

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

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For:

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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.

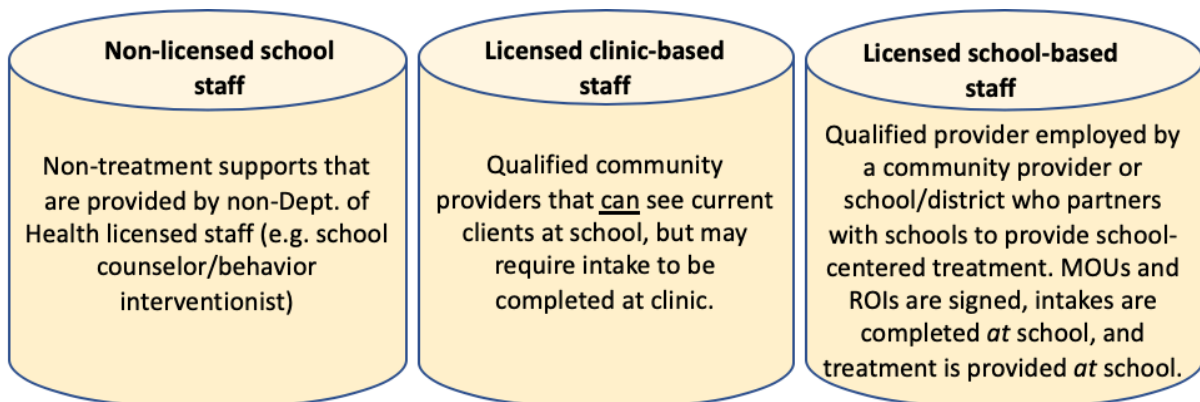
TABLE 4: Number of Districts w/licensed treatment providers by ESD Region and Class

	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?"

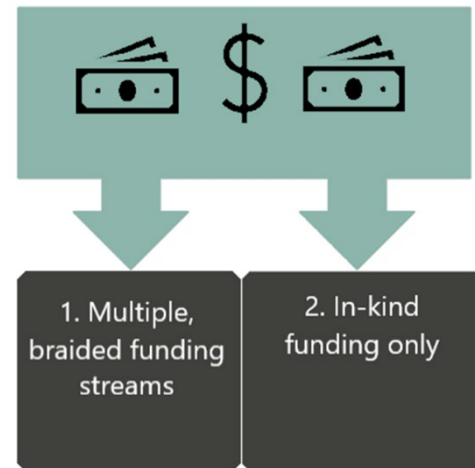
Overall, once a referral was made, the most common staff to coordinate services was a school counselor (25%). However, service coordination varied based on district class. For example, among larger Class 1 districts, the most common staff member to coordinate services was a Director of Student Support (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 “cobbled 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 occur 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.

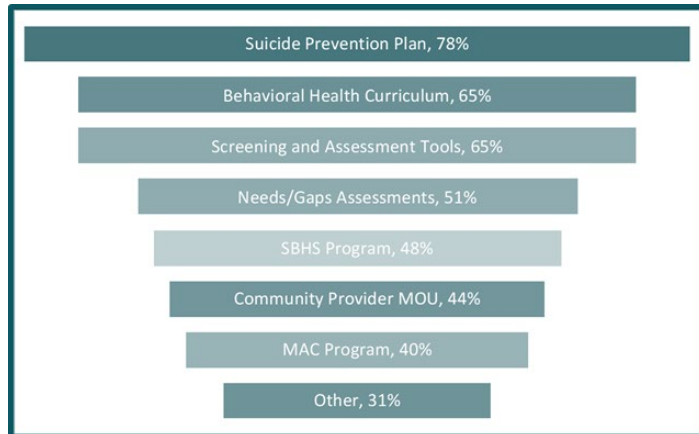
Collecting current national, state, and regional resources. Oftentimes schools are willing to try something different, they just don't know where to begin.

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).

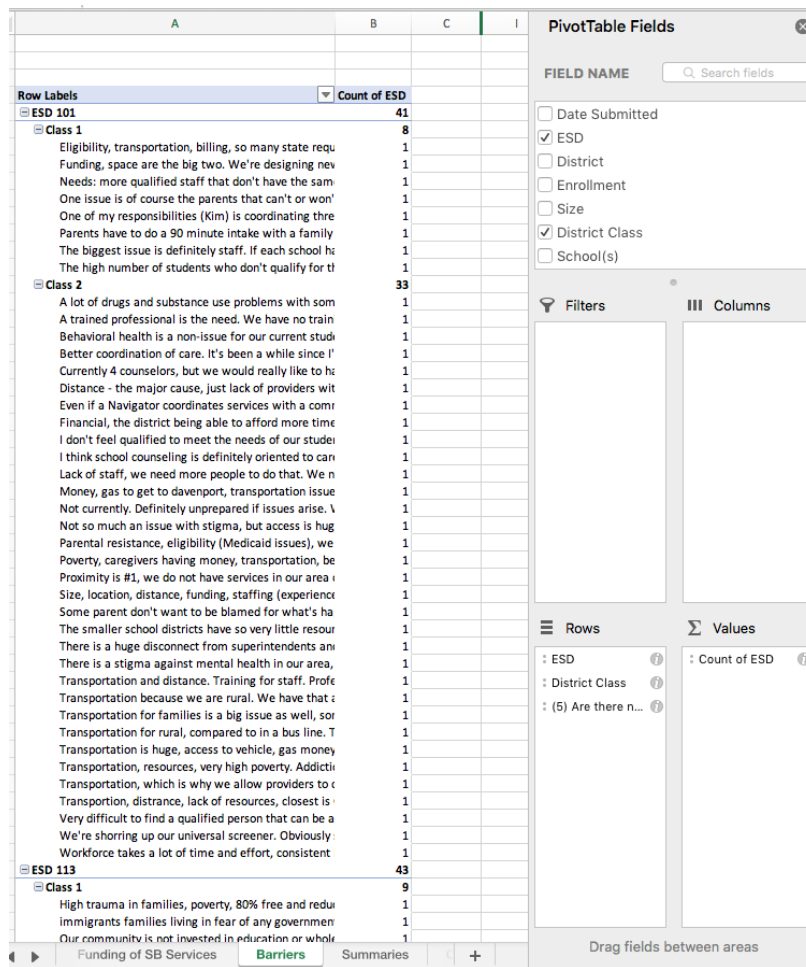
Example:¹²

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.*