present. Intermittently, he would check the time on his cell phone which produced an audible sigh. After twenty minutes of attempts to engage Assad, a break-through finally came. He looked at his therapist and asked in a very soft voice: "Why are you wasting your time?"

"What do you mean?" his therapist responded.

"With me," he stated flatly.

"Well, I don't consider this a waste of time at all. In fact, there are ways in which you remind me of myself years ago," the therapist noted.

Assad quickly dismissed the claim and noted, "There is no way I can remind you of you or anybody else!"

Surprised by Assad's expression of such strong emotion, the therapist cautiously asked, "What do you mean?"

"I mean, I'm a NOBODY....I ain't s--- and never gonna be s---...and that's a fact, so you are wasting your time."

"I just wonder whose voice that is that you are repeating, because that is not how I see you or what my experience with you has been. I see you as a gifted young brother."

Assad became quickly animated and slightly agitated as he stated: "Then you are clueless Doc...and WHOSE voice? ...WHOSE voice? You wanna know whose voice? It's everybody's voice. It's my mom's voice, which is why she don't come around more. It's my dad's voice, which is why he has never stepped up. It's the f---in' cops' voices, which is why they just dis' us, beat us, and kill us like we are a bunch of f---in' animals. It's the teachers' voices who come right out and tell you in so many words that you dumb as s--- and you ain't going to be nothing. C'mon Doc, you better get with it. You can't be as dumb as you trying to sound, dog. Look at Obama and all those smarts that he has. He gets the same message. They let him know that 'Yo, you might be President and s---, but you still ain't nobody....as far as we are concerned you are just another nigger!'"

Beneath Assad's seemingly disjointed and accusatory "outbursts" are the hidden wounds of racial oppression. His sense of hopelessness, despair, and rage are the by-products of chronic and repeated experiences of being systematically devalued and having his sense of self assaulted. His "angry self-absolving rant" lacks psychological sophistication, appropriate usage of Standard English, or evidence of any understanding of the nameless condition that plagues him. Still, it accurately describes the world of a youth of color in a society that seems hopelessly organized by race. But since Assad is clueless about the hidden wounds that shape how he sees himself, he cannot see the wall-less prison that racial oppression has placed around him.

For many youth of color, such issues are central to their healing and transformation but seldom addressed. Traditional interventions designed to "help" Assad and those like him would focus on goals such as: a) being more accountable and taking responsibility for his actions; b) being more respectful and using less profanity; c) examining his usage of the "N" word; d) getting his mother more involved in the treatment process; e) processing his feelings regarding the loss of a relationship with his father; e) anger management; and f) setting more positive goals for himself. While these goals are highly germane to the "rehabilitation" and "transformation" of Assad, they do very little to address the hidden wounds of racial oppression.

### Healing Hidden Wounds

We may not be able to prevent youth of color from being exposed to racially injurious and traumatizing conditions (Calvert, 1997). However, it is imperative that treatment protocols integrate steps to heal these hidden wounds. This does not require abandoning established treatment methods, but incorporating effective strategies to address racial oppression within standard operating procedures. Promoting healing involves eight critical and interrelated steps which are summarized below:
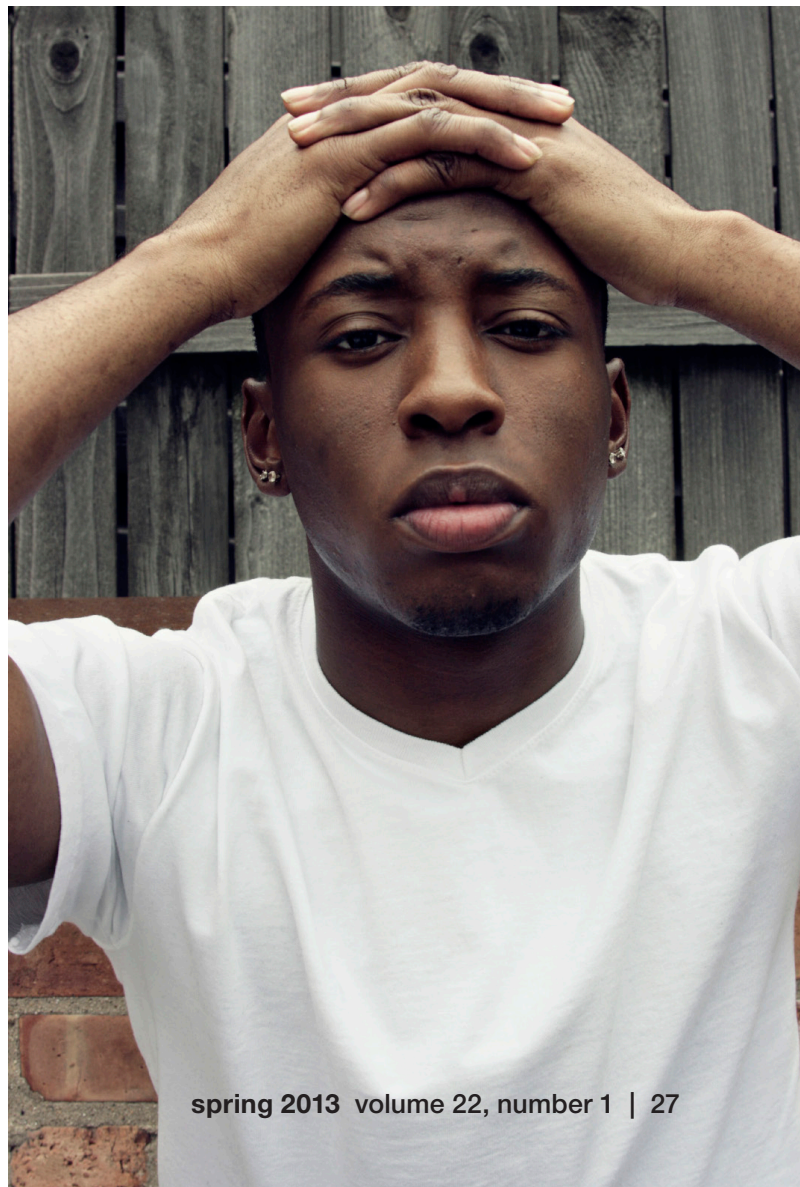
*Step One: Affirmation and Acknowledgement.* It is important for the helping professional to convey a general understanding and acceptance of the premise that race is a critical organizing principle in society. Through affirmation and acknowledgement, we allow conversations about race to emerge.

*Step Two: Create Space for Race.* Conveying a sense of openness and curiosity, we take a very proactive role in encouraging conversations about race. An effort is made to identify race as a significant variable, and we encourage youth to talk openly and candidly about race and their respective experiences with it.

*Step Three: Racial Storytelling.* Young people are invited to share personal stories of racial experiences. This enables them to develop their voices and begin to think critically about their experiences growing up as youth of color. Examples of specific questions to encourage storytelling are: 1) Can you tell me a story about the first time you realized you were treated differently because of your race? 2) Can you tell me about a time when someone attempted to dis' you based on your race? 3) Can you tell me a story about a time when you felt proud to be (Asian, Latino, African American, Native American, etc.)? Youth gain a better understanding of how their lives are affected by race, and they expose hidden wounds embedded in their life stories.

*Step Four: Validation.* This is a tool for counteracting devaluation and an assaulted sense of self. Validation is much more specific and personalized than

the affirmation and acknowledgement process described in Step One. Rather than conveying a global knowledge about race, validation provides confirmation of a youth's worldview and worth. We also discover strengths and redeemable qualities of the young person, and the youth's small acts of heroism are pointed out. Although suffering from internalized devaluation and an assaulted sense of self, there is an untapped hero within that has been overshadowed by stereotyping, pathologizing, demonizing, and criminalizing. For example, when Angel shared his gut-wrenching experiences on the subway where he was presumed to be a criminal, it would be important to validate the *untapped hero within* who is perceptive, sensitive, and able to exercise incredible restraint during the midst of such painful and infuriating racial micro-aggressions.

## *Rechanneled rage can be a powerful energy source helping youth of color to discover and cultivate what is great in and about them.*

*Step Five: The Process of Naming.* One of the most debilitating aspects of racial oppression is that this is a nameless condition, difficult to describe, quantify, or codify. Lacking a common language to convey what is happening deepens the self-doubt/self-denigration cycle. The major objective of this step is to affix words to racially based experiences. This offers external and consensual validation to racially oppressed youth and helps restore their voices. As we "name" the hidden wounds of racial oppression, we help youth understand how their lives are significantly impacted by them.

*Step Six: Externalize Devaluation.* This is a direct way to heal the wounds of internalized devaluation. Stated simply, we help youth understand why respect and the absence of respect are so important. They learn to recognize that devaluation and disrespect are directly connected to race and race oppression. Further, some of their problem behavior may have been counterproductive ways to try to gain respect. The goal is to increase their thirst for respect and to recognize that assaults on their dignity do not lessen their self-worth.

*Step Seven: Counteract Devaluation.* The process of externalization described above helps youth of color exhale and expunge the societal toxins regarding who they allegedly are. Step Seven endeavors

to provide an array of resources (emotional, psychological, and behavioral) that help build their strengths and provide a buffer against future assaults to their dignity and sense of self. This is vital if they are to successfully cope in the face of unrelenting messages from the broader society that can have a debilitating effect on their sense of self.

*Step Eight: Rechanneling Rage.* The pain of rage is a normal and predictable response to perpetual experiences with degradation, devaluation, and domination. It is the build-up and culmination of emotions that have been blocked expression (Gil, Vega, & Turner, 2002). As previously noted, there is a strong relationship between voicelessness and rage. Unless rage is properly channeled, it can be all-consuming, displaced, and destructive to self and others. Those who have rage are often enraged for good reasons. Thus, the goal of treatment is not to rid them of their rage but instead to help them be aware of it, gain control of it, and ultimately to redirect it.

Rechanneled rage can be a powerful energy source helping youth of color to discover and cultivate what is great in and about them. It drives them to stand again after they have been knocked down, to try again after not succeeding, and to believe in themselves when all others around them fail to do so. These are the positive outcomes of healing the hidden wounds of racial oppression.

**Kenneth V. Hardy, PhD,** *is a professor in the Couple and Family Therapy Department, Drexel University, Philadelphia, Pennsylvania. He may be reached by email at* kvh24@drexel.edu

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