Washington School-based Behavioral Health Efforts
A BRIEF

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Purpose

The aim of our work was twofold. First, to review evaluation findings from current and previous Washington State Project AWARE initiatives, as well as results from other related behavioral health-related efforts that addressed student social, emotional, behavioral (SEB) health. Second, to compile qualitative and quantitative data (related to student needs) and summarize key takeaways. The overarching purpose of this document is to provide evidence of best-practices, lessons learned, and recommendations from these efforts that will guide thinking and decision-making central to the implementation of strategies that support the vision and mission of OSPI's Student Engagement and K12 Support Department. In this document we discuss different programming that has been implemented in Washington State to address student SEB needs, reflect on lessons learned, challenges and barriers to implementation, and the overall successes of these various efforts. We close with recommendations for effective implementation.

Background: History of School-based Behavioral Health Efforts in Washington

On the education forefront, the Office of Superintendent of Public Instruction (OSPI), and its Educational Service District (ESD) and Local Educational Agency (LEA) partners have been leaders in providing school-based services and supports that address Washington's K 12 students' behavioral health and well-being needs. These efforts are far-reaching, span multiple decades, and have positively impacted the lives of thousands of students and their families. Below we provide a brief history of the types of school-based behavioral health services and supports delivered in the K-12 education system across Washington state.[1]

Student Assistance Prevention and Intervention Services Program (SAPISP): Launched in 1989 this statewide initiative, funded in part through the federal Safe and Drug-Free Schools and Community Act of 1986, established the foundational model for serving students at risk of or engaging in risky behaviors through a tiered approach. The SAPISP placed professional staff in schools to implement comprehensive student assistance programs that addressed problems associated with substance use, social, emotional, behavioral, mental health related problems and other at-risk behaviors. At the program's peak, nearly $5 million were distributed annually to 13 local grantees—including the four largest school districts in Washington (Seattle, Tacoma, Spokane, and Kent) and nine consortia—with services covering virtually the entire state. Key program components included school-wide, universal prevention activities, identification and screening, early intervention and support services, and referral and case management.

Safe Schools/Healthy Students: In the decade that followed, in response to school safety concerns, the US departments of Education, Health and Human Services, and Justice created the Safe Schools/Healthy Students initiative. This federal initiative sought to fund SEA and LEA-level

[1] This history brief focuses on services and supports that have been championed by OSPI's Student Engagement & K12 Supports, formerly known as Learning and Teaching Support and may not be reflective of other efforts conducted within OSPI, or in other collaborative efforts with outside agencies such as educational, state, and community partners.

multicomponent projects designed to address safe school environments and policies; substance use, violence prevention, and early intervention; school and community-based mental health services; early childhood social and emotional development; and supporting and connecting schools and communities. Across Washington state eight (8) SS/HS grantees were funded since the 1999-2000 school year (the first year the project was initiated). Grantees included eight of the nine ESDs and Spokane Public Schools. Although these projects were designed to meet the needs of the individual districts, a common goal across projects was to increase access to community-based mental health services for students and families. In many ways these projects laid the groundwork for the scaling up and replication of a tiered framework of services and supports built upon school-community partnerships. These projects introduced the concept of bringing community-based providers into the "schoolhouse," thus, began the integration of two often competing systems of supports -- education and behavioral health.

<u>School-based Treatment Programs:</u> During the same time frame, the US Department of Health and Human Services, through the Substance Abuse Mental Health Services Administration (SAMHSA), released funding to support adolescent treatment programs which allowed multiple ESDs to pursue substance-abuse disorder treatment licensure bringing more intensive Tier 3 services to schools to meet the increasing demands for alcohol, tobacco, and other drug treatment services, thus expanding SAPISP services and supports.

<u>Project AWARE/Multi-Tiered Systems of Supports</u>: In 2013, in response to the Sandy Hook Elementary school shooting of 2012, the Now is the Time initiative was launched by the White House. One component of the Now is the Time initiative was the US Department of Health and Human Services' launching of the Project AWARE (Advancing Wellness and Resilience in Education) SEA program in 2014 through the Substance Abuse and Mental health Services Administration (SAMHSA). Since the initial grant launch in 2014, OSPI has received three project aware grants (FY2014, FY2020, and FY2022), in partnership with the Washington State Health Care Authority, seven LEA school district sites, and four ESDs. In addition, Seattle Public Schools and NEWESD 101 also received LEA-level AWARE grants in FY2022.

The FY2014 Project AWARE grant has been the primary model for designing and implementing a multi-tiered systems of supports (MTSS) framework to address students' social, emotional, and behavioral (SEB) health needs using a tiered approach. Evaluation results indicated that the project demonstrated positive outcomes in addressing students' SEB issues engaged in school-based services and supports, with similar outcomes expected from the current grantee projects. Moreover, Project AWARE findings inspired the replication of the Tier 2/3 systems-level components adopted in three districts and one ESD as well as the strengthening of Tier 1/Foundational approaches in four districts beginning in the fall of 2019. These projects are funded by Kaiser Permanente of Washington's Thriving School Initiative.

<u>Other Statewide Efforts:</u> In addition to these federally funded project initiatives, OSPI has been actively engaged in efforts to address student SEB health needs in recent years.

Washington Integrated Student Supports Protocol – In 2016, the Washington State Legislature created the Washington Integrated Student Supports Protocol (WISSP) when it passed 4SHB 1541. The WISSP was one of an extensive set of interdependent strategies for closing educational opportunity gaps recommended by the State's Educational Opportunity Gap Oversight and Accountability Committee (EOGOAC). The components of the WISSP framework include needs assessments, community partnerships, coordination of supports, integration within the school, and a data-driven approach.

It is important to note that the components of the protocol are not unique to an integrated student supports approach. These are also found in other student support frameworks such as Response to Intervention (RTI), School-wide Positive Behavioral Interventions and Supports (PBIS), Interconnected Systems Framework (ISF), and other multi-tiered systems of support that address one or more domains of learning and behavioral development. Across these frameworks, Tier I, or universal supports, are provided to all students, Tier II, or targeted supports, are available to some students who need additional support, and Tier III, or intensive supports, are offered to a few students who need to overcome significant barriers to learning and behavioral health needs.

Behavioral Health Systems Navigator (BHSN) Pilot Project: Recommendations from the Children's Behavioral Health Workgroup established the Children's Regional Behavioral Health Pilot Project in July 2017. The purpose of the pilot project was to investigate the benefits of an Educational Service District Behavioral Health System Navigator. The pilot project, implemented in ESDs 101 and 113 in 2019, resulted in the garnering of legislative funding of the BHSN positions in each of the 9 ESD regions. These positions are responsible for bridging the education and behavioral health systems, with the goal of reducing access barriers to behavioral health services for students and their families who are eligible for Medicaid statewide.

Youth Suicide Prevention, Intervention and Postvention –The Revised Code of Washington (RCW) 28A.320.127 requires that all K–12 school districts adopt a plan to screen, recognize, and respond to indicators of social, emotional, behavioral, and mental health (SEBMH) such as, but not limited to, sexual abuse, substance use, violence, or youth suicide. In 2022, OSPI in collaboration with the University of Washington's Forefront Suicide Prevention and School Mental Health Assessment Research and Training (SMART) centers, developed a model district template for SEBMH recognition, screening, and response. The template guides districts in how to carry out the screening process for students and to refer and respond for appropriate intervention in a manner that is consistent with research-based practices and compliant with the law.

Expansion of School Counseling Services and Supports – Finally, in response to the impacts of the COVID 19 pandemic the federal government released funds through the American Rescue Plan Act, with a portion of these monies allocated to the Elementary and Secondary School Emergency Relief (ESSER) fund. OSPI used a portion of this funding to address the significant rise in the number of students experiencing behavioral health issues. Specifically, funds have

been used to increase the number of school counselors in district buildings statewide as well as to increase access to community-based mental health agencies.

Current Need for Behavioral Health Services

One in six youth aged 6-17 experience a mental health disorder each year, and 50% of all mental health conditions begin by age 14 (Whitney, D. G., Peterson, M.D., 2019). In Washington, this means that nearly 178,000 school-aged children may experience a behavioral health disorder that can impact their ability to function at home, school, and in the community.

The most common mental disorders in school-aged youth include depression, anxiety, attention-deficit hyperactivity disorder, and behavioral or conduct problems (Perou, R., Bitsko, R, Blumberg, S, et al., 2013), all of which can negatively affect their ability to function in the school, home, and community settings.

> "Across the nation, the mental and behavioral health of children and young adults is at a crisis point. According to the Centers for Disease Control (CDC), nationally, the proportion of emergency visits for mental health issues for youth 12-17 increased by 31% during the pandemic. The CDC also reported that one in four young adults was found to have seriously considered suicide — an increase from one in 10 pre-pandemic."
> University of Washington School Mental Health Assessment, Research, and Training (SMART) Center (2021)

Youth Mental Health & Wellness[2]

The Washington State Healthy Youth Survey (HYS) is an effort to measure health risk behaviors that contribute to morbidity, mortality, and social problems among youth in Washington State. These behaviors include alcohol, marijuana, tobacco, and other drug use; behaviors that result in intentional and unintentional injuries (e.g., violence); dietary behaviors and physical activity; mental health; school climate; and related risk and protective factors. The HYS has been administered statewide in even numbered years since 2001. The 2021 administration was the seventeenth such statewide survey of Washington students and participation has been steadily increasing over time. In 2021, over 200,000 students from all 39 counties participated in the HYS.

The most recent data (2021) indicate that since 2012, reports of anxiety have increased - both as students age, and across grade levels - with this rise most notable among 8th and 12th graders. Findings also indicate that, similar to anxiety levels, reports of worrying have increased with age and across grade levels, with these rising levels of worry also most notable among 8th and 12th grade participants.

The HYS also asks youth about the frequency of feelings of depression and suicide ideation. Current data demonstrate an alarming upward trend in depressive feelings since 2012 across survey periods and grade levels. In 2021, 35% of 8th graders, 38% of 10th graders, and 44% of 12th grade youth reported feeling sad or hopeless. Putting these data into perspective, **an**

[2] Graphs displaying HYS data can be found in Appendix A.

estimated 30,000 8th graders, and 32,336 10th grade youth reporting symptoms of depression in the past year.[3]

In 2021, nearly one in five youth across grade levels reported considering suicide in the past year, with these rates slightly below those reported in 2018. According to these data, approximately **16,300 8th grade youth and 16,635 10th graders considered suicide** in 2021.

Further, the percentage of youth that had a plan in place also demonstrates a troubling upward trend among middle school participants. In fact, rates among 8th grade students increased by 20% between 2012 and 2021. Among high school-aged youth, rates decreased in 2021 from their peak in 2018.

In 2021, 9.1% of 8th graders, 8.2% of 10th graders, and 6.7% of 12th grade students attempted suicide. According to these data, **over 14,700 8th (7,810) and 10th (6,960) grade students attempted suicide** at least once in the previous year.

Among 6th graders, suicide ideation demonstrates a 70% increase between 2012 and 2021 with a 73% rise in the percentage of students that reported attempting suicide (4.5% vs. 7.8%, 2021). In 2021, **nearly 6,300 6th grade students reported attempting suicide** at least once in their lifetimes.

The HYS also asked students, *"When you feel sad or hopeless, are there adults that you can turn to for help"* Data show that, in general, over one in four 6th graders and nearly one-third of 8th, 10th and 12th grade youth reported ***not*** having an adult to turn to when feeling sad or hopeless. Findings further indicate that the proportion of youth not having an adult to turn to in times of need has increased since 2012.

*Implications***:** A child's future depends on the ability to overcome and move beyond the emotional and other psychological challenges associated with growing up. Strong families and healthy communities are key parts of this process, and together with schools, should help a child transition into adulthood. Not surprisingly, students with mental health issues struggle in many aspects of their lives including interpersonal relationships with peers and adults, meeting academic demands, and self-determined behaviors (Greenwood et al. 1994; Patterson et.al 1992; Wehmeyer & Field 2007). These collective concerns in academic, social, and behavioral domains persist into adulthood leading to other challenges such as under-and unemployment, divorce, the need for mental health services, and contact with the criminal justice system (Moffitt 1993; Wagner et al. 2005).

[3] Extrapolations figures are based on the enrollment for 8th and 10th grade students in 2021 and assume a representative sample of students responded.

Adolescent Substance Use[4]

Adolescent use of alcohol, tobacco, and other drugs continues to be an issue that is at the forefront of problems facing school administrators. In fact, substance use is linked to a wide range of academic, social, mental, and physical consequences including poor academic progress, dropping out of school, increased risky behaviors, teen pregnancy, juvenile delinquency, and crime (Hawkins et al., 1992). A 2016 study of 10,000 adolescents found that two-thirds of those who developed alcohol or substance use disorders had experienced at least one mental health disorder (Conway, Swendsen, Husky, He, & Merikangas, 2016).

Alcohol Use: HYS data show that among Washington students, recent use of alcohol has declined since 2012, across grade groups. In 2021, 2% of 6th graders, 4% of 8th graders, 8% of 10th graders, and 20% of 12 grade participants reported recent alcohol use, with these rates considerably below those reported in all previous survey periods (except among 6th grade participants).

Marijuana Use: Like rates of alcohol use, data indicate that marijuana use rates declined precipitously between 2018 and 2021 among 8th, 10th, and 12th grade participants. In 2021, 3% of 8th graders, 7% of 10th graders, and 16% of 12th graders reported recent marijuana use, with few 6th grade students reporting any recent use.

Implications: Adolescents may begin using alcohol and other drugs to deal with the impacts of depression or anxiety; on the other hand, frequent drug use by teens may also cause or precipitate those disorders. Research suggests a strong link between early substance using behaviors and mental health. For example, estimated rates of co-occurring mental illness among adolescents with substance use disorders range from 60 to 75 percent (youth.gov). Adolescent substance use can impact physical, cognitive, and neurological development, leading to lifelong health and wellness issues.

System-level Needs

Nationally, as well as in the State of Washington, students and adults face multiple systems barriers that often inhibit access to needed behavioral health services. For example, most communities and schools do not have high quality, comprehensive treatment services for children and adolescents. Other barriers include workforce shortages, especially in rural areas, treatment deserts (regions in which services do not exist), access to a culturally and linguistically appropriate workforce as well as services, and a lack of service coordination and integration across multiple systems (Department of Social & Health Services 2017).

Mental Health America 2023 Rankings

Overall Youth Mental Health: WA ranks #40, indicating a national ranking of youth have that a higher prevalence of mental illness and lower rates of access to care.

19.6% of WA youth reported at least one major depressive episode (MDE) in the past year, ranking WA #45, with only 6 states that have a higher rate than WA.

14% of WA youth reported Sever Major Depression in the last year, ranking WA #39 in the nation.

[4] Graphs displaying HYS data can be found in Appendix A.

Navigating complex systems to seek care presents challenges and creates barriers that often inhibit access to needed behavioral health services (SAMHSA/CMS Bulletin, 2019). The resultant impact of these barriers is lower service utilization and lack of access to care. In fact, 58% of Washington youth with major depression in 2022 did not receive any mental health treatment (Mental Health America, 2023).

A 2017 statewide assessment on mental health and wellness in Washington's K-12 system (Maike & Associates, 2018) commissioned by Kaiser Permanente of Washington, identified multiple barriers and challenges that often prevent schools from addressing student and staff needs. These include: 1) Lack of appropriate resources, such as screening, direct services, funding, staffing, and workforce, and limited capacity to effectively implement a comprehensive SMH system; 2) limited school-based structures and/or policies to address students' mental health; 3) A dearth of knowledge and awareness of mental health and wellness, including stigma; 4) Poor access to mental health services; and, 5) Prevalence of mental health and wellness needs among school staff, including stress, anxiety, secondary trauma, compassion fatigue, and burnout.

According to interviews conducted in 2019 with school district staff in ESD regions 101 and 113 as part of the Behavioral Health System Navigator Pilot Project, 66 (77%) of 85 participating districts reported the availability of some form of school-based behavioral health services, with nearly (93%) indicating that their current system was not sufficient to meet their students' behavioral health need (Maike & Associates, 2020). Further, results revealed that these services often fall short of meeting best practice standards. In fact, 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.

When asked to expand upon existing systems-level gaps or barriers, 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.

Since this initial information was collected, the disruptions caused for youth and families by nearly two years with limited to no in-person access to public schools and their wealth of supports, due to the pandemic, have likely only exacerbated these issues.

Implications of the COVID-19 Pandemic

Figure 1: Behavioral Health Impacts During & After COVID-19 (2021)

What is Happening?

At the start of the pandemic, the Washington Department of Health forecasted (based on models derived from population-level responses to disasters) that "impacts from the COVID-19 outbreak and related government actions will likely cause a surge in behavioral health symptoms across the state."

Locally and nationwide, data indicates these predictions have come to pass:

- According to Census data, weekly surveying shows that **symptoms of anxiety and depression have increased** gradually for all Washington adults, to approximately 20% higher than pre-COVID levels.
- UW Medicine reports that, for patients under 27 years old, depression diagnoses have increased approx. 30% since 2019, and nearly 50% for anxiety diagnoses.
- According to the CDC, nationally, the proportion of emergency visits for **mental health issues for youth 12-17 increased by 31% during the pandemic**. This trend has also been found at state inpatient facilities such as Swedish, Seattle Children's, and Mary Bridge Children's Hospitals.
- A CDC report from June 2020 found that mental health conditions are disproportionately affecting young adults (aged 18-24). **One in four young adults was found to have seriously considered suicide – an increase from one in 10 young adults pre-pandemic.**
- From June 2020 to February 2021, the CDC found that the percent of young adults (aged 18-29) experiencing symptoms of depression or anxiety rose from 49% to 57%. The percent of young adults reporting an unmet need for mental health services rose from 16% to 22%.
- The CDC has released new vital statistics data on causes of death for all individuals in 2020. Not surprisingly, overall mortality increased 17.7%. While suicide deaths were down 5.6% overall, rate of death due to unintentional injury (which includes drug overdose) increased 11.1%.
- A more recent report confirmed that, nationwide and in Washington, **drug overdoses in 2020 showed the largest single-year increase in over 20 years.** As summarized by The Commonwealth Fund, "the final 2020 total in the United States could exceed 90,000 overdose deaths, compared to 70,630 in 2019." Preliminary data show a **35% increase in Washington State**.

Source: Northwest Mental Health Technology Transfer Center Network (April 2021). Behavioral Health Impacts During & After COVID-19: What to Expect and Ways to Prepare for the Return to In-Person Learning (p. 3). Retrieved from https://mhttcnetwork.org/centers/northwest-mhttc/product/behavioral-health-impacts-during-after-covid-19-what-expect-and

As part of the FY20 Washington State Project AWARE grant, in May of 2022, staff and student interviews were conducted in the three participating LEA school districts (Sunnyside, Wahluke, and Yakima). Questions were specific to the activities of Project AWARE and included what mental health issues participants felt were most prominent, whether those had changed since the previous year, how schools could better address these issues, and if students and staff knew how to access existing services.

From these interviews staff noted:

- Many students are showing increased aggression toward other students, their family members, or other individuals in the school and community. These behaviors had been escalating since before the pandemic.

- Mental health issues have worsened [since before the pandemic], although they acknowledged that it was harder to observe student behaviors in the 2019-20/2021-22 school years when classes were virtual and/or hybrid.
- A sense of loss of control.
- Extreme staff burnout.
- That COVID continues to be a major stressor for both youth and adults.
- That COVID has impacted students' academic performance.
- Many students have faced trauma associated with COVID related deaths, fear of getting sick, domestic violence, separation and divorce, job loss among their caregivers, parents who abuse substances, and housing instability.

Student participants expressed the need to elevate the importance of mental health, even above academics. This includes hiring more mental health staff; however, youth also noted the need to match services and providers in a manner that is reflective of the various access needs of families.

Students also shared that they are more likely to access services or supports if they know how to or have a teacher who they trust, but many students may not know what is available, nor how to access these resources.

There is also a need to hear students' voices and to involve them in meaningful decisions about mental health system changes at the schools. Interview findings suggest that students have certain staff members that they trust and talk to, but beyond that, they believed that teachers, or other adults in their schools, make little effort to connect with them. Students expressed a need for genuine engagement, with many students craving a bond with their teachers.

Best-Practice Implementation Frameworks

Adhering to best practices helps ensure the successful implementation of mental health services and supports in the school setting, which benefits students and staff in several ways.[5] First, and most importantly, it increases access to mental health services for many students, as they are available within their school, and at a significantly lower cost (if any). School-based mental health services delivered through an MTSS approach allows both learning and emotional needs to be addressed through the infusion of services into regular school routines and practices, while also reducing access barriers to services. In fact, school-based mental health services and supports have historically accounted for more than 70% of all mental health services provided to youth (Burns et al., 1995; Farmer et al., 2003; Rones & Hoagwood, 2000). In the following section, we outline several examples of best-practice implementation frameworks that can be used to address the social, emotional, and behavioral health of students.

[5] For a comprehensive approach to the development of a SBMH referral framework, see SAMHSA's School Mental Health Referral Pathways (SMHRP) Toolkit.

Multi-tiered System of Supports (MTSS): *"Multi-Tiered System of Supports (MTSS) is a framework for enhancing the adoption and implementation of a continuum of evidence-based practices to achieve important outcomes for every student. When MTSS is implemented with fidelity, this prevention-based framework ensures that schools create the necessary conditions to systematically integrate academic and nonacademic supports to meet the needs of the whole child. This integration involves coordination of tiered delivery systems, including Academic Response to Intervention (RTI) and Positive Behavioral Interventions and Supports (PBIS), Pyramid Model, and Social and Emotional Learning (SEL)."*
Source: Poulus, J., Pennel, A., McKechnie, M., LaPalm, M., Toney, A. (2020) Washington's Multi-tiered System of Supports Framework. Washington Office of the Superintendent of Public Instruction. Olympia, WA

Interconnected Systems Framework (ISF): *"The Interconnected System Framework (ISF) is an emerging approach for building a single system of SEB supports in schools. Integrating Positive Behavioral Interventions and Supports (PBIS) and school mental health, the ISF also brings community partners and families into one multi-tiered structure. Building on the success of PBIS, the ISF applies the core features of MTSS to deliberately integrate mental health, community, school, and family partners through a single system of support. The MTSS framework guides state, district, and community leaders to blend funding and modify policies and procedures to help systems work more efficiently. Supported by integrated district structures, clinicians become part of multi-tiered teams in schools where the SEB needs of all students are addressed."*
Source: Barrett, S., Eber, L., Perales, K., & Pohlman, K., (2019) ISF Fact Sheet Series, retrieved from Pacific Southwest (HHS Region 9) Mental Health Training and Technology Center Funded by Substance Abuse and Mental Health Services Administration

Comprehensive School-based Behavioral Health Supports: "*Comprehensive school mental health systems provide a full array of 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. Comprehensive school mental health systems are built on a strong foundation of district and school professionals, including administrators, educators and specialized instructional support personnel (e.g., school psychologists, school social workers, school counselors, school nurses and other school health professionals), in strategic collab- oration with students, families, and community health and mental health partners. These systems also assess and address the social, political and environ- mental structures — public policies and social norms included — that influence mental health outcomes."*
Source: Hoover, S., Lever, N., Sachdev, N., Bravo, N., Schlitt, J., Acosta Price, O., Sheriff, L. & Cashman, J. (2019). Advancing Comprehensive School Mental Health: Guidance From the Field. Baltimore, MD: National Center for School Mental Health. University of M

The core features of these implementation frameworks include:

- Collaboration and Teaming
- Needs Assessment and Resource Mapping
- Implementation of a Multi-Tiered System of Supports
- Screening and Referral Processes

- Implementation Of Evidence-Based Practices
- Progress Monitoring for Fidelity and Impact
- Use Of Data-Based Decision Making
- Diverse and Leveraged Funding
- Changes In Policy and Practices

Washington State Project AWARE Implementation Models

AWARE FY14: Capitol Region Educational Service District 113's School-Based Behavioral Health Services Program

In this model, the full continuum of behavioral health services (both mental health and substance abuse) for students were supported by ESD-employed, state licensed professionals. These staff, known as Student Assistance Professionals (SAP), were either licensed mental health or substance use disorder professionals that provided a variety of support services. Services included, but were not limited to, screening, assessment, evidence-based individual, group, and family treatment sessions, and case management. Additionally, staff acted as liaisons ensuring care coordination and referral services, and support connections between school staff and community-based personnel. SAP staff also served as members of school based MTSS teams.

Universal (Tier 1) and selective (Tier 2) services and supports were designed and implemented by school staff, which included the Good Behavior Game and Check-In/Check-Out at the elementary school level. Students identified with intensive behavioral health needs (Tier 3) were referred to school-based SAP staff. Families could be billed through Medicaid, private insurance, or self-pay for Tier 3 services. Students in need of acute or chronic behavioral health services which are beyond the scope of school-based services were referred to community-based treatment providers. As part of Project AWARE, this model was implemented in the Shelton School District from 2014-2019.

AWARE FY14: Battle Ground Public Schools in Partnership with Educational Service District 112's Community-Based Mental Health Service Providers Co-Located in Schools

In the second model, community-based mental health clinics – public or private – through memorandums of agreement with Battle Ground Public Schools, co-located mental health providers in school buildings to deliver direct services (Tier 3, Intensive). Families could be billed through Medicaid, private insurance, or self-pay. Like the ESD 113 model, services included screening, assessment, and evidence-based individual, group, and family treatment sessions.

Additionally, the district contracted with ESD 112 to manage and provide oversight of school-based mental health services and to act as a liaison between the district and the community-based provider. Tier 1 (Universal) and Tier 2 (Selective) services (e.g., Check-In/Check-Out, small group support) were supported by school-employed providers, such as school counselors, as part of the district's continuum of services.

The district also established a school-based "Point of Contact" (POC) to coordinate mental health services with the district's community-based providers. Using the POC system ensures that the agency's therapist has a consistent school staff member for whom to work with and report to and allows for accurate tracking and feedback of all referrals from the building. The POC is typically a school counselor or school psychologist and all referrals flow through this person. Weekly, the agency therapist and POC meet to review information about referrals (both new and pending). If the student was eligible for services, the agency offered an appointment, or made a referral to another provider, when necessary. The POC then informed school staff (as appropriate) of the outcome of the referral, while the agency communicated the outcome of the referral to the individual and/or guardian. Implementing this model across the district significantly closed the gap between date of referral and service enrollment and improved school staffs' knowledge of the outcomes of each referral. As part of Project AWARE, this model was implemented in Battle Ground Public Schools from 2014-2019.

> *Special Consideration.*
> Provider Agreements*:* The establishment of a memorandum of agreement (Provider Agreement) that clearly outlines the roles and responsibilities of the district and provider, establishes a "common language" and outlines expectations, ensures the needs of all parties are met.

AWARE FY14: Northwest Educational Service District 189's School-Based Mental Health Services "Lite"

The third model program was a hybrid model with ESD 189, district, and community-based service providers delivering services and supports in the school setting. ESD-employed, state licensed, mental health professionals delivered evidence-based group and/or individual therapeutic sessions to students identified as needing mental health supports (Tier 3) during the school day. The Marysville School District also employed licensed mental health staff that delivered Tier 2 services in school buildings that were not supported by Project AWARE funding. Youth in need of Tier 3 supports could also be referred to community-based mental health clinics (private and/or public) that provided clinical staff who were co-located and were able to deliver services to students in the school setting. These community-based agencies could bill families through Medicaid, private insurance, or self-pay, as appropriate. As with the previous two models, Universal (Tier 1) and selective (Tier 2) services and supports, such as Second Step at the elementary school level, were designed and implemented by school staff. As part of Project AWARE, this model was implemented in the Marysville School District from 2014-2019.

> *Special Consideration:*
> Treatment without Clinical Diagnosis: Because this model did not require a behavioral health diagnosis, services could be provided to all youth. The elimination of the "medical necessity" requirement reduces access barriers as well as other billing and/or insurance requirements.

AWARE FY20: Together 105 Treatment Services

As part of Project AWARE (FY20), ESD 105 successfully became a licensed behavioral health agency (BHA), in November of 2021. Together 105's goal is to "eliminate barriers to access to care by bringing a continuum of services to students in their school settings." Services and supports include wellness promotion and universal mental health literacy; substance use disorder prevention; mental health and substance use disorder early intervention, screening, and brief intervention; assessments; outpatient treatment; service referral; and ongoing recovery support. As part of the Project AWARE FY20 grant, the ESD has licensed behavioral health professionals and student assistance professional staff located in in all three AWARE LEAs.

Sunnyside School District: The Sunnyside School District continues to successfully grow partnerships with community-based behavioral health agencies with the goal of embedding these providers into the school settings. In partnership with the community-based organizations, United Family Center (UFC), and Comprehensive Healthcare, in collaboration with Together 105 Treatment Services, the district had 9 full-time mental health providers (employed by UFC and Comprehensive) and four Student Assistance Professionals (employed by Together 105) serving the district's eight buildings as part of Project AWARE at the start of the 2022-23 school year. These staff begin and end their day in the school-buildings are participants in building-level MTSS teams.

> *Special Consideration*:
> Universal Release of Information:
> To ensure seamless and coordinated service delivery for the upcoming year, the district lead recently met with all three service providers to identify shared best-practices including a universal Release of Information (ROI) form to further integrate their work in 2022-23 school year.

Wahluke School District: The district currently has one full-time mental health therapist, employed by Together 105, providing Tier 3 services districtwide. The district is also in ongoing negotiations with Grant County Behavioral Health to provide up to one full-time mental health professional to work directly at the school district.

Yakima School District: In partnership Together 105, the Yakima School District currently has two full-time licensed mental health providers serving the four middle schools of focus. In addition, the district also has two full-time Student Assistance Professionals (also employed by Together 105) alternating service days across these four buildings.

In all three of the AWARE FY20 districts, Universal/Tier 1 and Selective/Tier 2 supports are provided by school and district staff, including teachers, paras, school social workers, school counselors, school psychologists and behavior interventionists.

AWARE FY22: LEAs as BHAs -A New Framework

In the recently awarded Project AWARE FY22 proposal, three LEAs (two ESDs and one school district), all of which are also licensed BHAs, will provide direct services to an anticipated 6-8 school buildings in each of their regions. This regional service delivery model will allow LEA partners to address service delivery and access barriers especially in smaller, remotely located,

rural schools. Because LEA providers are from the education system, they have the knowledge and trusted relationships needed to implement SBMH services and supports. Specifically, during the pandemic, these LEA BHAs used COVID relief funds to expand their staffing and embedded therapists in schools thus laid the groundwork for this sustainable SBMH model.

Through the SBMH systems framework, LEA employed MH therapists will work in collaboration with school staff to assess, refer, triage, case manage, provide treatment, and monitor student progress. School staff, with support from the LEA project managers, will deliver Universal/Tier 1 supports, while SBMH therapists, in coordination with existing school staff (e.g., MTSS teams), will deliver Tier 2 and Tier 3 services; SBMH therapists will be embedded into the school system delivering MH services that are recovery-oriented, trauma-informed, and equity-based.

Takeaways & Lessons Learned

In the following section, we summarize lessons learned and offer considerations to ESDs, districts, and schools that may be interested in the development and implementation of a comprehensive, integrated school-based mental health program model.

Readiness: Implementation of school-based behavioral health services, including the development of a referral system, requires extensive planning and collaboration among key stakeholders. What we learned from these projects, without exception, is that once the referral system, services and supports are in place, children will be referred, and services will be utilized.

"If you build it, they will come."

To prepare for the setting up of a school-based behavioral health model using the MTSS framework, districts and schools should ensure that a solid foundation is in place that supports the implementation of tiered levels of services. These foundational best practice components include, 1) Family-School-Community Partnerships, 2) Mental Health Promotion and Awareness, 3) Staff Professional Development, 4) Positive School Climate and Culture, 5) Accountability Systems, and 6) Data-Based Decision Making. Programs that lack these fundamental components are less likely to be successful and may be overwhelmed by an influx of students inappropriately referred to Tier 2 and Tier 3 services.

Buy-in: It is critical to have district and building-level understanding of the infrastructure and administrative supports needed to successfully implement direct services (Tier 2 and Tier 3). Prior to implementation, school administrators should be fully aware of, champions of, and committed to, the provision of the basic requirements of a school-based service delivery model. These include: 1) a confidential workspace; 2) access to phone and internet services; 3) sufficient room to conduct group and/or individual services; and 4) agreements to collect and submit project-specific data.

Moreover, ensuring that school staff fully understand the who, what, when, where, why, and how of school-based mental health services is essential to both implementation and sustainability. Conducting brief professional development trainings that increase understanding of program services including confidentiality and the referral process, and awareness and identification of the signs and symptoms of behavioral disorders, ultimately reduces start-up challenges upfront and improves service accessibility over the long run.

Readiness & Buy-in Resources

Hexagon Readiness Tool: The Hexagon Readiness Tool engages stakeholders in determining how well a potential initiative addresses a problem and how prepared an organization is to implement the initiative. The tool also helps foster stakeholder buy-in and support for putting a new initiative in place.

The tool can help assess the appropriateness of an initiative based on need, the evidence of its effectiveness, and how the initiative aligns with an organization's values, mission, and other mandates; assess the readiness to put an initiative in place based on an organization's capacity, resources, staff and leadership motivation; and build stakeholder engagement, decision making, and strategic planning skills.

District Capacity Assessment: The primary purpose of the District Capacity Assessment (DCA) is to assist school districts to implement effective innovations that benefit students. The capacity of a district to facilitate building-level implementation refers to the systems, activities, and resources that are necessary for schools to successfully adopt and sustain Effective Innovations.

The DCA is an action assessment designed to help educational district leaders and staff better align resources with intended outcomes and develop action plans to support the use of effective innovations. Both the training and tool are available online.

The DCA is completed by staff intentionally selected for their implementation knowledge, experience with the innovation being used, and leadership in the district (i.e., an implementation team). The (State Implementation and Scaling-up of Best Practices) SISEP Center recommends that the DCA be administered by a trained administrator.

School Health Assessment and Performance Evaluation System (SHAPE): The SHAPE System, developed by the NCSMH at the University of Maryland School of Medicine, is a free, private, web-based portal that offers a virtual workspace for school mental health teams at school, district, and state levels to document, track, and advance quality and sustainability improvement goals as well as assess trauma responsiveness. The SHAPE System also offers access to free action planning, mapping, program implementation resources and other critical tools to advance comprehensive school mental health systems.

For additional information and resources, visit the Mental Health Technology Transfer Center Network.

Workforce: Difficulties hiring and keeping skilled mental health professionals has been an ongoing challenge in the provision of sustainable school-based mental health services and supports, with this even more so in rural communities. It is important, at the state and local levels, that partners work collaboratively to increase access to a qualified workforce if comprehensive school-based services are to be realized. Strategies should include identifying workforce barriers, including staff burn-out, secondary trauma, compassion fatigue, and overall adult wellness, prioritizing workforce development (such as through the recent projects awarded through the US Department of Education), including alternative credentialing options, and changing existing laws to allow graduate students to complete practicum requirements (similar to teachers) in the school setting.

"Our biggest challenge is the increasing request for services and the shortage of Mental Health Professionals to fill the need."

In addition, to reduce the burden of service delivery on a single staff person, and to build in sustainability, schools should consider utilizing existing staff (e.g., Student Assistance Professionals, school counselors, social workers) to deliver Tier 1 and Tier 2 services. Moreover, it is important to provide adequate and ongoing training, strong supervision, monitoring, and oversight, as appropriate, to these staff to increase and/or enhance their skills in relevant areas.

Evidence-Based Practices: As districts and schools move through the stages of implementation – Exploration, Installation, Initial Implementation, Full Implementation, and Continuous Improvement/Regeneration – it is important to support the sustainability of the MTSS framework through the identification of evidence-based practices (EBP). These EBPs should address both academic and non-academic barriers to learning through the intentional layering of student supports in the MTSS framework.

"Keep in mind, this [PBIS/MTSS] is a ten-year process."

There are wide range of evidence-based practices available to districts to support both the social emotional and academic needs of students. However, districts and school buildings often find themselves overwhelmed by the sheer number of initiatives and interventions being implemented at any given time. As such, buildings may find increased utilization and buy-in for such supports by first conducting a comprehensive resource inventory and gap analysis prior to launching additional initiatives or supports. In some cases, simply prioritizing higher model fidelity and consistency of use of an EBP can prove more efficient and effective than starting something new. It has also been observed that starting small (e.g., one grade level) and scaling up can provide many benefits to learning and can reduce the growing pains and overwhelm of wide-scale implementation.

Model Fidelity & Data-based Decision Making: To maximize system and individual-level change, districts and schools should focus on implementation/installation fidelity. This is best accomplished through continuous quality improvement and databased decision making, per standard practices, and the evaluation and documentation of program outcomes

Universal Screening: An essential component to successful Tier 1 programs and supports includes the use of universal screeners (e.g., BASC-2 Behavioral and Emotional Screening System; Student Risk Screening Scale) that can assist schools in the identification and referral of students in need of more intensive services (Tier 2 and/or Tier 3). Screeners, or brief assessments, are used to identify students who are at risk of emotional/behavior disorders and are especially useful for identifying students with less overt internalizing behavior (e.g., withdrawal, depression, anxiety). Implementation of universal screening should occur when foundational and Tier 1 supports are solidly in place and a district or building is prepared to meet the potential for increased referrals to services and service provision.

Communication & Collaboration: In effort to address challenges that often stem from confidentiality issues, it is important to establish communication and feedback mechanisms between the referral source and the practitioner. Doing so, at the onset, improves information sharing, ensures that all parties involved in the development and delivery of these services are heard, and that problems are solved in a thoughtful and meaningful manner.

Consistency & Relationships: To the best ability, strive for consistent delivery of services to building(s) across school years. Relationships between providers and clients, as well as providers and other school staff, takes time. Both students and staff need time to learn and understand the available services and how to access them. Students also need time to build trusting relationships with providers. Multiple providers or inconsistent availability/scheduling can hinder this relationship building process.

District-to District Coaching/Peer-to Peer Learning: Schools and/or districts may find it beneficial to seek support from ESDs to connect with other districts in their region implementing this work. Through the coordination of a site visit(s), districts can find out about best practices, and hear about lessons learned, as well as partner with and/or pool community resources to expand services in the region.

State-level Coordination & Leadership: Engaging in state, regional, and local level BH systems-level work requires OSPI and ESD leadership buy-in and investment. Without a regional staff person to develop the readiness at an ESD and build capacity within the ESD itself, it would be nearly impossible to create measurable change. A system change initiative requires time, expertise, knowledge, and strategic planning to develop internal agency engagement and buy-in as well as external community and school-based partnerships.

Navigating Different Systems: The education and healthcare sectors are different cultures and thus may experience conflicting values about levels of behavioral health service needed for all. Increasing access to care in the school setting requires collaborative partnerships and support from the entire K-12 systemic structure including OSPI, regional ESD's and local school districts to successfully engage in the publicly funded healthcare system.

Observations and Recommendations from the Authors

Assessing Readiness: All project partners looking to engage in this work, regardless of at what level (SEA/LEA), should understand the current state of the system BEFORE starting the work. (*Refer to Readiness Assessment section for additional details and resources.)*

From the State (SEA): Maintain a meaningful SEA team with policy-making authority and cross-jurisdictional/departmental representation to continue to de-silo state-level work.

Statewide policy development, change, and support should be aimed at decreasing barriers for schools to implement SBMH, not on additional mandates, unless other responsibilities and/or mandates are removed at the same time. Capacity is not infinite. *TIME* to do the work, inclusive of time for training, learning and peer sharing, as well as implementation, appears to be the most precious resource for schools at present. Without creating dedicated staff and time to do the work, implementation will stall and burn-out will occur.

The SEA can also support LEAs by providing current, relevant, and affordable training, technical assistance, and curriculum in topical areas requested by LEAs to promote and support program implementation. However, the SEA must allow flexibility for local adaptation and implementation based on the unique circumstances of each LEA. State partners can support strong implementation fidelity and accountability in partnerships with LEAs and evaluation (as appropriate), primarily by creating space to talk through challenges, address areas of weakness, and facilitate peer learning spaces in relevant areas.

At the regional level (ESDs): An observed beneficial role that ESDs can play in the implementation of SBMH services and infrastructure includes resource navigation, training, and technical assistance. A district's partnership with their ESD can, and will, vary. Not all districts need or want the same level of regional support. Support from the ESD can occur directly to a district-level team or to individual buildings, depending on the implementation strategy and relationships with the site(s). The ESD can and should have a clear menu of training, technical assistance, and policy development support available to LEAs as requested.

A second major role that ESDs can play to support the sustainable implementation of SBMH services and supports is as a licensed Behavioral Health Agency (BHA) for mental health and substance use disorders, providing direct services to LEAs while staff are embedded into the school system, coordinating with school staff on teaming and implementation. This model will be more thoroughly explored in Project AWARE FY22.

At the district-level: LEAs must have the leadership and capacity to commit to culture change to implement and champion this often challenging work. This includes a teaming structure with Superintendent and principal buy-in, establishing a vision and mission for the work that is framed as a whole child approach, delineation of roles and responsibilities of team members, and ensuring a shared language is established between education staff and behavioral health care providers.

Key is the ability and willingness to change/adapt policy and procedures, establish and/or enhance MOUs with relevant partners, a commitment to data-based decision-making, and sharing of data for evaluation purposes. These elements should be embedded into the purpose/mission/vision of the work.

While having a single point of contact with decision-making authority for this work is crucial (ideally this POC is a 1.0 FTE dedicated to the project, with 0.5 FTE a minimum.), it is also critical to ensure other school and district staff are informed and supported to play their role in the continuum of services, too. Establishing clear a clear communication policy and prioritizing time for staff training and implementation can reduce mission confusion and increase buy-in.

At the building-level: Similar to district-level recommendations, at the building-level administrative buy-in is crucial and should include a clear understanding of the expectations needed to implement SBMH services and supports. Building-level capacity assessments should include the willingness and commitment of a school-based team (with a dedicated POC), secure and confidential physical space for the work to occur (specifically for the implementation of treatment services), and a commitment to collect and submit data in a timely manner for project evaluation.

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Appendix: See attached.