

School-based Behavioral Health and Suicide Prevention subgroup meeting

July 31, 2020

Members					
<input checked="" type="checkbox"/>	Representative My-Linh Thai, Co-Chair (41 st Legislative District)	<input type="checkbox"/>	David Crump (Spokane Public Schools)	<input checked="" type="checkbox"/>	Jeannie Nist (Communities in Schools of Washington)
<input checked="" type="checkbox"/>	Camille Goldy, Co-Chair (Office of the Superintendent of Public Instruction)	<input checked="" type="checkbox"/>	Myra Hernandez (WA Commission on Hispanic Affairs)	<input checked="" type="checkbox"/>	Jill Patnode (Kaiser Permanente)
<input checked="" type="checkbox"/>	Tawni Barlow (Medical Lake School District)	<input checked="" type="checkbox"/>	Avreyal Jacobson (King County Behavioral Health and Recovery)	<input checked="" type="checkbox"/>	Elise Petosa (WA Association of School Social Workers)
<input checked="" type="checkbox"/>	Dr. Avanti Bergquist (WA State Council of Child and Adolescent Psychiatry)	<input checked="" type="checkbox"/>	Patti Jouper (Parent/Grandparent)	<input checked="" type="checkbox"/>	Eric Bruns (UW SMART Center) <i>Alternate for Kelcey Schmitz</i>
<input checked="" type="checkbox"/>	Antonette Blythe (Parent, Family Youth System Partner Roundtable)	<input checked="" type="checkbox"/>	Jeannie Larberg (Whole Child Sumner-Bonny Lake School District)	<input checked="" type="checkbox"/>	Susan Solstig (Parent, Family Youth System Partner Roundtable)
<input checked="" type="checkbox"/>	Harry Brown (Mercer Island Youth & Family Services (Forefront) [Alternate: Jennifer Stuber]	<input checked="" type="checkbox"/>	Sandy Lennon (WA School-based Health Alliance)	<input checked="" type="checkbox"/>	Jason Steege (Parent)
<input checked="" type="checkbox"/>	Brooklyn Brunette (Youth)	<input checked="" type="checkbox"/>	Molly Merkle (Parent)	<input checked="" type="checkbox"/>	Katrice Thabet Chapin (Vancouver Public Schools)
<input checked="" type="checkbox"/>	William (Bill) Cheney (Mount Vernon School District)	<input checked="" type="checkbox"/>	Robert (RJ) Monton (Snohomish School District)	<input checked="" type="checkbox"/>	Erin Wick (ESD 113) [Alternate: Mick Miller]
<input checked="" type="checkbox"/>	Jerri Clark (Washington PAVE)	<input checked="" type="checkbox"/>	Joe Neigel (Monroe School District)	<input type="checkbox"/>	Kathryn Yates (Chief Leschi School District)

Agenda Items	Summary Meeting Notes
Update on Regional Mental Health Coordinator Program	<p>Ann Gray, Behavioral Health and Suicide Prevention Program Supervisor, OSPI Grace Burkhart, Behavioral Health Navigator, Education Service District (ESD) 113 Emily Contreras, Behavioral Health Navigator, ESD 105 <i>See page 23.</i></p> <p>The Navigator data collection process is outlined in detail in the playbook (<i>see page 74</i>) and is also referenced thoroughly in the full report from the pilot project (<i>see page 107</i>). Email additional questions to ann.gray@k12.wa.us.</p> <p>Q & A</p> <ul style="list-style-type: none"> • Does the navigator also have a role of collecting data about where appropriate services are NOT available--in other words, nothing to navigate to meet a need? How will this role be shifting in response to the various models of school start-up in a few weeks? <ul style="list-style-type: none"> ○ <i>Like everything else, everything is virtual – much of what we do is online anyway. We are going to have to find trainings that are online. As things are evolving, we are growing and shifting.</i> • Does every ESD have a Navigator? How are we going to make sure that all ESD's have this available especially to areas that don't have access to a lot of resources for the navigators to access <ul style="list-style-type: none"> ○ <i>The program has been expanded statewide. Each ESD will be hiring a navigator.</i>

	<ul style="list-style-type: none"> ○ <i>The work of the navigator is to gather the data and serve as the bridge or network liaison, making sure the needs of the region are addressed.</i> ○ <i>A lot of our work is shifting to a virtual setting and evolving. Lots of trainings have been approved for virtual implementation.</i> ● It was my understanding that a pilot program in collaboration with the Jordan Binion Project had already identified an evidence-based curriculum for mental health education...? I believe it's a curriculum from Canada: "Teen Mental Health." <ul style="list-style-type: none"> ○ <i>ESD 113 is trained and using Mental Health in HS curriculum in partnership with Jordan Binion; we've been working with them to create the online version (not yet available). Schools do have options in choosing curriculum; we assist when they request support.</i> ● For smaller districts like Snoqualmie and Riverview (which are part of King county and ESD 121) which have many larger districts in them, is there a plan to make efforts towards equity of access to a single Navigator? <ul style="list-style-type: none"> ○ <i>Each ESD will have their districts/schools, and gather data, knowing districts vary widely, will tailor to needs of district.</i> ● I'm also wondering whether navigators are in collaboration with NAMI affiliates that offer Ending the Silence for schools? <ul style="list-style-type: none"> ○ <i>Jerri- I know myself and Grace and also Keira from ESD 101 have been in contact with our local NAMI sites and learning about the Ending the Silence for Schools and how we can all work together.</i> ● What types of data are navigators collecting? <ul style="list-style-type: none"> ○ <i>The Navigator data collection process is outlined in detail in the playbook, and is also referenced thoroughly in the full report from the pilot project.</i> <p>Other Questions (many answered in Chat)</p> <ul style="list-style-type: none"> ● Does the navigator also have a role in collecting data about where appropriate services are NOT available--in other words, no place to navigate to meet a need? ● How will this role be shifting in response to the various models of school start-up in a few weeks? ● How can we identify/get connected to our nearest Navigator? (Peninsula School District in Pierce County) ● How can we use the Family Youth System Partner Round Table (FYSPRT) as Navigators in the school ESD? ● How are you including other ESA's such as school social workers, school psychologists, school nurses to help with the overall suicide prevention system? ● What is the process/timeline for the review of the "million and 1" school based behavioral health-focused curricula? ● For smaller Districts, like Snoqualmie and Riverview which are part of King county and ESD 121 (where there are many larger districts), is there a plan to make efforts towards equity of access to a single Navigator? ● Do navigators work in collaboration with NAMI affiliates that offer Ending the Silence for schools.
<p>Presentation on Suicide Prevention Certification Requirement</p>	<p>Leiani Sherwin, Professional Educator Standards Board (PESB) <i>See page 47.</i></p>

	<p>Q & A</p> <ul style="list-style-type: none"> • Has the suicide prevention training certification requirement correlated to a reduction in student suicides? <ul style="list-style-type: none"> ○ <i>PESB has not conducted any research. (Maren will look into whether others have.)</i> • Would it be possible to make it available for parents with children going into high school to encourage better communication at home? <ul style="list-style-type: none"> ○ <i>WA PESB and WA DOH offer a variety of training which parents are welcome to take.</i> ○ <i>WA PESB evaluates the requirements for courses and does not restrict who can and cannot attend trainings, those regulations are established by providers.</i> ○ <i>OSPI has a free online course for those who are not seeking certification.</i> • Are the trainings specific to youth in schools? <ul style="list-style-type: none"> ○ <i>They are specific to youth in schools and educators for training requirements.</i> ○ <i>Connecting with the training providers is a great way to gain more information on a given training.</i> • Do we know the level of compliance (%) in training participation? <ul style="list-style-type: none"> ○ <i>Trainings are required for recertification. School professionals cannot have certification until proof is submitted to OSPI.</i> • Are principals required to have training? <ul style="list-style-type: none"> ○ <i>The new social and emotional learning requirement put forth by the Legislature requires that they are able to assess and know how to refer students to professional help.</i> • How are we addressing our special needs/special ed population of students. <ul style="list-style-type: none"> ○ <i>Trainings are required to be address the needs of varying populations; these trainings are also assessed by the PESB internal review team.</i> • Has Forefront reviewed this training and does it align with their evidence-based research and recommendations? <ul style="list-style-type: none"> ○ <i>Forefront was part of advocating for this training requirement and ensuring it is in place. They have provided training to educators.</i>
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<p>Implementation of House Bill 2589 requirement to add suicide prevention information on school ID cards</p>	<p>Logan Endres, Strategic Advocacy Coordinator, Washington State School Directors' Association Sierra Owens, Student, Riverview School District Jaxon Roberts, Student, Everett School District <i>See page 56.</i></p> <p>Logan: WSSDA is compiling a report on this work and will share their findings with the work group. Sierra and Jaxon shared their personal experiences.</p> <p>Discussion/Q & Answer</p> <ul style="list-style-type: none"> • Gratitude to Sierra and Jaxon for sharing their experiences and truth. • What I've seen is suicide due to drug/alcohol addiction. Could there also be a communication line on the cards that assist in drug and alcohol addiction and rehabilitation?
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	<ul style="list-style-type: none"> • What I heard you said Jaxon is the Peer-to-Peer support system as part of the Youth suicide prevention? • I heard trust, relationships, and peers need ADULT professional support. • Need awareness that many youth are struggling with parents having issues around alcohol and drug addiction and suicide; need help related to how to support their parents and take care of themselves. • What I heard: Provide youth with tools to help their friends. • What I heard, from this and other groups: We are supporting each other, but we need adults to step up and do this, so we can continue to be kids. • FYSPRTs – Family Youth System Partner Round Table – we hear what the community’s talking about. We’ve had many suicides in our community; it is not put in the paper. Students are crying out for adults to come forward and help them talk through this, get through this. We’ve got to get this out in the open. • Adults over react, become judgmental, blame drugs, the youth and not the topics that is causing them to self medicate or feel horrible. And sometimes its a issue of adults or a Discrimination Race, Gender, LGBTQA issue pressure to achieve issue , issues that are not the child fault, young adults fault. We want to treat the child but the environment might be the issue. (nonmember) • Huge thank you to WSSDA and Logan for creating this youth workgroup! • This is why we need to be brave and recommend funding of research based suicide prevention and school MH strategies in our state. It is a crisis and requires a commensurate response. • To young people: What does help really like? Not just asking the questions and checking the boxes. <ul style="list-style-type: none"> ○ <i>It’s really tricky.It’s extremely hard. Sometimes therapy doesn’t help. When someone’s in that mindset, it’s so hard to break that mindset. You have to show them in the form of a smile, a hug, every time, that you are 100% there for them. Have to actually show up rather than just using words. Requires action. Sometimes it’s better to just sit and hold someone.</i> ○ <i>Help is being a friend. The best thing you can do is be their friend.</i> ○ <i>Every single person struggles differently with mental health. It’s about being consistent, being someone the person can go to. Someone who’s able to provide some glimmer of hope, something that is worth living for. Being someone they can trust.They’re going to be able to do something in the future, this world won’t be just as they see it now.</i> • I would like to note that suicidal ideation may start in elementary school, so we need to consider this age group as well. They have even less of an idea as to how they are feeling and about their social/emotional well being or where to go for help. • There are strategies for aiding teachers/educators to take specific steps to build relationships with their students, particularly those who may be less likely to form those relationships naturally by virtue of shared experiences. Such strategies have been found to increase students' academic and MH outcomes, and reduce racial disproportionality in discipline. • Anything about model schools and sustainability would be helpful. I'm interested in learning about the systemic factors, such as policies, procedures, training and practices support it. I think it would be a good presentation for this committee!
Public Testimony	<p>Joline Messina (Board-certified Applied Behavior Analysis [ABA] behavior analyst)</p> <ul style="list-style-type: none"> • Lack of services for ID and DD populations.

	<ul style="list-style-type: none"> Concerns with ABA; “ABA therapy leads to higher risk for suicide.”
Decision Making Process for Recommendations: Deciding about Deciding	<p>Maria Flores, Executive Director, Center for the Improvement of Student Learning (CISL), OSPI <i>See page. 70.</i></p> <p>Decisions</p> <ul style="list-style-type: none"> Group will use modified consensus. If someone is not in consensus and they indicate a clear “no” – we would offer solutions that will get them to “yes”. We get to modified consensus with offering suggestion.
Close	<p>Rep. My-Linh Thai and Camille Goldy (Co-leads)</p> <ul style="list-style-type: none"> There are a lot of needs that need to be addressed. The practical reality is the budget will be less in the coming months/years due to revenue shortage. We should ask ourselves: What can we RIGHT NOW propose that is doable? This particular workgroup is put into statute with the understanding that we cannot meet all the gaps with one or two efforts – rather it is a long term approach. What might be useful for this group is not to get caught up in the crunch time for the next legislative session, but start doing some preliminary strategizing around scope. Prioritization is key. Long-term goal/scope as defined in statute: <p><i>HB 2737: The 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.</i></p> <ul style="list-style-type: none"> Rep. Thai: Our goal is to engage the voices of those who are experts and are impacted by the decisions. Long term and short term decisions are in our hands; we are the people that will shape that conversations – these decisions should be organic.

Other Attendees

Endalkachew Abebaw (Health Care Authority [HCA], staff)

Molly Adrian

Elizabeth Allen (Tacoma-Pierce County Health Dept)

Marci Bloomquist

Rachel Burke (HCA, staff)

Grace Burkhart (ESD 113)

Gina Cabiddu (Children’s Home Society)

Kate Chapman (pri

Representative Lisa Callan

Christianna Clinton

Diana Cockrell (HCA)

Lee Collyer (Office of the Superintendent of Public Instruction [OSPI], staff)

Emily Contreras (ESD 105)

Representative Lauren Davis

Sara Droz

Logan Endres (Washington State School Directors’ Association)

Maria Flores (OSPI, staff)

Sylvia Gil (Community Health Plan of Washington)

Ann Gray (OSPI)

Children and Youth Behavioral Health Work Group School-based Behavioral Health and Suicide Prevention

Kimberly Harris (HCA, staff)
Kristin Hennesey (OSPI)
Robin Howe (OSPI, staff)
Candace Hunsucker (Integrated Managed Care)
Mark McKechnie (OSPI, staff)
Joline Messina (Clinician, parent)
Sierra Owens (Student, Riverview School District)
Justyn Poulous (OSPI, staff)
Liz Perez

Jaxon Roberts (Student, Everett School District)
Leiani Sherwin (Washington State Professional Educator
Standards Board)
Daniel Smith
Melanie Smith (National Alliance on Mental Health)
Ashley Taylor (HCA, staff)
Megan Veith (Building Changes)
Lucinda Young (Washington Education Association)

School-based Behavioral Health and Suicide Prevention Subcommittee

Of the Healthcare Authority's
Child and Youth Behavioral Health Work Group
July 31, 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



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:

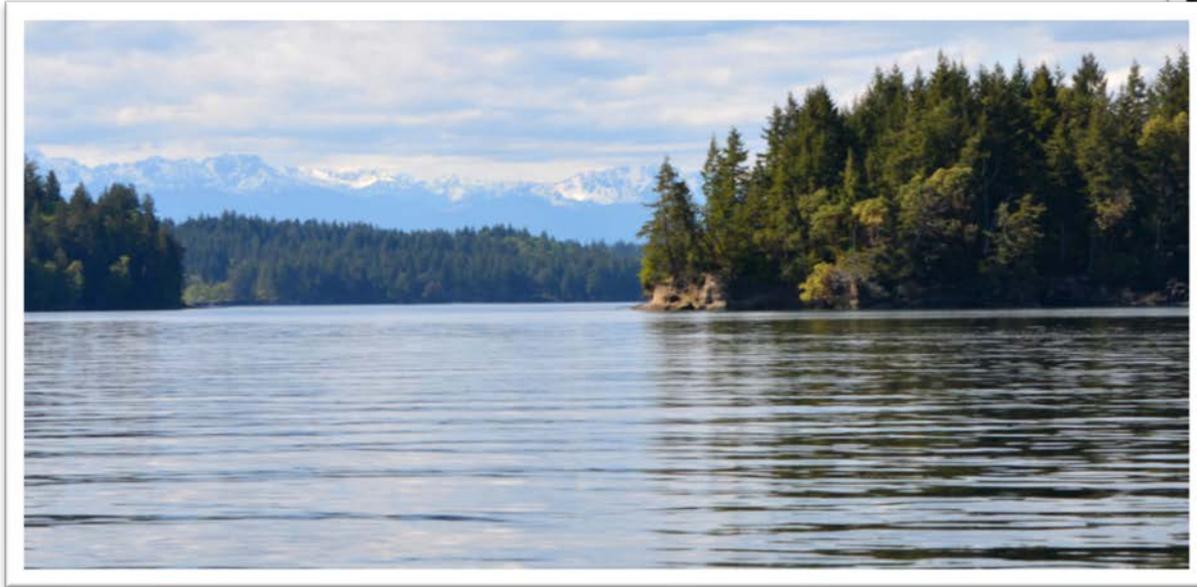
- Goes beyond equality; it requires education leaders to examine the ways current policies and practices result in disparate outcomes for our students of color, students living in poverty, students receiving special education and English Learner services, students who identify as LGBTQ+, and highly mobile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

- Squaxin Island Tribe



Agenda

Agenda Item	Leads	Time
Introductions	Co-Chairs	9:00 – 9:15
Housekeeping	Co-chairs	9:15 – 9:30
Update on Regional Mental Health Coordinator Program	Ann Gray , Behavioral Health and Suicide Prevention Program Supervisor, OSPI; Grace Burkhart , Behavioral Health Navigator, Education Service District (ESD) 113; and Emily Contreras , Behavioral Health Navigator, ESD 105	9:30 – 9:45
Question and Answer	Members	9:45 – 9:50
Break		9:50 – 10:10
Presentation on Suicide Prevention Certification Requirement	Leiani Sherwin , Professional Educator Standards Board (PESB)	10:10 – 10:25
Question and Answer	Members	10:25 – 10:30
Transition Time		10:30 – 10:35
Implementation of House Bill 2589 requirement to add suicide prevention information on school ID cards	Logan Endres , Strategic Advocacy Coordinator, Washington State School Directors' Association (WSSDA); Sierra Owens , Riverview SD; other invited guests	10:35 – 10:55
Question and Answer	Members	10:55 – 11:05
Public Testimony		11:05 – 11:15
Decision Making Process for Recommendations: Deciding about Deciding	Maria Flores , Executive Director, Center for the Improvement of Student Learning (CISL), OSPI	11:15 – 11:55
Close	Co-Chairs	11:55 - Noon



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

Eric Bruns, Director of Training and Technical Assistance, UW SMART Ctr.
[Alternate for: Kelcey Schmitz]

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

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

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. Member-selected presentations; discuss priorities
4. Develop preliminary recommendations – may need to designate subgroup to draft
5. Refine recommendations
6. Finalize recommendations



Addressing the Whole Child through the Integration of Behavioral Health and Education

The Role of the Behavioral Health Navigator

Ann Gray, Program Supervisor, OSPI

Grace Burkhart, BH Navigator ESD 113

Emily Contreras, BH Navigator ESD 105





Pilot Project Background

Brief History

- The Children’s Behavioral Health Workgroup, formed in 2016 by the legislature, was tasked with identifying barriers to children’s behavioral health services.
- Their recommendations to the legislature included strategies for improving access and coordination in early learning, K–12 education, and health care systems.
- One of the workgroup’s recommendations created the OSPI Children’s Regional Behavioral Health Pilot Project authorized by [RCW 28A.630.500](#).
- A legislative report in December 2019 [Legislative Report](#) addresses the pilot learnings.
- Positions established in all 9 ESDs in HB 1216, School Safety and Student Wellbeing (2019). Funded in the 2020 budget.

Goal

To increase equitable access to behavioral healthcare and services for students in need through state and regional cross-system collaboration with schools and communities.

Purpose

To investigate the benefits of a dedicated staff person networking with regional partners and K–12 school districts for the coordination of behavioral health services to students and families who are eligible for Medicaid.



Role of the Navigator

The Navigator is ***not*** a direct service provider, rather the Navigator designs their approach to the work using the following guiding principles:

Coordination of behavioral health resources, supports, service providers, schools, school districts, and communities in the ESD region.

Facilitation of partnerships across the multiple systems of behavioral healthcare services and supports for children and families.

Ensuring the adequacy of systems level supports for students in need of behavioral health services through the integration of various service delivery models appropriate for the school setting.

Collaboration with ESDs, OSPI, districts, schools, community partners, and other stakeholders to increase access to behavioral healthcare services and supports.

The Pilot Project recommended that each ESD Navigator spend the first several months engaging in data collection through an in-person interview with each district in their region. It is helpful and appropriate to include a variety of school and district staff (as available); superintendent, principal, student support coordinator, counselor, business manager, etc. This will give the navigator a formal introduction to the school district and create an opportunity to foster the relationships needed for outreach and implementation of services. Furthermore, this will allow the navigator to complete an assessment of the unique conditions in the region related to the ESD, school districts, and the behavioral health system.

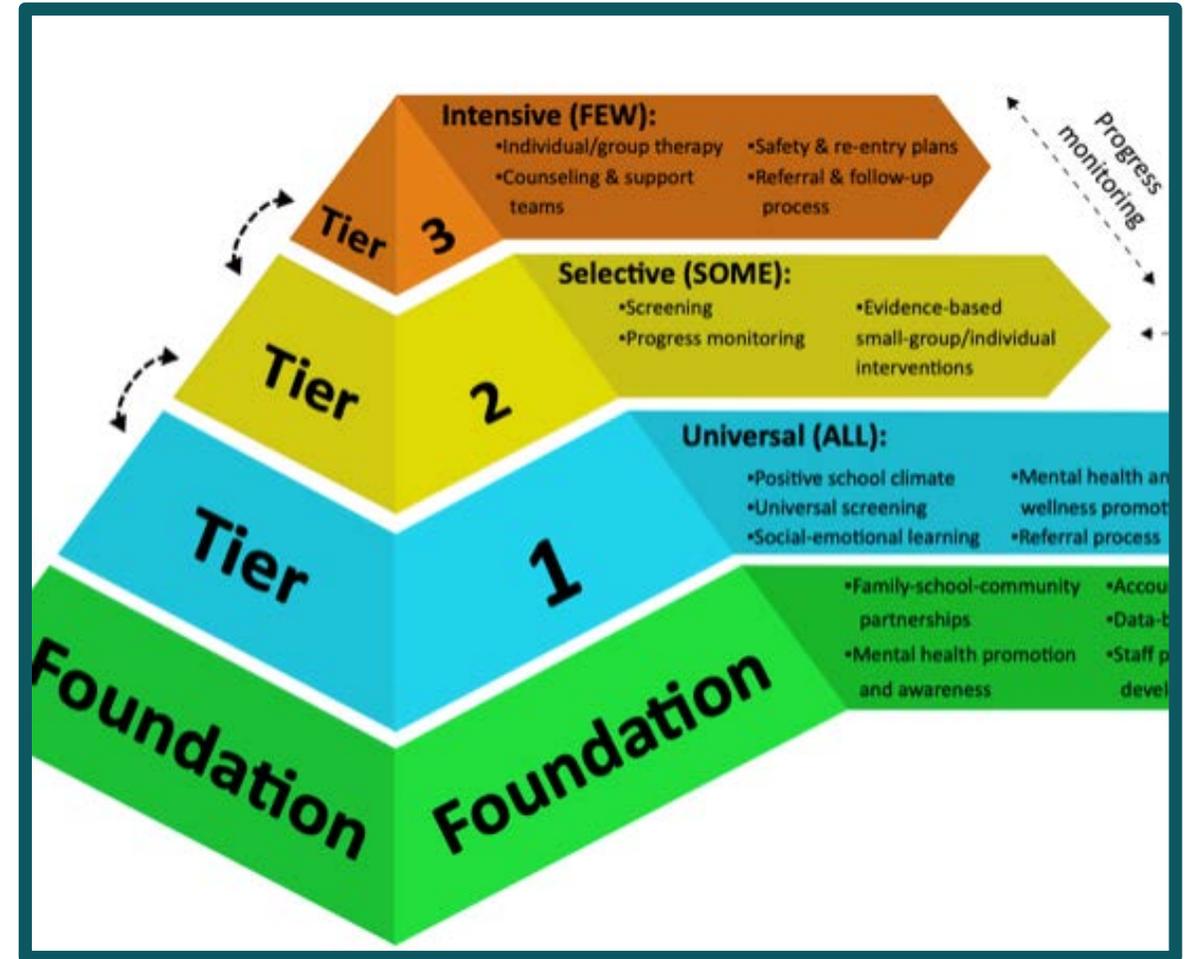




The Work of The Navigator

Best Practices: School-based Mental Health Supports through a MTSS Lens

School-based mental health supports are defined as mental health promotion, education, and the continuum of mental health services—prevention, assessment, intervention, treatment, consultation, and follow-up. These services and supports are provided in a school setting, through the collaboration of the school district’s student support services and the school-based and/or community-based mental health system, in partnership with youth and families. The goal of these is to create a seamless, coordinated, and comprehensive system of care to promote students’ emotional and social wellbeing, to ensure early identification of mental health needs, and to offer timely access to mental health services. These best practice strategies work best within a multi-tiered system of support (MTSS) framework.



Creating a Shared Language

Definitions:

Behavioral Health or Behavioral Healthcare means mental health and substance use prevention, intervention, and treatment.

Comprehensive School Mental Health Program means there is a full array of tiered supports and services that promote positive school climate, social and emotional learning, and mental health and well-being, while reducing the prevalence and severity of mental illness and substance use issues.

School-based Behavioral Health Services refers to both mental health and substance abuse prevention and intervention strategies delivered in the school-setting (i.e. students have access to services at the school building, during school hours. Services may be provided by community-based/outside providers and/or a district-hired MH provider or district staff (e.g. nurses, counselors, psychologists, social workers, etc.).

Community-based Behavioral Health Services, similar to school-based services, but these are delivered in the community-setting. (i.e. services that are not located in school-building but may be available for students in need).



Navigator Playbook

The Playbook: *A Guide for Linking Regional Education and Healthcare Systems*

Purpose: to provide a roadmap for an ESD Behavioral Health Systems Navigator to engage in regional K–12 and healthcare partnerships through relationships and collaboration activities that will ultimately increase access to care.

Each region has a unique makeup of school districts and healthcare systems. The Navigator can help determine the best approach for the ESD as they learn the healthcare and education landscape in their respective region.

This playbook draws upon the learning and experiences of the two ESD Navigators from Capital Region ESD 113 (CR ESD113) and Northeast Washington ESD 101 (NEWESD101) and OSPI's Behavioral Health and Suicide Prevention Program Supervisor during the ESD Regional Behavioral Health Pilot Project.

The Playbook

NAVIGATOR ACTIVITIES

The Pilot Project recommends that each ESD Navigator spends the first several months engaging in data collection through an in-person interview with each district in their region. It is helpful and appropriate to include a variety of school and district staff (as available); superintendent, principal, student support coordinator, counselor, business manager, etc. This will give the navigator a formal introduction to the school district and create an opportunity to foster the relationships needed for outreach and implementation of services. Furthermore, this will allow the navigator to complete an assessment of the unique conditions in the region related to the ESD, school districts, and the behavioral health system.

INTERVIEW PROTOCOL:

CONDUCTING THE INTERVIEW:

1. Initial Contact: Call appropriate point of contact to schedule interview. Inform staff the interview will take approximately one-hour and may be completed in-person (preferred) or via phone or video conference (i.e. Zoom). Interview participants may include district administrators, finance office staff, student support staff, special education staff, school counselors, school psych's, a school social worker, or school nurse. Ideally, at least two different staff members should participate in the interview.

Based on your knowledge and relationship with each district, use your best judgment to determine the most appropriate person(s) with whom to conduct the interview.

Ensure participants understand the context and purpose of the interview, which may include providing all or part of the following information:

Background: In 2017, the Legislature passed House Bill 1713 establishing the Children's Regional Behavioral Health Pilot Project. This measure directed the Office of Superintendent of Public Instruction (OSPI) to provide leadership in supporting two Educational Service Districts (ESD) to hire a dedicated staff person to serve as a behavioral health systems navigator. The role of the Navigator is to bridge the gap between the K-12 and publicly funded behavioral health systems with the goal to increase access to services and supports for students and families. This work was piloted in both Educational Service Districts 101 and 113 through June 30, 2020. And as a result of House Bill 1216 (2020) this position has been extended to all nine Educational Service Districts.



1. Do your students receive behavioral health services at school?

- Yes No
 Unsure: Is there someone else at the district that would know?

a. Who provides these services (school staff or outside agency)?

- School Outside Agency
 MOU – Interagency Agreement

b. What are their qualifications? (e.g. certificated school counselor, licensed treatment provider)

c. What types of services are available? (e.g. individual therapy, group, family therapy)

d. Where are services located?

e. Who in the district/school coordinates these services?

f. What is the process for referring students to these services?

g. What are the funding sources for these services?

h. Are your providers billing Medicaid for behavioral health services?

- Yes No Unsure

If NO, why not?

Additional comments:

ANALYZING INTERVIEW DATA:

During the pilot project, interview responses were documented by the Navigator at the time of interview. Notes were transcribed and sent to the Research Partner for analysis. Using an online platform (SurveyGizmo), interview responses were transferred to a database, and exported into an excel workbook for analysis. Analysis included a summarization of responses by ESD region, and class size as well as qualitative analysis of open-ended interview responses.

Analysis and use of interview data will vary by ESD region and will depend on the skills and resources available to each Navigator. The following provides a brief overview of basic data cleaning and analysis of interview responses.

Cleaning the data: Once interview data have been transcribed into the preferred format (e.g. online database platform, Excel, Access, etc.), ensure Spelling/Grammar check has been run, double check that all answers were transcribed correctly (e.g. answer makes sense for the question), and remove any duplicate entries, as appropriate.

The Playbook

Identifying and Engaging Regional Healthcare Partners:

The Health Care Authority's (HCA) Healthier Washington initiative aims to build healthier communities through a collaborative regional approach involving the Accountable Communities of Health (ACH). The Healthier Washington approach includes goals that all people with physical and behavioral health comorbidities will receive high quality care and that Washington's annual health care cost growth will be 2% less than the national health expenditure trend.

The nine ACH's (see Figure 4) bring together leaders from multiple health sectors with a common interest in improving health and health equity. As ACHs better align resources and activities, they support wellness and a system that delivers care for the whole person. Their boundaries are similar (although not exact) to the ESD regional boundaries.



Figure 1: Regional ACHs and ESDs.

Recommended Activities within the ESD:

1. Make connections, get introductions to program directors, build relationships, and conduct an analysis of agency work that intersects with the Navigator role (e.g.: Nursing, Counseling, Special Education, Threat Assessment, School Safety, etc.).
2. Set up one-on-one meetings and learn about program administration/activities, and how the Navigator can partner to ensure ongoing communication and program cross-collaboration.
3. Brief agency partners on the Navigator role and responsibilities and identify opportunities for partnership and collaboration.
4. Consider presenting to agency leadership and/or the board annually on the Navigator activities, progress, and plans.

Recommended Activities with Districts:

1. Outreach to all districts with a focus on readiness to benefit.
2. Establish a point of contact for behavioral health at each school district.
3. Share details of the Navigator role and generate interest.
4. Assist districts in conducting a needs assessment, gaps analysis, and resource mapping.
5. Identify next steps for increasing access to care.

The Playbook

Navigator Job Activity Examples:

- Attending School Based Health Care Services (SBHS), and Medicaid Administrative Claiming (MAC) webinars and trainings.
- Communicating with SBHS, and MAC Program Specialists with the Health Care Authority.
- Collaborating with internal ESD departments (e.g. Prevention Programs, Special Education, School Fiscal Services, Nursing Corps, etc.).
- Attending ACH Medicaid Transformation Collaboratives.
- Meeting with regional Amerigroup Washington (AMG), Coordinated Care of Washington (CCW), Community Health Plan of Washington (CHPW), Molina Healthcare of Washington (MHW), and UnitedHealthcare Community Plan (UHC), to discuss partnerships.



MEDICAID PROGRAMS AVAILABLE TO SERVE STUDENTS IN SCHOOL DISTRICTS

There are multiple ways in which the State Medicaid Plan administers behavioral health to children and youth in the state. On average, 42% of a school district's population is eligible for Medicaid in Washington. The Navigator can help schools maximize the resources available to them by leveraging available Medicaid resources.

BUILD BRIDGES BETWEEN SCHOOL DISTRICTS AND LICENSED BEHAVIORAL HEALTH PROVIDERS

The Navigator will need to build relationships with licensed behavioral health providers who contract with Managed Care Organizations. The five Managed Care Organizations (MCOs) collectively cover all students participating in Apple Health, WA's Medicaid Program. MCO coverage varies by region, and not all five MCOs cover all regions. The Navigator will need to establish relationships with the MCOs to fully understand the regional provider network and determine opportunities for partnerships.

Recommended Activities:

1. Identify the managed care organizations that cover students in your ESD region.
**All regions will need to work with Coordinated Care for foster students
2. Identify the regional behavioral health providers that serve your student populations.
3. Determine opportunities for partnerships (e.g.: care coordination, bidirectional referral relationships, etc.).

SUSTAINABILITY PLANNING

The Navigator will work in their region to engage in the healthcare systems. Sustainability for each ESD will vary depending on the role in which they play. This may include:

- Plans for reaching all districts in the region.
- Steps for supporting comprehensive mental health in schools using a Multi-Tiered System of Supports (MTSS) framework.
- Diversified funding resources to increase access for all students.
- Ongoing relationships through community partnerships.
- Ongoing relationships and coordination with the MCOs and ACHs to determine strategies for combatting the social determinants of health that have an impact on children and youth.

The Playbook



Current Navigator Work



- Creating a Suicide Prevention Protocol packet for districts.
- Coordinate and implement Mental Health Stigma Campaign backpacks for kids.
- Researching comprehensive resources for Mental Health Curriculum. (because there are 1 million and 1 to choose from)
- Implementation of Multi Tiered Systems of Support.
- Create and organize a community resource list for each county and help update our website resources for families.
- Coordinate 5 new mini Navigators in each of our counties to better support and implement the behavioral health needs of each district as we approach this unique school year.

Current Navigator Work



Communication Platform

- *NowPow*

Medicaid

- *SBHS*
- *MAC*

Suicide Prevention

- *QPR*
- *Sources of Strength*
- *Signs of Suicide*



Implementation

Behavioral Health Navigators in nine ESD's.

OSPI will provide state level leadership and facilitate collaborative support of ESDs in performing the following:

- Hiring/assigning a lead Behavioral Health Coordinator/Navigator.
- Designing a program that aligns with guidance from OSPI's Behavioral Health Navigator Playbook for step-by-step instructions on developing a plan for assessing the needs and gaps of the regions behavioral health system, the ESD's engagement within the system, and each school district's ability to meet student need.



- Developing positive relationships with school district staff members for the purpose of gathering and conveying information.
- Be utilized as a consistent resource regarding Behavioral Health and Suicide Prevention.
- Serve as the behavioral health navigator, regional liaison, and advocate for school districts in facilitating partnerships and coordinating local systems of behavioral health services, as referenced in the OSPI Behavioral Health Navigator Playbook.
- Provide leadership at the ESD level in the areas of suicide prevention, intervention, and postvention for all school districts within the ESD, including technical assistance and support for policy and procedure development.



Behavioral Health System Coordinator/ Navigator Monthly Meetings

Purpose:

To collaborate and coordinate the implementation and establishment of the behavioral health coordinator/navigator programming within the nine ESD's .

To ensure cross networking and sharing of information on programming, training, and current trends (including suicide prevention, intervention and postvention).

Identify common themes/issues/needs/learnings and opportunities for collaborative problem solving.

Representatives at these meetings are program and subject-specific staff from OSPI and each of the nine ESDs who contribute to informing and implementing shared statewide initiatives specific to the behavioral health coordinator/navigator work.

Provide leadership and expertise within the state and regions. Lead regional efforts that support and build capacity among educators specific to behavioral health.

Meetings facilitated by: OSPI



Discussion & Questions





Break (mute/cameras off)

Suicide prevention training

Certificate renewal requirement

Leiani Sherwin, Educator Preparation and Credentialing

Who we are



The Professional Educator Standards Board (PESB)

Created in 2000, PESB ensures that Washington's educator workforce is composed of highly effective, professional educators who meet the diverse needs of schools and districts. PESB creates innovative policies that improve and support **educator quality, workforce development, and diversity**. [RCW 28A.410.210](#)

The Paraeducator Board

Created in 2017, the Paraeducator Board establishes requirements and policies for paraeducator **professional development certificates**, and that will increase opportunities for paraeducator **advancement** through education, **professional learning**, and increased instructional responsibility. [RCW 28A.413.020](#)

What we do

Our work stretches
across the career
continuum



[Learn more about our draft
strategic plan](#)

Suicide prevention training

Three hours of suicide prevention training is required for ESA certificate renewal (every five years) for:

- School nurses
- School social workers
- School counselors
- School psychologists

RCW [28A.410.226](#); RCW [43.70.442](#)

WAC [181-79A-221\(2\)\(c\) and \(3\)\(c\)](#); WAC [181-79A-223\(2\)\(b\)\(iv\) and \(6\)\(b\)\(iii\)](#); WAC [181-79A-2511\(1\)\(c\) and \(2\)\(e\)](#);
WAC [181-79A-2512\(1\)\(c\) and \(2\)\(e\)](#)

Suicide prevention training

Initial ---> Continuing

Residency ---> Professional

This requirement has been in place for continuing and professional certificates since 2015.

Holders of initial and residency certificates in these roles must complete this requirement for applications received beginning September 1, 2020.

This was part of the July 2019 ESA WAC changes adopted by PESB.

Approval of suicide prevention training courses

- PESB approves courses meeting the suicide prevention training requirement. Courses must be reapproved every five years.
- PESB also considers suicide prevention training courses approved by the Department of Health (DOH) as approved courses.

Department of Health content standards

As referenced in RCW [43.70.442 \(7\)](#), PESB uses the Department of Health (DOH) content for three hour suicide prevention content when approving suicide prevention training courses.

These content standards are found in DOH WAC [246-12-630 \(4\)](#).

More information from PESB:

- Suicide prevention training certificate renewal requirement, and list of [approved courses](#)
- Information for prospective providers on [suicide prevention training course approval process](#)

Subscribe to the PESB newsletter. Register at the bottom of this page: <https://www.pesb.wa.gov/>

Transition/Stretch



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WSDDA Suicide Prevention Work Group

Presenters:

- Logan Endres, Strategic Advocacy Coordinator
- Sierra Owens, Riverview School District
- Jaxon Roberts, Everett School District



Washington State School Directors' Association

SHB 2589

IMPLEMENTATION SUPPORT

STUDENT ADVOCATE RECOMMENDATIONS

Logan Endres • Strategic Advocacy Coordinator, WSSDA • 360-742-4435



ABOUT WSSDA

- Washington State School Directors' Association (WSSDA)
- Support 1,477 locally-elected school board members
- Engage with student school board representatives to support our work
 - Legislative issues, testimony



ADVOCACY COMMITMENTS

We Are And Will Remain:

- Student-centered
- Public Education And Equity Focused
- Membership-driven
- Non-partisan
- Open
- Responsive
- Credible



SUICIDE PREVENTION WORKGROUP

- First-ever student representative workgroup | May-July 2020
- Focus on engaging student voice to support implementation of the ID card requirements
- Workgroup met 4 times to:
 - Compile implementation strategies re ID card design + suicide programming
 - Hear from various school districts + other education advocates about current work on the ground
 - Compile local, state, and federal information/resources

SHB 2589 OVERVIEW

(SPONSORED BY REPRESENTATIVE LISA CALLAN)

What Does the Bill Require?

Within existing resources, every public school that issues student identification cards, staff identification cards, or both, must have printed on either side of the identification cards:

- The contact information for a national suicide prevention organization; and
- The contact information for one or more campus, local, state, or national organizations specializing in suicide prevention, crisis intervention, or counseling, if available.

“I heard directly from students in my district about the need for more access to information and tools relating to crisis intervention,” said Rep. Callan. “This is not a new problem in our state, but this will provide our youth, faculty, and staff with some of the resources they need to act when a mental or behavioral health crisis occurs.” ([Governor’s press release](#))



ID CARD RECOMMENDATIONS

How might a school district design their ID card given these new requirements?

- Use the back-side for the hotline listing
- Use color and/or graphic design
- Make it personable – keep any local considerations
- Explore QR technology for suicide awareness & prevention apps, websites



SUPPORTS FOR STUDENTS, STAFF, AND FAMILIES

Communicating w/ Students About New ID Card Information:

- Review w/ students in advisory
- Send notification to families in native language
- Social media

Additional Supports – Schools Should:

- Address suicide (especially if it's happened in your district) – don't sweep it under the rug
- Create an environment where students know who they can talk to about these issues
- Breakdown silos between education + healthcare systems

STUDENT REFLECTIONS:

**WHAT'S MOST IMPORTANT FOR SCHOOLS TO
BE THINKING ABOUT REGARDING SUICIDE
AWARENESS & PREVENTION?**

JAXON ROBERTS, EVERETT SCHOOL DISTRICT

SIERRA OWENS, RIVERVIEW SCHOOL DISTRICT



NEXT STEPS

Workgroup Report Coming Soon!

CONTACT INFORMATION

- **LOGAN ENDRES**, STRATEGIC ADVOCACY COORDINATOR, WSSDA
L.ENDRES@WSSDA.ORG OR 360-742-4435
- **JAXON ROBERTS**, STUDENT REPRESENTATIVE, EVERETT SCHOOL DISTRICT
- **SIERRA OWENS**, STUDENT REPRESENTATIVE, RIVERVIEW SCHOOL DISTRICT



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

Deciding about Deciding

Maria Flores, Executive Director of the Center for the Improvement of Student Learning (CISL)

Identifying a decision-making process

Three primary approaches:

1. Consensus
2. Modified Consensus
3. Majority Vote

Next meeting: August 14, 2020

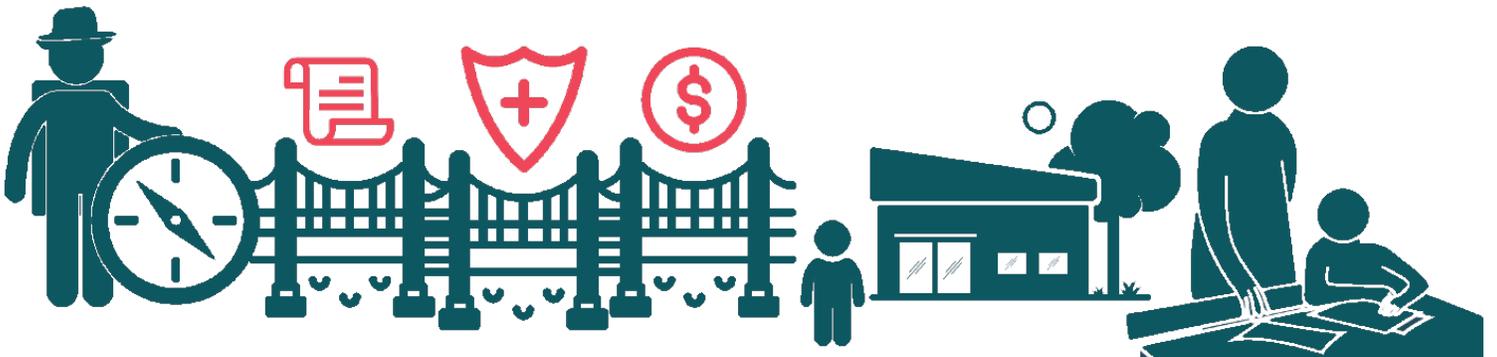
1. Presentation on LEARN Suicide Prevention Model, Harry Brown, Forefront in the Schools, consultant/trainer, Mercer Island Youth & Family Services
2. Multi-Tiered System of Supports, Justyn Poulos, OSPI
3. Interconnected Systems Framework, Kelcey Schmitz, UW SMART Center
4. Discussion time: Priorities and Forming Recommendations



Thank you!

Educational Service District Behavioral Health System Navigator Playbook

*A Guide for Linking Regional Education and
Behavioral Healthcare Systems*



Washington Office of Superintendent of
PUBLIC INSTRUCTION

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Background and Introduction

In 2017, [House Bill 1713 \(2017–18\)](#) directed the Office of Superintendent of Public Instruction (OSPI) to provide leadership in supporting two Educational Service Districts (ESDs) to hire a dedicated staff person as a Behavioral Health Systems Navigator (Navigator). The role of the Navigator is to increase access to behavioral health services and supports for students and families by piloting regional cross-system coordination. This pilot project ran from 2017–2020 and developed a series of guidance materials for the ESDs to take this concept to scale statewide.

In 2019, [House Bill 1216 \(2019–20\)](#), School Safety and Student Well-being established this position, the mental health coordinator, or Behavioral Health Systems Navigator position in all nine ESDs as part of the network of Regional School Safety and Student Well-being Centers.

In 2020, the legislature funded each ESD to provide a network of support for school districts to develop and implement comprehensive suicide prevention and behavioral health supports for students. This intends to support the role of the Navigator as outlined in HB 1216, codified in [RCW 28A.310.510](#).

Purpose

The purpose of this playbook is to provide a roadmap for an ESD Behavioral Health System Navigator to engage in regional K–12 and healthcare partnerships through relationships and collaboration activities that will ultimately increase access to care. Each region has a unique makeup of school districts and healthcare systems. The Navigator can help determine the best approach for the ESD as they learn the healthcare and education landscape in their respective region. This playbook draws upon the learning and experiences of the two ESD Navigators from Capital Region ESD 113 (CR ESD113) and Northeast Washington ESD 101 (NEWESD101) and OSPI’s Behavioral Health and Suicide Prevention Program Supervisor during the ESD Regional Behavioral Health Pilot Project. The Navigator is **not** a direct service provider, rather the Navigator designs their approach to the work using the following guiding principles:

- Coordination of behavioral health resources, supports, service providers, schools, school districts, and communities in the ESD region.
- Facilitation of partnerships across the multiple systems of behavioral healthcare services and supports for children and families.
- Ensuring the adequacy of systems level supports for students in need of behavioral health services through the integration of various service delivery models appropriate for the school setting.
- Collaboration with ESDs, OSPI, districts, schools, community partners, and other stakeholders to increase access to behavioral healthcare services and supports.

The Navigator performs activities that support the guiding principles such as:



- Conducting outreach to school districts in the ESD region to provide technical assistance and training for expanding behavioral health services.
- Conduct an inventory of the current behavioral health providers in the region to help schools make connections (e.g.: Federally Qualified Health Centers, Community-based Clinics, School-based Health Centers, ESD licensed behavioral health providers, etc.).
- Working with schools to coordinate behavioral health service delivery by assisting in needs assessments, gaps analysis, and resource mapping.
- Investigating and documenting barriers to behavioral health services for students and creating resource materials that assist schools in connecting students to services.
- Collecting data from school districts on their experience with collaborating with community-based providers and identifying opportunities to support with collaboration strategies.
- Surveying school district completion of their Plan for Recognizing and Responding to Emotional or Behavioral Distress authorized by [RCW 28A.320.127](#); Navigators provide technical assistance and support to districts on plan development and implementation.
- Conducting an inventory of appropriate ESD programs and resources and linking school districts to them when requested or when interested.

The Navigator participates in a learning community of their peers, with leadership from OSPI, to work together on shared initiatives and gather information from lessons learned. This peer network is critical to the Navigator’s work because each region’s unique circumstances offer perspectives that expand the Navigator’s knowledge as well as challenge the group to create innovative solutions.

Navigator Activities

The Pilot Project recommends that each ESD Navigator spends the first several months engaging **in data collection through an in-person interview with each district in their region**. It is helpful and appropriate to include a variety of school and district staff (as available); superintendent, principal, student support coordinator, counselor, business manager, etc. This will give the navigator a formal introduction to the school district and create an opportunity to foster the relationships needed for outreach and implementation of services. Furthermore, this will allow the navigator to complete an assessment of the unique conditions in the region related to the ESD, school districts, and the behavioral health system.

INTERVIEW PROTOCOL:

CONDUCTING THE INTERVIEW:

1. Initial Contact: Call appropriate point of contact to schedule interview. Inform staff the interview will take approximately one-hour and may be completed in-person (preferred) or via phone or video conference (i.e. Zoom). Interview participants may include district administrators, finance office staff, student support staff, special education staff, school



counselors, school psych's, a school social worker, or school nurse. Ideally, at least two different staff members should participate in the interview.

Based on your knowledge and relationship with each district, use your best judgment to determine the most appropriate person(s) with whom to conduct the interview.

Ensure participants understand the context and purpose of the interview, which may include providing all or part of the following information:

Background: *House Bill 1216 (2019) es established the Regional School Safety and Student Well-being Centers at the 9 Educational Service Districts.*

A successful result of this piloted concept at two ESDs helped design an interview protocol where they learned a number of valuable lessons regarding the role of the navigator as well as the ways in which the education and health care systems interact.. The purpose of this interview is to understand what access to behavioral health care for students looks like at the district and building levels. I am asking all districts in this ESD region the same set of questions. Our goal is to gain knowledge about what systems are being used for students to access behavioral healthcare, what is, or isn't working, and to get your thoughts on the best way to help schools navigate these systems. Upon completion of these interviews, I will be able to design my ESDs program and will be following up with resources and supports.

Follow Up Contact: At least one week prior to the scheduled interview, send each interview participant the following brief email reminder:

Thank you for agreeing to meet on [AGREED UPON TIME]. As a reminder, the purpose of this interview is to understand what access to behavioral health care looks like for students across our region, from both the building and district level perspectives. We are asking all districts in our ESD region the same set of questions. The interview will focus on behavioral health services and mental health awareness and prevention efforts. Our goal is to gain knowledge about how these systems are being used, what is, or isn't working, and to get your thoughts on the best way to help schools navigate these systems. This is not an evaluation, or audit, but simply an information gathering exercise to better inform future decisions and how we (the ESD) can best support school districts.

I look forward to meeting with you. Please let me know if you have any questions in the meantime.

Sincerely/best/thank you (your choice ☺),

NAVIGATOR

2. Prior to the Interview:



Collect the following information on each school district in your region:

- Student population
- Number of school buildings
- Community surroundings (i.e. understand the basic geography of the district – urban, rural, suburban)
- If you are new, ask some questions at your ESD about the district before you to onsite. This was a good lesson-learned from the pilot. Learn about the local conditions the district is experiencing (extreme poverty, lack of connection to resources, high mobility, etc.).

3. Before starting with the interview:

Please be aware of implicit bias: As a reminder, implicit bias is a natural human trait that has been essential to the evolution of the human race. It operates on autopilot and can have both positive and negative impacts on ourselves and others. As we conduct these interviews, we must insert a “pause” to consider whether our bias is impacting the way we ask these questions, as well as when and how we probe for more information. Here are a few examples for a “check-in” with yourself with as you conduct these interviews.

Confirmation bias: Is there any information that I am favoring, disfavoring, searching for, remembering, ignoring or forgetting that confirms an existing belief or hypothesis about this district’s system?

Focused bias: Am I relying too heavily on one piece of information that has been provided to me without listening to and understanding other components?

Adapted from <https://qualigence.com/common-hiring-and-interview-bias/>

4. Interview Introduction:

Introduce yourself and summarize the purpose of the interview, as appropriate.

The purpose of this interview is to understand what access to behavioral health care looks like for students across our region, from both the building and district level perspectives. We are asking all districts in our ESD region the same set of questions. The interview will focus on behavioral health services, Medicaid billing and reimbursement, and mental health awareness and prevention efforts. Our goal is to gain knowledge about how these systems are being used, what is, or isn’t working, and to get your thoughts on the best way to help schools navigate these systems.

Provide interviewee with a copy of the interview questions. Review and/or refer to definitions. Clarify as needed.



This interview will take approximately one hour. This is not an evaluation, or audit, but simply an information gathering exercise to better inform future decisions and recommendations. The information gathered through this process will be used to inform the ESD on the behavioral health needs of our schools and inform policy making and subsequent supports. You and your school/district will not be specifically named in any reporting without prior permission. Do you have any questions, or need for clarification on the definitions before we begin?

(If audio recording): *Before we get started, I also need to inform you that this call is being recorded for accuracy and transcription purposes. Do I have your permission to continue? (If no, probe for concerns.) Assure participant that we are only recording interviews because responses are very valuable to reporting accurate findings and as we speak, you will be focused on the conversation and do not want to miss any critical insights. None of the interview materials, including the recording, will be shared outside of the project team. If we decide to quote you directly, we will contact you beforehand to obtain permission.*

As we go through the interview process, if you're not able to answer any of these questions, I'll ask you to introduce me to someone in the district who may be better able to speak to the specifics of these programs.

5. Interview Questions:

Use **Children's Regional Behavioral Health District Interview Questions (Included on next page)** document to read and record interviewee responses.

6. Interview Closing:

Read: *Thank you for taking the time to talk with me today. [Add ESD specific next steps, based on role details, etc.]*



Date:

Navigator Conducting Interview:

School District(s):

Staff Interviewed (Name, role, additional details):

DEFINITIONS (review as needed):

Behavioral Health or Behavioral Healthcare

Mental health and substance use prevention, intervention, and treatment.

Comprehensive School Mental Health Program

There is a full array of tiered supports and services that promote positive school climate, social and emotional learning, and mental health and well-being, while reducing the prevalence and severity of mental illness and substance use issues.

School-based Behavioral Health Services

Refers to both mental health and substance abuse prevention and intervention strategies delivered in the school-setting (i.e. students have access to services at the school building, during school hours. Services may be provided by community-based/outside providers and/or a district-hired MH provider or district staff (e.g. nurses, counselors, psychologists, social workers, etc.).

Community-based Behavioral Health Services

Similar to school-based services, but these are delivered in the community-setting.(i.e. services that are not located in school-building but may be available for students in need).

School-based Health Services Program (SBHS)

A fee-for-service, optional Medicaid program that reimburses contracted school districts, educational service districts (ESDs), charter and tribal schools for providing medically necessary services to Medicaid eligible children with Individualized Education Programs (IEPs) or Individualized Family Service Plans (IFSPs).

Medicaid Administrative Claiming (MAC)

An optional Medicaid program that allows school districts and ESDs to receive federal reimbursement for administrative activities performed by school staff that support the goals of the Medicaid State Plan. Examples of eligible activities include outreach and providing



information about Medicaid programs and covered services to students and families, assisting individuals in applying for or accessing Medicaid covered services, and referring students and families to health providers.

1. Do your students receive behavioral health services at school?

- Yes No
 Unsure: Is there someone else at the district that would know?

a. Who provides these services (school staff or outside agency)?

- School Outside Agency
 MOU – Interagency Agreement

b. What are their qualifications? (e.g. certificated school counselor, licensed treatment provider)

c. What types of services are available? (e.g. individual therapy, group, family therapy)

d. Where are services located?

e. Who in the district/school coordinates these services?

f. What is the process for referring students to these services?

g. What are the funding sources for these services?

h. Are your providers billing Medicaid for behavioral health services?

- Yes No Unsure

If NO, why not?

Additional comments:

2. Do you make referrals to outside providers for behavioral health services for your students? (e.g. agency or independent provider)

- Yes No



Unsure: Is there someone else at the district that would know?

a. What kinds of concerns do you refer students for?

b. What is the process for referring students to these services?

c. What kind of follow up do you receive regarding their care/engagement in services?

Additional comments:

3. Has the district/school worked with an outside provider in the past?

Yes No

Unsure: Is there someone else at the district that would know?

a. Can you share what that experience was like for the district/school? Why are those services no longer available?

b. Did the district/school have an interagency agreement or MOU with the provider?

Additional comments:

4. Would your district be interested in having a template for an MOU?

Yes No

Unsure: Is there someone else at the district I should ask?

Additional comments:

5. Do you feel your current system is sufficient to meet the behavioral health needs of your students?

"YES", what's working?

"NO", what's not working? (unmet needs, gaps, barriers)



“UNSURE”, what’s working & not working?

Additional comments:

6. Does the district have a suicide prevention protocol?

“YES”, formal or informal? What does that look like?

“NO”

“UNSURE”, who should I ask?

Would you be interested in learning more about what suicide prevention protocols are available?

Yes No Unsure: Is there someone else at the district I should ask?

Additional comments:

7. Does the district use any screening or assessment tools for behavioral health?

“YES”, what does that look like?

“NO”

“UNSURE”, who should I ask?

Would you be interested in learning more about what screening and assessment tools are available?

Yes No Unsure: Is there someone else at the district I should ask?

Additional comments:

8. Do your students receive any mental health and substance use instruction?



"YES", what are you using?

"NO"

"UNSURE", who should I ask?

Would you be interested in learning more about what curricula are available?

Yes No Unsure: Is there someone else at the district I should ask?

Additional comments:

9. Does the district/school staff receive mental health and substance use training?

"YES", what are you using?

"NO"

"UNSURE", who should I ask?

Would you be interested in learning more about what trainings are available?

Yes No Unsure: Is there someone else at the district I should ask?

Additional comments:

10. Has the district participated in any needs and gaps assessments related to mental health and substance use?

"YES", what did this process look like?

"NO"

"UNSURE", who should I ask?



Would you be interested in learning more about what assessments are available?
 Yes No Unsure: Is there someone else at the district I should ask?

Additional comments:

11. Does the district currently participate in any Medicaid programs?

"NO":

"UNSURE", who should I ask?

"YES":

a. School-Based Health Care Services (SBHS) program (Billing for special education services, OT/PT/SLP):

What services do the district receive reimbursement for?

b. Medicaid Administrative Claiming (MAC) program: (Previously titled "Medicaid Match", and staff participated by making "tick marks" for interactions):

Is reimbursement used for behavioral health services?

Additional comments:

12. Has the district participated in any Medicaid programs in the past?

"NO":

"UNSURE": Is there someone else at the district I should ask?

"YES":

a. School-Based Health Care Services (SBHS) program (Billing for special education services, OT/PT/SLP):

Do you know why the district stopped participating?

b. Medicaid Administrative Claiming (MAC) program: (Previously titled "Medicaid Match", and staff participated by making "tick marks" for interactions):

Do you know why the district stopped participating?



Additional comments:

13. Would your district be interested in learning more about how to participate in the SBHS or MAC programs?

"NO":

"UNSURE": Is there someone else at the district I should ask?

If "YES":

a. The SBHS program:

b. The MAC program:

Additional comments:

14. Before we end, is there anything else you want to share about your district or students, as it relates to mental health and substance use?

Additional comments:

15. I am going to send you an email with the resources that we discussed today. Which of your staff should be included in this email?



ANALYZING INTERVIEW DATA:

Analysis and use of interview data will vary by ESD region and will depend on the skills and resources available to each Navigator. The following provides a brief overview of basic data cleaning and analysis of interview responses.

Cleaning the data: Once interview data have been transcribed into the preferred format (e.g. online database platform, Excel, Access, etc.), ensure Spelling/Grammar check has been run, double check that all answers were transcribed correctly (e.g. answer makes sense for the question), and remove any duplicate entries, as appropriate.

Add any additional information about each district that you want to analyze that was not included in the interview questions. For example, create an indicator for whether the district is urban/rural/suburban, Class 1 or Class 2, etc. This information can be used during crosstabulation to examine similarities and differences across your districts based on various characteristics.

Now you can begin analysis.

Descriptive statistics and frequency distributions can be used to calculate the number and type of responses to each question, as well as provide an overview of the types of districts in your region and how responses are similar or different based on district characteristics.

EXAMPLE 1:

Row Labels	Count of ESD
Class 1	17
Class 2	68
Grand Total	85

Row Labels	Count of ESD
ESD 101	41
ESD 113	44
Grand Total	85

EXAMPLE 2:

Row Labels	Count of ESD
ESD 101	41
Class 1	8
Yes	8
Class 2	33
No	9
Yes	24
ESD 113	44
Class 1	9
Yes	9
Class 2	35
No	10
Yes	25
Grand Total	85

RESOURCES

- [A beginner's guide to Excel](#)
- [Crosstabulations & Pivot Tables](#)

Qualitative analysis is the analysis of qualitative data such as text data from interview transcripts. This type of analysis is used to "make sense" of the responses to open-ended questions you asked in the interviews. Qualitative analysis is comprised of four basic steps:



1. Preparation/organization of responses by question:

EXAMPLE: "Are there needs/gaps/barriers that exist related to addressing behavioral healthcare for students in your district/school? →What are those specifically?"

The screenshot shows an Excel PivotTable with the following structure:

Row Labels	Count of ESD
ESD 101	41
Class 1	8
Eligibility, transportation, billing, so many state requ	1
Funding, space are the big two. We're designing nev	1
Needs: more qualified staff that don't have the sam	1
One issue is of course the parents that can't or won'	1
One of my responsibilities (Kim) is coordinating thre	1
Parents have to do a 90 minute intake with a family	1
The biggest issue is definitely staff. If each school h	1
The high number of students who don't qualify for tl	1
Class 2	33
A lot of drugs and substance use problems with som	1
A trained professional is the need. We have no train	1
Behavioral health is a non-issue for our current stud	1
Better coordination of care. It's been a while since I'	1
Currently 4 counselors, but we would really like to h	1
Distance - the major cause, just lack of providers wit	1
Even if a Navigator coordinates services with a comr	1
Financial, the district being able to afford more time	1
I don't feel qualified to meet the needs of our studer	1
I think school counseling is definitely oriented to can	1
Lack of staff, we need more people to do that. We n	1
Money, gas to get to davenport, transportation issue	1
Not currently. Definitely unprepared if issues arise. \	1
Not so much an issue with stigma, but access is hug	1
Parental resistance, eligibility (Medicaid issues), we	1
Poverty, caregivers having money, transportation, be	1
Proximity is #1, we do not have services in our area	1
Size, location, distance, funding, staffing (experience	1
Some parent don't want to be blamed for what's ha	1
The smaller school districts have so very little resour	1
There is a huge disconnect from superintendents an	1
There is a stigma against mental health in our area,	1
Transportation and distance. Training for staff. Profe	1
Transportation because we are rural. We have that	1
Transportation for families is a big issue as well, sor	1
Transportation for rural, compared to in a bus line. T	1
Transportation is huge, access to vehicle, gas money	1
Transportation, resources, very high poverty. Addicti	1
Transportation, which is why we allow providers to c	1
Transportion, distance, lack of resources, closest is	1
Very difficult to find a qualified person that can be a	1
We're shorring up our universal screener. Obviously	1
Workforce takes a lot of time and effort, consistent	1
ESD 113	43
Class 1	9
High trauma in families, poverty, 80% free and redu	1
immigrants families living in fear of any governmen	1
Our community is not invested in education or whol	1

The PivotTable Fields task pane on the right shows the following configuration:

- FIELD NAME:** Search fields
- Filters:**
 - Date Submitted
 - ESD
 - District
 - Enrollment
 - Size
 - District Class
 - School(s)
- Columns:** (Empty)
- Rows:**
 - ESD
 - District Class
 - (5) Are there n...
- Values:**
 - Count of ESD

Drag fields between areas



2. Review (read) and code responses:

EXAMPLE:

Raw Data	Codes			
Eligibility, transportation, billing, so m	Eligibility	Transportation	Billing	Workforce
Funding, space are the big two. We're	Funding	Space for Services		
High trauma in families, poverty, 80%	High trauma	Transportation		
Immigrants families living in fear of a	Vulnerable popu	Transportation	Stigma	
Needs: more qualified staff that don't	Qualified staff	Transportation	Knowledge and awareness	
One issue is of course the parents that	Stigma	Parental engagement		
One of my responsibilities (Kim) is cod	Eligibility			
Our community is not invested in educ	Stigma	Culture		
Parents have to do a 90 minute intake	Eligibility			
ransportation is a huge barrier, Childre	Transportation	Qualified staff		
The biggest issue is definitely staff. If	Qualified Staff	Transportation		
The fragility of the families, drug addi	Family issues/trauma			
The growth of the problem is so rapid	Growth of probl	Capacity		
The high number of students who don	Eligibility	Transportation		
The Prototypical school model is an ou	Funding model			
transportation, families who live in crisi	Transportation	Family trauma/issues		
workforce, transportation, eligibility, i	Workforce	Transportation	Eligibility	

3. Interpret codes, identify themes:

EXAMPLE:

Barriers - ALL	
Transportation	51
Parental issues/Family Trauma	25
Funding	15
Workforce	14
Stigma	13
Qualified Staff (school)	13
Eligibility/Access	12
Capacity/Resources	11
Geography	10
Mistrust of System	5
K&A	2
Coordination of Care	1
Barriers - Refined	
Transportation	51
Funding	27
Parental issues/Family Trauma	25
Stigma	15
Workforce	14
Qualified Staff (school)	13
Eligibility/Access	12
Geographic Isolation	10
Mistrust of System	5

RESOURCES:

[Four Basic Steps of Qualitative Analysis](#)

4. Summarize Findings:

EXAMPLE:

When asked about existing **gaps or barriers** in their district related to addressing the behavioral healthcare needs of their students, respondents identified a number of issues. These included a lack of capacity and resources, lack of coordination of care, eligibility and access issues (e.g. insurance barriers), lack of funding for services, geographic isolation of the district, a lack of knowledge and awareness of mental health and related services, mistrust of the school/government system (particularly by marginalized communities (i.e. immigrant populations), family dysfunction, including parental substance use, mental health and other trauma related issues, a lack of qualified school-level staff to support services as well as a lack of qualified provider workforce (e.g. licensed clinicians), transportation barriers and lingering stigma.

However, when examining the top three issues identified by respondents, **transportation, funding, and parental engagement/family issues were the three most frequently cited barriers or gaps** to addressing the behavioral healthcare needs of students in their district.



[What Does Coding Look Like? Qualitative Research Methods](#)

Interview Next Steps:

Once you have completed your interviews, compiled your data, and conducted analysis, you are now ready to develop a plan for how your ESD region needs to approach this work. This may include all of the following next steps outlined in the rest of this Playbook or may include additional activities your region identifies as a need (that falls within the scope of what is allowable within RCW 28A. 310.510). Consider how often your ESD will want to revisit this interview process to find how districts are doing within the systems and set a frequency for updating this process.



Needs Assessment, Gaps Analysis, and Resource Mapping

An important lesson during the pilot phases of the Navigator work was the value of internal agency communication, strengthened by the establishment of the Navigator position. Because this is new work for the agency, it is important to assess how the Navigator will intersect with other ESD programming. Once identified, the Navigator should provide ongoing briefings to agency staff on the progress of the work and identify opportunities for collaboration.

When working with districts to increase access to care to behavioral healthcare services, the Navigator can use tools to help districts conduct an initial needs assessment and gaps analysis to understand their current systems and identify where to start. A useful tool for the Navigator is the [School Health Assessment and Performance Evaluation System](#) (SHAPE). The Navigator can use this no-cost tool to assist schools/districts to determine steps for improving their system of care. Additionally, the Navigator should create an inventory of regional service providers available for referral services, care coordination, or the provision of co-located services.

Recommended Activities within the ESD:

1. Make connections, get introductions to program directors, build relationships, and conduct an analysis of agency work that intersects with the Navigator role (e.g.: Nursing, Counseling, Special Education, Threat Assessment, School Safety, etc.).
2. Set up one-on-one meetings and learn about program administration/activities, and how the Navigator can partner to ensure ongoing communication and program cross-collaboration.
3. Brief agency partners on the Navigator role and responsibilities and identify opportunities for partnership and collaboration.
4. Consider presenting to agency leadership and/or the board annually on the Navigator activities, progress, and plans.

Recommended Activities with Districts:

1. Outreach to all districts with a focus on readiness to benefit.
2. Establish a point of contact for behavioral health at each school district.
3. Share details of the Navigator role and generate interest.
4. Assist districts in conducting a needs assessment, gaps analysis, and resource mapping.
5. Identify next steps for increasing access to care.



Identifying and Engaging Regional Healthcare Partners:

The Health Care Authority's (HCA) Healthier Washington initiative aims to build healthier communities through a collaborative regional approach involving the [Accountable Communities of Health \(ACH\)](#). The Healthier Washington approach includes goals that all people with physical and behavioral health comorbidities will receive high quality care and that Washington's annual health care cost growth will be 2% less than the national health expenditure trend.

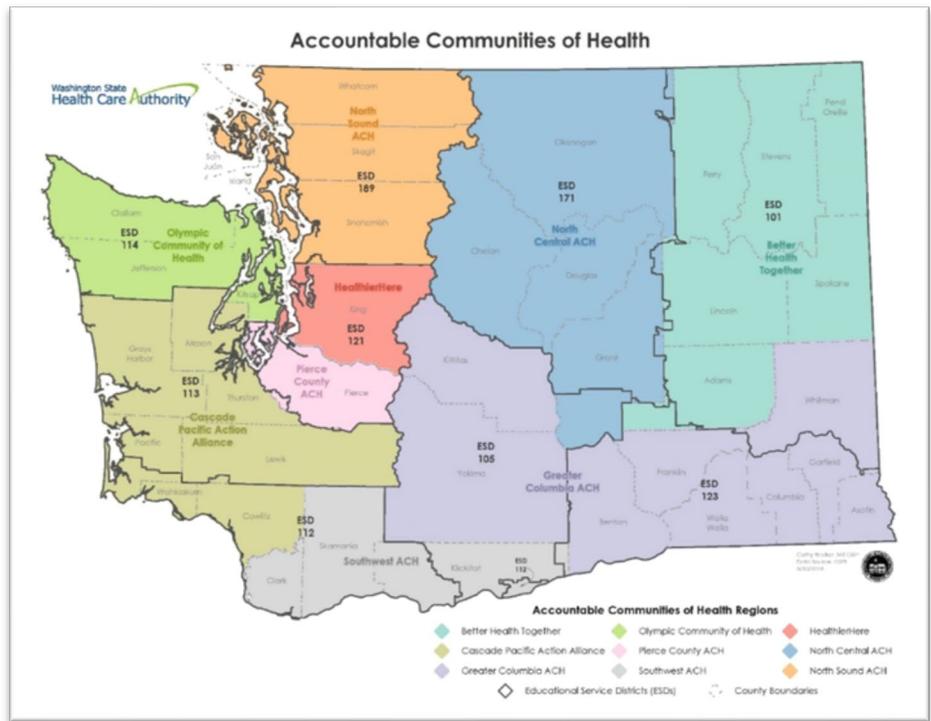


Figure 1: Regional ACHs and ESDs.

The nine ACH's (see Figure 4) bring together leaders from multiple health sectors with a common interest in improving health and health equity. As ACHs better align resources and activities, they support wellness and a system that delivers care for the whole person. Their boundaries are similar (although not exact) to the ESD regional boundaries.

Health system transformation depends on coordination and integration with community services, social services and public health. ACHs provide the necessary links and supportive environments to address the needs of the whole person.

ESDs can be important partners in this regional approach to a healthier population by participating with their regional ACH. Like ESDs, each ACH's body of work is unique to the region's needs. A Navigator begins building relationships with the region's healthcare leaders and spends time learning about their ACH's goals, programs, and initiatives by attending public meetings.



The Health Care Authority recommends that ESD Navigators take the following steps to begin fostering relationships with the ACHs:

1. Reach out to their ACH's Administration to set a meeting where the ESD can share about their role in the region and learn about the ACHs current work in the region with the population they share (children and youth).
 - a. Explain that the Navigator role is new, authorized by legislation, and charged with increasing access to behavioral health care in the region.
 - b. Share how the ESD is assessing how they can engage in regional partnerships creating awareness of bidirectional referral relationships.
 - c. Learn about the ACH Board makeup, governance structure, standing and ad-hoc committees, and public meeting schedules; explore if there is a place for the Navigator.
 - d. Learn about the ACH's identified goals, objectives, and outcome measures, specifically for interventions on social determinants of health related to children and youth.
2. Explore opportunities to partner in potential future proposal opportunities (e.g.: care coordination programs, create/build awareness about the region's strategies for integrated managed care, early and periodic screening, diagnostic and treatment (EPSDT), nursing services, etc.).
3. Find out how the ESD and ACH can partner on ensuring schools have a current understanding of the referral resources available in the region so that the right student is referred to the right care at the right time.
4. Attend the ACH's public meetings to learn more about current initiatives and ongoing plans for transforming healthcare.

Medicaid Programs Available to Serve Students in School Districts

There are multiple ways in which the State Medicaid Plan administers behavioral health to children and youth in the state. On average, 42% of a school district's population is eligible for Medicaid in Washington. The Navigator can help schools maximize the resources available to them by leveraging available Medicaid resources.

Medicaid Administrative Claiming – MAC

MAC is an optional Medicaid program that allows school districts and ESDs to receive federal reimbursement for administrative activities (performed by school staff) that support the goals of the Medicaid State Plan. Examples of eligible activities include outreach to provide information about Medicaid programs and covered services to students and families; assisting individuals in applying for or accessing Medicaid covered services; and, referring students and families to health providers. School District (SD) staff participate in a Random Moment Time



Study (RMTS) to determine what percentage of their time is spent performing reimbursable activities such as outreach, application assistance, and referring students/families to needed healthcare services.

Participation process

- Participating SDs use a web-based random moment time study/claiming system.
- Selected SD staff receive an email which requires them to describe a 1-minute interval (moment) of a specified workday.
- This moment consists of four short questions with pre-defined answers followed by an open-ended question to detail the specifics of the activity.
- Typically, the RMTS takes 1-2 minutes to complete.

Recommended Activities:

1. Visit the [SD MAC website](#) for current program information.
2. Connect with SD MAC Program Manager at HCA for information and training.
3. Request information from HCA regarding districts currently participating in the program.
4. Explore the option of participating in MAC at the ESD (if appropriate, and if not already participating).
5. Share details and generate interest with districts in the region.
6. Connect districts with the SD MAC Program Manager at HCA.

School-Based Health Care Services – SBHS

The Washington State School-Based Health Care Services (SBHS) program is an optional Medicaid program administered by the Health Care Authority (HCA). The SBHS program provides partial reimbursement to contracted school districts, educational service districts, and charter and tribal schools for Medicaid covered health-related services provided to Title XIX Medicaid eligible students. In order to receive Medicaid reimbursement through this program, services must be included in the child's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). School-based IEP/IFSP health-related services are carved out of the state Medicaid contract with Managed Care Organizations (MCOs) and are reimbursed fee-for-service by the HCA.

Covered Services

To receive reimbursement, covered services must be referred or prescribed by a physician or other Department of Health (DOH) licensed providers within their scope of practice provided by or under the supervision of DOH licensed providers and must be written in the child's IEP or IFSP.

Recommended Activities for the ESD Navigator:

1. Visit the [SBHS Website](#) for current program information.



2. Connect with the HCA SBHS Program Manager for information and training.
3. Request information from the HCA SBHS Program Manager on districts using the program.
4. Discuss with ESD leadership if the ESD might want to act as the coordinating organization for smaller districts.
5. Share SBHS program details and generate interest with non-participating districts in the region.
6. Connect districts with the HCA SBHS Program Manager.

Note: The ESD or SD may choose to contract with a 3rd party billing agency to assist with billing technology and SBHS program participation. Billing agents are not affiliated with HCA.

Build Bridges between School Districts and Licensed Behavioral Health Providers

The Navigator will need to build relationships with licensed behavioral health providers who contract with Managed Care Organizations. The five Managed Care Organizations (MCOs) collectively cover all students participating in Apple Health, WA's Medicaid Program. MCO coverage varies by region, and not all five MCOs cover all regions. The Navigator will need to establish relationships with the MCOs to fully understand the regional provider network and determine opportunities for partnerships.

Recommended Activities:

1. Identify the [Managed Care Organizations](#) that cover students in your ESD region.
2. **All regions will need to work with Coordinated Care for foster students
3. Identify the regional behavioral health providers that serve your student populations.
4. Determine opportunities for partnerships (e.g.: care coordination, bidirectional referral relationships, etc.).

Suicide Prevention Protocol

[RCW 28A.320.127](#) requires all districts to have plans for recognizing and responding to signs of emotional and behavioral distress. An ESD Behavioral Health System Navigator can help districts in their region with this work by providing support with:

- Prevention, intervention, postvention planning and implementation
- Training staff, students, and parents/caregivers
- Connecting districts to regional suicide prevention coalitions
- Connecting with regional public health to understand suicide rates, and levels of risk
- Inventorying school districts on their plan completion, helping them update plans, developing regional supports for plans to ensure districts are using the most appropriate resources and supports



- Providing leadership for regional teams to coordinate for postvention response

Sustainability Planning

The Navigator will work in their region to engage in the healthcare systems. Sustainability for each ESD will vary depending on the role in which they play. This may include:

- Plans for reaching all districts in the region.
- Steps for supporting comprehensive mental health in schools using a Multi-Tiered System of Supports (MTSS) framework.
- Diversified funding resources to increase access for all students.
- Ongoing relationships through community partnerships.
- Ongoing relationships and coordination with the MCOs and ACHs to determine strategies for combatting the social determinants of health that have an impact on children and youth.

Definitions and Acronyms

For the purposes of this project, the following terms, definitions, and acronyms will be used:

Accountable Community of Health (ACH)

Regional Medicaid delivery systems to bring together leaders from multiple health sectors with a common interest in improving health and health equity.

Americans with Disabilities Act (ADA)

The ADA is a civil rights law that prohibits discrimination against individuals with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public. The purpose of the law is to make sure that people with disabilities have the same rights and opportunities as everyone else.

Apple Health

Washington's Medicaid program.

Behavioral Health

Includes not only ways of promoting well-being by preventing or intervening in mental illness such as depression or anxiety, but also to prevent or intervene in substance abuse or other addiction disorders.

Behavioral Health Agency (BHA)

A licensed and certified agency providing mental health and/or substance use disorder treatment services.



Behavioral Health – Administrative Services Only (BH-ASO)

These organizations administer services such as 24/7 regional crisis hotline for mental health and substance use disorder crises, mobile crisis outreach teams, short-term substance use disorder crisis services for individuals who are intoxicated or incapacitated in public, application of behavioral health involuntary commitment statutes, available 24/7 to conduct Involuntary Treatment Act (ITA) assessments and file detention petitions, and regional ombuds.

Behavioral Health Organization (BHO)

The Health Care Authority manages contracts with Behavioral Health Organizations for mental health and substance use disorder (SUD) treatment services in regions that have not yet implemented Integrated Managed Care. As Apple Health continues to implement Integrated Managed Care across the state, responsibility for behavioral health coverage transfers to integrated managed care plans. This transition will be complete by January 1, 2020. The only current BHO's include Great Rivers, Thurston-Mason, and Salish.

Behavioral Health Services Only (BHSO)

Apple Health offers Behavioral Health Services Only (BHSO) plans in all regions with integrated managed care. These plans are for clients who are eligible for Apple Health, but not eligible for managed care enrollment. The Behavioral Health Services Only plans are offered by the same health plans administering Integrated Managed Care.

Community Provider MOU (Memorandum of Understanding) or IA (Interagency Agreement)

A non-legally binding document for the school district and community provider to converge on an agreement of terms. Usually stating how many days a week, what hours, and what space they will use, and how service will be conducted.

Department of Children, Youth, and Families (DCYF)

The lead agency for state-funded services that support children and families to build resilience and health, and to improve educational outcomes.

Department of Health (DOH)

The lead agency for state-funded public health programs and services.

Electronic Health/Medical Record (EHR/EMR)

Electronically stored patient health information that can be shared across different health care settings.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Child health component of Medicaid. Federal statutes and regulations state that children under age 21 who are enrolled in Medicaid are entitled to EPSDT benefits and that States



must cover a broad array of preventive and treatment services. Service(s) identified through EPSDT become medically necessary service(s).

Fee for Service (FFS)

Payment for services delivered on an encounter basis. Procedure codes, units, and reimbursement rates all determine reimbursement.

Healthcare Authority (HCA)

Washington's state Medicaid agency. Receives funding from the Center for Medicaid and Medicare Services (CMS).

Individualized Education Program (IEP)

A document that is developed for each public school child (ages 3-21 years) who needs special education. The IEP is created through a team effort and reviewed periodically.

Individualized Family Service Plan (IFSP)

A plan for special services for young children (0-3 years) with developmental delays. An IFSP only applies to children from birth to three years of age.

Integrated Managed Care

An initiative under Healthier Washington to bring together the payment and delivery of physical and behavioral health services for people enrolled in Medicaid, through managed care.

Intergovernmental Transfer (IGT)

Match and funds transfer process for the School-based Health Services Program, contracted with HCA.

Managed Care Organization (MCO)

Most Apple Health clients have managed care, where Apple Health pays a health plan a monthly premium for each enrollee's coverage. This includes preventive, primary, specialty, and other health services. Clients in managed care must see only providers who are in their plan's provider network, unless prior authorized or to treat urgent or emergent care. In Washington, there are five managed care plans: Coordinated Care, Community Health Plan of WA, Molina, Amerigroup, and United Healthcare, although every plan is not available in all parts of the state.

Medicaid

A joint government (federal and state) insurance program that helps with medical costs for persons of all ages whose income and resources are insufficient to pay for health care. In Washington, Medicaid is termed Apple Health.



Medicaid Administrative Claiming (MAC)

An optional Medicaid program that allows school districts and ESDs to receive federal reimbursement for administrative activities performed by school staff that support the goals of the Medicaid State Plan. Examples of eligible activities include outreach and providing information about Medicaid programs and covered services to students and families, assisting individuals in applying for or accessing Medicaid covered services, and referring students and families to health providers. School staff participate in an electronically administered time study and the results of the time study, along with the school population's Medicaid eligibility rate determine the funds received by the school.

Medicaid State Plan

The State Plan is the officially recognized statement describing the nature and scope of Washington State's Medicaid Program. A State Plan is required to qualify for federal funding for providing Medicaid services.

Mental Health Literacy

School mental health literacy includes four main components (teenmentalhealth.org):

1. Understanding how to optimize and maintain good mental health,
2. Understanding mental disorders and their treatments,
3. Decreasing stigma, and
4. Increasing health seeking efficacy.

Mental Health Treatment

Treatment choices for mental health conditions will vary from person to person. Treatments range from evidence-based medications, therapy and psychosocial services such as psychiatric rehabilitation, housing, employment and peer supports.

Multi-Tiered System of Support (MTSS)

A framework for enhancing the adoption and implementation of a continuum of evidence-based instruction and interventions to achieve important outcomes for all students.

Needs/Gaps Assessment

A process used by a district/school to measure behavioral health system quality within the education setting.

Random Moment Time Study (RMTS)

Web-based system for claiming/reimbursement through the Medicaid Administrative Claiming Program. Operated by the University of Massachusetts Medical School.

School Based Health Center

School-based health centers generally operate as a partnership between the school district and a community health organization, such as a community health center, hospital, or the



local health department and can provide a combination of primary care, mental health care, substance abuse counseling, case management, dental health, nutrition education, health education, and health promotion.

School Based Health Care Services (SBHS)

An optional Medicaid program administered by the Health Care Authority. The SBHS program reimburses contracted school districts, educational service districts, and charter and tribal schools for Medicaid covered health related services provided to Medicaid eligible students. In order to receive Medicaid reimbursement through this program, services must be included in the child's Individualized Education Program or Individualized Family Service Plan. School-based IEP/IFSP health related services are carved out of Medicaid Managed Care Organizations and are reimbursed fee-for-service.

Screening and Assessment Tools

Tools utilized by the district/school to assess the behavioral health needs of students.

Substance Use Disorder Treatment (SUD)

Treatments that usually involve planning for specific ways to avoid the addictive stimulus, and therapeutic interventions intended to help a client learn healthier ways to find satisfaction.

Suicide Prevention

Process of implementing strategies that reduce the likelihood of student suicide.

Suicide Intervention

Providing appropriate therapeutic services for identifying and treating underlying causes/conditions of suicidality within at-risk student populations.

Suicide Postvention

Process of providing supportive services to school staff and students following the completed suicide of a staff or student.

School Counselor

A certificated school staff with a focus on academic advising.

Community Counselor

A certified behavioral health professional employed by a community provider with a license through the department of health.

School Psychologist

a general practice and health provider that is concerned with the science and practice of psychology with children, youth, families; learnings of all ages, and the school process. School psychologists are prepared to intervene at the individual and system level, and develop, implement and evaluate preventive programs. They conduct ecologically valid assessments



and intervene to provide positive learning environments within which children and youth have equal access to effective educational and psychological services that promote healthy development (APA, <https://www.apa.org/ed/graduate/specialize/school>, retrieved 4/8/20).

Clinical Psychologist

Clinical psychologists address behavioral and mental health issues faced by individuals across the lifespan, including: intellectual, emotional, psychological, and behavioral maladjustment, disability and comfort, and minor adjustment issues as well as severe psychopathology (APA, <https://www.apa.org/ed/graduate/specialize/clinical>, retrieved 4/8/20).

Value-based Payment (VBP)

Also termed pay-for-performance, involves contracts with insurance payers that shifts health care reimbursement strategies away from a system that pays for completing specific services (fee-for-service) to one that pays for an array of other factors. VBP utilizes a multitude of Alternative Payment Methods (APM)s to provide reimbursement based on quality of care, cost savings, performance rewards/penalties, and population-based payment.

Navigator Job Activity Examples:

- Attending School Based Health Care Services (SBHS), and Medicaid Administrative Claiming (MAC) webinars and trainings.
- Communicating with SBHS, and MAC Program Specialists with the Health Care Authority.
- Collaborating with internal ESD departments (e.g. Prevention Programs, Special Education, School Fiscal Services, Nursing Corps, etc.).
- Attending ACH Medicaid Transformation Collaboratives.
- Meeting with regional Amerigroup Washington (AMG), Coordinated Care of Washington (CCW), Community Health Plan of Washington (CHPW), Molina Healthcare of Washington (MHW), and UnitedHealthcare Community Plan (UHC), to discuss partnerships.
- Meeting with school district superintendents, administrators, and counseling staff to discuss SBHS, MAC, and Medicaid integration.
- Attend the Annual Conference on Advancing School Mental Health to learn about national behavioral health efforts.
- Exploring 3rd party billing agencies, IT Technology systems, and options to support school-based Medicaid billing.
- Identifying community resources and producing current regional lists for districts/schools.
- Communicating with Public Consulting Group (PCG) regarding IEPOne partnership, and EasyTrac system.
- Monthly learning community meetings.



- Data collection and reporting.
- Present process and outcomes with peers.
- Identify and build relationship with school and community-based providers.
- Map providers and services available for schools to use for referral and decision making.
- Facilitate relationships between providers and schools.
- Provide education and awareness on Medicaid billing options available to schools.
- Provide support to schools interested in participating in Medicaid billing options by connecting them with HCA and/or MCO-contracted providers.
- Active participation representing K–12 voice among regional healthcare system partners: Accountable Communities of Health, Family Youth and System Partner Round Tables, Behavioral Health Providers.
- Serves as a conduit of information and resources bi-directionally between schools and the BH system.
- Explore funding opportunities to fill gaps that cannot be met by insurance reimbursement (infrastructure building, care coordination, services for non-insured).
- Collect data from districts on current system to partner/coordinate/fund BH services.
- Explore if school Medicaid reimbursement recovers the cost of services; learn how reimbursement funds are used, identify barriers for participating in available Medicaid programs.
- Inform ESD Network on lessons learned and recommendations for approaching the work.
- Implement a mental health literacy curriculum in at least one high school, document curriculum adoption process to inform case study.
- Contact each Superintendent in the region and establish a point of contact at each school district in the region.
- Establish relationships with Managed Care Organizations to increase access to care and coordinate care.
- Assist districts in completing needs assessment and gaps analysis of services.
- Support districts in developing and implementing a suicide prevention protocol.

NAVIGATOR REFLECTIONS

Reflections on the interview process

What lessons did you learn from the first few interviews?

I benefited from the fact that I had many informal meetings with districts in our region before conducting the interviews. **Know your audience beforehand.** Number of students, grades, buildings, town, region.



Do some research before you go asking questions. Get an idea of the size of the district, what is the local economy look like, where is the nearest medical clinic, etc. You don't need to do in depth research but knowing a few things will help you have more of a conversation that will answer questions and get better information.

What were districts most willing to share about?

Districts were very willing to share about a lot. They were eager to share about what they are able to do, but also open about where they feel they have shortcomings.

How hard their staff and teachers were working to make things work within an imperfect system. They talked about the everyday behavioral health needs that were being met by teachers and staff that already wear 10 hats and how far above and beyond these teachers would go for their students.

What were district least willing to share about?

Many districts didn't have good things to say about their regional behavioral health provider but didn't want to bad-mouth them. Several said **"this is off the record"** when sharing about a specific provider. Many said, "their services aren't great, but they're all we have, and we can't risk losing them".

Most districts get a little itchy when asked about MAC and funding for behavioral health. In recent history a district in my region was busted by the Attorney General for fraudulent Medicaid claims and that has scared a lot of districts away from using it entirely. Funding has a lot of rules around it, and No one wants to make a mistake.

Which of your skills were most important to conducting interviews?

My interpersonal skills and awareness were definitely my strength in these interviews.

When coming into someone's space and asking specific questions about their money, time, and how they do things the other person or people can feel defensive and a little invaded. **It is important to come in humble and gracious as they share this precious information.**

Being comfortable with silence and giving staff time to really think about and answer the question. **Validating statements in a way that is non-judgmental.** Maintaining equipoise when you receive an unexpected or difficult answer. Sometimes staff just needed to share a specific example of where they couldn't find a solution, and it clearly weighed heavily on their heart and mind. **It's a balance between "sticking to the script" to get the interview accomplished and going with the flow of difficult topics and conversations.**



Reflections on the interview responses

What were you most surprised by?

The hospitality of the schools. Several small schools provided me a tour because they were proud of what they've accomplished and enjoyed sharing. **These were really special moments to see the passion our schools have for their work.**

A few very rural districts greatly appreciated just having someone come visit them. Traveling 6 hours round trip showed their time and input was valuable. It was humbling to have someone appreciate something so simple.

I was most surprised by rural poverty and the devastating lack of resources for behavioral health in those schools and communities and the impact that has on families for generations. On the opposite side, when students in bigger urban schools need services they can be lost in a sea of students and never actually get what they need because no one sees them or the number of students is overwhelming. These were two concepts that I had never thought of until a few superintendents gave me examples and spelled it out for me.

What reinforced your previous understanding of how schools are approaching the behavioral health needs of their students?

That those rural schools do an out of this world job on building the necessary relationships needed to help with the behavioral health issues and urban schools are working tirelessly to keep up with the tidal wave of behavioral health issues.

Just how many barriers exist to accessing services. The growing number and severity of youth that have untreated behavioral health issues.

In hindsight:

If you were to conduct these interviews again, what is one thing you would do differently?

Make sure every interview has at least 2 staff from the district. I initially started by having individual meetings with staff because I believed this was the best way to get multiple perspectives. The first meeting I had with 2 staff together, an interesting thing happened. They didn't just provide multiple perspectives they began asking each other for clarification and information. It grew the interview from a purely "information gathering exercise" to a way of facilitating a valuable conversation between staff. After that first meeting, whenever possible, I would schedule multiple staff at once. In a several interviews with more than 2 staff, they actually began sharing resources and strategies with one another.

I don't know if I would do anything different, I had a great team and support leading the way. **Enjoy the ride, it's the best part!**



What is one thing you were glad you did, and would be sure to replicate?

Jump right in, go get em', talk with your fellow navigators about questions and experiences you had. **The whole thing is about gaining knowledge and learning, don't try and know it all.**

Print off a simplified version of the interview questions. Always have a bottle of water. **Plan for travel delays and don't be late.** Do everything in your power not to cancel the meeting.

What do you see as the biggest asset for an ESD having a navigator?

Getting a real idea of what changes are possible right now, and what changes are going to take more time. Short term solutions, mid-term strategies, long-term ideas.

Creating pathways for BH in schools, advocating for your region, connecting and building relationships with necessary partners in communities and sand at the systems level.

Where do you see this role making a positive impact in the future?

I see this role becoming the voice for BH within our regions. Navigators have the ability to get a pulse on what is happening throughout the region and show up for districts on multiple levels.

The Navigators are representatives for students with behavioral health needs. The school staff, caregivers, and students need someone to be their voice within the larger system of behavioral health.

Policy changes at the state level. There will always be ongoing work directly with districts and community providers to make short-term strategies, but changes to the behavioral health system itself will have the greatest long-term positive impact. We created a Suicide Prevention Protocol for our districts to have an evidence-based process for addressing concerns and connecting students of concern with appropriate services. State policy can provide proper guidance regarding its application, funding for school staff to become trained, and funding for behavioral health providers to work directly with schools.



*Children's Regional Behavioral Health Pilot
School Districts Speak to Need for Regional Behavioral Health
Coordination
Full District Interview Report*

May 2020

Compiled by:

Maike & Associates, LLC



In collaboration with:

Behavioral Health Systems Navigator, Educational Service District 101

Behavioral Health Systems Navigator, Educational Service District 113

For:

Washington Office of the Superintendent of Public Instruction



Washington Office of Superintendent of
PUBLIC INSTRUCTION

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Acknowledgements

The main component of this work was to conduct in-depth interviews with school districts in the Educational Service District (ESD) 101 and Educational Service District (ESD) 113 regions to better understand the nature, depth, and breadth of current school-based social, emotional and behavioral health strategies, as well as to identify barriers facing school districts as they try to meet the behavioral health needs of their students.

Thank you to all the participants who generously and graciously gave their time to this project. Each district represented participated in a 60-minute interview and provided a vast amount of honest and thoughtful insight about the state of school-based mental health services and supports within their district.

Participating Districts

Aberdeen	Harrington	Oaksdale	Southside
Adna	Hood Canal	Oakville	Spokane Public Schools
Almira	Hoquiam	Ocosta	Sprague
Benge	Kettle Falls	Odessa	Summit Valley
Boisfort	Lake Quinault	Olympia	Taholah
Central Valley	Lind-Ritzville (cooperative)	Onalaska	Tekoa
Centralia	Loon Lake	Onion Creek	Tenino
Chehalis	Mary M Knight	Orchard Prairie	Toledo
Cheney	Mary Walker	Orient	Tumwater
Colton	McCleary	PeEll	Valley
Columbia	Mead	Pioneer	WaHeLut
Cosmopolis	Medical Lake	Pullman	Wellpinit
Curlew	Montesano	Rainier	West Valley
Cusick	Morton	Raymond	White Pass
Deer Park	Mossyrock	Reardan-Edwall	Wilbur-Creston
East Valley	Napavine	Republic	Willapa Valley

Elma	Newport	Riverside	Winlock
Evaline	Nine Mile Falls	Rochester	Wishkah Valley
Freeman	North Beach	Satsop	Yelm
Garfield-Palouse	North River	Selkirk	
Grapevine	North Thurston	Shelton	
Great Northern	Northport	South Bend	

And a special thank you to the two pilot Regional Behavioral Health Systems Navigators, Andrew Bingham (ESD 101) and Grace Burkhart (ESD 113) for their time and commitment in conducting and recording these interviews.

Executive Summary

In the fall of 2019, as part of the Children’s Regional Behavioral Health Pilot Project (est. 2017), the Behavioral Health System Navigators (Navigators) in ESD 101 and 113 conducted in-depth interviews with 85 school districts across their regions. The intent of the interview was to better understand the behavioral health systems in place in school districts, the extent to which these systems were effective, and in what ways these might be improved.

Through this interview process, the Navigators were able to unearth a multitude of complex barriers facing districts as they try to meet the behavioral health needs of their students. Findings from interviews revealed that in a majority (77%) of these districts some form of school-based behavioral health services existed. However, access to services varied greatly; not only in terms of availability of services, but also regarding service eligibility. Most districts (93%) also acknowledged their current system was not sufficient to meet the behavioral health needs of their students.

The overarching purpose of the Children’s Behavioral Health pilot project was to investigate the benefits of an ESD-level Navigator, with the goal to increase access to behavioral health services and supports for students and families. Results demonstrate that through relationship building and coordination, Navigators help bridge the gap between the behavioral health and K–12 education systems. Thereby, addressing systemic barriers to the delivery of school based behavioral health services and ultimately increasing access to care for youth and families.

Introduction

In 2017, the Legislature passed [House Bill 1713](#) (2017–18) establishing the Children’s Regional Behavioral Health Pilot Project. The purpose of the pilot project was to investigate the benefits of an ESD Behavioral Health System Navigator (Navigator), with the goal to increase access to

behavioral health services and supports for students and families. The role of the Navigator is to integrate the behavioral health and K–12 education systems; thus, bridging the gap between these two systems. The Navigator is not a direct service provider, they connect and translate across the two systems in their respective regions. Northeast Washington ESD 101 and Capital Region ESD 113 piloted this project through June 30, 2020.

Since the pilot launched in July 2017, we learned several valuable lessons regarding the role of the Navigator as well as the ways in which the education and health care systems interact, and we wanted to gather data about what we had learned from districts in conversations we had throughout the pilot project. Prior to the project, it was assumed that K–12 schools effectively used Medicaid reimbursement to expand healthcare services to students. Our findings, however, show that most schools do not effectively use this funding mechanism in large part because the Medicaid system is complex and burdensome to navigate.

A second assumption was that Medicaid billing is readily accessible to schools—it is not. However, through our work, we have documented the tangled pathways to reimbursement. We now understand that these pathways are dictated by provider types, the kinds of services delivered, and regional Managed Care Organizations and provider networks. These pathways are complex and challenging for schools to utilize.

We also learned that a dedicated staff person working regionally within school districts can increase access to care for students eligible for Medicaid by improving districts' ability to navigate the complexities of the Medicaid system, and the healthcare system in general. To begin to increase access to care in the school setting, requires not only collaborative partnerships but also support from the entire K–12 system. This includes leadership at the state level from the Office of Superintendent of Public Instruction (OSPI) and oversight and management by the ESDs at the regional level, who in turn support the Navigators to help school districts at the local level successfully engage with healthcare system partners.

Through the collective knowledge gained in the first project period about the school-based Medicaid program, the publicly-funded regional healthcare structures, and the interaction of these within the K–12 education system, we identified the next level of information needed to further inform us about how districts strive to meet the needs of students' behavioral healthcare concerns. With the support of the Navigators, we designed a methodical and systematic approach for interviewing each district about their needs, the systems in place to meet those needs, and if existing systems were enough to address identified needs.

Interview Methodology

In the fall of 2019, the pilot Navigators conducted district-level interviews. The purpose of the interview process was to better understand existing behavioral health systems in place in school districts and their regions, including if these systems were effective, and in what ways these might be improved. The interview process was designed collaboratively among project

partners (OSPI, Navigators, and Research Partner). Questions were based on knowledge of school-based behavioral healthcare services and best practices for implementing comprehensive school-based mental health systems (See Appendix A for Interview Questions). The interview was designed, in part, to delve further into lessons learned from the 2016 Joint Legislative Audit and Review Committee (JLARC) Student Mental Health Services Inventory, while also informing our current work.

As part of this effort, each Navigator made initial contact with the districts in their region, first via email, with follow-up conducted by phone. Interviews were conducted in-person, via video conference, or by phone during the period of September 9th, 2019 to December 30th, 2019. Most (80%) interviews were conducted with a district administrator, primarily the superintendent/asst. superintendent or a building principal. The remaining interviews were conducted with other, or multiple school staff such as a school counselor, licensed mental health clinician, school social worker, or other administrative staff (e.g. Director of Student Support).

Interview responses were documented by the Navigator at the time of interview. Notes were transcribed and sent to the Research Partner for analysis. Using an online platform (SurveyGizmo), interview responses were transferred to a database, and exported into an excel workbook for analysis. Analysis included a summarization of responses by ESD region, and class size as well as qualitative analysis of open-ended interview responses. Specific data analysis methods can be found in Appendix B.

Definitions

One of the early learnings during this project is the importance of establishing a common terminology.

How the education and healthcare systems talk about behavioral healthcare in schools is very different, and because of these differences, confusion about needs, and how schools are meeting those needs can occur.

With this lesson in mind, and to ensure a common language, the following definitions were established by the project team and reviewed with each participant prior to the interview:

- **Behavioral Health or Behavioral Healthcare** means mental health and substance use prevention, intervention, and treatment.
- **Comprehensive School Mental Health Program** means there is a full array of tiered supports and services that promote positive school climate, social and emotional learning, and mental health and well-being, while reducing the prevalence and severity of mental illness and substance use issues.

- **School-based Behavioral Health Services** refers to both mental health and substance abuse prevention and intervention strategies delivered in the school-setting (i.e. students have access to services at the school building, during school hours. Services may be provided by community-based/outside providers and/or a district-hired MH provider or district staff (e.g. nurses, counselors, psychologists, social workers, etc.).
- **Community-based Behavioral Health Services**, like school-based services, but these are delivered in the community-setting. (i.e. services that are not located in school-building but may be available for students in need).

Although these definitions were included as part of the process, we came to understand that each participant came to the interview with their own understanding of these systems; thus, responses reflected the lens from which they observed their system, with these observations based on previous knowledge, expertise, and position within the education system (e.g. superintendent versus school counselor).

Educational Service District Interview Regions

Capital Region Educational Service

District (ESD) 113 is located on the western side of the state, based in Tumwater, WA. ESD 113 supports 45 school districts across five counties: Grays Harbor, Lewis, Mason, Pacific, and Thurston. School districts in this region range in size from 50 to 15,000 students, with Class 1 districts accounting for approximately 20% of districts. **ESD 113 represents a total student population of 73,000.**

Since 1998, the ESD has been a Washington state licensed outpatient substance use treatment disorder provider, adding mental health treatment and establishing themselves as a licensed behavioral health agency in 2014. As such, the ESD came to the pilot project with experience in providing direct behavioral health services in both the clinical and school settings, as well as existing relationships with school districts and other community partners through their existing services.

Across these two ESD regions a total of 88 individual district-level interviews were conducted, representing 98% of ESD 113 districts and 75% of ESD 101 districts, with a regionwide student population of 167,819 (OSPI, 2012-2020). The following data represents 85 district entities.¹



Northeast Washington Educational Service

District (ESD) 101 is located on the eastern side of the state and is based in Spokane, WA. ESD 101 supports 59 school districts across 7 counties: Adams, Ferry, Lincoln, Pend Oreille, Spokane, Stevens, and Whitman covers the largest geographic region of the nine ESDs in the state (14,026 square miles). Districts within the ESD 101 region range in size from 20 to 31,000 students, with Class 2 districts comprising approximately 80% of districts. However, it is important to also note that nearly half (48%) of the Class 2 districts in this region have a student population below 200, most of which are also geographically isolated. **ESD 101 represents a total student population of 101,382.**

ESD 101 is not a licensed behavioral health provider, however, is in the process of pursuing licensure at the time of this report (April 2020).

¹ In ESD 101, the following districts were combined into one interview entry: Wilbur-Creston, Garfield-Palouse, Lind-Ritzville.

Of these 85 districts, Class 1 districts (i.e., districts with more than 2,000 students) represented 20% of interviewees (n=17), with the remaining 80% Class 2 districts (n=68) (i.e., district with less than 2,000 students).

TABLE 1: Percentage of Districts Interviewed by ESD and Size

ESD	Class 1	Class 2	Total
ESD 101	20% (8)	80% (33)	100% (41)
ESD 113	21% (9)	79% (35)	100% (44)
Total	20% (17)	80% (68)	100% (85)

The proportion of Class 1 and Class 2 districts was similar across the two ESDs.²

What We Found

Overall, 66 (77%) districts reported students had access to some form of school-based behavioral health services (SBBHS). However, nearly all districts (93%) also reported that their current system was not sufficient to meet the behavioral health needs of their students.

Findings indicate that 100% of Class 1 districts and 72% of Class 2 districts reported access to school-based behavioral health services. However, as the following information illustrates, what districts described as school-based behavioral health services varied widely.

TABLE 2: Number of Districts w/School-based BH Services by ESD Region and Class

	ESD 101	ESD 113	Class 1	Class 2	Total
YES	32	34	17	49	66 (77%)
NO	9	10	0	19	19 (23%)
Total	41	44	17	68	85 (100%)

In fact, many larger districts had one or multiple providers spread across their districts in various buildings and grade levels delivering direct services from one to several days per week.

Among the smaller districts, participants also indicated that service providers were on site a specified number of days, however, due to eligibility criteria and provider schedules, services were not always consistently delivered (e.g., weekly).

These variations in service delivery models illustrate a gap between known best practices (as defined below) in a comprehensive school-based mental health services and supports system and those available to students in schools, with these disparities acknowledged by the districts themselves.

For example, one district described their school-based behavioral health services program as: *“Different counselors through [Provider]. Specific counselors with different positions and credentials who see students. Don't seem to be specific to youth or have very much experience serving children...Communication is not always great, definitely room for improvement. We*

² Class 2 districts comprise 64% (188) of the 295 districts in the State. SOURCE: <https://app.leg.wa.gov/committeeschedules/Home/Document/183987>

provide an office space for them to meet students, the counselor refers students to them. No intakes here at the school, they go to [Provider] to have an intake for services.” – ESD 101, Class 2

On the other hand, another district described their system as having “school counselors [that] are certificated, and some of them have active licenses or previous licenses as a treatment provider. They provide individual work, family, group, instructions in the classroom, training/information for the staff.” ESD 101, Class 1, alluding to a more formalized system than the example given above.

For another... “We have a private therapist who comes up to us 2-3 days a week to see kids. She is a licensed mental health counselor in [City] and we pay her a sub fee for her service. She is really just being generous, and we can’t afford to keep her. She is leaving at the end of the year.” – ESD 113, Class 2

As noted, results revealed that although most districts reported having school-based behavioral health services in place, these services fall short of meeting best practice standards. In fact, our findings suggest that there is a significant gap between the perceived (or reported) state of school-based behavioral health services and the recommended (or preferred) state of school-based behavioral health services across these districts.

School-based Mental Health Supports Best Practices³

School-based mental health supports are defined as mental health promotion, education, and the continuum of mental health services—prevention, assessment, intervention, treatment, consultation, and follow-up. These services and supports are provided in a school setting, through the collaboration of the school district’s student support services and the school-based and/or community-based mental health system, in partnership with youth and families. The goal of these is to create a seamless, coordinated, and comprehensive system of care to promote students’ emotional and social wellbeing, to ensure early identification of mental health needs, and to offer timely access to mental health services. These best practice strategies work best within a multi-tiered system of support (MTSS) framework.

In their words...

“Funding is number one, we have none. Finding a licensed treatment provider who is talented and qualified to meet the needs of our kids is not available. We need training and education for counselors who are qualified to provide treatment.” - ESD 113, Class 2

Overwhelmingly, districts acknowledged that existing systems lacked the needed infrastructure and supports to meet the behavioral health needs of their students.

³ Additional School-based Mental Health resources can be found on the following sites: [Office of the Superintendent of Public Instruction](#), [School Health Assessment and Performance Evaluation \(SHAPE\) System](#), [School Mental Health Referral Pathways Toolkit](#), SAMHSA

TABLE 3: % of Districts reporting having sufficient system capacity to meet student

	ESD 101	ESD 113	Class 1	Class 2	Total
YES	4	2	0	6	6 (7%)
NO	37	42	17	62	79 (93%)
Total	41	44	17	68	85 (100%)

“Access, quality, qualification, all severely lacking. Some students have severe concerns that don't have access to the services they need. There is a

severe lack of qualified people and community supports. We've had concerns about the qualifications of counselors: we have serious doubts whether staff are properly trained, credentialed, and educated. We've seen some issues with [community] counselors siding with students, not really advocating or partnering, but they side against the school instead of working together toward solutions to issues.” - ESD 101, Class 2

“We have had an influx in explosive extreme behaviors in the last few years with kindergarteners who appear to be feral and have zero control or connection to anything. We are so small we aren't unequipped to deal with this kind of thing. When we need a counselor, we need it on demand, and they are usually so booked out. There is stigma attached to behavioral health and parents hardly ever follow through with a community referral for all sorts of reasons. But, if we say the service will be at the school, the school seems to be a safe neutral space where the services are not attached to the stigma, so parents always say yes and are invested.” - ESD 113, Class 2

Interestingly, among the larger districts, none believed their system was enough to meet the needs of their students. Only a handful of class 2 districts indicated that their system was adequate and among these six districts, four had student populations of less than 200. Several participants noted, however, that this was more a matter of being fortunate to not have many students with high needs, rather than a true reflection of the district's ability to respond, as noted by this respondent:

*“Right now, [our system] is [sufficient]. We had a counselor here last year from the ESD cooperative for 1 day a week. There wasn't really much for her to do.... The teachers eat lunch with the students, they all know them really well. Each staff works as quasi-counselors every day. If there was something out of our wheelhouse, we would definitely reach out to the ESD or a community provider (and hope there was ability to serve our students) **There are so many issues that don't pertain to us because we are smaller, and our staff have such good relationships with the students and their families.**” - ESD 101, Class 2*

When asked about existing **gaps or barriers** in their district related to addressing the behavioral healthcare needs of their students, respondents identified several issues. These included a lack of capacity and resources, lack of coordination of care, eligibility and access issues (e.g. insurance barriers), lack of funding for services, geographic isolation of the district, a lack of knowledge and awareness of mental health and related services, mistrust of the

school/government system (particularly by marginalized communities (i.e. immigrant populations), family dysfunction, including parental substance use, mental health and other trauma related issues, a lack of qualified school-level staff to support services as well as a lack of qualified provider workforce (e.g. licensed clinicians), transportation barriers and lingering stigma.

However, when examining the top three issues identified by respondents, transportation, funding, and parental engagement/family issues were the three most frequently cited barriers or gaps to addressing the behavioral healthcare needs of students in their district.

In their words...

"The problem is so big that we can't keep up. We have Kindergarteners with suicide ideation, behavioral [issues] are more intense, and the violence from students is worse than ever. The need for mental health continues to grow and we can't keep up." - ESD 113, Class 1



"Too many needs, and not enough hands. That we don't all have the knowledge and expertise to do the work ourselves. We are a Band-Aid trying to triage the situation." - ESD 101, Class 1

"Access, quality, qualification, all severely lacking. Some students have severe concerns that don't have access to the services they need. There is a severe lack of qualified people and community supports." ESD 101, Class 2

"Lack of resources and providers in the community make it a huge barrier and the Prototypical school model is a barrier for us to get the student services we need for behavioral health." - ESD 113, Class 2

"Eligibility, transportation, billing, so many state requirements to become licensed, workforce, workforce education, if our staff are a good fit for working in an education setting with that culture." – ESD 101, Class 1

"The Prototypical school model is an outdated unrealistic idea about schools. It is a model that was created 50 years ago that is not up to date with the Behavioral Health, poverty, and ACES that kids are bringing to school these days." - ESD 113, Class 1

"Transportation because we are rural. We have an agreement with [Provider], but for students to make it to appointments is a hit or miss. Our licensed professional comes every two weeks, that's very difficult for them to establish relationships and rapport to build trust, so the students often

default back to me in the meantime. I do the best I can, but I don't have the training and qualifications of a licensed provider, which some students need to address their complex issues.”
- ESD 101, Class 2

So, what does access to school-based behavioral health care look like?

School Based Behavioral Health Services

LOCATION

Approximately 60% of districts indicated that services were available to any youth that needed them (e.g. all buildings, all grades).

However... **ACCESS** to services varied greatly; not only in terms of *availability* of services, but also regarding service *eligibility*.

In their words...

“[Provider] uses our building (have to find an empty classroom) one day a week. Must be on Medicaid. Lots of turnover with their staff, there was a grant and we had a school-based counselor that came for a couple years, there was constant turnover and then they stopped providing the services last year.” ESD 101, Class 2

“[Provider] comes 2 days a week to see kids already enrolled. [Other provider] comes one day a week for private insurance, self-pay, and threat assessments.” ESD 113, Class 2

“[The provider] doesn’t actually coordinate services with the district, counselors show up and say they need a room to meet with a student, without prior information or warning to the district. Not the way we want services to be provided, but we are taking what we can get.” ESD 101, Class 2

The source of **FUNDING** for these services often affected eligibility, and fell into two general categories:

1. Multiple, braided, district funding streams (e.g. general funds, levy dollars, grant funding)

2. In-kind Funding Only

(services limited to eligible clients through service provider (i.e. Medicaid & private insurance clients only))

An in depth look at school-based behavioral health service

The following section provides an overview of the types and scope of behavioral health services and supports available to students among the 66 districts with reported services in place.

We asked: "If school-based behavioral health services are available, are these services provided by a Department of Health licensed treatment provider?"

Among the 66 districts with access to school-based behavioral health services, 58 (88%) had licensed providers delivering services to youth, with this similar across ESD regions.

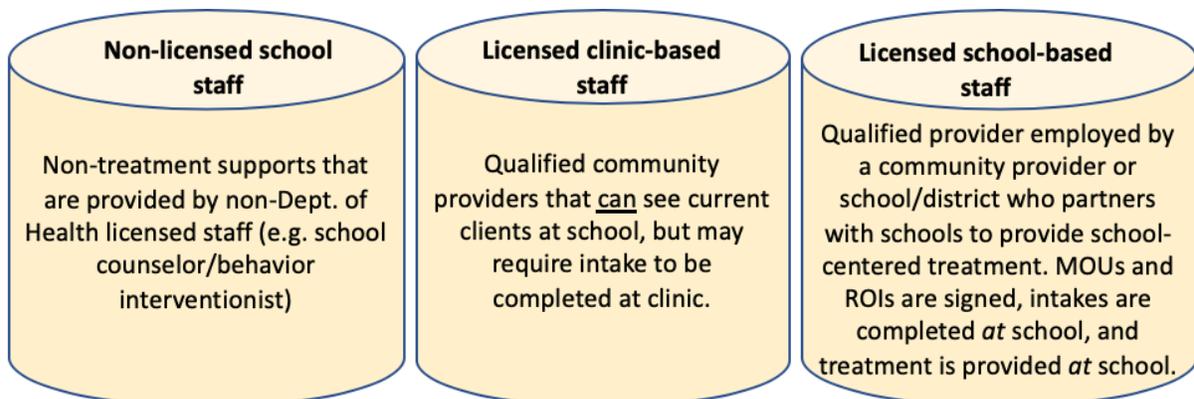
TABLE 4: Number of Districts w/licensed treatment providers by ESD Region and Class

	ESD 101	ESD 113	Class 1	Class 2	Total
YES	28	30	16	42	58
NO	4	4	1	7	8
Total	32	34	17	49	66

Although most districts reported having a licensed therapist providing services, similar to other responses, the systems through which these services were delivered varied. For example, as noted by this district, outside providers came to the school building to treat Medicaid eligible youth:

"[Provider] uses our building (have to find an empty classroom) one day a week. Must be on Medicaid. Lots of turnover with their staff, there was a grant and we had a school-based counselor that came for a couple years, there was constant turnover and then they stopped providing the services last year. The therapist's caseloads are already full, we have referral forms, but we know they're full. We do have WISE services up here, extremely difficult to get into, must be Medicaid, there is a waitlist, we just now have one student." – ESD 101, Class 2

In general, the way these services were provided fell into three broad buckets:



In their words...

“Licensed therapist comes once every two weeks to provide school-based therapy services at the high, middle, and elementary schools.” - ESD 101, Class 2

“Here at the one school for K-8. For the kids at the school we have a retired counselor who comes in 3 days a week as a stop gap for our behavioral health. This person is simply a response person for crisis situations.” – ESD 113, Class 2

“[Services are] spread across all 6 schools. Brand new program, so the hope is for it to continue to grow even more. There could easily be 3 or 4 more therapists in the district, providing the same services, just to meet the needs of the students and staff (development).” – ESD 101, Class1

“[Services are in] all buildings, K-12. We have fulltime {provider name} counselors at all our high schools and Social workers and licensed mental health clinicians. The MH staff are at the middle schools 3-4 days a week and elementary 1.5-2.5 days a week. [Provider] will come to the middle schools by request from the principal when needed.” – ESD 113, Class 1

Among the eight (8) districts without licensed providers,⁴ school or ESD-based staff e.g., behavioral interventionists, school counselors, ESD employees, and school psychologists facilitated a variety of behavioral health offerings:

- Small group therapy and individual sessions.
- Care coordination, behavior assessment, counseling
- Outreach, resource connecting, family meetings and counseling.
- Coping skills, developing different strategies to be successful, understanding brain effecting behavior.
- One on one with students with needs, and also classroom-based lessons.

We asked, “What is the process for referring students that have been identified as needing behavioral health support to services?”

Most districts (40%) reported referrals to services could be made by anyone (e.g. self-referral, staff-referral, principal, counselor, parent, etc.), while one-in-five acknowledged that referrals started with a teacher/staff concern. In another 17% of districts, referrals primarily originated from the school counselor. Only a small number of districts had a teaming structure in place to review and take action on referrals (a best practice), and in a few districts students were referred as a result of disciplinary actions. (see, Table 5)

TABLE 5: Behavioral Health Referral Pathway by District Size

Referral Pathways	Class 1	Class 2	All Districts
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⁴ Licensed staff refers to those licensed by the Department of Health as a behavioral health treatment provider; these staff can diagnose and bill for treatment services. Clinical diagnosis of a mental health illness is defined through the American Psychological Association DSM-5.

Multiple pathways	24%	46%	40%
Teacher/Staff	24%	19%	20%
Counselor	35%	10%	17%
No process	-	6%	5%
Teaming	-	4%	3%
Discipline	-	4%	3%
Unsure/Unclear	18%	10%	12%
TOTAL	100% (17)	100% (49)	100% (66)

In their words...

"This varies greatly by school building. There is no districtwide policy/procedure. Sometimes more built around the relationships that are made between provider and building staff, not necessarily systemic." - ESD 101, Class 1

"Anyone can refer. Parents, staff, self. We have weekly MTSS meetings with admin and all BH staff at each school to discuss kids of concern. The counselor will make the official referral with the family or help coordinate services outside of the school." -ESD 113, Class 1

"We typically aren't even referring students to the program; we're really just providing a location for the services. Intakes are completed at the agency; students must be an active client to be seen at the school. This has been a big frustration at the HS, especially when families make just enough not to be eligible for services, but really can't afford to pay for private services." - ESD 101, Class 2

"If a student is having classroom behavior issues or seems like they need help with mental health services, the teacher fills out a referral form and gives it to the community provider that is in the building one day a week. The referral form is a form that the (community provider) uses for referrals. Teachers and principals can refer as well as students can self-refer." - ESD 113, Class 2

"A staff person will bring it to the counselor or administrator, they will speak with the student (13+ can consent and fill out paperwork) younger students can talk about the kinds of services that are available, a school staff speaks to parents, and provides information in paper form with parents, and multiple phone calls and meetings with parents (if necessary). For some students it's a matter of, 'It's your 13th birthday, let's fill out your paperwork.'" - ESD 101, Class 2

We asked, "Who in the district/school coordinates these services?"

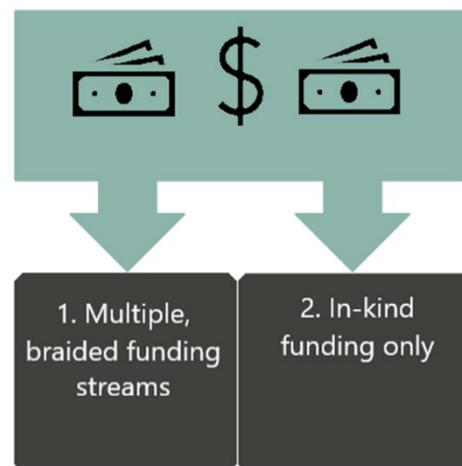
Overall, once a referral was made, the most common staff to coordinate services was a school counselor (25%). However, service coordination varied based on district class. For example, among larger Class 1 districts, the most common staff member to coordinate services was a Director of Student Support (or similar position/title) (47%). Among Class 2 districts, this role was equally likely to be held by the District Superintendent/Assistant Superintendent (27%) or a school counselor (27%). Others identified as coordinating these services included building

principals, student assistance professionals, behavioral interventionists, school psychologists, social workers, or mental health staff.

For a very small number of districts, there was no internal coordination of services, as summarized by this district, “[The provider] doesn’t actually coordinate services with the district. Counselors show up and say they need a room to meet with a student, without prior information or warning to the district. Not the way we want services to be provided, but we are taking what we can get.” (ESD 101, Class 2)

We asked, “What are the funding mechanisms for supporting behavioral health services?”

Funding for behavioral health services fell into two broad categories; 1) district support through multiple, braided funding streams, or 2) in-kind contributions only (no out of pocket district costs were required; rather, districts ensured community-based providers, who billed public and private insurance for services delivered, had access to students including space to deliver services). In the latter case, community-based providers delivering services in the school setting would directly bill Medicaid and private insurance for services.



Among districts that did pay for services, the following funding streams were typically used to support behavioral health services: General funds, levy dollars, Title 1/LAP funding, General Ed dollars, Impact Aid, MFLAX (Military Family Support), Special Services funding, grant funding, Small Rural School Achievement Program (SERSAP), Medicaid billing, School Board commitment, Title 4 Part A funding, and timber dollars.

Among Class 1 districts, six (35%) indicated that they did not provide any funding to support the behavioral health services available to their students. Instead, the providers billed Medicaid and/or private insurance directly to cover the cost of services. For example, as this one district summarized, “We don’t have funding for it, it is an MOU with [Provider]” (ESD 113). For this district, “No district funding. Therapists are all licensed and only serve Medicaid youth for which they can bill for” (ESD 101). As these comments imply, non-Medicaid eligible youth and youth without private insurance are not eligible for these services. As identified earlier, a significant access barrier is linked to the billing structure for these services as such, this funding gap leaves many youths unable to access needed services.

The remaining nine⁵ class 1 sites (53%) referenced multiple and often braided funding streams to support behavioral health services. These included basic education dollars, levy money, general fund, grant dollars and Title 1/LAP funding.

Among class 2 sites, 10 districts (21%) also indicated that they did not provide any district funding for services, but that these services were paid for through MOUs with community-based providers. However, for the majority of class 2 sites, services were also supported by braided and often “cobbed together” resources. As this district summarized, *“Title 1, LAP, basic education; it is really patchwork funded, a little from here and little from over there. We scrape it together to try and just have something”* - ESD 113

Several districts supported services through direct hires or contracts with private providers, specifically citing this as a way to reduce barriers students may experience with the complexities of insurance eligibility and access. As these sites stated:

“I believe the district pays fully for the services. Talking to our elementary/middle school administrator and the therapists are contracted and under our service when they are here. I don't think there's any Medicaid/non-Medicaid issues of eligibility. Just based on the behavioral need of the student for them to be seen at the school.” - ESD 101, Class 2

“General fund from [district]. She (therapist) takes all students, regardless of Medicaid/eligibility. \$374 per day, a total of \$7106 for 19 days for the school year (current year).” - ESD 101

Although, this option was limited to those districts that, 1) could afford it, and 2) had access to qualified licensed staff to provide these services (i.e. had a viable workforce).

We asked, “What about Medicaid reimbursement programs for schools?”

Results of the Navigator’s work in the first two project years indicate that the Medicaid system in the school setting is complex and includes multiple pathways that schools must navigate. We were interested in knowing about the extent to which districts directly participated in Medicaid reimbursement programs available to schools (without them having to become a licensed behavioral health provider): The School-based Health Care Services Program (SBHS) and Medicaid Administrative Claiming Program (MAC).

School-based Health Services (SBHS)	Yes	No	Total
Does your district participate?	30% (25)	70% (60)	100% (85)
Is this reimbursement being used for behavioral health Services?	12% (3)	88% (22)	100% (25)

⁵ The remaining two Class 1 districts were unsure of the funding that supported these types of services.

Among the 25 districts who reported participating in the SBHS Program, three indicated that they were receiving SBHS reimbursement for behavioral health services.

Among the 15 districts that participate in the MAC Program two indicated that this program was used to support behavioral health services. their district.

Medicaid Administrative Claiming (MAC)	Yes	No	Unsure	Total
Does your district participate?	18% (16)	82% (69)	NA	100% (85)
Is this reimbursement being used for behavioral health Services?	15% (2)	31% (4)	54% (7)	100% (14)

Districts that were not participating in these programs were asked if they had in the past. Nine districts had previously participated in SBHS and 32 had participated in the MAC program. Asked to explain why they no longer used these programs; they gave the following responses:

[SBHS] *"It's just not feasible for a small rural district to participate in programs like this due to the amount of work it takes for a small amount of money. I don't have the staff and all of my staff already wear 10 hats. I can't ask them for anymore. We already struggle with supporting our staff and keeping them healthy, mentally, with the heavy workload that we have."* - ESD 101, Class 2

[SBHS] *"Stigma around Medicaid fraud made the last superintendent wary of the program. Over 25% of our students are SPED so we should be doing this."* - ESD 113, Class 2

[MAC] *"A number of the guidelines changed and made it incredibly difficult, it became onerous for staff to participate. About 5 years ago, there were some large lawsuits and districts got in trouble for gaming the system. The amount of work combined with the risk/liability; it just wasn't enough to justify participating. Not sure we will ever participate again"* - ESD 101, Class 1

[MAC] *"It is so disconnected from schools and how they operate, there is no support, no direction, and no facilitation on this program. It is an impossible program for schools to operate without a full-time staff person dedicated to it."* - ESD 113, Class 2

We asked, "What about community-based referrals?"

Overall, 82% (70)⁶ of districts reported making referrals to community-based providers for behavioral health services. Referrals were typically for:

⁶ NOTE: This question was asked of all 85 districts, regardless of whether they reported having school-based behavioral health services. Of the 85 districts interviewed, 70 responded that they made referrals to

- Mental health
- Substance use
- Homeless (basic needs) services
- Tribal services
- WISE/Wrap around

In their words...

“Mental health, trauma, anxiety, depression, substance use, anything that is above the ability of the school counselors.” – ESD 101, Class 1

For most districts the process for referring students to these types of services was like that for school-based services. For others, this depended upon the service provider’s process, or it was simply a teacher or school counselor making a call to the student’s parent/caregiver, as noted by this respondent,

“The lead teacher/SPED teacher calls the parents and suggests they seek treatment with a local provider. Sometimes we have a meeting with the family to engage them into getting help. We call the behavior specialist for the ESD to come out and assess.” – ESD 113, Class 2

When asked what kind of follow-up the district received from the community-based provider once a referral was made, responses showed wide variation. Follow up ranged from no communication to what one Navigator coined “small-town follow-up” in which interactions occurs because of existing relationships between the family, school, and provider. In these types of examples, although there were no formal processes in place, information (as appropriate) is shared between school staff and the provider. Districts that reported existing multi-tiered system of supports or Student Support teaming structures also reported more consistent follow-up from outside providers than districts that lacked these structures.

For districts who had previous relationships with community-based provider, we asked about their experiences and why these services were no longer in place. Respondents indicated several different reasons for changes in relationships with community-based providers. Generally, these included the district being unsatisfied with services due to inconsistent delivery and high rates of staff turnover.

In their own words...

“[Provider] comes in once a week to provide care for students who are already enrolled in services. We have made referrals to them, but they are only able to be here one day a week. [I]t creates no chance to establish trust with the students and they are not really invested in the school or the community. We have had some no-shows from the counselors provided and that is a big deal for small communities because a lot of this is based on trust and consistency in order for students and families to trust someone and be open. We have had a high turn-over with counselors within a year and that is not helpful, as a matter of fact it is disruptive to the kids who already are struggling with chaos in their environment.” – ESD 113, Class 2

community-based providers. Among the 66 districts with school-based behavioral health services, 22 (32%) districts had both school-based services and made referrals to community-based providers.

Awareness & Prevention

Suicide Prevention Plan: Per [RCW 28A.320.127](#), each school district is required to have a Suicide Prevention Plan “for recognition, initial screening, and response to emotional or behavioral distress in students, including but not limited to indicators of possible substance abuse, violence, youth suicide, and sexual abuse. The school district must annually provide the plan to all district staff.”⁷

It is important to note that [House Bill 1336](#) (2013–14) established these requirements for school districts, beginning in the 2013-2014 school year. This is an unfunded mandate in that school districts are required to meet this state statute, however, have not received an allocation from the state to meet this requirement.

We asked, “Does the district have a Suicide Prevention Plan, including a protocol/procedure per RCW 28A.320.127?”

Most districts (59%) indicated that they had a suicide prevention plan/protocol in place. This was much more common for larger districts as compared to smaller districts (88% vs. 51%, respectively).

In their words...

“We do have a policy and procedure. We did a lot of work last year for our counseling staff to develop forms and questions and follow a formal process. But we’re always interested in learning how to improve the process and see what others are doing.” – ESD 101, Class 1

Mental Health Literacy Curriculum: Curriculum refers to a set of lessons and/or content that is taught in the classroom, or as its own course.

School mental health literacy includes four main components:⁸

1. Understanding how to optimize and maintain good mental health,
2. Understanding mental disorders and their treatments,
3. Decreasing stigma, and
4. Increasing health seeking efficacy.

We asked, “Does the district/school have a mental health literacy curriculum?”⁹

Approximately one third (36%) of districts stated they had a mental health literacy curriculum in place. However, when providing examples, most of these sites referenced a specific program

⁷ [RCW 28A.320.127](#): <https://app.leg.wa.gov/RCW/default.aspx?cite=28A.320.127>

⁸ SOURCE: <http://teenmentalhealth.org/schoolmhl/school-mental-health-literacy/evidence-based-school-mental-health-literacy/>

⁹ NOTE: This was an open-ended question. The definition above was not provided at the time of the interview. This was asked because it was a deliverable of HB 2779 (2018) for this pilot project.

of activities rather than an actual curriculum.¹⁰ In addition, many of the programs referenced were more specifically focused on social emotional learning and skill building rather than mental health literacy.

For example, in ESD 101, 17 districts (41%) indicated they had a mental health literacy curriculum. Of these, seven (7) specifically referenced the Mental Health in High Schools Curriculum, for which the ESD provided training for as another component of the Regional Pilot project. The remaining 10 districts referenced various other programs, such as Second Step, Character Strong, and Life Skills (all SEL focused) while others generally touched on the topics of trauma, mindfulness, anger management, and/or coping skills.

For the 14 districts (33%) in ESD 113 that reported having a curriculum, the following programs were referenced: Second Step, Character Strong, PBIS, Steps to Respect, Safe Schools, Sandford Harmony, Life Skills, PAX Good Behavior Game, and UW's Forefront Suicide Prevention.

Staff Mental Health Literacy Training: Training provided to school/district staff to increase their own mental health awareness, to reduce stigma related to help-seeking, and to promote mental well-being among adults in the system.

We asked, “Does the district/school staff receive mental health literacy training by the district, or do you have mechanisms to make this available to your staff?”¹¹

Among those districts interviewed, over half (54%) reported that the district/school staff received training on mental health literacy (i.e. mental health literacy for adults in the school system). In addition, larger districts (Class 1) were much more likely to report the availability of these types of staff trainings than smaller districts (76% vs. 48%, respectively).

Overall, the most frequently cited training topic was Adverse Childhood Experiences (ACEs) (20 districts), followed by the effects of trauma (11). Nine districts specifically mentioned that Youth Mental Health First Aid (YMHFA) training was available to their staff (but not required). Other training topics included suicide prevention and positive behavior interventions and supports (PBIS). Specific programmatic trainings included Safe Schools, Threat Assessment, Character Strong,

In their words...

“In pockets of staff, I would say yes. Some teachers have ACES, trauma, prevention and other training. There are a few staff who are helpful in bringing information back to the district. We would definitely like a PD day dedicated to trauma for all of the staff. It takes a paradigm shift for staff to recognize the growing needs of our students...” – ESD 101, Class

¹⁰ DEFINITIONS: Curriculum: A set of lessons and/or content taught in the classroom. Program: A set of structured activities.

¹¹ NOTE: This was an open-ended question. The definition above was not provided at the time of the interview.

Second Step, Kelso's Choice, and Sandford Harmony, most of which tailor more closely to SEL than mental health literacy.

Many sites expressed the desire to have more staff development training regarding mental health literacy, including staff self-care.

So, what do districts need to increase access to school-based behavioral healthcare for their students?

As a result of this interview process, the Navigators were able to unearth a multitude of complex barriers facing districts as they try to meet the behavioral health needs of their students. These include:

Lack of staff training opportunities:

"... Our teacher training programs need to do more to prepare [teachers] for the behavioral health needs of students. One of the things we've learned is that while mental health supports are needed, [so is] the funding, time and training for all staff to be competent in addressing issues with their students. There is a spectrum of needs, it's not like a 6-hour class will teach you everything you need. There needs to be in the moment and consistent changes to training staff on up to date, evidence-based strategies. The discipline laws have put a magnifying glass on some of these issues. It takes work to change the mindset of administration and staff. It takes more time and support to do it right, and there is sometimes conflicting opinions and recommendations from administration." - ESD 101, Class 1

Limited capacity & resources:

"In general, the message needs to be that we are spread too thin with the limited resources we have. We are often not qualified to meet the needs of students with significant behavioral health challenges. Because of this we're simply trying to "manage" a student or situation, this is taxing on our limited resources throughout the district and in buildings and limits our capacity to do prevention work...Until we actually attend to the whole child, education will always be secondary. We know that we can't intervene ourselves out of poor-quality core support, then we're already behind to meet the needs of our students "10 feet behind the starting line" and always in reactive mode..." - ESD 101, Class 1

"We don't know what we don't know, so we need help accessing resources (what very few there are available). Rural communities need some kind of satellite office that provides services within the community, because providers are spread way too thin, high turnover, and very inconsistent availability. We have to have behavioral health professionals available in the community. We need real financial help and assistance providing infrastructure for school-based mental health services. I know all the small rural communities need the same. We absolutely have families and students who WILL access these services in an instant if they are available in the school. Like we

had last year (at least once a week) that was only partially meeting the needs. The staff understand the mental health piece is critical with students, so they're very willing to give up class time and work with a provider, we just don't have the resources. We're trying, we aren't even touching the tip of the iceberg. There are school issues, and then the even larger home/family issues. It's the same Band-Aid every day for these students. We talk with them and get them settled down, then walk them back to class. We tell them to come back and talk with us again when they need to, because we know we've only provided a very temporary solution to complex issues." - ESD 101, Class 2

Increased behavioral needs of students:

"This is my 29th year working in schools with kids and behavioral health, the mental health needs of kids have grown drastically in the last 3 years. We have feral kindergartners coming in literally trying to kill each other." - ESD 113, Class 1

"We're getting more and more younger students who are just out of control, and we just don't have the resources to deal with them. Getting parents on board is extremely difficult. We have students that bite and spit on others, run away, multiple students that are an absolute interruption to the entire elementary school...There is somewhat of a pervasive culture around discipline and controlling the classroom. Inclusion and comprehensive support seem to be conflicting goals...It takes a really long time to change a culture. And some schools are still stuck 20 years in the past. So many socio-economic and social/emotional baggage within our community. There's a perfect storm with some of our staff who have been doing it a very long time, and students who have very high needs. We are concerned for the long term supports of our students who have high needs, both behavioral health and special education... Special Education was originally for all students to succeed academically but has become a catch-all for behavioral and mental health issues. We have good people that care, and are doing the best that they can, without specific training for the skills they need... We know all the districts in our region need more mental health services. The school is caught in the middle between expectations of society (and state requirements) and what is available..." - ESD 101, Class 2

The bottom line...

"In my 30 years I have always been focused on academics and learning. In the last 5 years I have seen so much in children's behaviors and the effects that is having on learning, we cannot simply talk about academic outcomes. We cannot continue to do things the same as we have. If we do not address the behavioral health of our students right now, academics will never come. We can continue to pour as much money as we want into academics but if we don't take a look around and realize that we are in a real children's behavioral health crisis right now, then none of it matters." - ESD 113, Class 2

"We are heavily mandated and underfunded for things like behavioral health and McKinney Vento. We make it work but it is really just barley touching the issue. Teachers are not prepared

for the broken kids that come to school every day. We end up pouring all of our time and energy into these desperate high needs kids during school just to fumble around and try everything we can to help them but we are not trained or equipped for that kind of work, we are education, so it's very hard on everyone. The kids who are ready to learn get ignored and under stimulated because we are constantly trying to address the students who are struggling with behavioral health needs." -ESD 113, Class 2

"The prototypical school model is a major roadblock for providing behavioral health for our students. It does not support the behavioral health needs of the kids. Behavioral health is bigger than that model and we need allocated dollars for behavioral health supports." - ESD 113, Class 1

Recommendations for future consideration:

There have been many recent legislative initiatives proposed to meet the behavioral health needs of students in schools. The data from this report support the need for:

- Fully funding the 9 Behavioral Health Navigators as established in [RCW 28A.310.510](#).
- Fund the recommendations from the [Staffing Enrichment Workgroup](#).
- Require OSPI to develop a statewide Multi-tiered System of Support Framework as a model for districts to use across the state.
- Explore how a state School-based Health Center Model could expand healthcare services to students in need in schools in Washington.
- Support the recommendations that are elevated from the Children's Behavioral Health Workgroup School-based Behavioral Health & Suicide Prevention Subcommittee.
- Support recommendations from the WA Action Alliance for Suicide Prevention.

Navigator Reflections

At the close of the pilot, we asked the two Navigators to spend some time reflecting on the interview process through some guided questions. In the following section, we include their heartfelt reflections on what they heard, and the lessons learned from this process.

What were you most surprised by?

Not every school has a fulltime counselor. Not every school district even has a fulltime counselor. Some of them have no counselor at all because they can't find a qualified person to work part time in such a remote location.

How many roles each person has in a small district. Each person has several competing priorities, and the person has to struggle with fulfilling the requirements of their position and meeting the needs of students.

That educators who have been working their whole lives to teach children academics or have paid tens of thousands of dollars and worked hard to get a degree in education are suddenly faced with spending the majority of their day managing a health crisis for their students.

What reinforced your previous understanding of how schools are approaching the behavioral health needs of their students?

The strategies used in schools are such short-term. Not for a lack of caring, but of staffing, funding, and time. So many schools said all they have are “Band-Aids” for students with large behavioral health needs. Staff have to settle for getting the student through that day.

Schools said more and more young children are coming to school with emotional dysregulation and signs of trauma. Several schools said there’s clearly a need for pre-K services and supports.

How everyone from district to building level is working hard...like really hard...like way above, above and beyond, to meet kids where they are, getting their daily needs met while at school and make things work as best they can while teaching.

Which themes were most common across districts?

That kids are showing up every day and every year with more behavioral health issues that directly impact their ability to learn. Multiple interviews used the phrase “the tidal wave” of behavioral health issues that we are not equipped to manage.

Students rely so much on their caregivers to access services. School-based services would be the solution. Students age 13 would be able to consent to and access services independently, while maintaining their privacy. Caregivers could consent to students age 12 and under to receive services and know that accessing those services isn’t dependent on their availability, money, and transportation. The majority of schools said students and caregivers would take advantage of services if they were school based.

Which themes differed among most districts? In what ways were they different?

I was most surprised by rural poverty and the devastating lack of resources for behavioral health in those schools and communities and the impact that has on families for generations. The stigma and mistrust by families in rural or smaller communities is a huge barrier for accessing behavioral health. On the opposite side, when students in bigger urban schools need services they can be lost in a sea of students and never actually get what they need because no one sees. The number of students is overwhelming and so that leaves schools with triage-type systems of prioritization by good hearted, well intended staff that are not qualified to make those types of decisions and shouldn’t have to. These were two concepts that I had never thought of until a few superintendents gave me examples and really spelled it out for me.

The issue of stigma varied greatly, even across similar/nearby districts.

What words or situations stuck with you the most?

The correlated words that each district used in the interviews were the most fascinating part. Even across the state the words were the same. They are all singing the same song:

Prototypical school model, lack funding, feral kindergarteners, transportation, stigma, access, eligibility, trust, qualified, consistent, teacher burnout, relationships, families.

In hindsight, what do you see as the biggest asset for an ESD having a navigator?

Creating pathways for behavioral health in schools, advocating for your region, connecting and building relationships with necessary partners in communities and at the systems level.

An administrator from a very small district that said, "We have a finger on the pulse of every student in our building. We can respond to issues early on." By having a Navigator, the ESD is able to have a finger on the pulse of their districts. This provides the relationship to move the needle from "reaction" to "intervention", and from "intervention" to "prevention".

ESD 101 administrators have said the Navigator is able to accomplish work they know needs to be done, they've just never had a dedicated person to actually do it.

Where do you see this role making a positive impact in the future?

I'd like to see regular in-person visits to all districts. Taking the time to sit down with staff and ask them about their concerns and where they need help. This accomplishes multiple things at once:

- Collecting information from each region to inform ongoing reports.
- Validating concerns and providing a voice to all schools.
- Creating informed strategies and solutions to address school needs.

The frequency will depend entirely on each ESD region, but it's time well spent. I'd like to see the number and variety of school staff participating increase. I'd be interested to see a few interviews with caregivers and students be piloted across the state. Asking students what their relationship is like with their school counselor, if there's anyone they feel they can talk to, if they learn about mental health, and if staff have ever asked them about suicide.

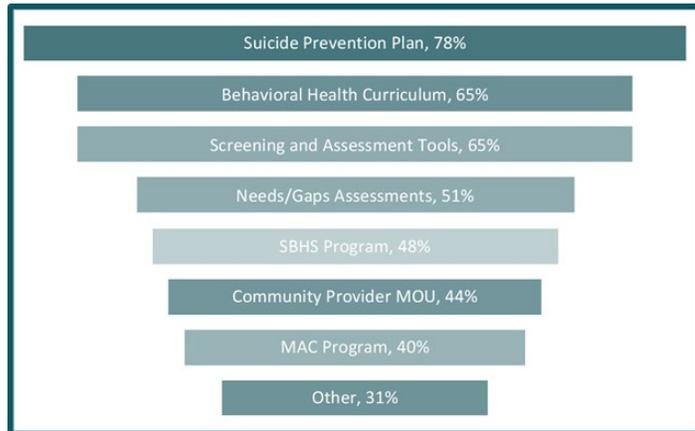
Collecting current national, state, and regional resources. Oftentimes schools are willing to try something different, they just don't know where to begin.

There is a lot more work to be done with suicide. Policy and funding, training, protocols, information, prevention AND postvention.

The ongoing work of the Behavioral Health Systems Navigators

Establishing the role of the Behavioral Health Systems Navigator at the ESD level can increase access to care by better understanding the barriers districts face in implementing and sustaining comprehensive school-based behavioral health services for their students. As

defined though the pilot study, the role of navigator is to coordinate behavioral health resources, integrate service delivery systems, collaborate among districts, schools and community partners to increase access to care and facilitate partnerships for the betterment of behavioral health supports. Through the implementation phase, we have learned the value of having a



fulltime dedicated staff person charged with navigating between the education and behavioral healthcare systems. This position enables ESDs and the State to support schools in the implementation of comprehensive behavioral health supports.

At the end of the interview, the Navigators asked each district about the types of resources needed to help support their school based behavioral health care systems. Overwhelmingly, districts were interested in learning more about a suicide prevention protocol (78%), screening and assessment tools (65%), and a behavioral health curriculum (65%).

As a result of the overwhelming request for additional resources from their districts, the Navigators are compiling a "Resource Guide" for schools and districts to help provide support in the above-mentioned areas. Follow-up with each site was occurring at the time of this report. Further, in anticipation of the Navigator role expanding to all nine educational service districts (ESDs), OSPI has worked with pilot project participants to create a Playbook to be used as new Navigators begin this work in their respective regions.

Appendix A

Children's Regional Behavioral Health Pilot District Interview Questions

Behavioral Health or Behavioral Healthcare means mental health and substance use prevention, intervention, and treatment.

Comprehensive School Mental Health Program means there is a full array of tiered supports and services that promote positive school climate, social and emotional learning, and mental health and well-being, while reducing the prevalence and severity of mental illness and substance use issues.

School-based Behavioral Health Services refers to both mental health and substance abuse prevention and intervention strategies delivered in the school-setting (i.e. students have access to services at the school building, during school hours. Services may be provided by community-based/outside providers and/or a district-hired MH provider or district staff (e.g. nurses, counselors, psychologists, social workers, etc.).

Community-based Behavioral Health Services, similar to school-based services, but these are delivered in the community-setting. (i.e. services that are not located in school-building but may be available for students in need).

Behavioral Health Services

1. Do your students have access to school-based behavioral health services?

Yes No Unsure

IF YES,

a. Are these services provided by a licensed treatment provider?

Yes No (see next page) Unsure

If YES, what is the name of the provider(s)?

If NO, who provides these services? (e.g. ESD as providers, district-hired MH provider, district staff (e.g. nurses, counselors, psychologists, social workers, etc.)?)

What types of services are available (e.g. educational support groups, group/individual therapy, family therapy)?

For all that answer YES to question 1:

Where are services located? (e.g. elementary school, middle school, high school level).

What is the process for referring students that have been identified as needing behavioral health support to services?

Who in the district/school coordinates these services?

What are the funding mechanisms are for supporting behavioral health services?

Are your providers billing Medicaid for behavioral health services?

Yes No Unsure

If NO, why not?

2. Do you make referrals to community-based providers for behavioral health services for your students?

Yes No (skip to question 3) Unsure

IF YES,

What types of behavioral health services do you refer your students to? (e.g. mental health, substance abuse, other)?

What is the process for referring students to these services? (e.g. referral pathway).

If you refer a student to a community-based provider what kind of follow up do you receive regarding their care/engagement in services?

3. Has the district/school worked with a community provider in the past?

Yes No Unsure

IF YES, can you share what that experience was like for the district/school? Why are those services no longer available?

4. Do you feel your current system is sufficient to meet the behavioral health needs (e.g., mental and/or substance use prevention, intervention and treatment) of your students?

Yes No Unsure

Why or why not?

5. Are there needs/gaps/barriers that exist related to addressing behavioral healthcare for students in your district/school? What are those specifically? (e.g. workforce, transportation, eligibility)

Explain:

Medicaid Billing & Reimbursement

School-based Health Services Program (SBHS) is a fee-for-service, optional Medicaid program that reimburses contracted school districts, educational service districts (ESDs), charter and tribal schools for providing medically necessary services to Medicaid eligible children with Individualized Education Programs (IEPs) or Individualized Family Service Plans (IFSPs).

6. If the district *does* participate in the School-Based Health Care Services (SBHS) program:

How is reimbursement being utilized? Are you able to reinvest any SBHS dollars into supporting your behavioral health system?

Does reimbursement through this program adequately cover the cost of providing behavioral health services?

Yes No Unsure

Does SBHS support the equitable access of behavioral health services for your students?

Yes No

Why or why not?

7. If the district *does not* participate in the School-Based Health Care Services (SBHS) program:

a. Has the district participated in the SBHS program in the past?

Yes No Unsure

If yes, why did the district stop participating in the SBHS program?

Medicaid Administrative Claiming Program (MAC) is an optional Medicaid program that allows school districts and ESDs to receive federal reimbursement for administrative activities performed by school staff that support the goals of the Medicaid State Plan. Examples of eligible activities include outreach and providing information about Medicaid programs and covered services to students and families, assisting individuals in applying for or accessing Medicaid covered services, and referring students and families to health providers.

8. If the district *does* participate in the Medicaid Administrative Claiming (MAC) program:

Is reimbursement from this program used to support behavioral health programs in your district?

Yes No Unsure

If so, how?

Does participating in MAC support the equitable access of behavioral health services for your students?

Yes No

Why or why not?

9. If the district *does not* participate in the Medicaid Administrative Claiming (MAC) program:

Has the district participated in the MAC program in the past?

Yes No Unsure

If yes, why did the district stop participating in the MAC program?

Awareness & Prevention

10. Does the district have a Suicide Prevention Plan, including a protocol/procedure per RCW 28A.320.127?

Yes No Unsure

If yes, briefly explain what this looks like.

11. Does the district/school have a mental health literacy curriculum?

Yes No Unsure

If yes, which curriculum? (*e.g. Mental Health in High Schools*):
What population receives this curriculum?

12. Does the district/school staff receive mental health literacy training by the district, or do you have mechanisms to make this available to your staff?

Yes No Unsure

If yes, briefly describe.

13. Would you be interested in learning more about any of the following?

- Suicide Prevention Protocol
- Behavioral Health Curriculum
- Community Provider MOU
- SBHS Program

- MAC Program
- Screening and Assessment Tools
- Needs/Gaps Assessments
- Other? Please describe.

14. Before we end, is there anything else we should know or that you want to share about your district's capacity to meet the behavioral health needs of its students? Are there any questions that we asked today that you felt like you were unable to answer?

15. Is there someone else in your district who may be able to answer those questions?.

Appendix B

Data Gathering & Cleaning:

Interview responses were documented by the Navigator at the time of the interview. Notes were transcribed and sent to the Research Partner for analysis. Using an online platform (SurveyGizmo), interview responses were transferred to a database, and exported into an excel workbook for analysis. Analysis included a summarization of responses by ESD region and class size, as well as qualitative analysis of open-ended interview responses.

Data was reviewed for submission errors (e.g. that responses matched the question asked), and then analyzed.

Data Analysis:

Descriptive statistics and frequency distributions were used to calculate the number and type of responses to each question, as well as to provide an overview of how responses were similar or different based on district characteristics (e.g. ESD region or Class size).

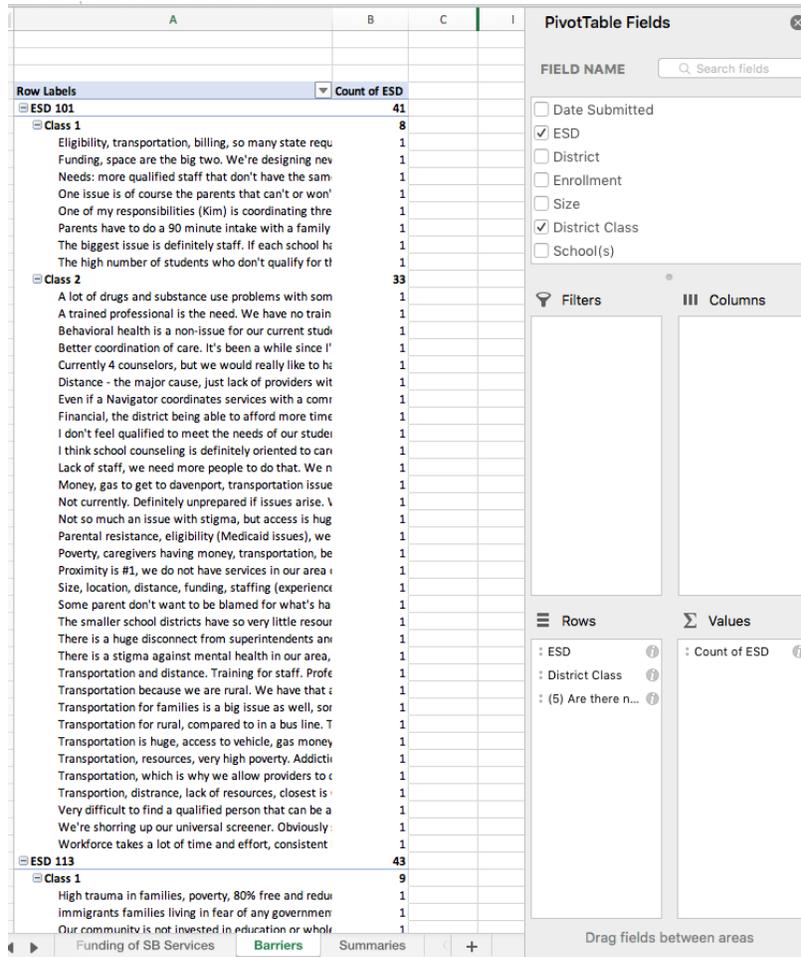
Example:¹²

Row Labels	Count of ESD
ESD 101	41
Class 1	8
Yes	8
Class 2	33
No	9
Yes	24
ESD 113	44
Class 1	9
Yes	9
Class 2	35
No	10
Yes	25
Grand Total	85

¹² In the ESD 101 region, there were several districts in which multiple interviews were conducted to obtain complete data. For those in which data matched, only one was kept. This was the case for the following districts: Lind-Ritzville Cooperative merged data; West Valley; kept interview with Dishman High, merged comments from interview with Early Learning Center. Tekoa-Oaksdale combined, based on completed answers between the two interviews.

Qualitative analysis was conducted on all open-ended responses. These steps included:

1. Preparation/organization of responses by question:



2. Reviewed (read) and coded responses:

Raw Data	Codes			
Eligibility, transportation, billing, so m	Eligibility	Transportation	Billing	Workforce
Funding, space are the big two. We're	Funding	Space for Services		
High trauma in families, poverty, 80%	High trauma	Transportation		
Immigrants families living in fear of a	Vulnerable popu	Transportation	Stigma	
Needs: more qualified staff that don't	Qualified staff	Transportation	Knowledge and awareness	
One issue is of course the parents that	Stigma	Parental engagement		
One of my responsibilities (Kim) is coc	Eligibility			
Our community is not invested in educ	Stigma	Culture		
Parents have to do a 90 minute intake	Eligibility			
ransportation is a huge barrier, Childre	Transportation	Qualified staff		
The biggest issue is definitely staff. If	Qualified Staff	Transportation		
The fragility of the families, drug addi	Family issues/trauma			
The growth of the problem is so rapid	Growth of probl	Capacity		
The high number of students who don	Eligibility	Transportation		
The Prototypical school model is an ou	Funding model			
transportation, families who live in crisi	Transportation	Family trauma/issues		
workforce, transportation, eligibility, s	Workforce	Transportation	Eligibility	

3. Interpreted codes to identify themes:

Barriers - ALL	
Transportation	51
Parental issues/Family Trauma	25
Funding	15
Workforce	14
Stigma	13
Qualified Staff (school)	13
Eligibility/Access	12
Capacity/Resources	11
Geography	10
Mistrust of System	5
K&A	2
Coordination of Care	1
Barriers - Refined	
Transportation	51
Funding	27
Parental issues/Family Trauma	25
Stigma	15
Workforce	14
Qualified Staff (school)	13
Eligibility/Access	12
Geographic Isolation	10
Mistrust of System	5

4. Summarized Findings:

EXAMPLE:

*When asked about existing **gaps or barriers** in their district related to addressing the behavioral healthcare needs of their students, respondents identified a number of issues. These included a lack of capacity and resources, lack of coordination of care, eligibility and access issues (e.g. insurance barriers), lack of funding for services, geographic isolation of the district, a lack of knowledge and awareness of mental health and related services, mistrust of the school/government system (particularly by marginalized communities (i.e. immigrant populations), family dysfunction, including parental substance use, mental health and other trauma related issues, a lack of qualified school-level staff to support services as well as a lack of qualified provider workforce (e.g. licensed clinicians), transportation barriers and lingering stigma.*

*However, when examining the top three issues identified by respondents, **transportation, funding, and parental engagement/family issues were the three most frequently cited barriers or gaps** to addressing the behavioral healthcare needs of students in their district.*