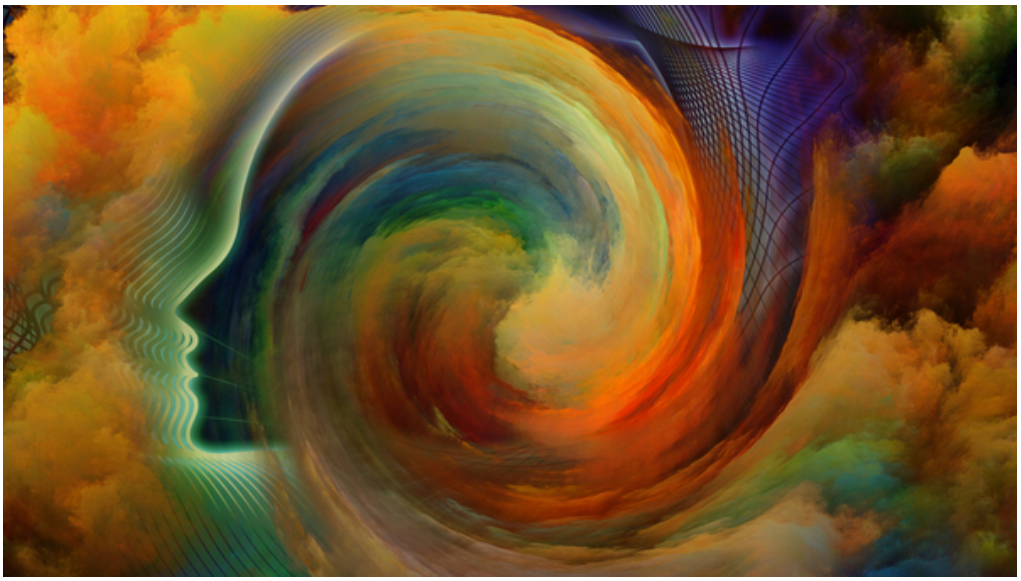
EXPLORING THE LANDSCAPE OF MENTAL HEALTH AND WELLNESS IN WASHINGTON'S K-12 EDUCATION SYSTEM



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ACKNOWLEDGEMENTS

A major component of this work was to conduct interviews with key informants to better understand the nature, depth, and breadth of current school-based social, emotional and behavioral strategies being implemented across the state, as well as to identify barriers and challenges that may hinder the implementation of these services.

A special thank you to all of these stakeholders who generously and graciously gave their time to this project. Each of these individuals participated in a semi-structured 30-60-minute phone interview and provided a vast amount of honest and thoughtful insight about the state of school-based mental health and wellness across Washington.

Key Informants

Joe Avalos Chief Operating Officer, Thurston/Mason Behavioral Health Organization	Kim Beeson Director, Puget Sound Education Service District
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INTRODUCTION

The aim of our work was to conduct an environmental scan of existing resources, services, and programs related to the scope and nature of school-based social, emotional, and mental wellness strategies in Washington State's K-12 education system. The overarching purpose was to provide a sufficient level of detail to guide thinking and decision-making central to the implementation of strategies that support the vision and mission of Kaiser-Permanente's Washington Thriving Schools initiative. We approached this work with a basic knowledge of not only the K-12 system, but also of current efforts to build capacity around, and scale up, school-based mental health supports statewide.

Our findings inform this work and add to the existing body of knowledge as a means of supporting the implementation of a comprehensive system of programs, services, and supports. Our knowing is not new. On the contrary, the knowledge that we bring builds upon decades of work in Washington State. Since the late 1990s this work has been simmering, ebbing and flowing, with a myriad of champions along the way; many of whom remain steadfast, as new leaders emerge, we collectively move this work forward.

Ours in not a singular voice; rather we join a chorus of voices throughout the State whose message is the same,

"Children are hurting. Adults are hurting.
The needs are clear. The time to act is now."

The report contains four sections: 1) a needs assessment; 2) a review of the academic literature; 3) findings from structured key informant interviews; and 4) a summary of findings and recommendations for the future, as determined by the overall body of this work.

The needs assessment and gap analysis provide the data to inform this work. The literature review provides the rationale for undertaking this work and focuses on best practices related to school-based mental health programs, services, and supports. The information gleaned through the literature review informed the development of the process undertaken during key informant interviews. Interview questions were based upon what research indicated were best practices in the development, implementation, and delivery of school-based mental health services. By designing questions informed by best practices, we were better able to understand how, if at all, these services were being delivered and to identify barriers that may be inhibiting the development of a comprehensive school-based service delivery model.

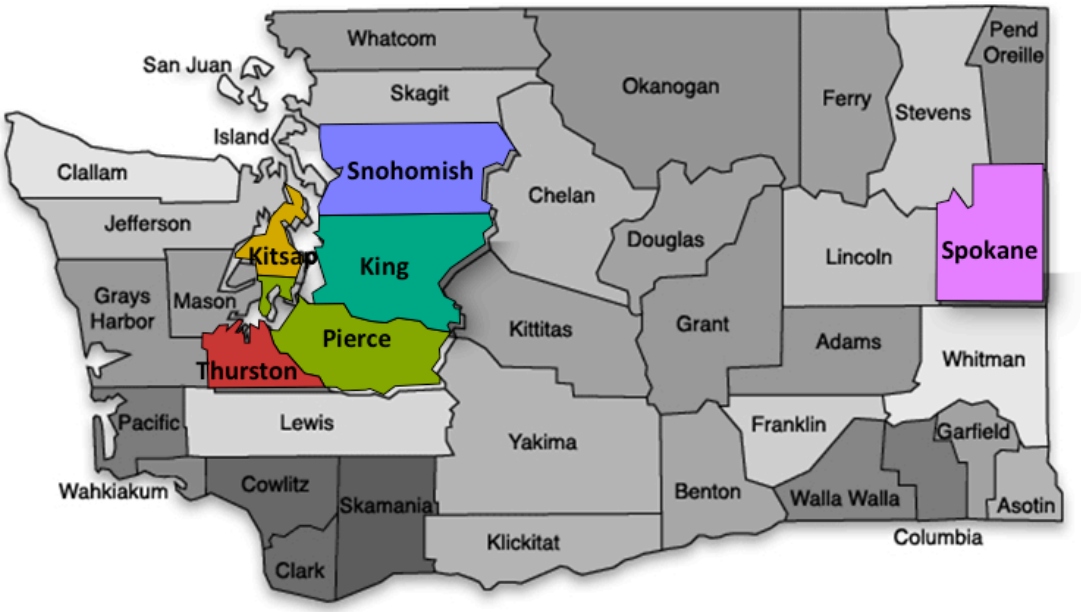
Our findings are supported by identified needs, the research base, and are echoed in the voices of our informants. This work is aligned with the two recommendations of the Educational Opportunity Gap Oversight and Accountability Committee including providing support to districts/schools to: 1) adopt an integrated student support framework (similar to MTSS); and 2) adopt a social emotional learning framework. Both recommendations include the development of professional learning opportunities and school-family-community partnerships, with these to be culturally, linguistically, and developmentally appropriate.[1]

[1] See http://www.k12.wa.us/Workgroups/EOGOAC/pubdocs/EOGOAC2017AnnualReport.pdf

EXECUTIVE SUMMARY OF NEEDS & FINDINGS

THE LANDSCAPE – SELECTED NEEDS ASSESSMENT INDICATORS

To provide a context from which to view the landscape of the mental, emotional, and behavioral health needs of Washington's youth and families, a needs assessment was conducted for the population of focus. This includes the State of Washington, as well as identified Kaiser Permanente counties: King County, Kitsap County, Pierce County, Snohomish County, Spokane County, and Thurston County.



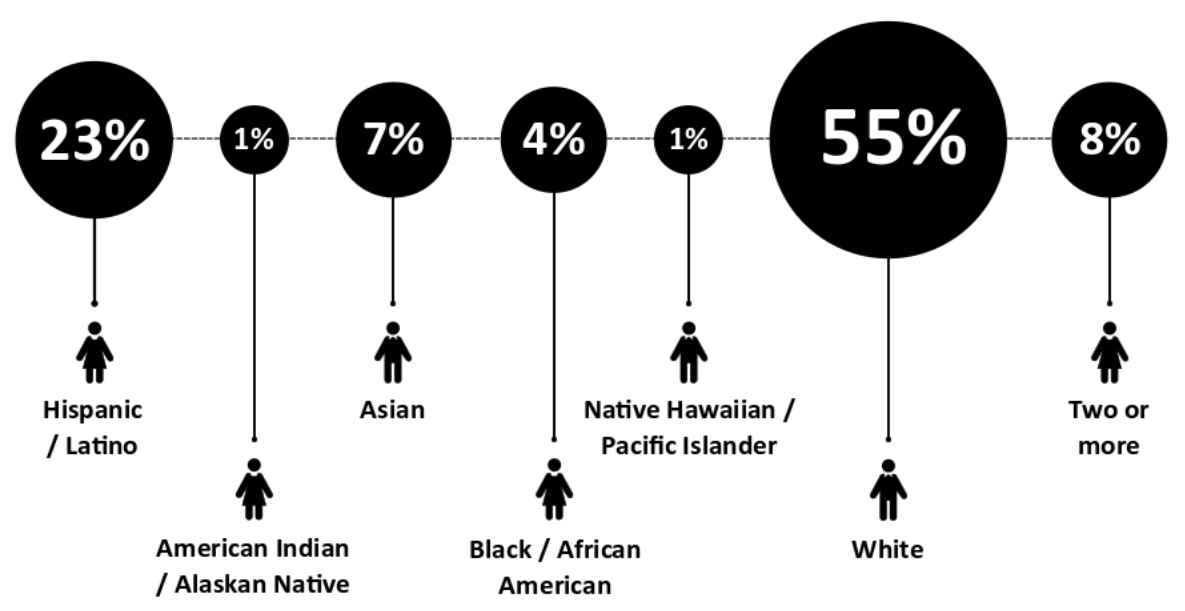
Public School Demographics

There are 295 school districts statewide, representing 2,392 public schools, with a student population of over 1 million. Nine percent (9%) of youth enrolled are in Pre-K-Kindergarten, 38% are in grades 1-5, 22% are in grades 6-8, and 31% are in grades 9-12.

Two-thirds of the 63,500 teachers statewide hold a Master's degree or higher. The average years of teacher experience in Washington State is 13 years.

In general, student demographics are slightly more diverse than the State population, with regional variation among school districts in the targeted KP regions.

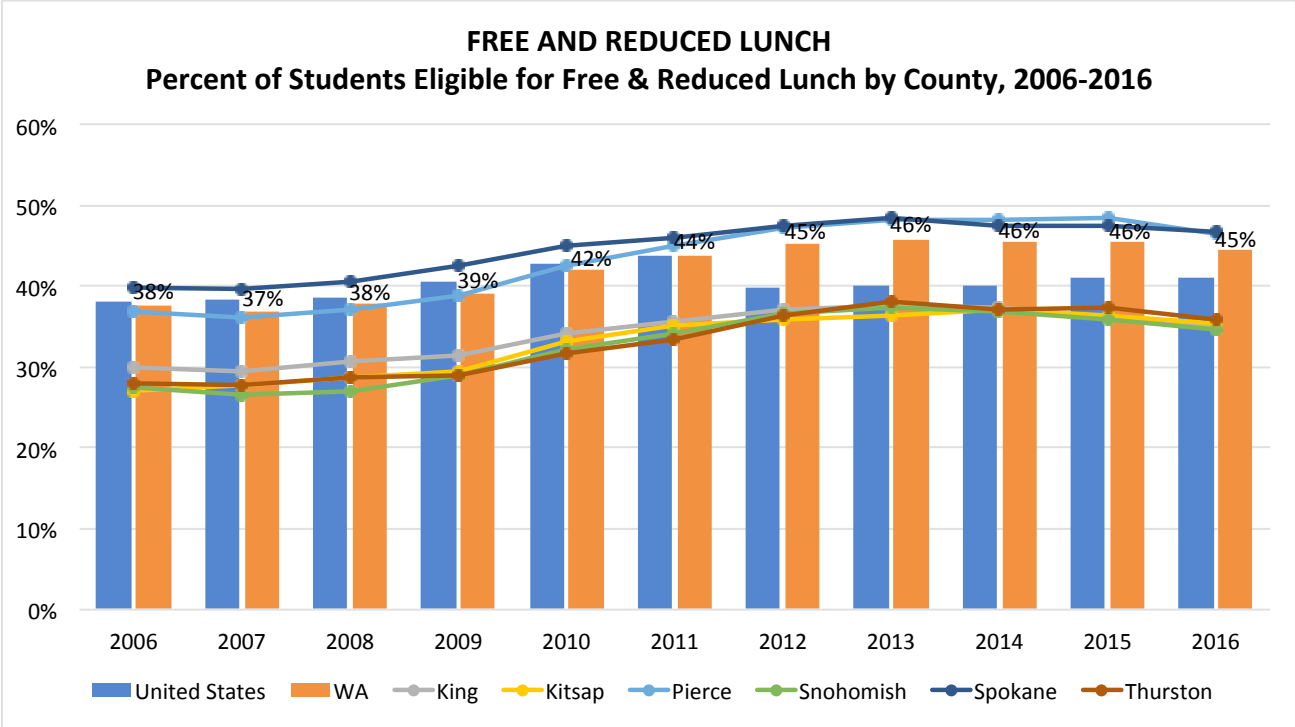
Washington State Student Enrollment Racial Demographics:



SOURCE: OFFICE OF THE SUPERINTENDENT OF PUBLIC INSTRUCTION, STATE REPORT CARD, 2016

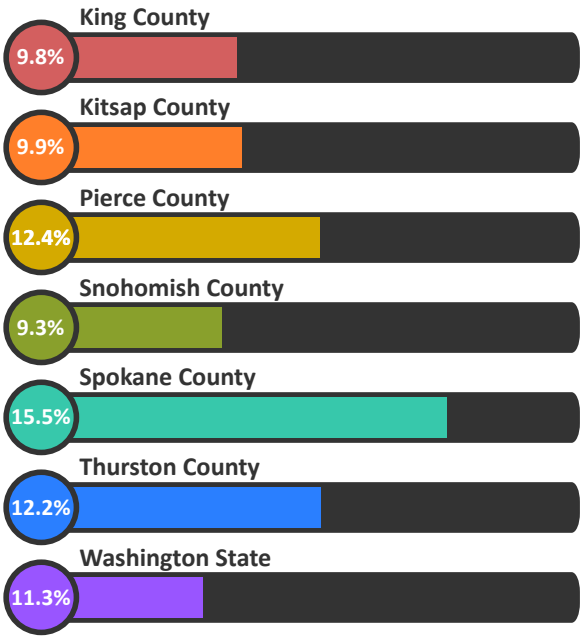
Poverty Indicators

Food insecurity is associated with a wide range of adolescent mental health disorders including increased risk of past-year mood, anxiety, behavior, and substance disorders (McLaughlin, et. al, 2012). The figure below demonstrates the percentage of student eligible for Free and Reduced lunch (a poverty indicator), by county, and statewide for a 10-year period.



SOURCE: RISK & PROTECTION PROFILE, WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES, 2016

Poverty Rate (2015):



Statewide, over one in ten families live below the federal poverty level. These rates varied by county. Poverty makes it hard for families to provide the safe and stable environment necessary for healthy development, and parental stress affects children's emotional, physical, and academic options and progress.

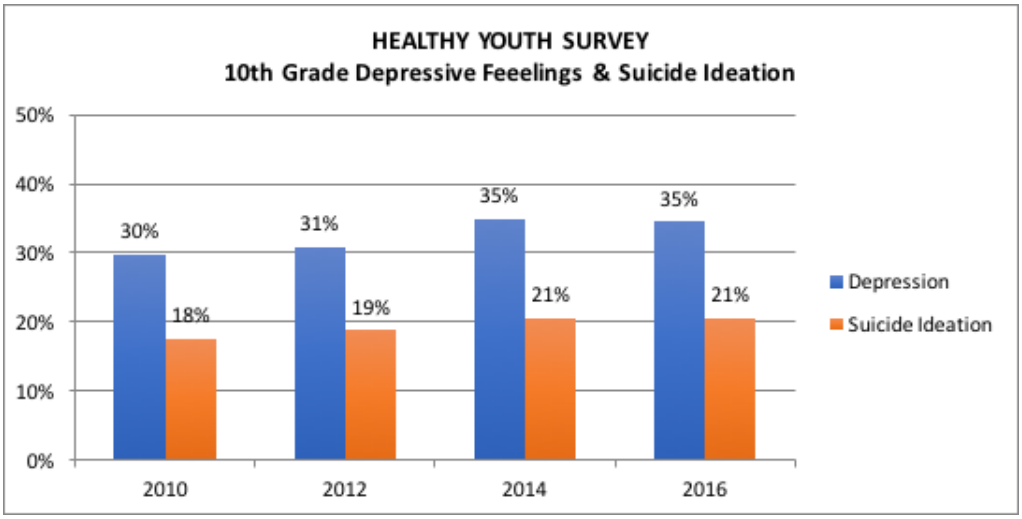
For children, poverty is also associated with poor educational achievement, and places them at higher risk of poor health and mental health challenges (Aber, Bennett, Conley, & Li, 1997; Brooks-Gunn & Duncan, 1997; National Center for Children in Poverty, n.d.).

SOURCE: STATE AND COUNTY QUICK FACTS, US CENSUS BUREAU; *JULY 1, 2016 ESTIMATES

Prevalence of Mental Health Disorders

One in five children (ages 13-16) will experience, or have had, a significant mental health problem during their education years (National Alliance on Mental Health, 2015; U.S. Department of Health and Human Services, 1999).

Depressive feelings and thoughts of suicide among 10th grade youth across the state have increased over the past 6 years, with **more than one-third** experiencing signs of depression and **one in five considering suicide** in 2016.



School Climate

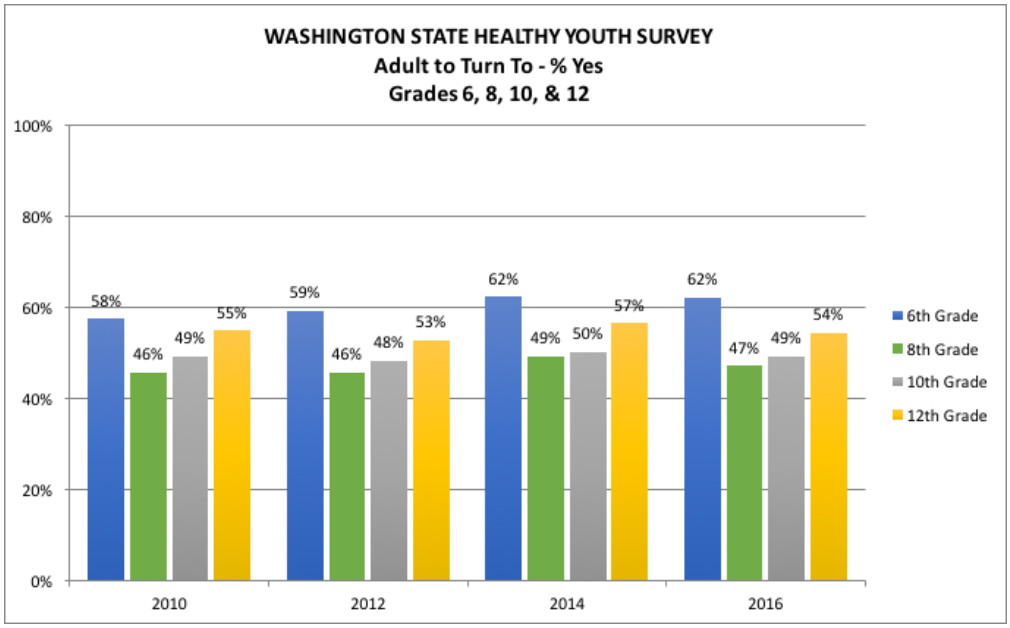
A child's future depends on the ability to overcome and move beyond the emotional and other psychological challenges associated with growing up. Being a target or victim of bullying has immediate and long-term psychological and social effects, influencing a young person's academic achievement and psychosocial adjustment (Espelage & DeLaRue, 2012).

Healthy Youth Survey data indicated that in 2016, on average, one in four middle and high school students in Washington State reported being bullied in the past 30 days.

Nearly two-thirds of middle and high school youth expressed feeling anxious in the previous two weeks in our State in 2016 (HYS, 2016).

Trauma and Resilience

Adverse Childhood Experiences (ACEs) are stressful or traumatic events, which include experiences such as abuse, neglect, domestic violence, parent separation or divorce, economic hardship, or an incarcerated household member. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan. ***In Washington State, just over one-third of youth (36%) have experienced one or two ACEs, with 11% experiencing 3 or more*** (CDC, 2014; Child Trends, 2014).



To build resilience in children and teenagers is to improve their ability to make connections; as connections (or relationships) with others increases social support and resilience. HYS data indicate that on average, over half of youth statewide reported having an adult to turn to when needed; however, responses varied by grade level.

KNOWLEDGE: WHAT WE KNOW

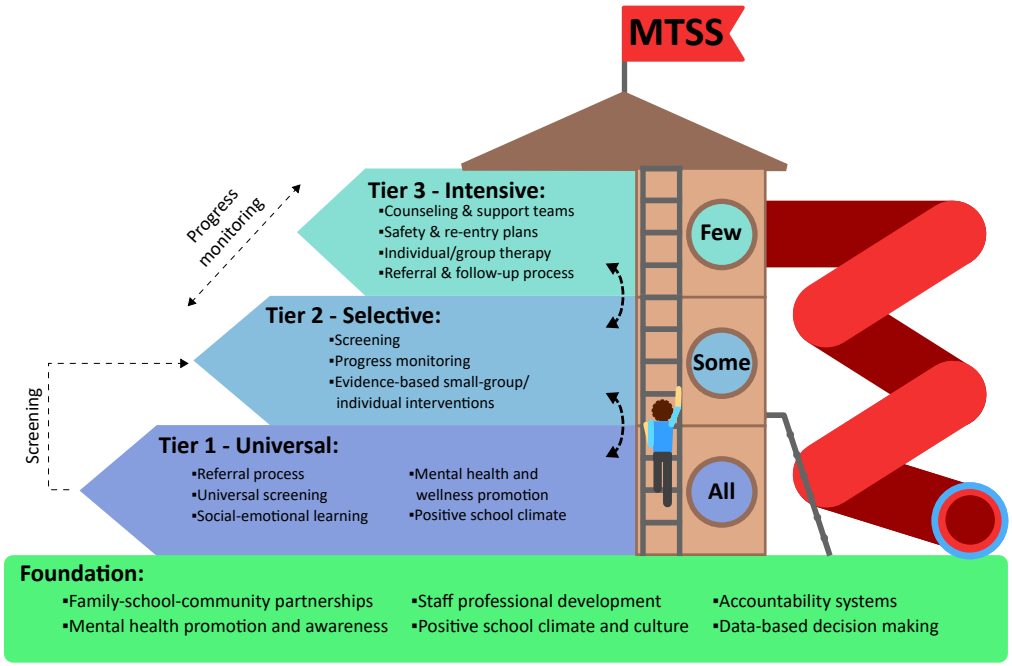
Schools play a critical role in offering youth the mental health care they need. ***With one-in-five children impacted by a diagnosable mental health or learning disorder, it is crucial that schools, communities, and families work to identify and address students' needs*** (Behrens, 2013; California Health Interview Survey, 2005; Gall et al., 2000; Kataoka et al., 2002). The infusion of school based mental health (SBMH) services into regular school routines and practices allows students' learning and emotional needs to be addressed, while also reducing their barriers to treatment.

Several foundational best practices have been identified that improve the implementation of school-based mental health services, including:

- Family-school-community partnerships,
- Mental health promotion and awareness,
- Staff professional development,
- Positive school climate,
- Accountability systems, and
- Data-based decision-making

Students with mental health disorders experience higher rates of tardiness, absenteeism, suspension, expulsion, and dropout.

These best practices work best within a multi-tiered system of supports (MTSS) framework, which enables successful prevention, early intervention, and monitoring of adolescents' mental health and wellness (Hess et al., 2017). Trauma-sensitive practices can assist educators in recognizing students' triggers, coping mechanisms, and emotional needs. Students who have endured trauma can learn how to be resilient over time through making connections, helping others, practicing self-care, and moving toward goals, among other strategies.



Many students will move in between tiers in one area while others may move in between the tiers based on another area. Remember, the pyramid is fixed; students' needs are not.

Effective SBMH services also include supports for school staff, who may have significant mental health and wellness needs of their own. When schools proactively address students' social, emotional, and behavioral health, positive educational outcomes are increased, school climate and safety are improved, mental health awareness is increased, and stigma is reduced.

An effective multi-tiered system results in seamless service delivery at increasingly intensive levels of support, and allows for efficient identification, assessing, monitoring, and improvement of mental health outcomes.

DISCOVERY: WHAT WE FOUND

Throughout the interview process, key informants at every level identified regions, districts, or individual school buildings that were successfully implementing a multi-tiered system of supports (MTSS) framework. All of these "pockets of excellence" had something in common: a foundational structure. In other words, those that were showing success had many of the foundational best practices in place, thus enabling them to successfully create a system to not only address the academic needs of students, but also the non-academic barriers to teaching and learning. These key elements included:

- Strong district-level leadership and staff buy-in from the top down;
- Prioritized social, emotional learning (SEL);
- Included SEL accountability measures in their school improvement planning processes;
- Routinely utilized data to inform practices, including progress monitoring;
- Ensured resources (i.e., programs, services and supports) were available across tiered levels of support;
- An established system for identification and referral of students; and
- Strong school-community provider partnerships.

> *"In the past it used to be, 'Oh, just send them to the mental health therapist, they'll fix them' and now it's more of, 'No, we're all a team. We're all surrounding and loving and supporting our kids and we all need to do our part to help them not only academically, but emotionally and socially.'" District-level informant*

These "pockets of excellence" are encouraging and provide evidence not only of the changing state of school-based mental health programs, services and supports, but also emphasize the level of leadership and commitment needed to scale up this work across the K-12 system. That said, there is a wide range of challenges that can hamper the development of this foundational structure and the implementation of programs, services, and supports.

OVERALL BARRIERS AND CHALLENGES

The single most cited barrier to effective implementation of mental health strategies was *stigma.* Stigma can impact an individual's decision to seek mental health services or supports, and can even result in judgment from peers.

"We are still feeling the stigma, and even culturally, to get people to the point to talk comfortably about the fact that they might have mental health issues without fear in the work place. We still have made very little strides in my mind, changing that stigma, to even have people talking comfortably about some of these concerns." – ESD-level informant

Other important barriers discussed with regard to *knowledge and awareness* included a lack of professional development opportunities, as well as the *lack of buy-in and readiness* at both the school and district levels. Teachers frequently lacked the preparation, experience, and certification necessary to meaningfully address mental health issues in the school setting.

"Staff are inadequately trained to understand the signs and symptoms they see, and to know how to intervene with kids who are blocked from their ability to learn as a result of undergoing trauma, or distracted by mental health distress." – ESD-level informant

Overall, however, the most frequently mentioned challenges were related to *resources and capacity* (i.e. funding, workforce, time, and sustainability).

"So, that's the other big area – funding…you may want to do all of these things in your school but you have to look at what is being provided for basic education, where your resources are, and if you have the capacity to fund those things in a way that is sustainable…" – District-level informant

SUMMARY OF FINDINGS

Throughout this exploration process, we uncovered a number of key findings related to the nature, depth, and breadth of current school-based social, emotional, and behavioral strategies implemented in Washington State. A summary of these findings is outlined below.

Concerns

Mental Health Concerns – Students: **Mental-emotional-behavioral (MEB) issues** were the primary concern, with the majority of people citing **depression and anxiety**. Many respondents also discussed sharp increases in suicide and suicide ideation in recent years.

Unmet Needs – Students: Similarly, the primary unmet needs were **MEB issues, including depression, anxiety, ACEs, and trauma**. Educators – whose primary job is to teach academics – are often inadequately trained to recognize and respond to symptoms of mental health issues. As a result, mental health often takes a back seat to academics in the school setting.

Mental Health Concerns – Staff: **MEB issues were the most troubling for staff, including stress, anxiety, and burnout;** however, staff and their wellness needs are significantly overlooked in the school setting. One of our more significant findings was the extent to which students' trauma takes a toll on the teachers, often resulting in compassion fatigue.

Unmet Needs – Staff: **Lack of knowledge and awareness** about mental health – including **stigma** – were crucial unmet needs. Self-care, inadequate resources, and limited capacity to meet staff needs were also considerable concerns.

> *"[Staffs'] own emotional needs aren't met...You know like they say on an airplane, you put your own mask on first and then help those around you. I think that their masks are not on."— ESD-level informant.*

Foundational Best Practices

Family-School-Community Partnerships: Most districts/schools had **some level of family-school-community partnership** in place, but the strength of those ties varied. We found that many schools were in the process of discovering their potential as leaders in the community, and partnerships were improving with each passing year.

Mental Health Promotion and Awareness: The majority of districts/schools conducted **some type of campaign** to reduce stigma and promote mental wellness. With that said, it was not uncommon for only some schools within a district to be involved with these awareness activities. In general, we found that lack of funding and buy-in prevented more meaningful mental health campaigns from taking place.

Staff Professional Development: Districts and schools routinely provided a variety of trainings to school staff, focused on increasing **knowledge and awareness**, and practical application of programs/supports related to mental health and wellness. There was a need for additional ongoing trainings, however, as we noted a lack of follow-through upon completion of these programs. Just as booster shots are necessary to preserve the integrity of certain vaccines, so are refresher trainings for many mental health programs.

Positive School Climate and Culture: Positive school climate and culture is **becoming a higher priority** for districts/schools, with nearly all informants stating that they have seen improvement in this area. PBIS, social-emotional learning curriculum, increased professional development opportunities, and restorative justice were common methods discussed. Informants indicated, however, that despite good intentions, schools often fell short of fully implementing a positive school climate and culture.

Accountability Systems: The majority of informants stated that accountability systems were embedded within their districts'/schools' School Improvement Plan, however these, as a general rule, focused on academic improvements. Overall, **most schools did not have a cohesive, structured accountability system in place** to address social, emotional, behavioral goals, thus, staff are not held accountable for SEB learning benchmarks.

Data-Based Decision Making: Overall, we found that meaningful data-based **decision-making was rare with regard to mental health efforts**. The use of data varied from district to district. In fact, many informants stated that data were collected but rarely analyzed – likely because staff were not informed or trained how to do so.

Multi-Tiered System of Supports

Tiered Levels of Programs, Supports and Services: The majority of informants reported **some type of Tier 1 (Universal) and Tier 2 (Selective) programs, services, or supports** within their districts/schools. Despite this, we found a general lack of mental health interventions at all three tier levels within districts/schools, including a lack of a universal screening tool (behavioral) for student identification and referral. In short, there was a need for a more holistic, comprehensive approach to student mental health and wellness.

Culturally, Linguistically, and Developmentally Appropriate Services: While some informants identified strategies related to the cultural, linguistic and developmental needs of students and staff, knowledge in this area was lacking overall. In fact, **the majority of informants were unaware of steps being taken in these areas.** With a general lack of mental health services for all students, culturally, linguistically, and developmentally appropriate services are frequently overlooked.

Underdeveloped and/or Inadequate Programs, Supports and Services: When asked about underdeveloped or inadequate programs, **65% of informants reported that program level supports were underdeveloped or inadequate**. Moreover, services for youth most at risk, Tier 3, were the least likely to be fully developed, including access to quality, intensive school-based mental health services and supports. **Insufficient resources** (e.g., funding, workforce, services) have hindered the quality of (and access to) mental health programming. Districts/schools often **lack the internal capacity** to develop adequate school-based mental health programs, supports, and services.

Coordination and Integration

Informants regarded **coordination and integration across systems (school and community) as often underdeveloped, inadequate, and inconsistent**. While coordination with non-school based partners was not uncommon, the level and type of engagement varied. Partnerships tended to center around existing community-based coalitions with these mostly focused on addressing the prevention of adolescent substance use. Contrary to our expectations, duplicative services were not identified or regarded as problematic for the vast majority of informants. Many informants expressed a desire for duplicative services, rather than the lack of services they were currently experiencing

Impacts

Informants reported **increased access to mental health services** in recent years. Programs utilizing the delivery of services in an integrated approach, across the continuum of services, were regarded as more successful than those without. Program success was dependent upon a multitude of issues, including:

- Buy-in (administrative and legislative);
- Adequate funding;
- The delivery of evidence-based programs;
- Access to services; and
- Trust and effective communication between schools and community partners.

NAVIGATION: BUILDING THE PATHWAY FORWARD

Despite years of positive efforts within the K-12 education system to support the mental health and wellness needs of children and adults, the gap between research and practice remains. Nevertheless, there is a path forward. In our current study, we found evidence of "pockets of excellence." More importantly, there is a general consensus – from the legislature on down – regarding the need to provide those working in the education system with the tools to improve the school environment, and to meet the mental, emotional, and behavioral health and wellness needs of children and staff.

The recommendations we present here echo, support, and build upon similar suggestions from others in the state who are also currently involved in this work. Our recommendations are made in the spirit of collaboration and hope. Hope that we in Washington State have reached the collective recognition that together we can move this meaningful work forward…our children are depending upon us.

1. Build capacity to implement comprehensive, multi-tiered, school-based mental health (SBMH) system of programs, services and support.[2]

Fund school-based pilot sites that demonstrate a level of readiness to fully implement an MTSS school-based mental health model. Build in a planning period, ideally 3 to 9 months, depending upon level of readiness, to conduct a resource inventory, needs assessment, and a well-developed implementation plan.

Work collaboratively with these pilot sites to focus on implementation of foundational pillars of support.

Provide sites with technical assistance/training related to:

1) School-Family-Community partnerships and sustaining engagement;
2) Social norming campaigns for mental health promotion and awareness;
3) Staff professional development opportunities, specifically related to screening and referral, signs and symptoms of mental health issues, progress monitoring, family engagement, mental health promotion and awareness, trauma-sensitive and culturally responsive schools, child and adolescent development, and staff self-care;
4) Positive school climate, including how to build teams with school and community-based providers;

[2] Similar frameworks have been adopted by a number of other states, with these states laying the ground work for how to scale up this work. In addition, a number of partners within the State are, and have been, at the forefront of championing this work within the K-12 education system. These leaders include the Office of Superintendent of Public Instruction's Department of Learning and Teaching, and Department of Student Supports, the University of Washington's SMART (School Mental Health Assessment Research & Training) Center, Sound Supports, the Many Minds Collaborative, Capital Region Educational Service District 113, NorthEast Washington Educational Services District 101, the Joint Legislative Audit & Review Committee (JLARC), and the Washington State Legislature's Children's Mental Health Workgroup, among others. In addition, a number of states have adopted a similar framework, thus have established a knowledge base and the structural processes necessary to assist in the scaling up of this work in Washington State. These include the states of California, Colorado, Florida, Michigan, and Wisconsin to name a few.

5) Implementing meaningful social emotional learning accountability systems (e.g., OSPI's SEL benchmarks); and,
6) Using data to drive decision-making for SBMH programs, services, and supports and examine the impacts of academic and non-academic student-level outcomes.

Work collaboratively with these pilot sites to build capacity to deliver culturally, developmentally, and linguistically appropriate services across the tiered levels of supports.

Provide sites with technical assistance/training related to:

1) Universal (Tier 1) supports including the identification and implementation of a universal behavioral health screener, development of a standardized referral process, and selection and implementation of culturally, linguistically, and developmentally appropriate evidenced-based practices (EBPs).
2) Selective (Tier 2) supports including EBPs to address identified mental, emotional, behavioral issues, and progress monitoring; and,
3) Intensive (Tier 3) supports including culturally and developmentally appropriate individual and group counseling services, re-entry and transition planning, crisis response planning, and a system of care model including MOUs, data sharing agreements and common languages between school and community-based partners.

2. Collaborate with other state level partners to expand access to a stronger, qualified, and culturally competent mental health workforce.

1) Identify workforce barriers and implement strategies to dismantle these;
2) Consider alternative credentialing options for graduate and/or professional programs; and,
3) Use graduate students, such as social workers or counselors, to deliver services while completing their degree program's practicum requirement (similar to a Chemical Dependency Trainee program).

3. Build a common language around MTSS and School-Based Mental Health.

1) Move knowledge to practice through sustained training and technical assistance offerings throughout the education system (from bus drivers to administrators);
2) Identify a team of subject matter experts that can provide training, technical assistance, and mentoring to districts/schools implementing and MTSS-SBMH structure;
3) Develop a set of modules, in collaboration with subject matters experts (SMEs), that outline the basic and next steps in the development and implementation of this framework; and
4) Collaborate with identified partners, such as OSPI, and the UW SMART Center to support a professional learning community to ensure the continued learnings of the MTSS-SBMH framework.

4. Identify others in the school system to deliver Tier 1 and Tier 2 services.

1) Utilize existing school staff such as Prevention/Intervention Specialists, Education Advocates, or para-educators to build internal capacity to deliver services; and,
2) Provide the necessary training to increase skill levels among identified staff and ensure adequate supervision, monitoring and oversight, as appropriate.

5. Advocate for meaningful family and youth engagement.

1) Provide models for replication and/or access to SMEs to build capacity in the development of this work.

6. Reduce access barriers to care.

1) Reconsider insurance and/or billing criteria to improve and expand access to care;
2) Change reimbursement structures to allow for case management, consultation, and care coordination, including problem solving teams, and wrap-around services;
3) Identify Point-of-Contact Systems Navigator in the schools, provide training in billing procedures, including accessing Title I and Medicaid funding; and,
4) Consider use of technology as an option for service delivery (e.g., telemedicine).

7. Integrate and coordinate care across systems.

1) Facilitate care coordination between community-based and school-based providers;
2) Provide opportunities for each system to learn from each other;
3) Identify common cross-systems barriers; and,
4) Provide training and technical assistance related to the development of a systems of care model.

8. Normalize mental health in the academic education system.

1) Champion the inclusion of social emotional learning and self-care as part of the pre-service curriculum in all higher education degree programs.

9. Act as a Convener.

1) Bring partners together;
2) Dismantle silos;
3) Merge parallel work;
4) Build a cohesive network of champions; and
5) Use political power to bring awareness to this issue.

10. Be the Champion of Mental Health Promotion and Awareness.

1) In collaboration with partners, conduct developmentally and culturally appropriate statewide awareness campaigns (similar to Tobacco prevention) to reduce stigma and promote mental wellness with a strong focus on youth between the ages of 10-17;
2) In collaboration with education partners, develop and conduct self-care campaigns for education staff with a focus on reducing stress, anxiety, burnout and compassion fatigue; and,
3) Consider the development and dissemination of innovative strategies to increase self-care within the K-12 education system.

THE LANDSCAPE: A NEEDS ASSESSMENT

To provide a context from which to view the landscape of the mental, emotional, and behavioral health needs of Washington's youth and families, the following section provides an overview of our population of focus. This information is provided for the State of Washington, as well as identified Kaiser Permanente counties: King County, Kitsap County, Pierce County, Snohomish County, Spokane County, and Thurston County. This overview includes basic demographic information as well as a snapshot of needs indicators, including economic wellbeing and poverty, academic performance and school climate, youth substance use, and mental health.

Data were compiled from multiple sources, which included the Substance Abuse and Mental Health Services Administration (SAMSHA), the National Alliance on Mental Illness (NAMI), the Office of the Superintendent of Public Instruction (OSPI), United States Census Bureau, Washington State Department of Social and Health Services (DSHS), and results from the Washington State Healthy Youth Survey (HYS, 2010-2016).

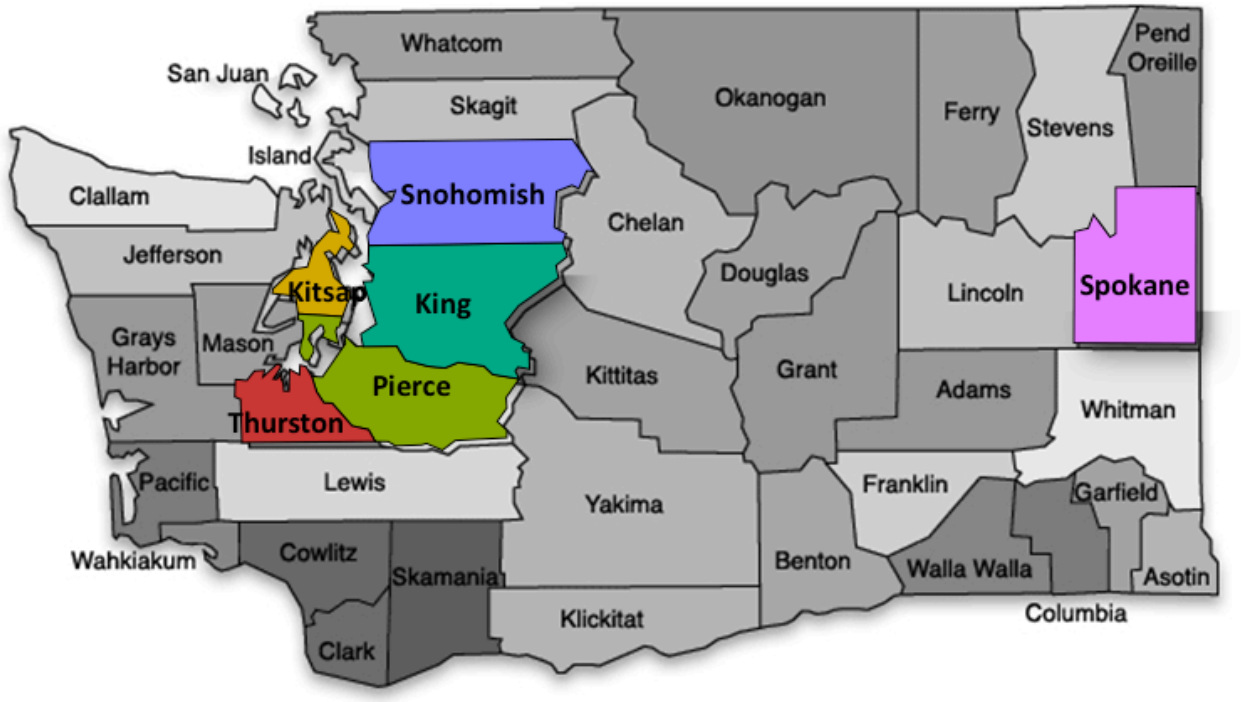
COMMUNITY DEMOGRAPHICS

WASHINGTON STATE

Washington State is located in the most northwest corner of the continental United States, bounded to the north by Canada and the Strait of Juan de Fuca and to the west by the Pacific Ocean. Washington is the 18th largest state in terms of its geographic size, with a land area of 66,456 square miles. It is also the 13th most populous state, consistently increasing in population over the past two decades and growing by 8.4% from 2010 to 2016. The estimated 2016 population of 7,288,000 gives Washington a population concentration of 101.2 persons per square mile versus 87.4 for the United States as a whole. This population is distributed unevenly. Some portions of the state are densely populated and urbanized, while much of the remainder is agricultural, forested, or sparsely inhabited with scattered small towns and unincorporated communities.

Approximately 60% of the State's residents live in the Seattle-Tacoma-Bellevue metropolitan area on the western side of the state. The city of Seattle itself (2017 est. population 713,000) is by far the single largest city, with all but three of the state's nine other largest cities in close proximity. This concentration of population is associated with economic and political dominance in the greater Seattle metropolitan area. Washington is often characterized as comprised of two distinct parts, divided by the Cascade mountain range to form a western and eastern side. The western side is generally wetter, more urban, and politically more liberal; the eastern side is drier, more rural, and politically more conservative. In terms of needs, Washington is a very complex state, with its children and families affected by a variety of factors, including but not limited to location and population density. Some of these other factors will be examined in the following assessment of needs.

Figure 1.1: Washington State's 39 Counties



For the purpose of this project, six of the State's 39 counties were identified for special focus due to the presence of Kaiser Permanente (KP) services in these areas. These counties include King County, Kitsap County, Pierce County, Snohomish County, Spokane County, and Thurston County. As shown in Figure 1.1, five of these counties are located in and around the Puget Sound region, and include the Seattle-Tacoma-Bellevue metro area, as well as the city of Everett in Snohomish County. Spokane County, home to the city of Spokane, Washington's second largest city (est. 2017 population of 215,900) borders the state of Idaho on the far east side of Washington State. This needs assessment examines indicators at a state level, as well as by county, when appropriate and available.

TABLE 1.1: POPULATION BY COUNTY*

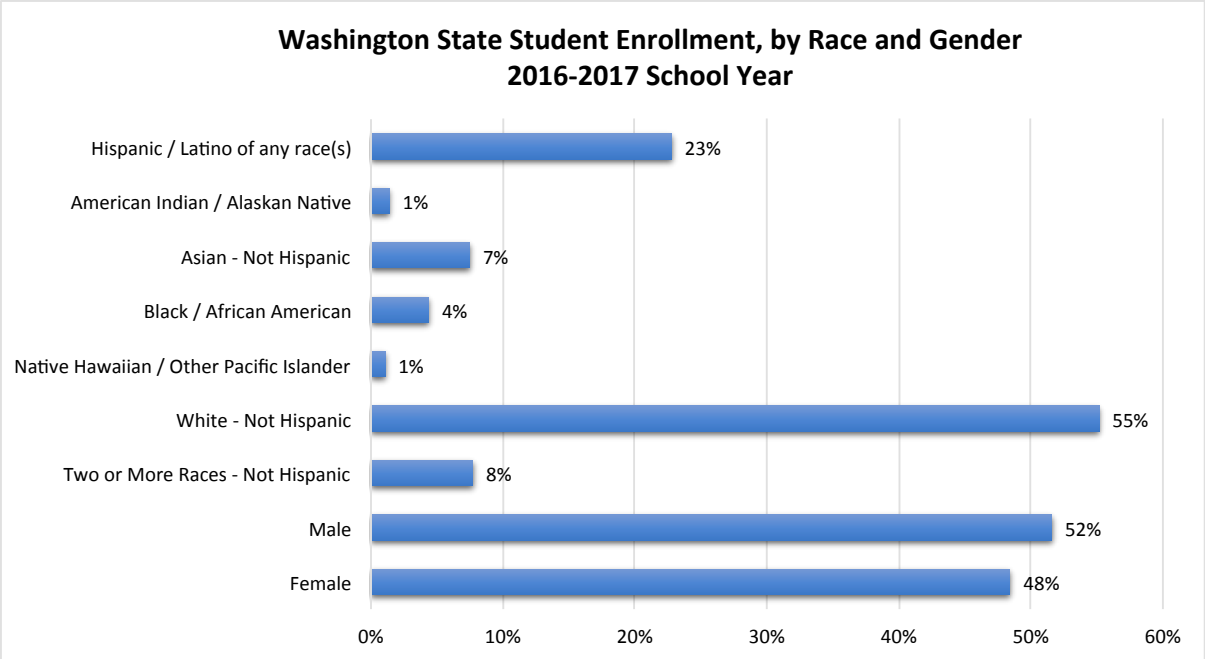
	2016 POPULATION	% OF TOTAL POPULATION		
		UNDER 5 YEARS	UNDER 18 YEARS	65 YEARS & OVER
KING COUNTY	2,149,970	6.0%	20.6%	12.7%
KITSAP COUNTY	264,811	5.9%	20.6%	17.0%
PIERCE COUNTY	861,312	6.8%	23.7%	13.4%
SNOHOMISH	787,620	6.3%	22.8%	12.8%
SPOKANE	499,072	6.1%	22.2%	15.6%
THURSTON	275,222	5.9%	21.7%	16.5%
WASHINGTON STATE	7,288,000	6.2%	22.4%	14.8%
US	323,127,513	6.2%	22.8%	13.0%

SOURCE: STATE AND COUNTY QUICK FACTS, US CENSUS BUREAU; *JULY 1, 2016 ESTIMATES

The distribution of residents by age in Washington State is similar to that of the country as a whole, with a slightly larger 65 and older population. County population distribution is also similar with a few exceptions; Pierce County is home to slightly more residents under the age of 18 compared to the other counties, and Kitsap and Thurston counties have a slightly larger population of residents 65 and older (Table 1.1). Nearly all Washington residents 25 years or older are high school graduates (90%), and one-third (33%) have a Bachelor's degree or higher, both above the national educational levels.

There are 295 school districts, representing 2,392 public schools statewide. According to the Office of Superintendent of Public Instruction (May, 2017), Washington State public schools enroll just over 1.1 million youth, with 9% of youth enrolled in Pre-K-Kindergarten, 38% in grades 1-5, 22% in grades 6-8, and 31% in grades 9-12. Most enrolled youth are White (55%) and male (52%). Approximately 63,500 classroom teachers are employed across the state to teach these youth, with two-thirds of them holding at least a Master's degree. The average years of teacher experience in Washington State is 13 years.

Figure 1.2: Washington State Student Enrollment



SOURCE: OFFICE OF SUPERINTENDENT OF PUBLIC INSTRUCTION 2016

In general, student demographics are slightly more diverse than the State population as a whole, however there is regional variation among school districts in the targeted KP regions. For example, in Seattle Public Schools – located in King County with 99 school buildings – students of color make up a majority of the student population (53%) and one-quarter of youth are from non-English speaking backgrounds. Thirty-four percent (34%) of these youths are eligible for Free or Reduced-Priced Meals (a poverty indicator). Further south, in the Franklin-Pierce School District, just over one-third of enrolled youth are White with approximately one-quarter of Hispanic/Latino descent, and 72% eligible for Free or Reduced-Priced Meals. In the

North Thurston School District, located just to the West, in Thurston County, nearly one-in-five (19%) youth are from military families and 41% qualify for Free or Reduced-Priced Meals. On the East side of the Cascades in the Spokane School District (located in Spokane County), the student population is predominantly white (67%) with 57% of youth eligible for Free or Reduced-Priced Meals.[3]

ECONOMIC WELLBEING & CHILDHOOD POVERTY

Why This Is Important

A broad range of social, economic, and other environmental factors affect the health of individuals and communities (American Psychological Association, n.d). These conditions can have a profound influence on the choices made that promote or inhibit both physical and behavioral health. Unemployment has been shown to lead to an increase in unhealthy behaviors associated with substance use and related behaviors, which in turn can lead to increased risk of other health disorders, such as suicide (Dooley, Fielding, Levi 1996).

TABLE 1.2: UNEMPLOYMENT RATE (DECEMBER) 5-YEAR TREND

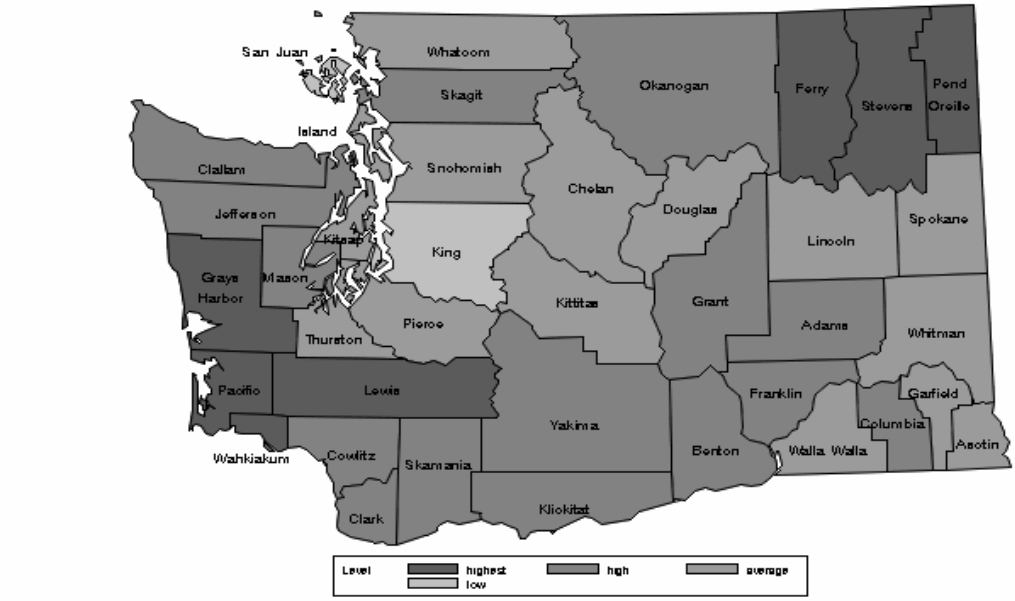
	2012	2013	2014	2015	2016
KING COUNTY	5.3%	4.6%	4.0%	4.2%	3.4%
KITSAP COUNTY	7.4%	6.4%	5.9%	5.5%	5.5%
PIERCE COUNTY	8.8%	7.5%	6.7%	6.3%	6.0%
SNOHOMISH	6.2%	5.3%	4.4%	4.7%	3.9%
SPOKANE	8.8%	7.7%	7.1%	6.7%	6.3%
THURSTON	7.9%	7.0%	6.2%	6.0%	5.5%
WASHINGTON STATE	7.6%	6.6%	5.9%	5.8%	5.3%
US	7.9%	6.7%	5.6%	5.0%	4.7%

SOURCE: US BUREAU OF LABOR STATISTICS 2016 (SEASONALLY ADJUSTED)

Washington State's unemployment rate in 2016 was slightly above the national average, with variability across counties of focus (Table 1.2). For example, the unemployment rate in King County was the lowest among these regions, at just 3.4% compared to a high of 6.3% in Spokane County. Figure 1.3 shows the level of risk among standardized five-year rates for unemployed persons. Level of risk was lower in King County as compared to the other five regions.

[3] Additional school level and district level demographic information is available at: http://reportcard.ospi.k12.wa.us/summary.aspx?groupLevel=District&schoolId=1&reportLevel=State&yrs=2016-17&year=2016-17

Figure 1.3: Level of Risk Among Standardized 5-year Rates for Unemployed Persons (Age 16+)[4]



SOURCE: RISK & PROTECTION PROFILE, WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES 2016

Table 1.3 shows income and poverty by county, as compared to the state and country as a whole. These data demonstrate the variability among counties in terms of income, with per capita income ranging from $26,093 in Spokane County in 2015 to $41,664 in King County. Similarly, the percentage of individuals living below the poverty level in these counties varied from a high of 15.5% in Spokane County to a low of 9.3% in Snohomish County. Statewide, over one-in-ten individuals lived below the poverty level in 2015, slightly below the US average.

TABLE 1.3: INCOME AND POVERTY BY COUNTY

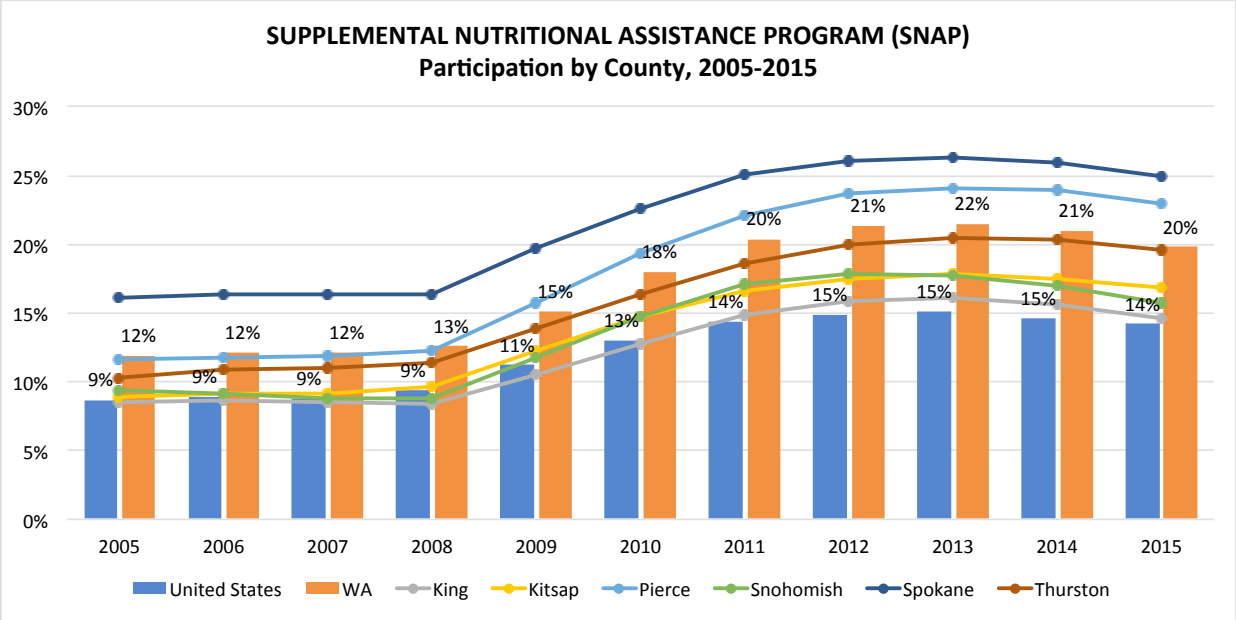
	PER CAPITA INCOME 2015	MEDIAN HOUSEHOLD INCOME 2015	PERSONS BELOW POVERTY LEVEL 2015
KING COUNTY	$41,664	$75,302	9.8%
KITSAP COUNTY	$32,063	$62,941	9.9%
PIERCE COUNTY	$28,824	$59,953	12.4%
SNOHOMISH COUNTY	$32,542	$70,722	9.3%
SPOKANE COUNTY	$26,093	$50,079	15.5%
THURSTON COUNTY	$29,741	$61,677	12.2%
WASHINGTON STATE	$31,762	$61,062	11.3%
US	$28,930	$53,889	12.7%

SOURCE: STATE AND COUNTY QUICK FACTS, US CENSUS BUREAU; *JULY 1, 2016 ESTIMATES

[4] The information provided in this, and future maps, illustrates the 5-year standardized indicator rate for all counties from highest to lowest risk. Indicators were grouped based upon standardized scores for risk level as follows: 1.5 and above (highest); .5 up to 1.5 (high); .5 to -.5 (average); -.5 down to -1.5 (low); -1.5 and lower (lowest); suppressed - no color. For additional details see: Washington State Department of Social and Health Services—Risk & Protection Profile, 2014. Available at https://www.dshs.wa.gov/sesa/research-and-data-analysis/county-and-state.

Research has shown that food insecurity is associated with a wide range of adolescent mental health disorders, even when controlling for other aspects of socioeconomic status. For example, one study found that food insecurity was associated with increased risk of past-year mood, anxiety, behavior, and substance disorders in adolescents (McLaughlin, et. al, 2012).

Figure 1.4: Participation in the Supplemental Nutritional Assistance Program, by County



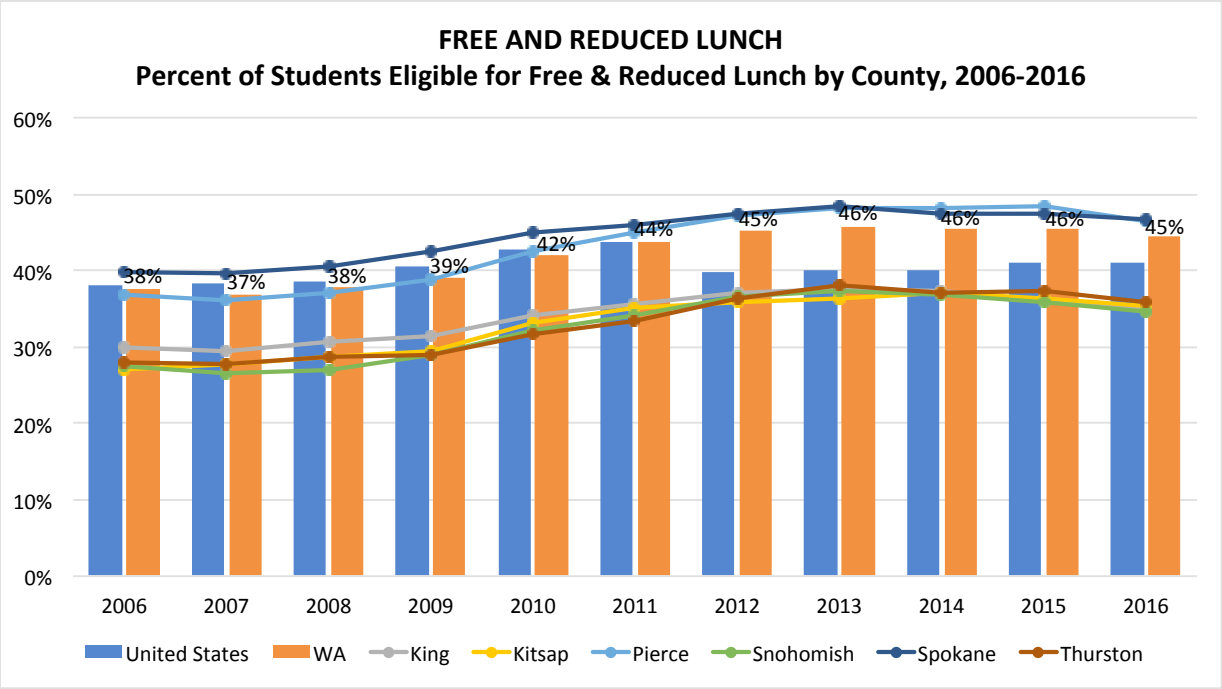
SOURCE: RISK & PROTECTION PROFILE, WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES 2016

Figure 1.4 shows the 10-year trend of participation in the Supplemental Nutritional Assistance Program (SNAP),[5] also known as food stamps. SNAP data indicate a steady increase in participation overall, with a slight decline since 2014. The State rate is consistently above the national average. At the county-level, rates for both Pierce and Spokane counties were above the State average.

Other research has found that children from chronically food insecure homes were approximately one-and-a-half times more likely to have internalizing problems and two times more likely to have externalizing problems, when compared to children in food secure homes (Slopen, et.al, 2010). Additionally, in *The Social Determinants of Health* (2015), the authors, Compton and Shim, observed "the effects of food insecurity on the mental health of children are even more profound than its effects on adults."

[5] For a family to be eligible for SNAP benefits, gross monthly income must be at or below 130% of the FPL, and net income 100% of FPL.

Figure 1.5: Percent of Students Eligible[6] for Free and Reduced-Price Meals, by County



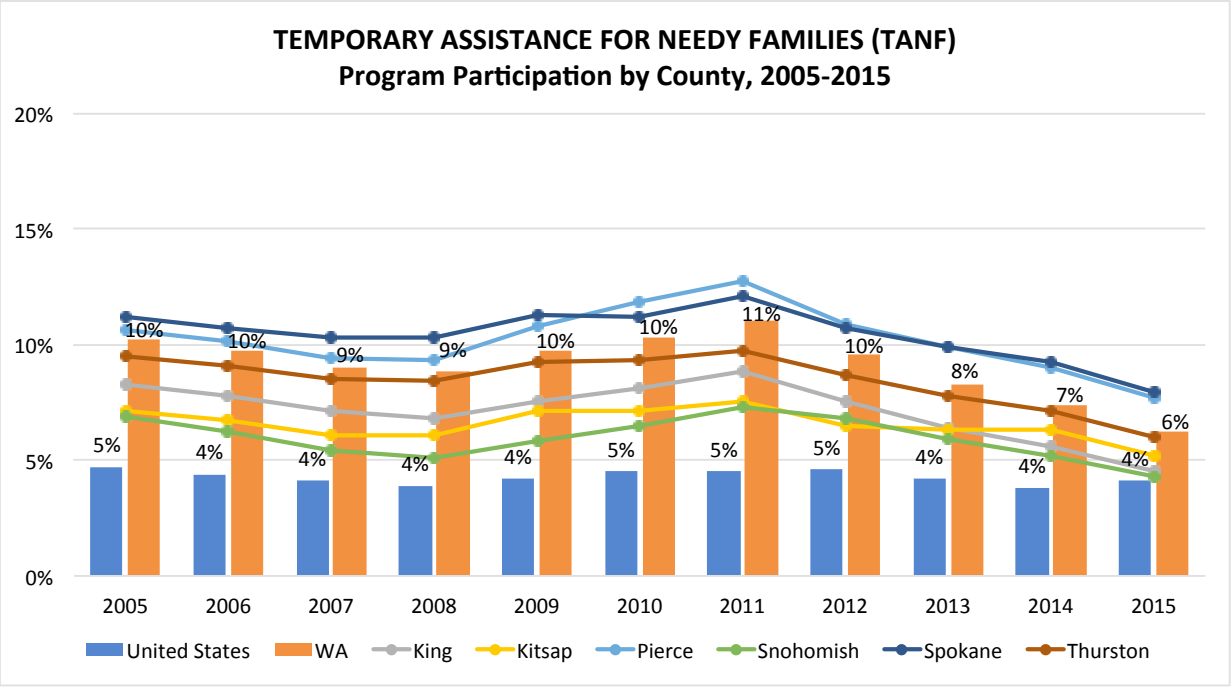
SOURCE: RISK & PROTECTION PROFILE, WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES 2016

Figure 1.5 shows the 10-year trend for Free and Reduced Priced school meals. These data indicate that eligibility across the state increased slowly between 2007-2012 and have remained fairly stable, at just under 50%. Data also showed that King, Kitsap, Snohomish, and Thurston counties experienced similar patterns of increase and stability, with rates below both the state and national averages. In contrast, eligibility rates in Pierce and Spokane counties have consistently been above state and national averages.

Data in Figure 1.6 (following page) shows the past 10-year trend of participation in the Temporary Assistance for Needy Families Program (TANF), informally referred to as welfare. Families eligible for TANF must have assets of $1,000 or less to receive this short-term Federal assistance. These data indicate that between 2005-2013, state participation rates were approximately twice those of national levels, with this gap lessening in recent years. At the county level, data showed similar trends. In King, Kitsap, and Snohomish counties, participation rates have trended below the state average, while participation rates in Pierce and Spokane counties have been consistently above the state average.

[6] Families are eligible for free and reduced priced school meals when family income is at or below 130% (free) and 185% (reduced) of the FPL.

Figure 1.6: Participation in the Temporary Assistance for Needy Families Program, by County

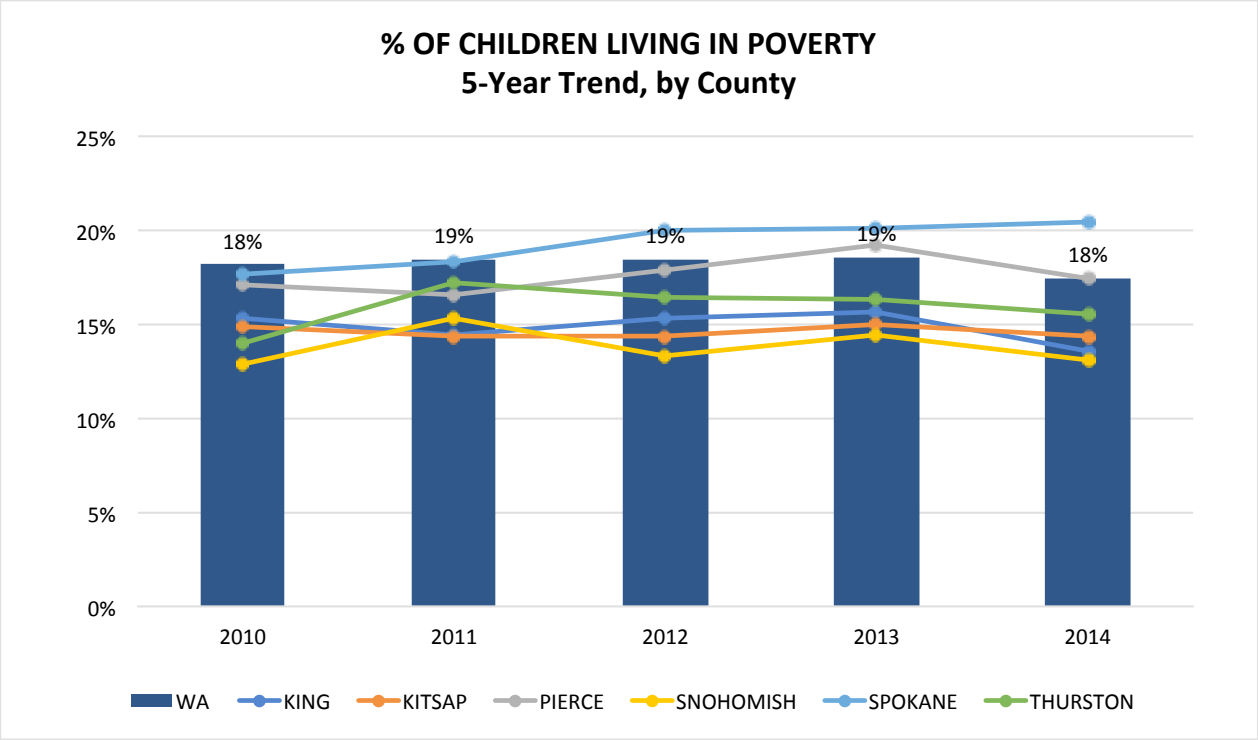


SOURCE: RISK & PROTECTION PROFILE, WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES 2016

Poverty makes it hard for families to provide the safe and stable environment necessary for healthy development, and parental stress affects children's emotional, physical, and academic options and progress. Poverty can result in an increased risk of mortality, depression, domestic violence, and poor health behaviors (Krieger, Williams, & Moss 1997). For example, children in poverty are more likely to have low reading scores, and are less likely to graduate (National Center for Children in Poverty (n.d.). Homelessness, a concomitant of poverty, is similarly associated with more academic problems as well as increased mental health and psychosocial problems (Bassuk, DeCandia, Beanch, & Berman, 2014).

Figure 1.7 shows the percentage of children living in poverty by county, as compared to the state. These data demonstrate that approximately one-in-five youth in Washington were living in poverty between 2010-2014. Youth living in Spokane County experienced rates of poverty at or above the state average during this time period. Averages in the counties of King, Kitsap, Snohomish and Thurston remained below the state average during the same timeframe, consistent with other hardship indicators.

Figure 1.7: Percent of Children Living in Poverty[7], By County



SOURCE: KIDS COUNT DATA CENTER, WASHINGTON STATE

Additionally, according to the National Center for Children in Poverty, in 2015, 39% of juveniles in Washington State were living in low-income[8] families, slightly below the national average of 43% (Table 1.4). A slightly larger percentage of youth ages 0-5 were reported as living in low-income families than older youth.

TABLE 1.4: CHILDREN IN LOW INCOME FAMILIES (2015)

	CHILDREN AGED 0-17 YEARS	CHILDREN AGED 0-5 YEARS
WASHINGTON	39%	42%
US	43%	45%

SOURCE: STATE PROFILES, NATIONAL CENTER FOR CHILDREN IN POVERTY 2015

Further, data in Table 1.5 demonstrate substantial disproportionality among youth of color. For example, nearly one-in-three Asian and White youth were living in low-income families in 2015, compared to nearly two-thirds of Hispanic youth. Black/African American youth and American

[7] NOTE: The number and percent of children under age 18 who live in families with income below the poverty threshold (100% Federal Poverty Guideline) as defined by the U.S. Office of Management and Budget. In 2014, the poverty threshold for a family of two adults and two children was $24,008 (in 2016 is was $24,300).

[8] NOTE: Children living in families with incomes below $48,071 for a family of four with two children in 2015 are referred to as *low income.*

Indian youth were also much more likely to be living in low-income households, with 58% and 53% living in these circumstances, respectively.

TABLE 1.5: CHILDREN IN LOW INCOME FAMILIES BY RACE - AGED 0-17 (2015)

	WASHINGTON STATE	UNITED STATES
AMERICAN INDIAN	53%	61%
ASIAN	30%	29%
BLACK	58%	63%
HISPANIC	65%	61%
WHITE	29%	30%

SOURCE: STATE PROFILES, NATIONAL CENTER FOR CHILDREN IN POVERTY 2015

In the school setting, only one-third of adolescents with mental health diagnoses receive treatment. This problem is intensified for youth living in poverty, with one study finding that more than 90% of low-income adolescents were untreated (Behrens et al., 2013; California Health Interview Survey, 2005). Moreover, schools in high poverty areas tend to experience higher levels of teacher burnout, turnover, and general changes in school leadership – all of which negatively impact the school climate (Beteille et al., 2011; Greenberg et al., 2016).

ACADEMIC INDICATORS & SCHOOL CLIMATE

Why This Is Important

Graduating from high school is a critical step towards a successful adulthood. Youth who do not complete high school are more likely to have difficulties with employment and are less likely to obtain high wage jobs as adults. These deficits contribute to a greater likelihood of other social and personal problems including mental, emotional, and behavioral disorders (Annie E. Casey Foundation, 2014). Graduating also relates to attendance; students who are truant are less likely to stay up with their classes and, thus, less likely to graduate. Further, research showed that academically at-risk students are more likely to engage in health-risk behaviors than their classmates with better grades, including substance use, violence-related behaviors, and risky sexual behaviors (United Way Worldwide, 2011).

Figure 1.8 demonstrates the level of risk for poor academic performance among 4th grade students, by county. These data indicated that among the KP regions, five of the six counties had average risk, while King County was at low risk.

Figure 1.8: Level of Risk for Poor Academic Performance[9], Grade 4

SOURCE: RISK & PROTECTION PROFILE, WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES 2016

In contrast, Figure 1.9 indicates that by 10th grade, level of risk for poor academic performance increased in Pierce County, but remained unchanged for the other five areas.

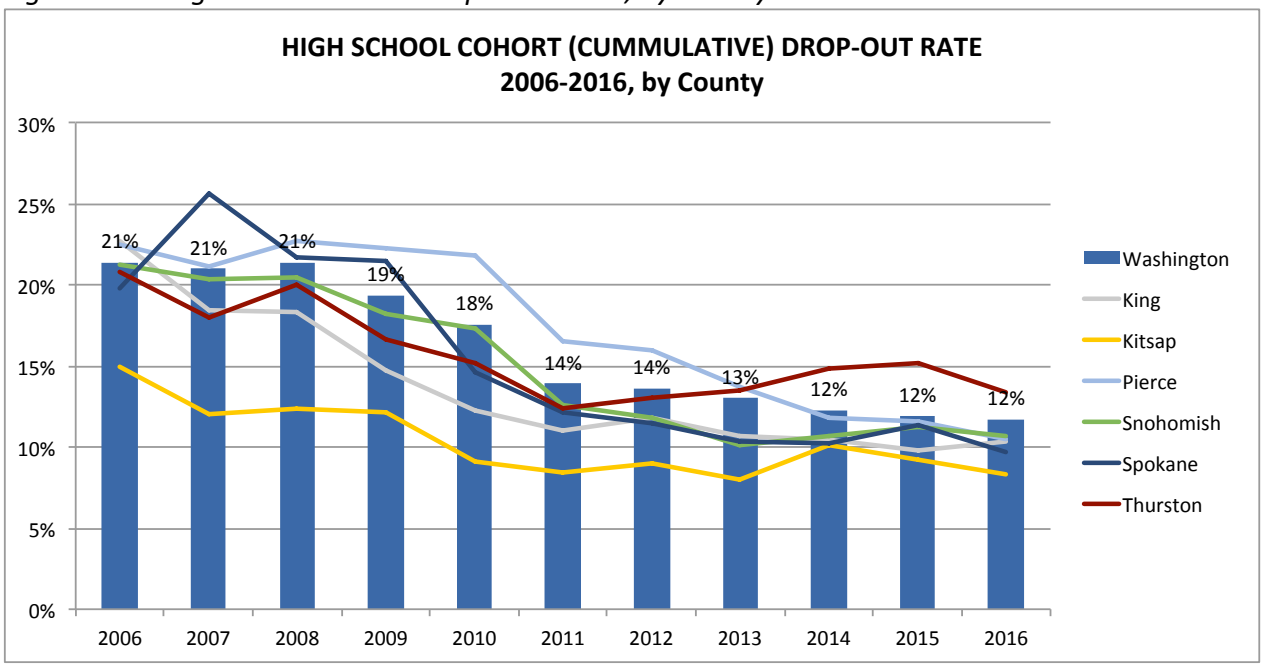
Figure 1.9: Level of Risk for Poor Academic Performance[10], Grade 10

SOURCE: RISK & PROTECTION PROFILE, WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES 2016

[9] Note: Students tested who failed one or more content areas as a percent of all students tested at the 4th grade level. Tests are given in the spring of the year. Data for 2012 is for students in the 4th grade during the school year 2011/2012.
[10] Note: Students tested who failed one or more content areas as a percent of all students tested at the 10th grade level. Some districts have chosen to test students in both grades 9 and 10 for the 10th grade assessment. All students being tested at the 10th grade level are included in these data regardless of their grade placement.

Figure 1.10 shows the 10-year trend of student dropout rates by county, compared to the state. At the state level, these data display a downward trend beginning in 2008, with the rate leveling off to a low of 12% by 2014. These data also indicated that the dropout rate between 2006 and 2016 declined from one-in-five youth to approximately one-in-ten youth statewide. At the county level, high school dropout rates in Kitsap County have been considerably lower than the state average, with rates in Spokane, Thurston, and Pierce counties increasing above the state norm at several points throughout this 10-year period.

Figure 1.10: High School Cohort Drop Out Rate[11], by County

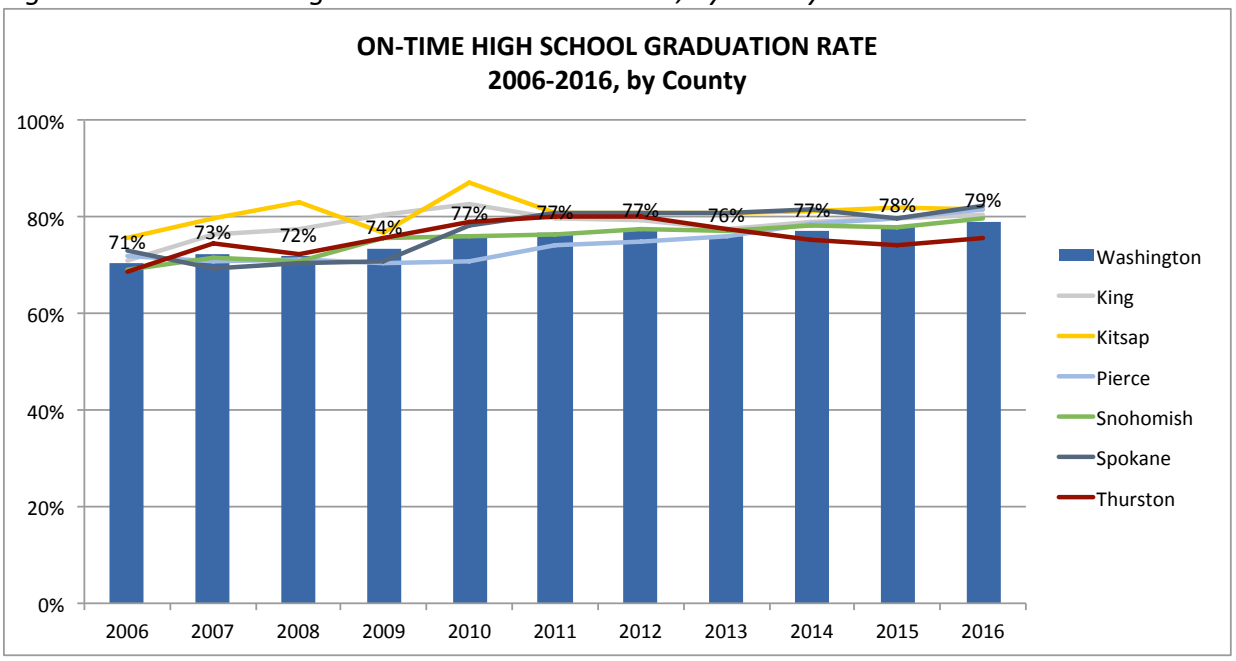


SOURCE: RISK & PROTECTION PROFILE, WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES 2016

Data in Figure 1.11 shows on-time high school graduation rates between 2006 and 2016, by county as compared to the state. These data showed positive progress towards on-time four-year graduation rates for youth across the state, and within each county.

[11] Note: Defined as the percentage of students entering the 9th grade for the first-time and who are reported as dropouts within the 4-year timeframe.

Figure 1.11: On-Time High School Graduation Rate[12], by County



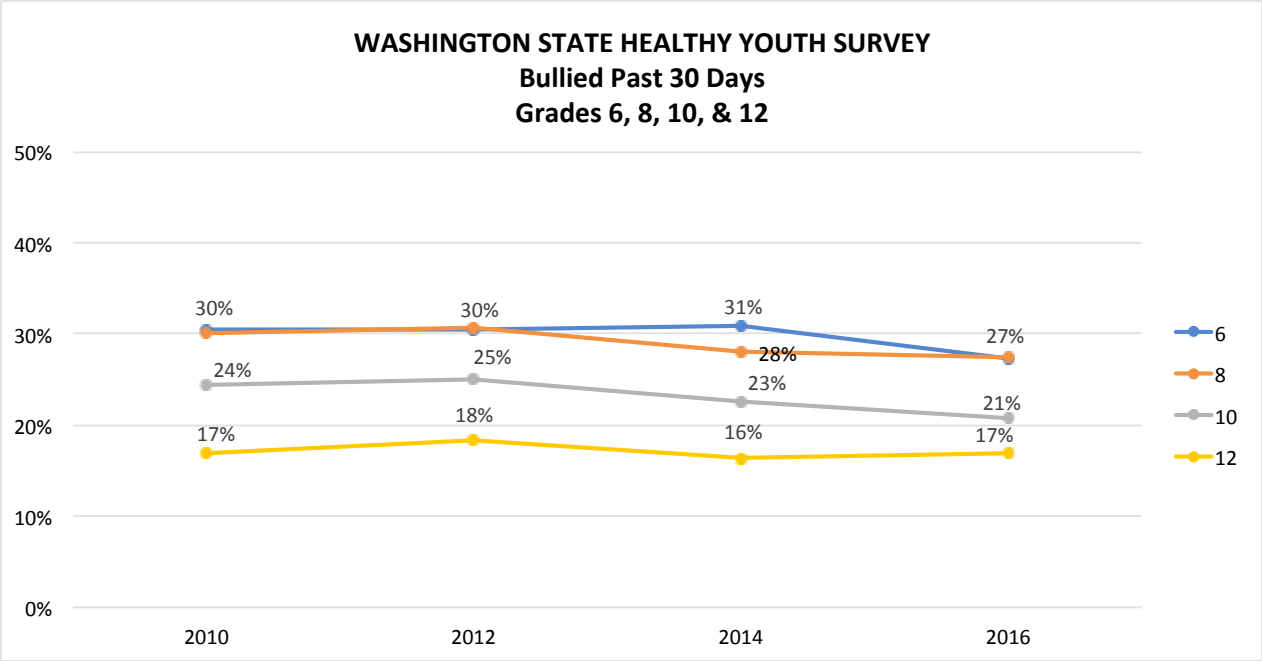
SOURCE: RISK & PROTECTION PROFILE, WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES 2016

Safe classrooms and hallways promote a culture of learning and help establish an environment for successful progress and development. A school culture that clearly defines and reinforces behavioral expectations makes it more likely that students will reach their academic goals and become responsible citizens. Research has shown that being a target or victim of bullying has immediate and long-term psychological and social effects, influencing a young person's academic achievement and psychosocial adjustment into adulthood (Espelage & DeLaRue 2012). One of the most effective ways to address bullying in the school setting is to improve the school's climate and culture (Fein et al., 2004). In fact, the climate and culture of the school set the general tone for learning and teaching, and are critical factors in school success.

Data in Figure 1.12 show statewide Health Youth Survey (HYS) results for the percentage of youth that reported being bullied during the previous 30 days. Generally, these results indicated higher levels of bullying among 6th and 8th grade youth as compared to older youth. Over the four survey periods, reports of bullying among 12th grade students have remained fairly stable with less than one-in-five reporting being a victim of bullying in 2016. Bullying rates among 10th grade youth have declined, with 21% reporting being bullied in 2016. Similarly, rates of bullying declined slightly among 6th and 8th grade students. However, in 2016, over one-in-four 6th and 8th grade youth (27%) reported being bullied during the previous 30-days. Rates of bullying by KP county can be found in Appendix A.

[12] Note: Defined as the percentage of students who graduate in within the 4-year timeframe by completing graduation requirements.

Figure 1.12: Washington State Healthy Youth Survey, Bullied Past 30-Days



WASHINGTON STATE HEALTHY YOUTH SURVEY 2010-2016

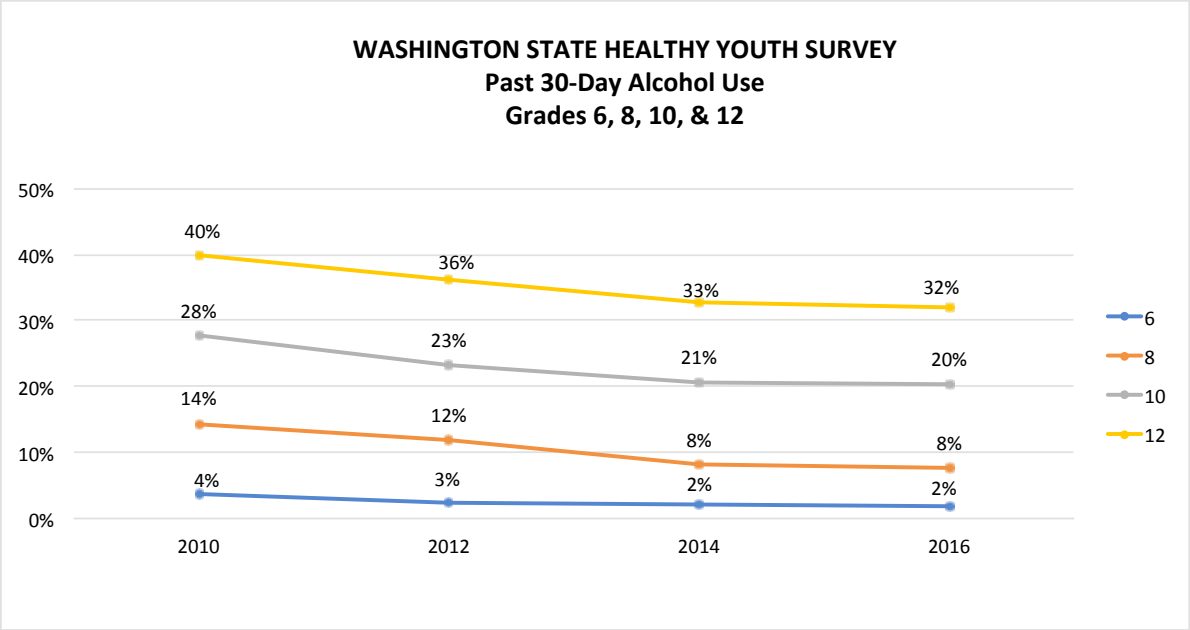
ADOLESCENT SUBSTANCE USE

Why This Is Important

The research related to substance use by adolescent youth is clear. Findings indicate that substance use can impact an individual's physical, cognitive, and neurological development, leading to lifelong health and wellness issues. Furthermore, substance use is linked to a wide range of academic, social, and mental consequences, including poor academic progress, dropping out of school, increased risky behaviors, teen pregnancy, juvenile delinquency and crime (Hawkins et al. 1992). For example, Mandell and colleagues (2002) found that moderate substance use among middle and high school students substantially lowered overall academic achievement (standardized test scores) – a full level – as compared to groups of students with minimal or no engagement in substance use.

Statewide results from the HYS over the past four administrations (2010, 2012, 2014, and 2016) indicated that past 30-day alcohol use across all grade levels was declining (Figure 1.13). The most recent results showed that approximately one-third of 12th grade students, one-fifth of 10th grade students, and less than one-tenth of 8th grade students reported drinking in the previous 30 days.

Figure 1.13: Washington State Healthy Youth Survey – Past 30-day Alcohol Use

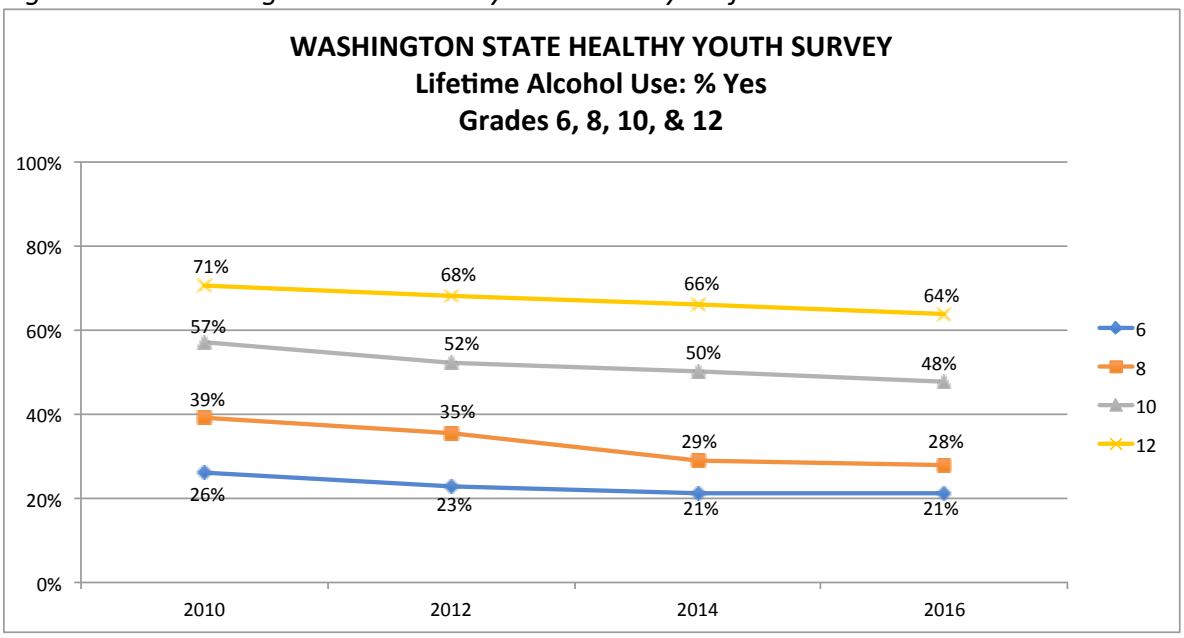


WASHINGTON STATE HEALTHY YOUTH SURVEY 2010-2016

County-level HYS results indicate similar downward trends in past 30-day youth alcohol use in Kitsap, Snohomish, Spokane, and Thurston counties. Pierce County data showed variability in youth use rates with an increase in 2012, but then declining in subsequent survey periods. King County data showed a slight rise in use among 12th grade youth in 2016, with downward trends observed among the lower grade levels (See Appendix B for results by county).

Data on lifetime alcohol use also demonstrated a downward trend across grade levels from 2010-2016 (Figure 1.14).

Figure 1.14: Washington State Healthy Youth Survey – Lifetime Alcohol Use

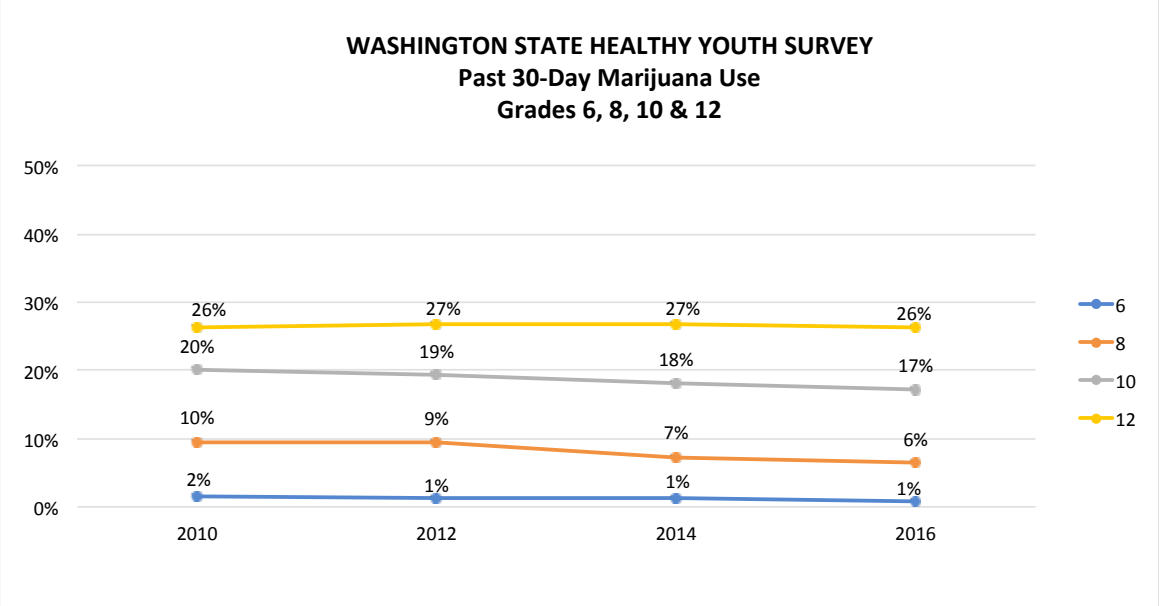


WASHINGTON STATE HEALTHY YOUTH SURVEY 2010-2016

However, these data also showed that by 6th grade, one-in-five youth admitted to at least trying alcohol, and by 12th grade this rate increased to nearly two-thirds. The largest increase in lifetime use occurred between 8th and 10th grades – typically the transition from middle school or junior high, to high school. Trends were similar by county (See Appendix C).

Data in Figure 1.15 shows past 30-day marijuana use among students over the same time period. These data indicated that use rates have remained relatively steady across grade levels. In 2016, over one-in-four 12th graders and nearly one-in-five 10th graders reported recent marijuana use.

Figure 1.15: Washington State Healthy Youth Survey – Past 30-day Marijuana Use

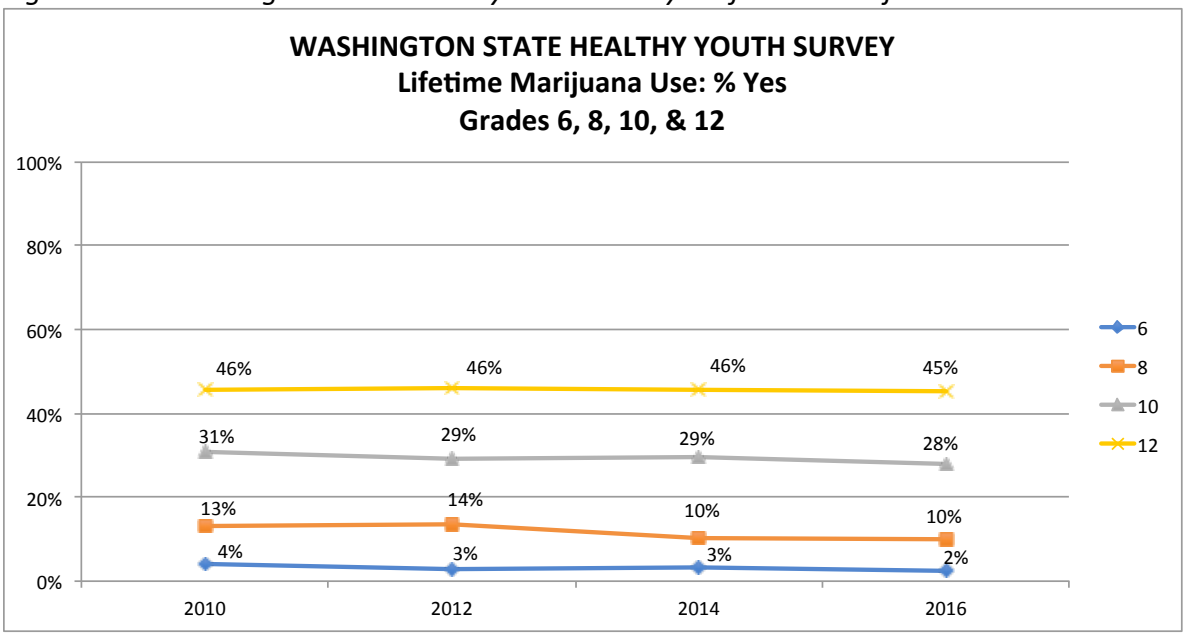


WASHINGTON STATE HEALTHY YOUTH SURVEY 2010-2016

County-level results indicated a similar trend in reported marijuana use among youth in King, Snohomish, and Spokane counties. Use rates in Kitsap, Pierce, and Thurston counties were stable between 2010 and 2014, with an increase in use among 12th graders and a decrease in 10th grade use reported in 2016 (See Appendix D for results by county).

Lifetime marijuana use has also remained fairly stable (figure 1.16). In 2016, less than half of youth had used marijuana by 12th grade with one-in-ten having used by 8th grade. At the county level, lifetime use was similar by grade level (See Appendix E).

Figure 1.16: Washington State Healthy Youth Survey – Lifetime Marijuana Use

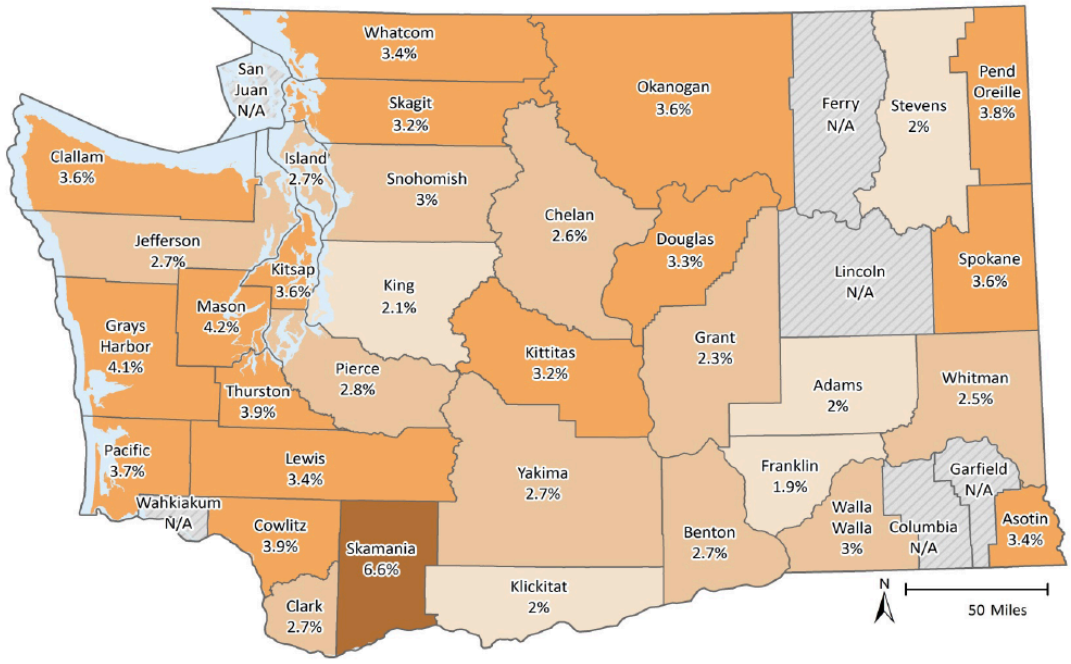


WASHINGTON STATE HEALTHY YOUTH SURVEY 2010-2016

It is also important to understand the intersection of substance abuse, substance use disorders, addiction, mental illness, and/or mental disorders in children and youth. According to SAMHSA's report, *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health*, an estimated 340,000 youth aged 12-17 (1.4 percent of adolescents) had a co-occurring substance use disorder and a major depressive episode (MDE) in the past year. Youths aged 12-17 in 2014 who had a past year MDE were twice as likely than those without a past year MDE to have used any illicit drugs in the past year (33% vs. 15%).

Figure 1.17 shows the co-occurring disorder treatment need rates among Medicaid children across the state, by county. These data show that statewide need rates ranged from a low of 1.9% to a high of 6.6% of Medicaid youth. Among the KP target regions, Thurston County had the highest rate, with 3.9% of Medicaid children having a co-occurring treatment need, followed by 3.6% in Kitsap and Spokane counties.

Figure 1.17: Co-Occurring Disorder Treatment Need Rates Among Medicaid-Children, by County



SOURCE: WASHINGTON STATE DSHS COMMUNITY OUTCOME & RISK EVALUATION, 2017

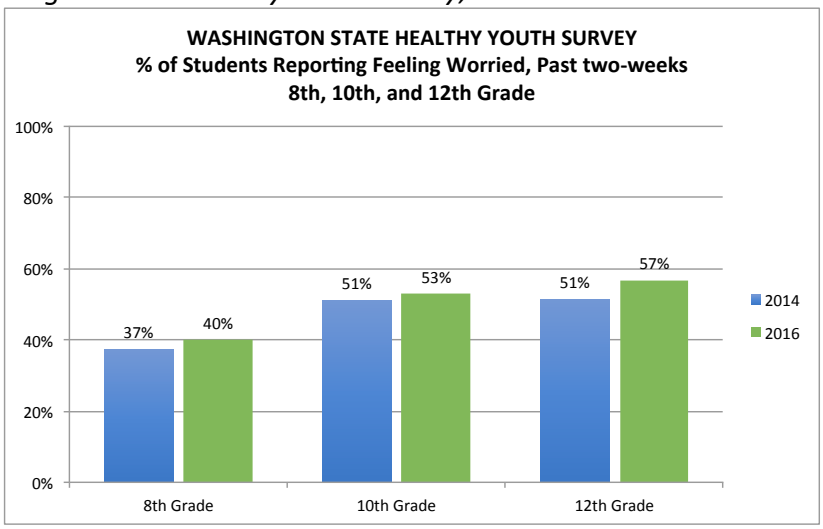
MENTAL HEALTH & WELLNESS

Why This Is Important

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. One in five children (ages 13-16) will experience, or have had, a significant mental health problem during their education years (National Alliance on Mental Health, 2015; U.S. Department of Health and Human Services, 1999). The most common mental disorders in school-aged youth include depression, anxiety, attention-deficit hyperactivity disorder (ADHD), 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 setting. In the school setting, students with mental health disorders experience higher rates of tardiness, absenteeism, suspension, expulsion, and dropout (Gall et al., 2000; Kataoka et al, 2002; Kataoka et al, 2009; California Community Schools Network, 2013). These students also tend to engage in disruptive classroom behavior, and are more likely to be involved in drug and alcohol use (Breslau et al, 2008). Unaddressed mental health issues can have a vast impact on a child's life, as 50% of youth with mental health symptoms drop out of school, and many are referred to juvenile justice systems (National Conference of State Legislatures, 2015).

In 2014, two mental health related questions were added to the HYS for 8th, 10th, and 12th grade youth: *"How often over the last 2 weeks, were you bothered by feeling nervous, anxious, or on edge?"* and, "*How often over the past 2 weeks were you bothered by not being able to stop or control worrying?"* Figure 1.18 shows the percentage of 8th, 10th, and 12th grade youth who expressed feeling worried in the previous two weeks. These data indicate that reports of worrying increased as youth aged, and across grade levels since 2014.

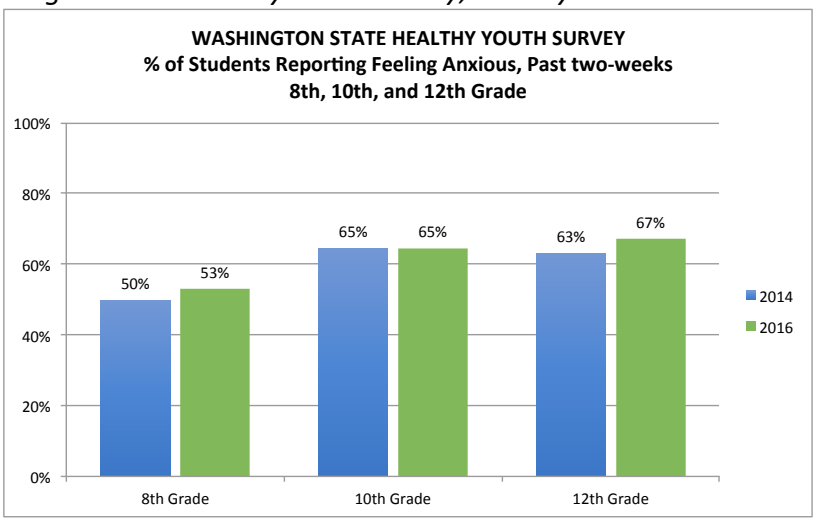
Figure 1.18: Healthy Youth Survey, Worried Past Two-Weeks



WASHINGTON STATE HEALTHY YOUTH SURVEY 2014, 2016

Data in Figure 1.19 shows a similar trend, with experiences of anxiety increasing, as youth aged. In 2016, two-thirds of both 10th and 12th grade youth reported feeling nervous, anxious or on edge across the state. At the county-level, data showed similar trends, with these feelings becoming more frequent and increasingly more common in as students aged. (See Appendix G for county-level results).

Figure 1.19: Healthy Youth Survey, Anxiety Past Two-Weeks

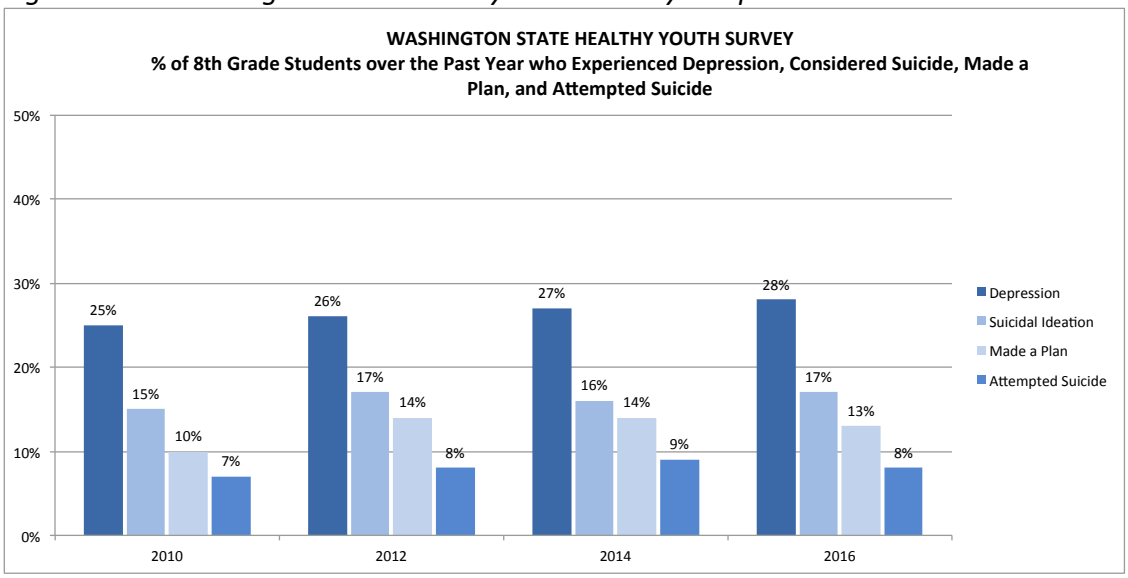


WASHINGTON STATE HEALTHY YOUTH SURVEY 2014, 2016

The HYS also asks youth about the frequency of feelings of depression and suicide ideation. Figures 1.20-1.22 show statewide responses to the following four questions, by grade level: *"During the past 12 months, did you ever feel so sad or hopeless almost everyday for two or more weeks in a row that you stopped doing some usual activities?"*, *"During the past 12 months did you ever seriously consider attempting suicide?", "During the past 12 months did you make a plan about how you would attempt suicide?",* and, *"During the past 12 months, how many times did you actually attempt suicide (any)?"*

Figure 1.20 shows that rates of depression among 8th grade youth have remained fairly stable since 2010, with just over one-in-four youth experiencing depressive feelings. In 2016, this equated to over 42,000 8th grade youth reporting symptoms of depression in the past year. Reports of suicide ideation, making a plan, and actual attempts have also remained stable. These data indicated that in 2016, nearly one-in-five (17%) 8th grade youth seriously considered suicide, 13% made a plan, and 8% - or nearly 6,400 youth – reported attempting suicide. [13] (Results by county can be found in Appendix H).

Figure 1.20: Washington State Healthy Youth Survey - Depression & Suicide – 8th Grade



WASHINGTON STATE HEALTHY YOUTH SURVEY 2010-2016

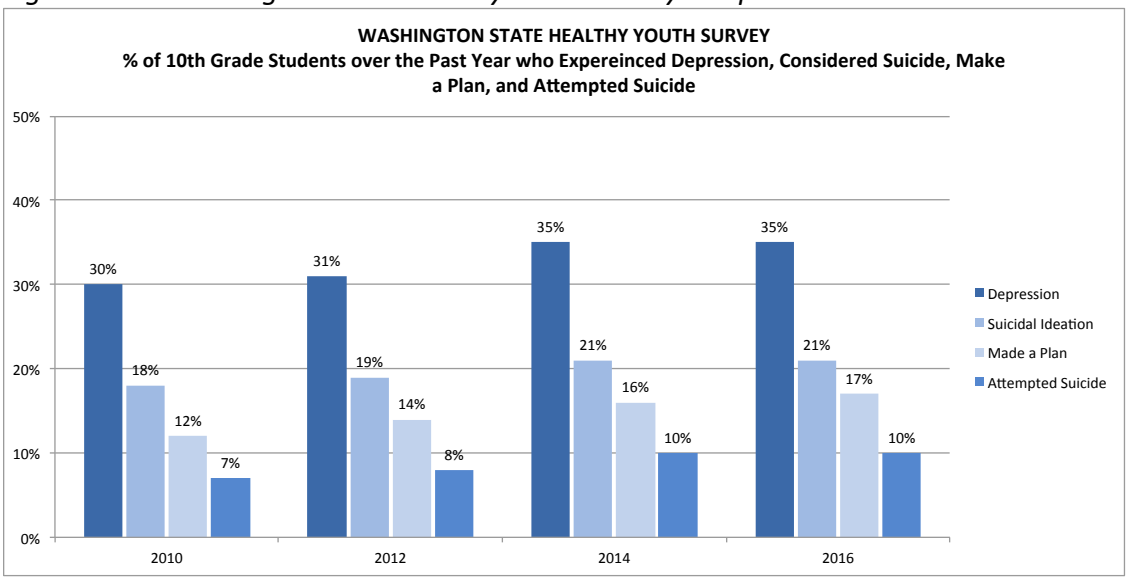
Figure 1.21 demonstrates that among 10th graders levels of depression have increased since 2010, with 35% reporting depressive feelings in the past year. Reported rates of suicide ideation, plan making, and actual attempts have also increased slightly across survey periods, with one-in-five (21%) youth considering suicide and one-in-ten (10%) attempting suicide in 2016. According to these data, over 17,000 10th grade youth considered suicide and an estimated 8,300 reported attempting suicide in 2016.[14] Findings indicated that Kitsap, Pierce,

[13] Extrapolations figures are based on the statewide enrollment for 8th grade students in 2016, and assume a representative sample of students responded.

[14] Extrapolation figures are based on the statewide enrollment for 10th grade students in 2016, and assume a representative sample of students responded.

Snohomish, and Thurston county attempt rates were slightly above the state average in 2016.

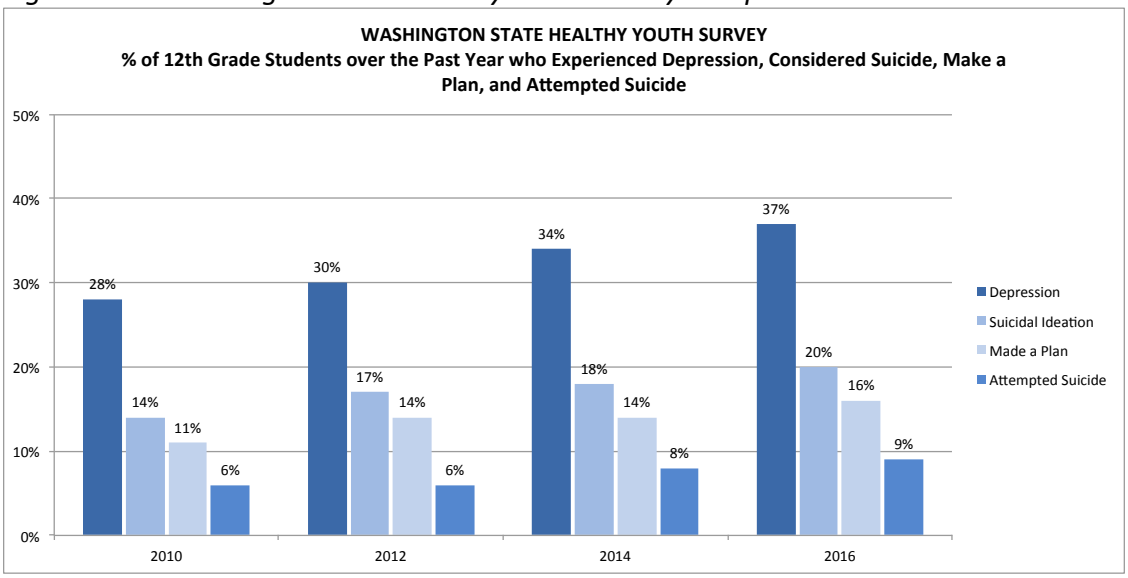
Figure 1.21: Washington State Healthy Youth Survey - Depression & Suicide – 10th Grade



WASHINGTON STATE HEALTHY YOUTH SURVEY 2010-2016

Figure 1.22 shows responses among 12th grade students. Similar to the trend among 10th grade youth, levels of depression, suicide ideation, plan making, and actual attempts of suicide were on the rise among this group of youth.

Figure 1.22: Washington State Healthy Youth Survey – Depression & Suicide – 12th Grade



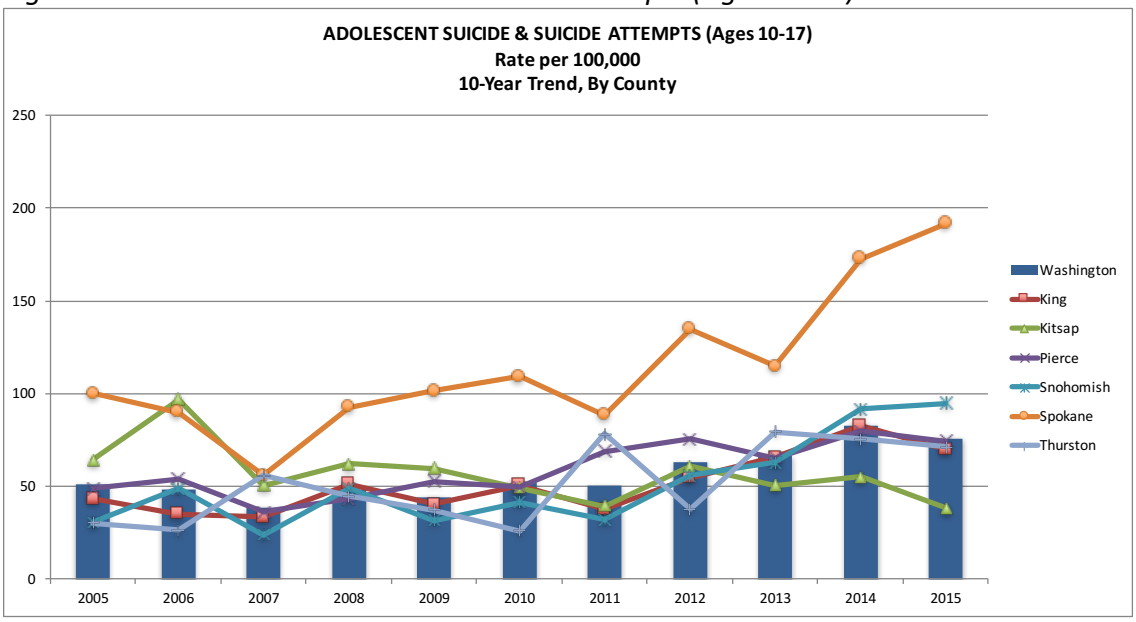
WASHINGTON STATE HEALTHY YOUTH SURVEY 2010-2016

Reports of depression have risen to 37% in 2016, up from 28% in 2010 – a 32% increase. Similar to 10th grade youth, one-in-five 12th graders considered suicide in the previous 12 months in

2016, with 16% of them making a plan. Reported suicide attempts among 12th grade youth increased from 6% in 2010 to 9% in 2016.

Figure 1.23 shows the rate of adolescent suicide and suicide attempts among youth aged 10-17 across the state and by county from 2005-2015. Statewide, data indicated an upward trend in attempts and completed suicides across the 10-year period. Rates followed a similar trend in King, Pierce, and Snohomish counties. In contrast, rates in Kitsap County were well above the state average between 2005-2007, and declined in subsequent years. Rates in Thurston County, following a spike in 2011, returned to near state norms in subsequent years. Disconcertingly, Spokane County showed a high and persistent rate of adolescent suicide attempts and completions; well above the state average and on an upward trajectory.

Figure 1.23: Adolescent Suicide and Suicide Attempts (Ages 10-17)[15]

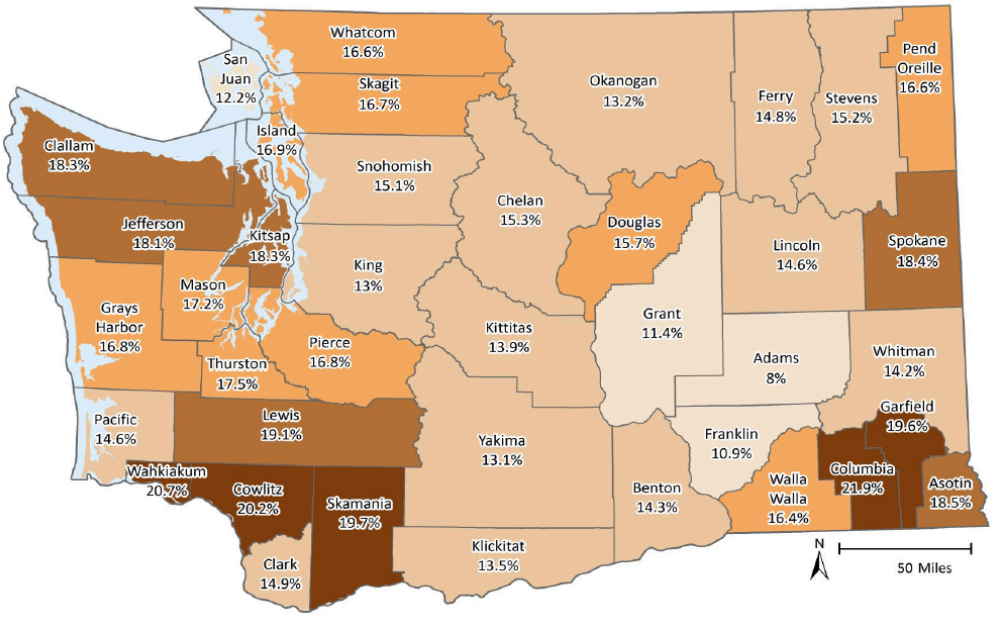


SOURCE: RISK & PROTECTION PROFILE, WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES 2016

Figure 1.24 (following page) shows the proportion of the child Medicaid population having at least one indicator of mental illness treatment needs in at least one month during the state fiscal year 2016.

[15] Note: The adolescents (age 10-17) who committed suicide or were admitted to the hospital for suicide attempts, per 100,000 adolescents (age 10-17). Suicides are based on death certificate information. Suicide attempts are based on hospital admissions, but do not include admissions to federal hospitals.

Figure 1.24: Mental Illness Treatment Need Rates Among Medicaid Children, by County



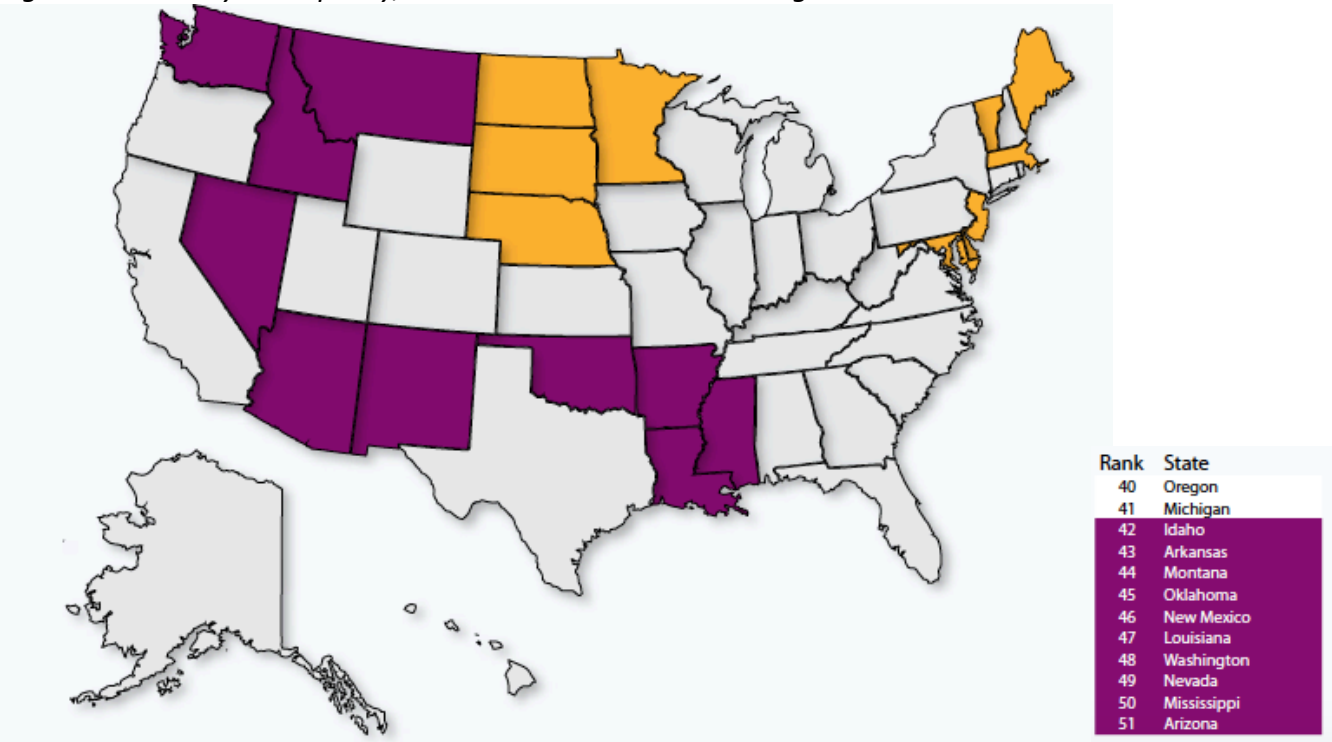
SOURCE: WASHINGTON STATE DSHS COMMUNITY OUTCOME & RISK EVALUATION, 2017

Statewide, mental illness treatment needs among Medicaid youth ranged from a low of 8% to a high of 26.9%. Among KP counties, need rates were highest among Medicaid youth in both Spokane and Kitsap counties, at 18.4% and 18.3%, respectively. Need rates were also on the higher end in Thurston and Pierce counties, with 17.5% of Medicaid children in need of mental illness treatment in Thurston County and 16.8% in Pierce County.

In addition, the *Washington State Children's Mental Health Workgroup Final Report* (2016) found that, on average, 17% of children with Health Care Authority coverage demonstrated a mental health or substance use treatment need (in SFY 2015). However, behavioral health needs varied by services used. For example, among children in the foster care system, the rate of youth demonstrating a mental health or substance use need increased to 55%, and to 87% of children in juvenile rehab services.

In a report by the national non-profit organization Mental Health America, *"Parity or Disparity: The State of Mental Health in America 2015,"* states were ranked on overall mental health system indicators, which included fifteen measures. These measures examined such things as; the number of youth with at least one major depressive episode, adults with any mental illness, the number of adults and youth in need with and without insurance, and mental health workforce availability. Shockingly, Washington State ranked 48th (out of 51), indicating a high prevalence of mental health needs and among the lowest rates of access to care (Figure 2.25).

Figure 1.25: Parity or Disparity, Overall Mental Health Ranking



SOURCE: MENTAL HEALTH AMERICA, PARITY OR DISPARITY: THE STATE OF MENTAL HEALTH IN AMERICA (2015)

This report also found that 46% of youth in Washington State who needed mental health services did not receive them, compared to 39% of youth nationwide. Further, the analysis found 21% of adults in Washington had a mental health illness and 4.2% had serious thoughts of suicide, both among the top highest rates nationwide.

ADVERSE CHILDHOOD EXPERIENCES & RESILIENCY

Why This Is Important

As more and more research is finding, adverse childhood experiences (ACEs) are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with co-occurring related problems (Felitti et al., 1998). ACEs are stressful or traumatic events, and include experiences such as abuse (physical, emotional, sexual), neglect, domestic violence, household substance use, household mental illness, parent separation or divorce, economic hardship, or an incarcerated household member. ACEs have been empirically linked to chronic health conditions, risky health behaviors, and early death (CDC, 2014). These traumatic experiences are not only common, but tend to occur together. The more ACEs an individual has, the more likely they are to experience health, behavioral, and social problems throughout their lifetime.

According to the Child Trend's (2014) report, *"Adverse Childhood Experiences: National and State Level Prevalence,"* in Washington State, just over one-third of youth (36%) have experienced one or two ACEs, with 11% experiencing 3 or more. Similar to national findings, economic hardship and divorce were the most commonly experienced ACEs in Washington State (Table 1.6).

TABLE 1.6: MOST COMMON ADVERSE CHILDHOOD EXPERIENCES

	Highest	2nd	3rd	4th
WASHINGTON STATE	Economic Hardship (25%)	Divorce (21%)	Alcohol (12%), Mental Illness (12%)	Violence (9%)
UNITED STATES	Economic Hardship (26%)	Divorce (20%)	Alcohol (11%)	Violence (9%), Mental Illness (9%)

CHILDHOOD TRENDS RESEARCH BRIEF, ADVERSE CHILDHOOD EXPERIENCES, 2014

In Washington, mental health treatment needs among youth (ages 12-17) reporting no ACES was 11%, increasing to 44% for youth reporting five or more ACEs. Data also indicated increased rates of emergency room use, criminal justice system involvement, and increased risk for homelessness for children with mental health service needs, consistent with other available national research (Children's Mental Health Workgroup Report, 2016).

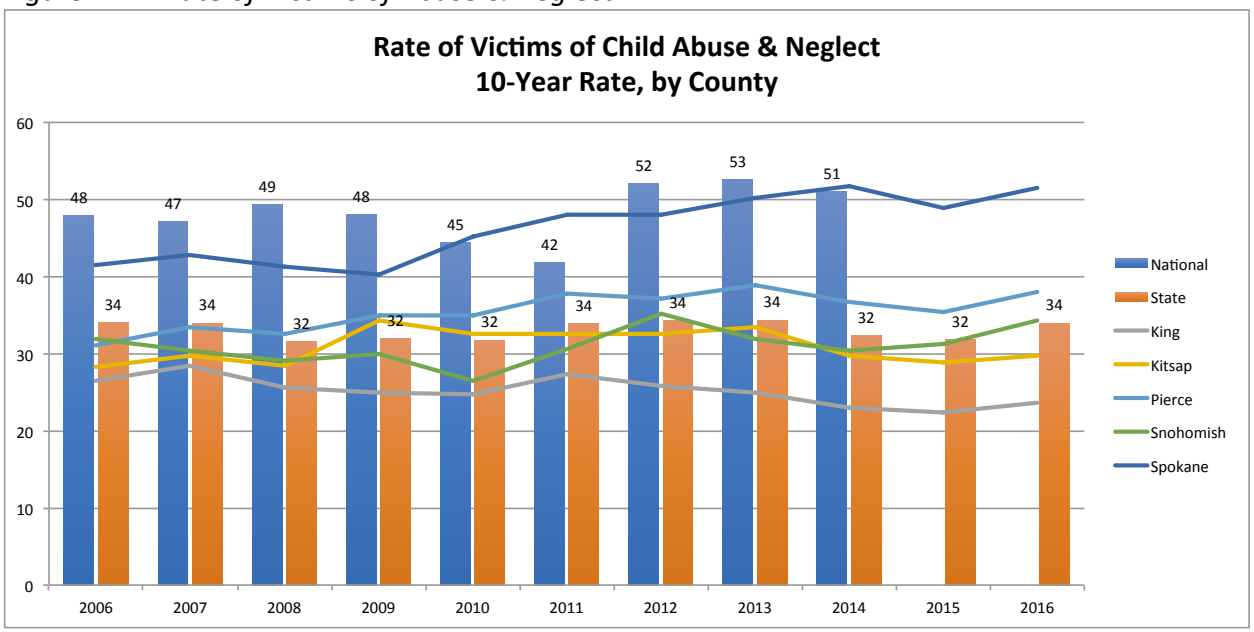
The map in Figure 1.26 shows the five-year standardized level of risk for divorce across the state. These data demonstrated that Thurston County had one of the highest risk rates statewide, with Spokane, Pierce, Snohomish, and Kitsap counties at average risk and King County at low risk.

Figure 1.26: Level of Risk Among Standardized 5-year Rates for Divorce

SOURCE: RISK & PROTECTION PROFILE, WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES 2016

In addition, data in Figure 1.27 shows the 10-year rate of child abuse and neglect (based on accepted CPS reports, per 1,000 youth) at the state, county, and national levels.

Figure 1.27: Rate of Victims of Abuse & Neglect[16]



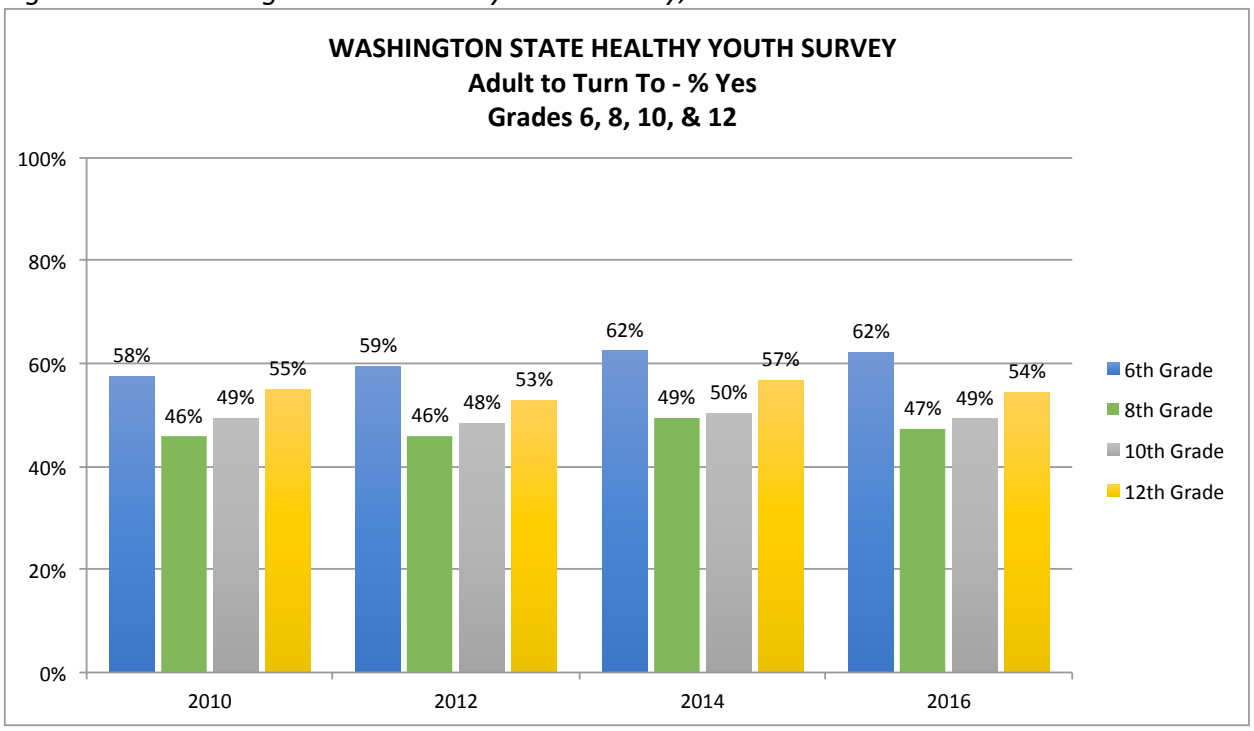
SOURCE: RISK & PROTECTION PROFILE, WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES 2016

Overall, Washington State had a rate that was consistently lower than the national average. Rates at the state and county levels remained fairly steady over the past 10 years, with Pierce County experiencing rates above the state average, and King County well below. In Spokane County, victimization rates were well above the state norm and reached national levels in 2010.

Children who have experienced these, and other ACEs, are at increased risk of disease (e.g., heart disease, cancer), incarceration, drug and alcohol abuse, and suicide (Anda et al., 2009; Brown et al., 2010; Center for Youth Wellness, 2015). However, resilience, the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress can counter these impacts. Resilience occurs when individual, social, and environmental factors interrupt the trajectory from trauma to maladjustment. Resilience is not a trait that people either have or do not have. Rather, it involves behaviors, thoughts, and actions that can be learned and developed in anyone. According to the American Psychological Association (2017), one way to build resilience in children and teenagers is to improve their ability to make connections, as connections (or relationships) with others increases social support and resilience.

[16] Note: The children (age birth-17) identified as victims in reports to Child Protective Services that were accepted for further action, per 1,000 children (age birth-17). A "referral" is a report of suspected child abuse, which may have multiple listed victims.

Figure 1.28: Washington State Healthy Youth Survey, Adult to Turn To



WASHINGTON STATE HEALTHY YOUTH SURVEY 2010-2016

The HYS also asked students, *"When you feel sad or hopeless, are there adults that you can turn to for help."* Overall, findings showed that, on average, over half of youth statewide reported having an adult to turn to when needed. Responses varied by grade level, with these feelings somewhat stronger among younger youth. For example, 62% of 6th graders answered in the affirmative in 2016, compared to 47% of 8th graders, 49% of 10th graders, and 54% of 12th graders. At the county level, survey results showed similar patterns (See Appendix I).

SUMMARY

Overall, these data indicate that Washington's youth and families face a number of challenges, ranging from the economic stability and wellbeing of their families, to academic success and a plethora of mental and behavioral health needs and challenges. The student population is slightly more diverse than the state population as a whole, however this varies widely by school district and geographical region. Data show increased ethnic diversity closer to urban cores and higher eligibility of Free and Reduced Priced Meals in rural and periphery regions. Data also indicate that, while Washington State overall trends slightly above the national norm on economic indicators such as income, unemployment was slightly above the national average and the State has higher rates of SNAP and TANF participation than the United States as a whole. In addition, economic need varies by county and population, with youth of color facing higher rates of economic hardship than their white counterparts.

The Healthy Youth Survey data provides insight into youth perceptions of school climate and reports of substance use and mental health issues. In 2016 this data indicated that 23% of middle and high school students reported being bullied in the past 30-days and 62% reported feeling anxious in the previous two weeks. Youth use of alcohol has trended downward over the past four survey periods (2010-2016), with lifetime use remaining stable. Marijuana use by youth, both lifetime and past 30-day, has remained stable over the same time period. However, these data indicate that depressive feelings among students are on the rise, with approximately one in three reporting feelings of depression in 2016. In addition, and even more alarming, the most recent data indicate that statewide, approximately 6,400 8th graders and 8,300 10th graders *attempted suicide* in the previous year. Despite the clear need for mental health intervention and supports for youth in our State, data indicate that just one in three adolescents with mental health diagnoses will receive treatment, with connection to services even less likely for our most vulnerable student populations.

From this landscape, we now turn to "what we know"; a review of the literature on school based mental health services and supports.

KNOWLEDGE: WHAT WE KNOW - A REVIEW OF THE LITERATURE

School-Based Mental Health Services and Supports

Abstract

Schools play a critical role in offering youth the mental health care they need. With one-in-five children impacted by a diagnosable mental health or learning disorder, it is crucial that schools, communities, and families work to identify and address students' needs (Behrens, 2013; California Health Interview Survey, 2005; Gall et al., 2000; Kataoka et al., 2002). Research has clearly demonstrated that there are links between students' mental health and academic success. The infusion of school based mental health (SBMH) services into regular school routines and practices allows students' learning and emotional needs to be addressed, while also reducing their barriers to treatment.

Several foundational best practices have been identified that improve the implementation of school-based mental health services, including family-school-community partnerships, mental health promotion and awareness, staff professional development, positive school climate, accountability systems, and data-based decision-making. These best practices work best within a multi-tiered system of support (MTSS), which enables successful prevention, early intervention, and monitoring of adolescents' mental health and wellness (Hess et al., 2017, p. 216). Trauma-sensitive practices can assist educators in recognizing students' triggers, coping mechanisms, and emotional needs. Students who have endured trauma can learn how to be resilient over time through making connections, helping others, practicing self-care, and moving toward goals, among other strategies. Effective SBMH services also include supports for school staff, who may have significant mental health and wellness needs of their own. When schools proactively address students' social, emotional, and behavioral health, positive educational outcomes are increased, school climate and safety are improved, mental health awareness is increased, and stigma is reduced.

Introduction

Before delving into school-based mental health, it is important to briefly discuss general adolescent development. It is known that adolescents experience rapid physical, cognitive, emotional, and social development during their teenage years, albeit at uneven rates (McNeely & Blanchard, 2009). During this time, youth tend to endure stress and anxiety about the physical changes they are experiencing. As a result, self-consciousness, fear, withdrawal, confusion, and a strong need to feel accepted are common (McNeely & Blanchard, 2009).

Meanwhile, cognitive development occurs in three main areas – advanced reasoning skills, abstract thinking skills, and meta-cognition. There are important links between an adolescent's brain development and their ability to consider consequences of actions, develop logical solutions, or filter thoughts before expressing them. Brain changes occur until the age of 21,

with many scientists arguing that maturation is not complete until age 25 (McNeely & Blanchard, 2009; Wallis, 2013).

McNeely & Blanchard (2009) also described four areas of emotional and social development, including self-awareness, self-management, social awareness, and the ability to get along with others. Self-awareness can be conceptualized as wondering, "what do I feel?" Self-management is the process of controlling one's emotions. Social awareness is the consideration of how others feel, while the peer relationship aspect deals with creating and maintaining friendships. Emotional development also involves developing a sense of identity, relating to others, and learning to manage emotions and cope with stress (American Psychological Association, 2002).

While it is understood that one's sense of identity continues to develop beyond adolescence, adolescence is the first time that individuals have the ability to consciously think about who they are and what makes them unique (American Psychological Association, 2002). Simultaneously, one's self-concept and self-esteem develop during this time. Self-concept includes the beliefs one has about their attributes, roles, goals, interests, values, and ideas. Self-esteem, on the other hand, involves the evaluation of how one feels about their self-concept. Self-esteem can remain stable throughout adolescence for some, while steadily improving or worsening for others (American Psychological Association, 2002). It is during this period of rapid development that many adolescents begin to experience symptoms of mental health disorders.

Prevalence of Childhood Mental Health Issues

Within this literature review, the term mental health is defined by using the terminology provided by the US Department of Health & Human Services, *"Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood"* (U.S. Department of Health and Human Services, n.d.).

In addition, the Substance Abuse and Mental Health Services Administration (2007) further indicates that the term "behavioral health" is an umbrella term that encompasses both mental health status and substance use and abuse. As such, it is important to also understand the intersection of substance abuse, addiction, substance use disorders, mental illness, and/or mental disorders in children and youth.

Mental health disorders are prevalent among school-aged children, with one-in-five children impacted by a diagnosable mental health or learning disorder.

Mental health disorders are prevalent among school-aged children, with one-in-five children impacted by a diagnosable mental health or learning disorder. Of all lifetime cases of mental health disorders, 50% begin before age 14, while 75% are developed by age 24 (National Alliance on Mental Illness, 2017; U.S. Department of Health and Human Services, 1999;

SAMHSA, 2007; Child Mind Institute, 2016). The most common mental health issues among youth are depression, anxiety, Attention Deficit/Hyperactivity Disorder, conduct disorders, and substance use disorders (Barrett et al., 2006; Centers for Disease Control and Prevention, May 2013). Moreover, mental health disorders, such as depression and anxiety, often precede suicide attempts. Indeed, mental health disorders are involved in 90% of suicides – the second leading cause of death in individuals aged 10-24 (National Conference of State Legislatures, 2015), and the leading cause of death for girls aged 15-19 worldwide (World Health Organization, 2014).

Among youth in Washington State, 36 percent of high school-aged students reported experiencing symptoms of depression on the 2016 Healthy Youth Survey (HYS), with 20 percent admitting to have seriously considered suicide during the previous 12 months. The 2016 HYS also found that less than half of high school students in Washington State had been informed of the warning signs of suicide, or how to get help. Over half (52%) of students indicated that they did not have an adult they could turn to when feeling sad or hopeless. These statistics reveal several opportunities for improvement in Washington State schools, with regard to student mental health and wellness.

The average delay between the onset of mental health symptoms and intervention is eight to ten years, with many youth never receiving services.

Astonishingly, the average delay between the onset of mental health symptoms and intervention is eight to ten years, with many youth never receiving services (Behrens, 2013; California Health Interview Survey, 2005; Gall et al., 2000; Kataoka et al., 2002). In fact, Behrens et al. (2013) found that only one-third of adolescents with mental health diagnoses received treatment. This problem was intensified for youth living in poverty, with one study finding that more than 90% of adolescents were left untreated (California Health Interview Survey, 2005). In other words, more than one in five youth experience mental health issues, but only one in three of those receive any treatment services (Foster et al., 2005).

Students with mental health disorders experience higher rates of tardiness, absenteeism, suspension, expulsion, and dropout.

Mental health issues and learning disorders have an immense impact on school success. Students with mental health disorders experience higher rates of tardiness, absenteeism, suspension, expulsion, and dropout (Gall et al., 2000; Kataoka et al, 2002; Kataoka et al, 2009; California Community Schools Network, 2013). These students also tend to receive lower grades and test scores, engage in disruptive classroom behavior, and are more likely to be involved in drug and alcohol use (Breslau et al, 2008). Furthermore, adolescents with mental health issues are frequently involved in bullying, either through perpetration or victimization (Kataoka et al., 2009). All of these issues create substantial barriers to successful instruction and academic achievement. Failure to intervene in a timely manner can have a vast impact on a child's life, as

50% of youth with mental health symptoms drop out of school, and many are referred to juvenile justice systems.[17]

Unmet mental health needs are a very pressing concern for educators, with student attendance, behavior, and readiness to learn being significantly affected. The best possible protections for our youth are interventions that reach all children, and prevent these types of disorders before they even develop. In addition, providing these interventions early and in accessible settings (such as schools) greatly reduces negative outcomes, and supports positive outcomes associated with a productive citizenry (Hawkins, 2009).

School-based Mental Health Services and Supports

A Brief History

There is currently an unprecedented focus on children's mental health services and supports in schools in Washington State and nationwide. The initial movement toward increasing access to mental health services has been similar to the general implementation of child mental health services that occurred in the late 1800s, when schools started offering counseling to children with behavior problems. During this time, advocates emphasized the importance of community-based mental health services (rather than hospital-based), and worked with certain school districts to help accomplish such (Pumariega & Vance, 1999).

In the 1970-80s, the medicalization model of mental health treatment became prevalent, and child/adolescent mental health and psychiatric services were more hospital-based. As a result, community-based mental health services and hospital-based psychiatric care were split, and two treatment modalities were created. This divide resulted in the majority of public mental health dollars being absorbed by hospitals, leaving few resources for community-based care.

Meanwhile, in 1975, the first law regarding the education of children with disabilities, P.L. 94-142, was passed which ultimately transformed into the current Individuals with Disabilities Education Act (IDEA). The enactment of P.L. 94-142 increased the education system's liability in meeting the mental health needs of students with emotional disturbances (Pumariega & Vance, 1999). This new legislation resulted in confusion, however, regarding who was responsible for providing mental health services to students. Mental health professionals argued that schools were required to fund mental health services, while education professionals argued that they did not have adequate resources to support such unfunded mandates.

Recently, through legislative will, grassroots advocacy, and a series of tragic events, several additional laws and policies have been enacted and have allocated funds for children's mental health services. The most well-known of these initiatives has been the Patient Protection and Affordable Care Act (Patient Protection and Affordable Care Act, 2010), which increased Medicaid coverage for children, provided funding to create and expand school-based health

[17] More than 70% of children in the local and state juvenile justice systems have mental health disorders (National Conference of State Legislatures, 2015).

centers, and renewed the Children's Health Insurance Program (National Association of School Psychologists, 2013). In 2013, the Obama Administration also announced the *Now is the Time* initiative, which called for increased mental health promotion and awareness, and enhanced access to mental health services for school-aged children and youth (White House, 2013).

Unfortunately, these new policies have not eased the uncertainty regarding who is responsible for the provision of mental health services. In fact, new conflicts have risen between mental health and education professionals, regarding who should receive funding for service delivery. While both systems have certainly provided a multitude of mental health services for students, these are often not coordinated or integrated, and are conducted within systems silos. That is, rather than collaborating on service delivery, the two systems often work parallel to one another, providing duplicative services that result in the inefficient use of resources (Kutash et al., 2006).

The Current Context

Historically, there has been considerable disagreement and competition as to what the definition of school-based mental health services and supports are and how these should be delivered. *School-based professionals* who ascribe to the in-house definition have argued that it refers to the provision of mental health services by school employees, while *community-based providers* have argued that it involves community-employed mental health staff coming into school buildings to deliver services (the outside-in definition) (Doll et al., 2017).

With these disagreements in mind, our study conceptualizes school-based mental health services as comprehensive, multi-tiered systems of supports (MTSS) delivered through an integrated approach by school-employed *and* community-employed providers in school buildings (Adelman & Taylor, 2012; Fazel, Hoagwood, Stephan, & Ford, 2014; Hoagwood et al., 2007; Roanes & Hoagwood, 2000). When the definition of school-based mental health is expanded to include both community and education systems delivered within the context of the schoolhouse, physical, behavioral, and mental health services are increased and resources are used more efficiently (Doll et al., 2017). Further, delivering services and supports within the school setting increases the likelihood of a comprehensive, whole child system, where academic, social, emotional, and behavioral needs are addressed.

Doll and colleagues (2017) noted that despite the positive progress made over the past two plus decades regarding how best to deliver services within the school setting, these services are complex and difficult to maintain over time. Nonetheless, the literature has identified a number of foundational best practices. In the following section, we discuss the pillars of these best practices and offer some examples.

Foundational best practices have been identified that increase the effective implementation of comprehensive school-based mental health (SBMH) services and supports.

School-based Mental Health Services and Supports: Foundational Best Practice

Schools have a unique opportunity to play a leading role in the universal prevention, identification, and treatment of mental health needs.

Because children and adolescents are mandated to attend school, schools have a unique opportunity to play a leading role in the universal prevention, identification, and treatment of mental health needs (Lendrum, et al., 2013; National Association of School Psychologists, 2016). While research has established that there are significant unmet mental health needs in school-aged children, it is important to recognize that seven out of ten children who *do* receive services, do so through their schools. Equally important, the provision of school-based services enhances access and removes barriers that often prevent children and families from seeking out services. For that reason, school-based mental health services should be accessible to all students in need, and fully incorporated into their school's everyday functioning.

Foundational best practices have been identified that increase the effective implementation of comprehensive school-based mental health (SBMH) services and supports. These best practices evolved from the knowledge gained in the field of school mental health as well as from the experiences obtained through other large-scale federal initiatives (e.g., Safe Schools/Healthy Students, Project AWARE, School Climate Transformation) (Lever et al., 2015, Rones & Hoagwood, 2000). The resulting foundational elements provide SBMH programs with the stability needed to support the implementation and scaling up of direct services and supports. These elements 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. Below, we provide a brief overview of these elements.

Family-School-Community Partnerships: Effective partnerships are inclusive of *all* stakeholders' perspectives – family, school and community – with a shared vision and goals for the program to promote students' mental health and wellness (Center for School Mental Health, 2015). This approach implies that families, schools, and community-partners have vested interest in providing the most effective services that ensure the mental health and wellbeing needs of all students are met. These partners have specific roles in the support of SBMH and are outlined as follows:

Family engagement in intervention and counseling services is key to the success of mental health services for school-aged children.

The Role of Family Partners: Inclusion means that family, school, and community partners organize as a team to advance student mental health and social emotional learning. Family engagement in intervention and counseling services is key to the success of mental health services for school-aged children. After all, students and families make up the largest stakeholder group in SBMH services, as the primary consumers, beneficiaries, and advocates. More importantly, family members are most knowledgeable of their individual child's social and emotional development

and are in the best position to know how to support behavioral learning at home. Unless youth and families are engaged in a meaningful way in the delivery of prevention, intervention and treatment, and promotion of services, attempts to deliver effective services will be compromised and less likely to meet the needs of the student population (Lever et al, 2015).

The Role of School Partners: Ensuring buy-in of school partners is a vital component of successful SBMH programs. Programs that lack the support of school administration and the collaboration of educational staff will likely be unsuccessful. School staff play a critical role in ensuring the success of program services. Classroom teachers identify and refer students, engage in consultation, and provide support to the students. School-based mental and behavioral health providers (e.g., school psychologists, school counselors, school nurses), provide students ongoing social, emotional, behavioral support and can assist to address non-academic barriers to learning. Administrative-level school staff provide the institutional support needed for effective integration and sustainability of services in the school setting.

Programs that lack the support of school administration and the collaboration of educational staff will likely be unsuccessful.

The Role of Community-Partners: Research indicates that a child's mental health is influenced by the web of interactions between their family, school, neighborhood, and community (Kellam, et al., 1975; SAMHSA, 2011). As such, it is important that community-based mental health providers work in tandem with schools and families to design and deliver SBMH services, and ensure that services are culturally relevant. In doing so, a common language can be adopted and silos reduced. Establishing a network of cross-system collaboration follows a systems of care model bridging the gap between schools and the community (Rones & Hoagwood, 2000). Collaboration reduces the likelihood of duplicative services and supports, provides more integrated and coordinated care, and assists in leveraging resources for sustainability of SBMH program services.

A child's mental health is influenced by a web of interactions between their family, school, neighborhood, and community.

Mental Health Promotion and Awareness: Intentional and purposeful efforts to reduce stigma, increase awareness of mental health issues and promote mental wellness is the responsibility of districts, schools, and community-partners. These can take place at the school, district, or community level. The intent of these activities is to increase knowledge and awareness of mental health and wellness for students, families, and school staff, with the overarching goal of reducing stigma of mental health disorders. These strategies are designed to create environments and conditions that support mental and behavioral health and the ability of the individuals to overcome challenges related to these. Promotion strategies also reinforce the entire continuum of mental and behavioral health services (SAMHSA, n.d.). Mental health promotion attempts to encourage and increase protective factors and healthy behaviors that can prevent the onset of a mental health disorder and reduce risk factors (WHO, 2016). For example, NAMI (2015) developed three messages to promote school-based mental health

awareness. These are: “It’s okay to talk about mental illness,” “There is no shame in seeking help,” and, “There is hope after diagnosis.” Students can engage in the types of activities through project-based learning or school-wide campaigns, while school staff and other adults in the community can engage in or facilitate Youth Mental Health First Aid Trainings.[18]

Staff Professional Development: In order for educators to promote mental wellness, they need to have opportunities to acquire the knowledge, tools, and resources to promote positive youth mental and behavioral development. To be meaningful and effective, professional development offerings are coordinated and reflective of the school and district improvement plans, are sustained, and progress from introductory to in-depth. At a minimum, these should address social-emotional learning, child and adolescent mental health, trauma-sensitive and culturally-responsive classrooms and the school-based mental health system. Topics may also include identification and referral of at-risk students, how to talk with others about mental health concerns, promotion, awareness and stigma reduction, how to conduct universal screening, and progress monitoring of students. In addition to student- and school-focused opportunities, providing school staff with training to increase knowledge and awareness of self-care is essential to ensuring staff wellness.

Positive School Climate and Culture: One of the most effective ways to address social, emotional, and behavioral issues in the school setting, including violence and bullying, is to improve the school’s climate; thereby increasing trust and communication between students and staff (Fein et al., 2004). According to the National School Climate Center (Nader, 2012), school climate refers to the quality and character of school life, including its norms, goals, values, interpersonal relationships, and organizational processes and structures. The climate and culture of the school set the tone for learning and teaching, and are critical factors in school success. In fact, a growing body of research has demonstrated the link between positive school climate and teacher retention, dropout rates, absenteeism, suspension, connectedness (teacher and student), attachment to school, as well as motivation to learn (Nader, 2012; Thapa et al, 2012).

Effectively building and sustaining a positive school climate requires schools to intentionally embed mental health staff – school- and community-based – into the culture of the school.

Schools that embrace positive school climates focus on creating positive classroom and school environments with clear and consistent behavioral expectations. A focus is placed on “inclusion” rather than “exclusion.” Schools focus less on exclusionary discipline practices with an intentional focus on problem solving, encouraging resilience, and understanding the underlying causes for student behaviors. Equally important is the need to create and sustain trauma-informed and culturally responsive classrooms (see Trauma and Resilience section for a

[18] Youth Mental Health First Aid is designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis.

more detailed discussion). Effectively building and sustaining a positive school climate requires schools to intentionally embed mental health staff – school- and community-based – into the culture of the school. Doing so means that mental health staff have purposeful and meaningful roles in the creation of support systems for students alongside school staff. Research also demonstrates that district- and school-wide implementation of an evidence-based, multi-tiered behavioral framework, such as Positive Behavioral Interventions and Supports (PBIS), can help improve overall school climate and safety.

Accountability Systems: Traditionally, schools have focused on academic achievement as their measure of success, with little regard to student's social, emotional, and behavioral wellbeing. However, as noted, social, emotional, and behavioral (SEB) health determinants are linked to academic performance, school climate and culture. As such, schools should embed comprehensive mental and behavioral health measures into their school improvement plans as a means of ensuring the prioritization and monitoring of these. Further, school administrators should establish systems and structures to hold school staff accountable for the attainment of SEB learning benchmarks, and the implementation of SBMH systems. The social emotional learning benchmarks recently adopted in Washington State assist in the accountability process through family and community partnerships, cultural responsiveness, professional development, and other strategies that align with foundational best practices.[19]

Data-Based Decision Making: To understand the impacts and effectiveness of SBMH programs and services and to guide program needs requires routine assessment of progress. Continuous quality improvement means using data in a meaningful, thoughtful manner. Schools benefit from embracing an ongoing, reflective data analysis comparing current trends to the desired state, with a commitment to adjust practices based upon data. This includes administering comprehensive assessments of school climate and culture, mental health issues and concerns, conducting resource inventories of existing program and practices, and a review of existing data to analyze risk and protective factors, identify problems, and address gaps in services. Data-based results are routinely shared with the stakeholders – family, school and community – as well as any proposed recommendations for addressing identified challenges (SAMHSA, 2011). Once structures and systems have been in place, districts and schools should routinely assess progress toward academic and behavioral health outcomes (e.g., suspension rates, academic achievement, and discipline referrals).

[19] See http://www.k12.wa.us/Workgroups/SELB-Meetings/SELBWorkgroup2016Report.pdf for specific information about the social emotional learning benchmarks in Washington State's K-12 schools.

TABLE 2.1: SCHOOL-BASED MENTAL HEALTH SERVICES AND SUPPORTS: FOUNDATIONAL BEST PRACTICE

Foundational Best Practice	Description	Who is responsible	How to accomplish it
Family-School-Community Partnerships	Partnerships inclusive of *all* stakeholders' perspectives – family, school and community – with a shared vision and goals for the program. All partners have vested interest in providing the most effective services that ensure the mental health and wellness needs of all students.	District and school teams, family, community organizations	Make families aware of their child's social and emotional development and how to support behavioral learning at home. Include families and community partners in intervention planning and counseling efforts. Organize school-based teams that include family members, community partners, and key school personnel. Collaborate across systems to reduce duplication of services.
Mental Health Promotion and Awareness	Intentional and purposeful efforts to reduce stigma, increase awareness of mental health issues, and promote mental wellness. These can take place at the school, district, or community level.	District staff, school staff, community partners	Students can do this through project-based learning assignments. School personnel can work closely with the community, including families, to reduce the stigma around mental health by conducting awareness campaigns and hosting Youth Mental Health First Aid Trainings and creating a culture of care.
Staff Professional Development	Coordinated training events that are reflective of the school and district improvement plans, are sustained, and progress from introductory to in-depth. Trainings address social-emotional learning, child and adolescent mental health, trauma-sensitive and culturally-responsive classrooms, adolescent development, and the school-based mental health system.	District staff, school staff	School leaders schedule staff professional development for behavioral health throughout the entirety of the year, with follow-up or "booster" sessions as needed. Staff should be trained on who and *how* to refer students for services, how to speak with families about concerns, how to promote mental health, stigma reduction and mental health awareness, and how to universally screen and progress monitor students.
Positive School Climate and Culture	The quality and character of school life, including its norms, goals, values, interpersonal relationships, and organizational processes. Includes a school-wide commitment to ensuring the wellbeing, safety, sense of belonging, and success of every student.	District leaders, school staff	Embed behavioral health professionals into the culture of the school. Health professionals and educators can work together to create a support system for students. Ensure trauma-informed and culturally responsive classrooms. Utilize Positive Behavior Interventions and Supports (PBIS) at the district and school level.
Accountability Systems	Systems and structures to hold school staff accountable for the attainment of social, emotional, and behavioral health determinants of students, as embedded into school improvement plans.	School administrative staff	Establish learning benchmarks within schools. Create family and community partnerships, cultural responsiveness, professional development, and other strategies that align with foundational best practices.
Data-Based Decision Making	Ongoing, reflective data analyses comparing current trends to the desired state (i.e., progress monitoring), with a commitment to adjusting practices based upon data. Includes routine assessment of progress toward academic and behavioral health outcomes (e.g., suspension rates, academic achievement, and discipline referrals).	District staff, school staff	Administer comprehensive assessments of school climate and culture, mental health issues and concerns. Conduct resource inventories of existing program and practices. Routinely review existing data to analyze risk and protective factors. Identify problems and address gaps in services. Focus on larger school population to maximize program effectiveness (i.e., public health approach).

School-Based Mental Health: A Multi-Tiered System of Supports

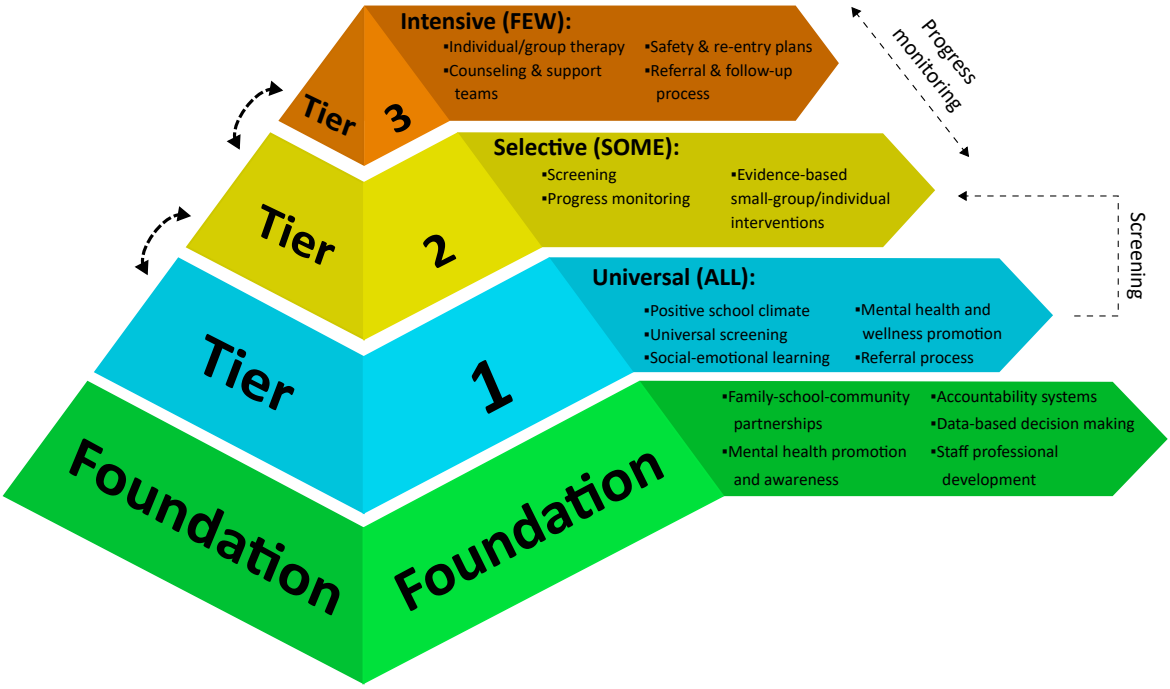
In addition to those foundational best practices, the literature provides clear guidance regarding the effective *delivery* of school-based mental health services. Through leadership and collaborative efforts, school staff can build responsive and supportive systems in which all students can learn. To that end, the aforementioned best practice elements work best within multi-tiered system of supports (MTSS), which are necessary to ensure prevention, early intervention, and continued development of adolescents' social, emotional, and behavioral health. The MTSS framework is aligned with the public health model, and "when implemented together broadens the scope and definition of children's mental health and behavioral health services to include a full continuum of service provision" (Hess et al., 2017, p. 216).

Utilizing the MTSS framework, school-based mental health programs, services and supports are comprehensive, and provide a full array of services across a continuum of tiered supports. Purposeful partnerships are established between the school and community to ensure effective service delivery. In doing so, school-based mental health staff work collaboratively with community-based partners to provide a continuum of necessary services and supports to meet the needs and growth of children across the tiers of functioning with the school system. These services should be culturally-responsive, high-quality, and meet the full range of social, emotional, and behavioral needs of students in general and special education environments. Included in the full range of needs are social skills, emotional awareness, externalized problems (e.g., disruptive behavior, attention deficit hyperactivity disorder), internalized problems (e.g., depression, anxiety, trauma), and substance use, among others.

An effective multi-tiered system results in seamless service delivery at increasingly intensive levels of support, and allows for efficient identification, assessing, monitoring, and improvement of mental health outcomes.

An effective multi-tiered system results in seamless service delivery at increasingly intensive levels of support, and allows for efficient identification, assessing, monitoring, and improvement of mental health outcomes. Furthermore, educators in schools that follow a multi-tiered approach have reported lower levels of burnout and higher efficacy (Ross et al., 2012). Tiered levels of support include: (1) universal programs, assessments, and curriculum that all students receive; (2) selective services for at-risk students; and (3) indicated services for individual students in need of more intensive treatment. Students move up and down the tiered levels of supports depending upon identified needs. Levels of support are designed to be fluid and flexible – not static. The MTSS three-tiered approach is demonstrated in Figure 2.1.

Figure 2.1: MTSS Tiered Levels of Support



Universal Supports: Universal strategies (Tier 1) include programs and supports that *all* students within a school receive, regardless of whether they are at risk for mental health problems. These supports are delivered at the district, school, or class level, and can also be included in regular curriculum (Adelman & Taylor, 2010; Jones & Bouffard, 2012; Colorado Education Initiative, 2013). Universal strategies promote mental health and wellness and build students' social, emotional, and behavioral skills (e.g., wellness education, suicide prevention, life skills). Effective universal strategies provide rich learning opportunities, and focus on positive school climate, relationship building, resilience, and coping with adversity.

Schools must ensure a positive and supportive environment where students can develop the social and emotional skills they need to thrive, and services should be integrated into regular school activities. A supportive school environment creates the foundation upon which effective mental health services can be delivered. Furthermore, when basic, universal needs are met, the mental health service system is not as easily overwhelmed by crises.

Schools must ensure a positive and supportive environment where students can develop the social and emotional skills they need to thrive, and services should be integrated into regular school activities.

Successful Tier 1 programs and supports include formal referral processes for students in need of more intensive Tier 2 and/or Tier 3 strategies. Universal screeners (e.g., BASC-2 Behavioral and Emotional Screening System; Student Risk Screening Scale) can assist in this effort (Colorado Education Initiative, 2013). These screeners are brief assessments that are used to identify or predict students who are at risk for poor behavioral or emotional health outcomes. This can be especially useful for identifying students with internalizing behavior (e.g.,

withdrawal, depression, anxiety), as they generally do not display overt symptoms of emotional or behavioral health issues (e.g., aggression, conduct issues) and often "fly under the radar."

Selective Supports: When universal efforts are not successful, more intensive services and supports (Tier 2) are needed. These selective interventions include evidence-based, targeted strategies that can be implemented quickly and efficiently for *some* students (as identified in Tier 1) (Colorado Education Initiative, 2013). Tier 2 interventions are administered at the group or individual level, and progress monitoring is integrated into natural settings throughout the school day (Colorado Education Initiative, 2013; Wisconsin Department of Public Instruction, 2015). Teacher identification is used to assist in identifying students with internalizing behaviors (Wisconsin Department of Public Instruction, 2015). Examples of Tier 2 services include psychoeducational approaches (e.g., stress reduction, anger management), goal setting, and opportunities for practicing new skills (e.g., coping skills, mindfulness). It is crucial that families are given information about the referral system for how to access support services (Wisconsin Department of Public Instruction, 2015).

School staff, stakeholders, and community partners should emphasize mental health prevention and early intervention, and ensure that services are continuously available to all students (not just those experiencing crises).

School staff, stakeholders, and community partners should emphasize mental health prevention and early intervention, and ensure that services are continuously available to all students (not just those experiencing crises). This will allow for problems to be addressed early on, as well as lessen the need for subsequent, more intensive services. Examples of easily accessible early interventions include short-term counseling, mentor programs, support groups, and alcohol and drug counseling. Schools should also provide referrals to necessary services through mental health provider partnerships or family resource centers.

Intensive Supports: When Tier 1 and 2 supports are unable to meet a student's needs, indicated services and supports (Tier 3) are delivered. In general, *few* students (i.e., approximately 1-5% of the student population within the school) will receive this level of intervention, as identified in Tier 1 and/or 2 (Sugia et al, 2002). These ongoing strategies are used to support students with significant mental health needs (e.g., crisis response plans, school re-entry programs, Trauma-focused Cognitive Behavioral Therapy, Multisystemic Therapy, and high-quality wraparound services). When it is not feasible to provide Tier 3 services within the educational setting, school wellness staff help the student and family find necessary, comprehensive services in collaboration with community partners, agencies, and supports. When collaborating with the community, schools need to ensure seamless referral and effective follow-up processes (Colorado Education Initiative, 2013; Wisconsin Department of Public Instruction, 2015). A system of care model is followed to ensure students' home, school, community, cultural, and linguistic needs are being met. Appropriate information-sharing practices and a continuous communication loop are also essential components to this approach (Wisconsin Department of Public Instruction, 2015).

Multi-disciplinary teams, comprised of school staff and mental health providers, should work to

provide efficient care and coordinated services to students. These teams provide case management and referrals, in addition to supporting students' health needs. These teams can identify interventions that address students' mental health and academic needs, while also ensuring that they do not fall through the cracks.

Additional Considerations: There are several additional best practices that can be incorporated into the multi-tiered approach. Most specifically, services need to be responsive to the unique needs of the school community. Planning committees are developed at the school and district level, to represent the community, as well as oversee mental health service provision. Ideally, these committees consist of students, teachers, families, community mental health professionals, district personnel, family support services staff, and anyone interested in ensuring successful mental health programming. Services can meet students' unique needs by being educationally responsive, student-centered, and culturally appropriate (CSHA; California Community Schools Network, 2013).

Providers should serve as an ongoing resource to teachers, administrators, and other school staff. Frequent collaboration between school staff and mental health professionals can be built into the implementation plan as a fundamental part of service delivery. This will contribute to the ongoing development of educators' skill sets, further increasing support for students and positive classroom management strategies. Mental health professionals should provide professional development activities related to student mental health topics, such as staff wellness, trauma-informed care, classroom management, and burnout prevention.

School districts can partner with community-based agencies to provide mental health services. Schools may employ wellness staff who can coordinate services from community providers. These school-based mental health staff members should take the lead on: (1) developing multi-disciplinary teams to address students' mental health needs; (2) ensuring appropriate case management for students; and (3) leveraging community resources to increase services. These tasks will contribute to the school's overall goals related to a positive climate.

School-based mental health services and supports accounts for more than 70% of all mental health services provided to youth.

Benefits

Adhering to established best practices helps ensure the successful implementation of mental health services and supports in the school setting, which benefits students and staff in a number of ways. 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 reduced fee (if not free). Research has demonstrated that when children and adolescents receive mental health care, it is most often provided within a school-based setting (Farmer, Burns, Phillip, Angold, & Costello, 2003; Rones & Hoagwood, 2000). In fact, school-based mental health services and supports accounts for more than 70% of all mental health services provided to youth (Burns et al., 1995; Farmer et al., 2003; Rones & Hoagwood, 2000). On the individual level, adolescents who receive mental health services at school experience lower suspension rates, improve peer relationships, and increase connections with their school and adult role

models (Stone et al, 2013; Strolin-Goltzman, 2010). These connections and relationships, in turn, increase students' sense of purpose and improve long-term health and success.

Secondly, school-based mental health services and supports increase families' opportunities to participate in their children's mental health services, as they are occurring in a familiar environment – the school. Additionally, school-based mental health services may have less perceived stigma attached to them than outside services (Vernberg et al., 2008); thus, improving the likelihood of follow-through and engagement by students and families. School-based mental health services can also address the delay between the onset of mental health symptoms and intervention – improving treatment access for disadvantaged youth and overall quality of life (Behrens et al., 2013; DeSocio & Hootman, 2004; Kataoka et al., 2002; Kataoka et al., 2007; Lyon et al., 2013). This is especially beneficial for underserved youth, such as students of color, who have traditionally gone without treatment (Snowden & Yamada, 2005).

Adhering to established best practices helps ensure the successful implementation of mental health services and supports in the school setting, which benefits students and staff in a number of ways.

Delivering services within the school setting allows school-based mental health professionals to work with students in the environments where the challenging behaviors often occur, providing them with first-hand knowledge of how the behaviors unfold over time (Vernberg et al., 2008). Finally, school-based services enable staff to seamlessly integrate prevention (promotion and awareness), screening, intervention, aftercare, and monitoring into a comprehensive system of mental health and wellness (Clayton et al., 2010; Doll et al., 2017; Soleimanpour, et al., 2010). In sum, 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 barriers to mental health services.

Trauma and Resilience

Throughout all tiers of service delivery, it is important to consider how health and wellness can be directly impacted by traumatic experiences. The term *trauma* carries several different meanings that vary by context. In the behavioral and mental health context, however, trauma is described as "experiences that cause intense physical and psychological stress reactions" (SAMHSA, 2012). This is often referred to as psychological trauma, and is the focus of the current study. It can involve a single event, multiple events, or a series of circumstances. Moreover, psychological trauma can have lasting adverse effects on an individual's social, emotional, and physical wellbeing (SAMHSA, 2012). Even broader, the Diagnostic and Statistical Manual of Mental Disorders (DSM) (5th edition)[20] includes both direct and indirect trauma

[20] The DSM defines trauma as: Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: 1) Directly experiencing the traumatic event(s). 2) Witnessing, in person, the event(s) as it occurred to others. 3) Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or

exposure. Indirect means that an individual can experience trauma vicariously, through others.

Trauma is subjective, meaning that an event may be traumatic for one individual, but not for another (SAMHSA, 2012). Moreover, an event can be perceived as traumatic even if serious injury or threatened violence has not occurred (Briere & Scott, 2015). Responses to trauma can include intense fear, extreme stress, inability to cope, and helplessness. Trauma can be naturally- or human-caused (SAMHSA, 2014). One in four children in school has experienced a traumatic event and many experience multiple or repeated traumas. Examples of trauma frequently experienced by adolescents include abuse, neglect, maltreatment, bullying, traumatic loss, medical trauma (e.g., serious illness), accidental injury, experiencing violence in neighborhoods, schools, or homes, natural disasters, and terrorism.

Adverse Childhood Experiences (ACEs)

Many students experience trauma through what are termed adverse childhood experiences (ACEs). *Adverse childhood experiences* are traumatic negative experiences that have been empirically linked to chronic health conditions, risky health behaviors, and early death. Research on ACEs became prevalent in the mid-1990s when the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente conducted an epidemiological study of childhood trauma experiences of 17,337 patient volunteers. This groundbreaking study identified ten common ACEs that can impact a child's physical, cognitive, and neurological development, leading to lifelong health and wellness issues.

Adverse childhood experiences *are traumatic negative experiences that have been empirically linked to chronic health conditions, risky health behaviors, and early death.*

These ten ACEs can be organized into three general categories – *neglect* (physical and emotional), *abuse* (physical, emotional, sexual), and *family/household challenges* (mental illness, incarcerated relative, mother treated violently, substance abuse, and divorce) (CDC, 2016; Center for Youth Wellness, 2015). In the ACE study, researchers found that adverse childhood experiences were not only common, but tended to occur together, or in clusters (Felitti et al., 1998). Specifically, two-thirds of study participants reported having at least one ACE, with 87% of those having more than one. As a result, ACEs often had cumulative effects on an individual's long-term health, as well as co-occurring related problems (Felitti et al., 1998). Researchers also found that the more ACEs an individual had, the more likely they were to experience health, behavioral, and social problems throughout their life course.

ACEs occur in all communities, regardless of race, ethnicity, geography, or income, with the most commonly reported being family violence, relative incarceration, and divorce (Center for Health and Justice, 2014). Children who have experienced ACEs have an increased risk of

accidental. 4) Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse) (DSM–5, 2013, p. 271).

disease (e.g., heart disease, cancer), incarceration, drug and alcohol abuse, and suicide (Anda et al., 2009; Brown et al., 2010; Center for Youth Wellness, 2015). With these negative health and social consequences in mind, schools are in a unique position to identify and address ACEs, with the hope of preventing subsequent chronic illness, behavioral problems, substance abuse, or death.

Trauma Informed Approaches

Trauma can negatively impact a child's school performance, impair learning, and cause physical and emotional distress. Thus, it is crucial that schools employ trauma-informed care and approaches to learning (NCTSN, 2008). Trauma-informed care is an organizational approach and treatment framework comprised of recognizing, understanding, and responding to the effects of trauma in individuals. Trauma-informed approaches are holistic, and seek to help students rebuild a sense of empowerment and control, with an emphasis placed on physical, emotional, social, psychological, and academic safety (The Trauma Informed Care Project, n.d.). Schools that use trauma-informed approaches are mindful of the profound psychological, social, emotional, neurological, and biological effects of trauma on students (Jennings, 2004; Los Angeles Unified School District, 2014). Furthermore, trauma-informed care involves the awareness that individuals with histories of trauma benefit significantly from mental health services.

Trauma-informed care is an organizational approach and treatment framework comprised of recognizing, understanding, and responding to the effects of trauma in individuals.

Providers of trauma-informed approaches need to be mindful of potential triggers or triggering events that may impact trauma survivors, and help the students recognize them, too. Triggers occur when external events or circumstances produce negative reactions in an individual. When an individual becomes aware of their emotional reactions to particular circumstances, they can take steps to avoid them and, thus, reduce their power. Service providers should also be cognizant that anything can be a trigger for someone, so questions are often necessary to determine what upsets someone and, relatedly, what calms them. Potential triggers include loud noises, tone of voice, removal of privileges, specific dates/anniversaries, chaotic environments, small spaces, crowds, darkness, aggressive behavior, not being believed, lights, colors, and smells.

Trauma-informed care also involves viewing past experiences through a trauma lens, and recognizing that specific behaviors (e.g., difficulty engaging, disruptive behavior, learning difficulties) may be an attempt to cope with trauma or communicate emotional needs (Jennings, 2004). It involves shifting the question "What is wrong with you?" to, "What happened to you?" and moving toward recovery (Los Angeles Unified School District, 2014).

Resilience

How one responds to stress and trauma is more important than the trauma itself in determining the long-term effects on the individual (Center for the Study of Social Policy, n.d.). When an individual is resilient, they are more easily able to manage the accompanying feelings of stress, anxiety, and uncertainty. Resilience occurs when individual, social, and environmental factors interrupt the trajectory from trauma to maladjustment. Specifically, resilience refers to one's ability to adapt well to trauma, adversity, tragedy, threats, and stress. Understanding resilience helps explain why some people are able to overcome exposure to trauma, while others are not.

Resilience refers to one's ability to adapt well to trauma, adversity, tragedy, threats, and stress.

While those experiencing trauma may continue to feel emotional pain and sadness, resilience allows them to thrive despite such challenges. Research has demonstrated that up to two-thirds of children with resilience are able to overcome initial traumatic life experiences, such as being abused, or having an incarcerated parent (Grotberg, 1999). Fortunately, resilience skills can be learned over time. Therefore, teaching resilience is a necessary way to improve the social and emotional development of adolescents. The American Psychological Association (2017) outlined ten suggestions for building resilience in children and teenagers[21]. These included:

1. Make connections:

   Teach children how to make friends, including empathy and understanding others' feelings. Individuals without a functional social support system are less likely to effectively cope with external stresses (Hepworth, 2002). Connections with others increase social support and resilience.

2. Help others:

   Helping others increases feelings of empowerment and resilience. Children should be encouraged to engage in age-appropriate volunteer work, and other brainstorming about how to help others.

3. Maintain a daily routine:

   Developing a routine can provide the structure that young children need in their lives. Adherence to a routine and maintaining an organized environment (home or school) is comforting for children.

4. Take a break:

   Help children learn how to focus on something other than what is worrying them. Set aside time for unstructured activities to allow children to be creative.

[21] See http://www.apa.org/helpcenter/resilience.aspx for the complete details of these suggestions

5. Practice self-care:

   Lead by example – teach children the importance of eating properly, exercising, and getting adequate rest. Avoid overly structured schedules that do not include "down time" to relax. Stay balanced by taking care of yourself, but having fun, too.

6. Move toward goals:

   Work with children to set reasonable goals and work toward them one step at a time. At school, break large assignments into small, attainable goals, and acknowledge accomplishments throughout the process.

7. Nurture a positive self-view:

   Emphasize confidence and independence to solve problems and make good decisions. Discuss the importance of seeing humor in situations, and laughing at one's self.

8. Maintain perspective and a positive outlook:

   Optimism has been found to improve resilience and overall health (Smith, 2002). Use history to demonstrate how life moves on after painful events.

9. Look for opportunities of self-discovery:

   Encourage children to reflect upon how strong they are following a traumatic event. At school, initiate a discussion about what students have learned after enduring a difficult situation.

10. Accept that change is a part of life:

    Encourage students to replace goals that have become unattainable. Discuss how students have changed throughout each new grade level and consider how those changes have impacted their lives.

Due to changing hormonal levels and developmental processes, adolescents often experience extreme emotional highs and lows. With that in mind, additional stress or trauma can cause these shifts to seem more extreme. It is important to be understanding when adolescents respond to stress with anger or sadness. Developing resilience is an individual journey, and it is not uncommon for an approach to work well for some but not others. Individual counseling can help children strengthen resilience during times of trauma. Ideally, a whole-school approach, with the involvement of different stakeholders in the school, family, and community, would be used to nurture and develop resilience.

Educator health and wellness

The wellness needs of staff are often overlooked in the school setting. Researchers have determined that half of teachers experience high daily stress, which compromises their quality of life, health, sleep, and teaching performance.

The majority of resources and attention regarding school-based mental health services are directed toward the students. The fact remains, however, that teachers and other school staff have important health and wellness needs, too. These have increased in recent years, as the profession has become more demanding (Gallup, 2014; Greenberg et al., 2016). Alas, the wellness needs of staff are often overlooked in

the school setting, as was reaffirmed in the current study. This is a significant oversight, as researchers have determined that half of teachers experience high daily stress, which compromises their quality of life, health, sleep, and teaching performance (de Souza et al., 2012; Greenberg et al., 2016). Chronic work stress among school staff has been associated with negative changes in biological indicators of stress, as well as atypical physiological stress reactivity (Bellingrath et al., 2009; Katz et al., 2016; Wolfram et al., 2013).

Teacher stress has also been linked to poor job performance and decreased student outcomes. Indeed, students of highly stressed teachers demonstrated lower levels of academic performance and social adjustment (Jennings & Greenberh, 2009). For example, in one study, students with teachers who exhibited more depressive symptoms experienced lower rates of academic achievement as compared to their peers (McLean & Connor, 2015). In another study, teachers who reported greater burnout at the beginning of the school year also reported more behavior problems from students (Hoglund et al., 2015). In contrast, a survey of over 78,000 students across 160 schools demonstrated that high teacher engagement increased student engagement, and, thus, achievement outcomes (Gallup, 2009; Gordon, 2010).

There are four main sources of teacher stress: school organization (i.e., leadership, climate, and culture), job demands, work resources, and social-emotional competence (Greenberg et al., 2016). School organizations that are supportive and collaborative, with strong principal leadership, are correlated with higher job satisfaction and lower turnover among school staff (Johnson et al., 2012; Kapadia & Easton, 2007). High levels of trust between teachers, their colleagues, and leadership are associated with lower stress and burnout. Poor relationships with colleagues, administrators, or students are related to lower job satisfaction, increased stress, and lower commitment to students (Kyriacou, 2001; Lee et al., 2011; Van Maele & Van Houtte, 2012). There is also an association between principal turnover and teacher turnover. Frequent principal turnover often leads to lower teacher retention rates. These changes in leadership are especially harmful in high poverty schools, and schools with many inexperienced teachers (Beteille et al., 2011; Greenberg et al., 2016).

High job demands are also a significant predictor of teacher stress. With the increased use of high-stakes testing, teachers' control over their content and pace of work are limited. As a result, they face increased threats of termination and school closure (Center on Education Policy, 2016). Teachers' job demands are further increased by the added responsibilities of managing problematic student behavior and working with parents experiencing their own difficulties and stress. These interpersonal challenges can result in chronic stress and increased vulnerability to depression (Greenberg et al., 2016).

Teachers' job demands are further increased by the added responsibilities of managing problematic student behavior and working with parents experiencing their own difficulties and stress.

When high job demands and stress are combined with low social-emotional competence, teacher performance and classroom management worsens (Montgomery & Rupp, 2005). As noted, a teacher's social-emotional wellbeing has a direct influence on student and classroom

outcomes (Jennings & Greenberg, 2009). Despite this, few teachers receive professional development opportunities related to social-emotional competence. These types of training opportunities are important, as teachers with high social-emotional competence are more able to help students recognize and manage their own emotions. Additionally, these teachers reported higher job satisfaction and student performance (Brackett et al., 2010). When teachers and school staff are *unable* to adequately manage their stress, their instruction (and, accordingly, student well-being and achievement) will suffer (Li-Grining et al., 2010; Swartz & McElwain, 2012; Jennings & Greenberh, 2009).

Finally, educator wellness is significantly impacted by exposure to secondary trauma. Secondary traumatic stress can occur when an individual learns about trauma experienced firsthand by another. Its symptoms are similar to those of post-traumatic stress disorder (PTSD). When educators are affected by secondary trauma, they may find themselves reliving personal trauma or avoiding situations related to the indirect trauma (NCTSN, 2017; Sizemore, 2016). Educators may exhibit secondary trauma in the form of compassion fatigue – a unique form of burnout that decreases one's capacity to empathize with others who are suffering. Compassion fatigue takes a physical and psychological toll on educators, and can manifest itself in anger, cynicism, avoidance, disconnection, guilt, social withdrawal, illness, anxiety, exhaustion, fear, guilt, sleeplessness, poor self-care, hypervigilance, and hopelessness (Sizemore, 2016). Numerous studies have demonstrated that when an individual experiences secondary traumatic stress, they are significantly more likely to leave their profession for another field of work (NCTSN, 2017).

Educator wellness is significantly impacted by exposure to secondary trauma. Educators may exhibit secondary trauma in the form of compassion fatigue – a unique form of burnout that decreases one's capacity to empathize with others who are suffering.

Implementing school-based mental health services for staff can assist in minimizing the negative effects of educator stress. Decreasing staff members' job demands, while increasing school organization, support, autonomy, and personal emotional resources can be beneficial. Specifically, programs for social emotional learning, mindfulness, mentoring, and workplace wellness have all been shown to improve teacher wellbeing (and, thus, student outcomes) (Greenberg et al., 2016). These services can occur on the organizational or individual level (or both), and can reduce teacher stress by shifting the culture of the school.

Programs for social emotional learning, mindfulness, mentoring, and workplace wellness have all been shown to improve teacher wellbeing.

Organizational interventions aim to change the general practices of the organization. They involve promoting supervisor/peer support, open communication, job redesign (e.g., reduced workload), training, and an increased participatory environment. The primary goal of organizational interventions is to prevent educator stress from occurring in the first place, as this is often more effective than intervening post-stress (van den Bossche & Houtman, 2003). Additional goals of organizational interventions include reducing turnover and increasing job satisfaction (Cox et al., 2012). Individual

interventions focus on promoting co-worker social support and professional development for educators and students. Examples of these services include mentoring programs for teachers, workplace wellness promotion programs, and social-emotional learning programs. These types of programs increase job satisfaction, commitment, and retention, while also improving instructional practices and student academic achievement (Ingersoll & Strong, 2011). Individual interventions are the most common approaches in addressing educator stress, and can include cognitive behavioral therapy, psychological relaxation, mindfulness, and meditation. The goals of individual interventions are to improve coping, stress-management, and goal-setting skills (Greenberg et al., 2016).

Conclusion

Schools play a critical role in offering youth the mental health care they need. With one-in-five children impacted by a diagnosable mental health or learning disorder, it is crucial that schools, communities, and families work to identify and address students' needs (Behrens, 2013; California Health Interview Survey, 2005; Gall et al., 2000; Kataoka et al., 2002). Research has clearly demonstrated that there are links between students' mental health and academic success. We also know that adolescents thrive when schools proactively address their social, emotional, and behavioral health.[22] When students with mental health needs receive appropriate support and intervention, positive educational outcomes are increased, school climate and safety are improved, mental health awareness is increased, and stigma is reduced.

Students' academic success is also impacted by the quality of available support services. Strong school leadership and collaboration can assist in the establishment of responsive, supportive systems where all students can learn. Several foundational best practices have been identified that improve the implementation of school-based mental health services, including family-school-community partnerships, mental health promotion and awareness, staff professional development, positive school climate, accountability systems, and data-based decision-making. These foundational elements work best within a multi-tiered system of support (MTSS), which enables successful prevention, early intervention, and monitoring of adolescents' mental health and wellness (Hess et al., 2017, p. 216). Effective MTSS services and strategies are evidence-based, guided by families and youth, built upon existing school programs and services, focus on *all* students, and include a full array of programs, services, and strategies. Schools benefit from establishing early identification systems and referral processes, as pressing issues can be addressed proactively at the Tier 2 level.

The infusion of school based mental health (SBMH) services into regular school routines and practices allows students' learning and emotional needs to be addressed, while also reducing their barriers to treatment. When delivered through an MTSS approach, SBMH increases access to mental health services, reduces costs, and enables families to more easily participate in treatment. In sum, school-based services allow staff to integrate prevention, screening,

[22] For example, a study of more than 270,000 students found that educational achievement increased by 11-17 percent when schools incorporated universal social, emotional, and behavioral learning programs into academic curriculum (Durlak et al., 2011).

intervention, aftercare, and monitoring into a comprehensive system of mental health and wellness.

Throughout all levels of MTSS and service delivery, trauma-informed care should be used, as many students have been exposed to adverse experiences. Trauma-sensitive practices provide educators with an alternative lens through which to view and understand students' behavior, and assist them in recognizing specific triggers, coping mechanisms, and emotional needs (Wisconsin Department of Public Instruction, 2015). Students who have endured trauma or adverse childhood experiences can learn how to be resilient over time through making connections, helping others, practicing self-care, and moving toward goals, among other strategies.

Effective SBMH services include supports for school staff, who may have significant mental health and wellness needs of their own. Teacher stress has been linked to decreased student outcomes and poor job performance, in addition to decreased quality of life and overall health. Secondary trauma and compassion fatigue are two notable areas in need of attention for staff, with symptoms that can mimic those of post-traumatic stress disorder (NCTSN, 2017; Sizemore, 2016).

Even when best practices are known, their implementation can be difficult. To be sure, approximately two-thirds of implementation initiatives in schools fail (Damschroder et al., 2009), and only 25-50 percent of newly adopted programs are implemented with fidelity (Gottfredson & Gottfredson, 2002). Effective program implementation is a long, difficult process, and often takes between two and five years (or longer) to fully achieve results (Fixsen et al., 2005). Ongoing training is required to produce meaningful change in practice following implementation (Lyon, 2017). When initial implementation *is* successful, program sustainment can still be difficult to accomplish (Stirman et al., 2012). In many cases, partial sustainment occurs (Scheirer, 2005).

Despite the vast knowledge related to mental health and its impact on academic success, schools are rarely measured on the health and wellness outcomes of students. To that end, schools have an exciting opportunity to address students' mental health needs at the onset of symptoms, reducing barriers to services and supports. When schools create supportive and engaging environments for students and staff, the foundation is laid for a comprehensive system of mental health and wellness.

EXPLORATION: KEY INFORMANT INTERVIEWS

Introduction and Methodology

In August, 2017, Maike & Associates began the process of conducting an *environmental scan of mental health and wellness supports in K-12 schools in Washington state for* Kaiser Permanente*.* The purpose of this part of project was to provide Kaiser Permanente with a synthesis of perspectives from key informants about the current state of mental health and wellness in the education system.

In-depth qualitative interviews were conducted with local experts via conference calls to understand the nature, depth, and breadth of current mental health strategies implemented in Washington State's K-12 schools. Initial contact was made with three subject matter experts (SME) at the Office of Superintendent of Public Instruction (OSPI), as well as one SME at each of the nine Educational Service Districts (ESD). The remainder of the sample was gathered through a snowball sampling technique, where respondents were asked to nominate two others in the education system, either at the ESD, district, or community level, who were knowledgeable of school-based mental health services. In addition, individuals with particular expertise in areas of interest were also contacted. For example, an OSPI Tribal Liaison was interviewed in an effort to learn more about mental health services available to tribal students.

Once identified, potential participants were contacted via email with a brief explanation of the project and a request for an interview. Follow-up by phone or e-mail was conducted as needed. Of the 40 people contacted, 37 (92.5%) completed the interview. Among participants, 9 represented state-level agencies, 16 were ESD and/or community-level participants, with the remaining 12 district/school-level informants. Each participant was asked to answer questions from their perspective, with regard to their specific experience and expertise. As such, not all respondents answered all questions and not all questions were asked of all respondents. The main purpose of the interview was to obtain a deeper understanding of the scope of resources, services, or programs available to students and staff within each respondent's region. We also sought to identify barriers or challenges that could hinder the implementation of school-based mental health services. Interviews were between 30-60 minutes and were recorded for accuracy and transcription purposes (all participants consented to being recorded). Completed interviews were transcribed, coded for themes, analyzed, and are summarized below.

For the purpose of this study, special attention was given to King, Kitsap, Pierce, Snohomish, Spokane, and Thurston Counties, due to the presence of Kaiser Permanente (KP) services in those areas. Identifying information is not provided for participants, but direct quotes are included when useful or necessary. (See Appendix J and K for interview questions and code book).

In the following, each section begins with a reminder about why, within the context of this study, the information collected is important. Furthermore, it is intended to remind the reader of the link between research and practice; thus, reinforcing the need for school-based mental health services.

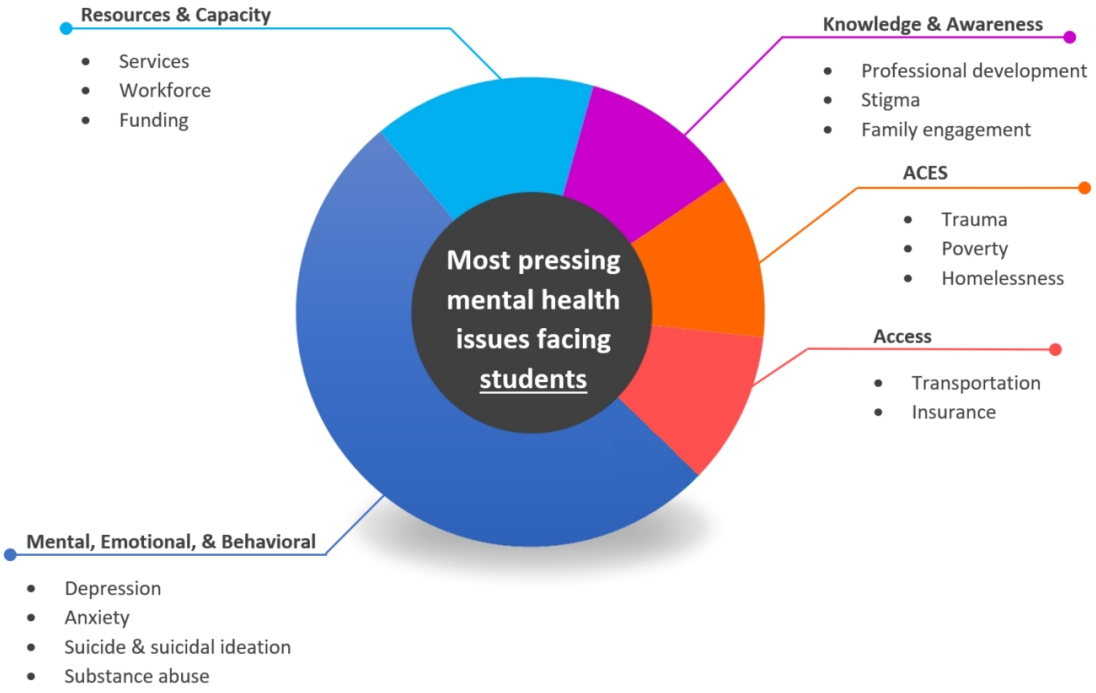
MENTAL HEALTH CONCERNS

Why We Care: Nationally, one-in-five children are impacted by a diagnosable mental health or learning disorder, with depression, anxiety, Attention Deficit/Hyperactivity Disorder, conduct disorders, and substance use disorders the most common. In Washington State, one third of high school-aged students reported experiencing symptoms of depression, and nearly one-in-five considered suicide (Healthy Youth Survey, 2016). Research indicates that only one-third of adolescents with mental health diagnoses receive treatment (Behrens et al., 2013). This is of significant concern, as mental health disorders have an immense impact on students' academic success (e.g., tardiness, absenteeism, suspension, expulsion, dropout) (Gall et al., 2000; Kataoka et al, 2002; Kataoka et al, 2009; California Community Schools Network, 2013).

Mental Health Concerns- Students

We Asked: "What do you believe is the *most pressing* mental health issue facing students in your schools?"

Figure 3.1: Most Pressing Mental Health Issues Facing Students



We Heard: Informants across the board found it difficult to distill their concerns about students' mental health and wellness into a single issue. Rather, they spoke in terms of categories of concerns ranging from specific mental, emotional, behavioral issues (MEB) and the challenges students face as a result of adverse childhood experiences, to more broad systems related issues. These systemic problems often inhibited students from seeking and receiving the level of care needed to address mental health and wellness concerns with districts/schools having limited capacity to efficiently and effectively impact student concerns.

Not surprisingly, informants were most likely to identify concerns related to students' *MEB issues*, with 62% citing these types of concerns. In fact, many informants spoke about high rates of depression and suicidal ideation, as well as the increased number of students attempting and completing suicide in their schools and communities. Informants also spoke to the number of students experiencing anxiety and stress, with these exacerbated by a combination of factors: home life, the pressures of school, relationships, substance use, and the influences of social media. These issues coupled with the impacts students face as a result of ACEs (events or factors that cause or can lead to trauma, such as homelessness or poverty), further complicate MEB issues.

> *"Suicidal ideation is the most critical. The most common [are] anxiety and depression." – District-level informant*

> *"Certainly, substance use. We have seen a decline in the use of several substances over the last decade and half or so, but it impacts a great deal of our student body in the State…All of those early mental health issues certainly impact the students and we're seeing that younger and younger, quite honestly." – State-level informant*

> *"Stress at every level - if I'm a high school senior and I have tremendous uncertainty about what I'm going to be doing next year. Or as a junior, taking the SATs and such - the issue being what happens upon graduation. At the middle school level, it's about acceptance and being part of the peer group and the pressures of what brings that into play. The other piece that comes to play in every school district is social media and the pressures that come with that. And so, they have many more stress points in their lives than what I had at that age level." – District-level informant*

Informants also identified *resource and capacity* concerns associated with the lack of appropriate services to address the multiple needs of students. These included not having the tangible components needed to effectively implement school-based mental health programs, such as direct services, funding, staffing and workforce. Many informants also talked about the need for structures, policies and resources that would allow them to appropriately address students' needs.

> *"Currently, our schools do not have the structures, or policies, or resources to allow them to adequately address mental health and mental wellness and social emotional wellness…." ESD-level informant*

Additionally, informants recognized the need to increase the *knowledge and awareness* of adults and students surrounding the issues of mental health and wellness, particularly the delivery of information about the existence and causes of social, emotional, and behavioral issues. These included increasing the number of staff learning opportunities, improving efforts at stigma reduction, ensuring cultural competency, and improving family engagement. Another

noted concern was related to *access to services,* with informants indicating that the lack of transportation as well as issues surrounding insurance eligibility requirements often complicated students' ability to get adequate and appropriate services.

> *"I think it is a lack of ability to respond to mental health issues within the school district. I think we sometimes feel like we identify students who may be having mental health issues and we lack the in-school district resources to support those students in that way. We look for outside resources, within the community, but sometimes it is hard for us to then assure that they are receiving the services." – District-level informant*

TABLE 3.1: MOST PRESSING STUDENT CONCERN BY INFORMANT TYPE

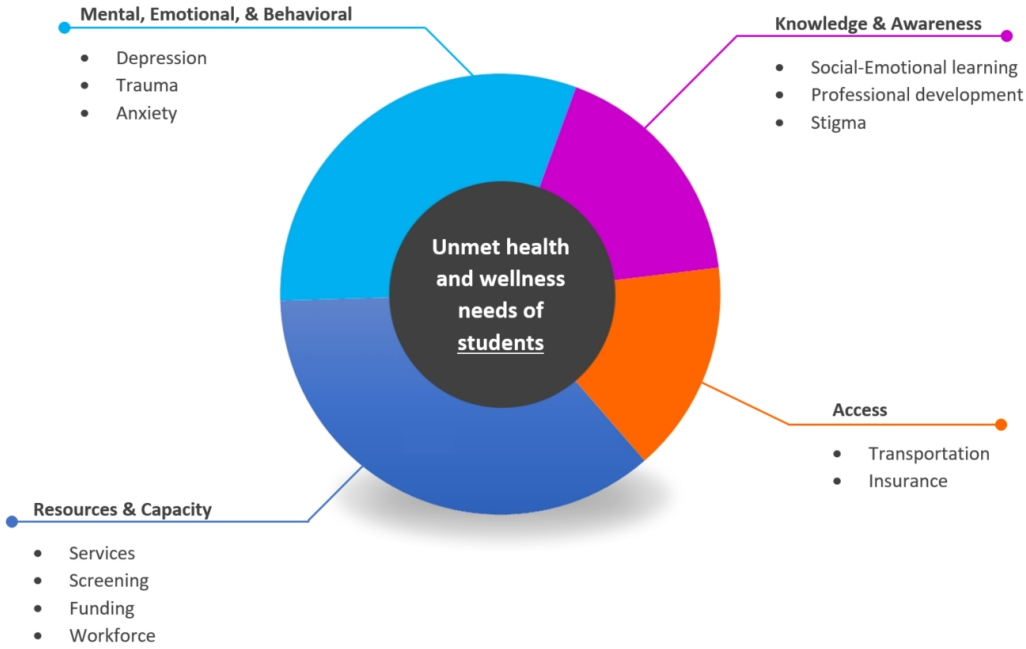
KEY INFORMANT TYPE N=37	MOST PRESSING CONCERN: STUDENT
District/School n=14	Adverse childhood experiences Mental, emotional, behavioral issues
ESD or Community Agency Director n=15	Mental, emotional, behavioral issues Resources/capacity
State Agency n=8	Access Mental, emotional, behavioral issues

Table 3.1 demonstrates the top two identified concerns by informant type. Those informants directly involved with students, district/school respondents, were more likely to identify ACEs and MEB related issues. In contrast, informants who held high level organizational positions, not surprisingly, identified access (system) issues as most problematic.

Unmet Needs-Students

We Asked: "What mental health and wellness needs of students are going *unmet*?"

Figure 3.2: Unmet Mental Health and Wellness Needs of Students



We Heard: Undeniably, the number one unmet need, as expected, centered around students' *MEB issues*. Specifically informants cited problems associated with the increasing rates of depression and anxiety among students, including the impacts of ACEs and trauma. Moreover, an overwhelming number of informants recognized that the education system was, in large part, failing to address the whole child and meet the non-academic needs of students. This gap was seen more as a result of a system that is set up to address the academic needs of students; thus, mental health and wellness needs often go unaddressed.

> *"We've spent decades teaching teachers how to do their job academically, curriculum, instruction-wise, better. We have not figured out a way yet, in this country, in the United States, to teach teachers in a very comprehensive way about the other part of the whole child, which is the non-academic piece." ESD-level informant*

Many informants identified the need to improve *knowledge and awareness*, placing a stronger focus on social, emotional learning and changing the way in which educators are educated. This includes providing training to those in the education system – administrators, teachers, school counselors – on how to appropriately identify (screen) and refer students at risk of social, emotional, and behavioral problems, so that students no longer "fall through the cracks." Informants also identified a desire to increase knowledge and awareness among students and parents of mental, emotional issues.

> *"There is not a systematic response to when a child has a difficulty. Everyone kind of just looks at each other and asks, "Well what do we do?"" – ESD-level informant*

> *"Staff are inadequately trained to understand the signs and symptoms they see, and to know how to intervene with kids who are blocked from their ability to learn as a result of undergoing trauma, or distracted by mental health distress." – ESD-level informant*

Inadequate *resources* as well as a limited *capacity* to meet the multiple physical, social, and emotional needs that students bring with them into the classroom was also an identified unmet need. Informants talked about how the lack of prevention services and mental health promotion activities were starting to impact the education system, with this linked to "the increase in suicide attempts/completions, and everything that goes along with that." Moreover, that due to limited financial resources, districts/schools found it hard to provide services beyond those required to meet academic standards. In the rare event that those services and systems were in place, *access* to both school and community-based mental health services was a significant problem.

> *"Every student has the right to some kind of service if they need it and we just don't have the people to provide those services." – District-level informant*

"If you look at the national average of 20% of the students in need of mental health care, and Washington is 48th in accessibility in the nation, and…less than 50% of people who need mental health services in the nation are getting them, then I would say that our mental health counselors are a drop in the bucket to what is needed." -- District-level informant

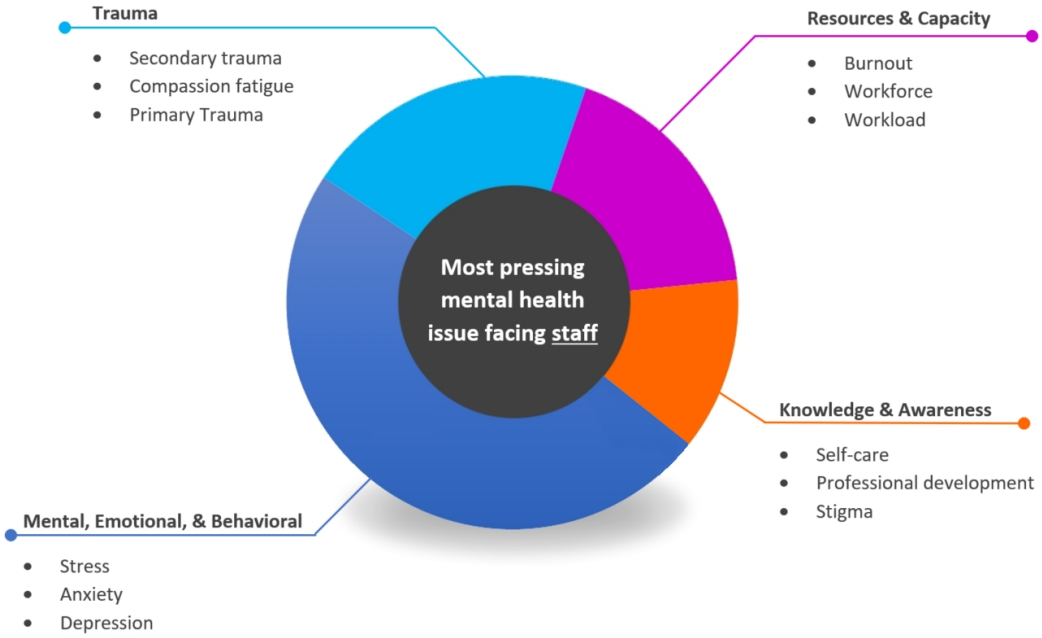
Mental Health Concerns- School Staff

Why We Care: The education profession has become more demanding in recent years. Half of teachers experience high daily stress that results in increased vulnerability to depression and poor social-emotional wellbeing (Greenberg et al., 2016). Educator wellness is also significantly impacted by exposure to secondary trauma, which can manifest in the form of compassion fatigue. Despite this, staff wellness needs are often overlooked, resulting in compromised quality of life, health, sleep, and teaching performance (de Souza et al., 2012; Greenberg et al., 2016).

In addition to students' mental health and wellness needs, Kaiser Permanente partners were equally interested in knowing about the concerns and needs of the adults in the K-12 school system.

We Asked: "What do you believe is the *most pressing* mental health issue facing staff in your schools?"

Figure 3.3: Most Pressing Mental Health Issues Facing Staff



We Heard: Interestingly, we found that informants had a much more difficult time responding to this question. In large part, as noted by one participant, this was due to the fact that while those in the education system are really good at knowing about students and students' needs,

these adults often do not have the same connectedness to their peers or to other adults in the system. Nonetheless, informants believed overwhelmingly that, as with students, concerns related to *MEB issues* were the most concerning for school staff, with 89% of respondents identifying these issues as the most concerning. As a result of the "pressure of being in education", these types of issues in adults were expressed as high levels of stress, anxiety, rates of absenteeism, and extreme burnout. Oftentimes, as a result of these things, staff face difficulties with depression and are at increased risk of suicide, with these linked not only to the stressors of the job but also to economic and family problems.

> *"The extreme burnout of an education system that continues to be stressed and over-burdened…The stress level of our teachers is at a high level, and we have had three suicides in our region with teachers last year." – ESD-level informant*

> *"I think that there are similar issues [as the children], economic issues, family structures, there is always a few things. The intensity of the work they are doing with these kids, impacts their mental health and wellbeing." – District-level informant*

Many informants spoke about the concerns related to *trauma* – secondary and vicarious – that directly impact school staff. Secondary trauma, as a result of working in districts and communities with high rates of ACEs, was noted as a specific example of the toll taken on adults that work in these types of environments. In fact, informants talked about the number of teachers and other school staff who experience compassion fatigue, thus affecting their ability to respond to their own needs in addition to student needs.

> *"One is [com]passion fatigue, one is burnout, and the other is job satisfaction." - ESD-level informant*

Informants were candid about the need for additional *resources* to improve the internal *capacity* of the education system to provide educators the needed support to address their own and their students' mental health and wellness issues. This lack of resources was expressed in the high number of students in classrooms, a shortage of qualified teaching staff, and an overall lack of support for teachers. As one informant noted educators lack a support system that provides them with the tools and resources needed to address the types of student behaviors that face them in the classroom each and every day.

> *"[L]ook at the absenteeism rate for staff and just feeling stressed and burnt out….We've let them hang out there …and [are] not providing them with the tools and resources ..to meet the behavior needs [of students]." – State-level informant*

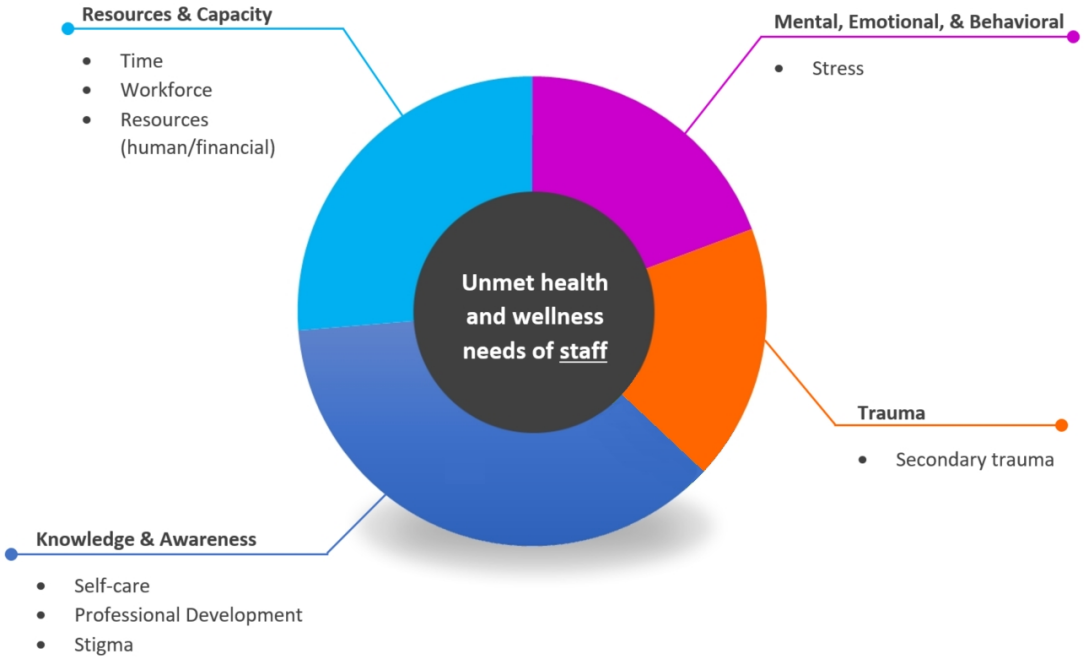
Informants were equally concerned about the lack of staff *knowledge and awareness* (literacy) regarding mental health and wellness (their own as well as others'). The need to increase literacy was high on the list of informant concerns. The following quote aptly demonstrates the overall mental health and wellness concerns for school staff.

"The pressure of being in education, of being all things to everyone, the sheer requirements of what it takes to be a successful educator and teacher in this day and age, all of the expectations, standards, requirements. The fact that people teach student content, they act as counselors, therapists, parents, just all of the services and the emotional investment it takes to be an awesome educator is a stressful scenario. I think it's part of the equation as to why we have teacher shortages, substitute shortages, administrator shortages. The retention of teachers is becoming more challenging, getting a pipeline into education has become more problematic in higher ed and drawing people into the profession. I think there's a lot of pressure, a lot of stress and the ability to cope through that mental and psychological energy that it takes to be an educator today." – District-level informant

Unmet Needs-School Staff

We Asked: "What mental health and wellness needs of staff are going *unmet*?

Figure 3.4: Unmet Mental Health and Wellness Needs of Staff



We Heard: Overwhelmingly, informants believed that the lack of *knowledge and awareness* of mental health and wellness was a critical missing factor. Many participants felt that raising staffs' knowledge and awareness of self-care strategies, addressing the stigma associated with mental health, and the provision of professional learning opportunities to address these issues were specific unmet needs. Oftentimes these types of services and supports are overlooked or not fully embedded into professional development opportunities. One ESD-level informant noted that intentional discussions with staff about their mental health and wellness needs are relatively rare. Unlike other types of professionals, such as mental health counselors, there is

not typically a system in place to routinely debrief with education staff to assess boundaries, level of burn out or stress, or to intentionally address self-care and other areas of concern.

> *"We are still feeling the stigma, and even culturally, to get people to the point to talk comfortably about the fact that they might have mental health issues without fear in the work place. We still have made very little strides in my mind, changing that stigma, to even have people talking comfortably about some of these concerns." – ESD-level informant*

> *"I think that it's [self-care] something we may give a nod to it, but not the same intense response for staff after a critical incident as we might for students." – Community-level informant*

> *"…to not have the district just pay lip service to the idea of self-care, but actually change policies and practices so that teachers and staff are really able to do that self-care. I think that is probably really key to preventing the burn out and also just helping the staff be healthy so that they can help the kids." – Community-level informant.*

Inadequate *resources and limited capacity* were also named as inhibiting districts'/schools' ability to meet staff needs. Informants acknowledged that for many staff both MEB and trauma needs were likely going unmet.

> *"Their own emotional needs aren't met...You know like they say on an airplane, you put your own mask on first and then help those around you. I think that their masks are not on."— ESD-level informant.*

> *"We are always so worried about our youth and their mental health, we don't take the time to look out for each other were it vicarious trauma in the work that we are doing, or just in general to start to be okay about having those conversations, that I've got a medical issue going on, and it's related to mental health." – ESD level informant*

FOUNDATIONAL BEST PRACTICES

Why We Care: Adhering to foundational best practices helps to ensure the successful implementation of mental health programs, services, and supports, while increasing students' access to mental health services, and to quality programming. Best practices include; Family-School-Community Partnerships, Mental Health and Wellness Promotion and Awareness, Staff Professional Development, Positive School Climate and Culture, Accountability Systems, and Data-Based Decision Making. These best practices help to reduce the stigma associated with mental health disorders, provide students with tools for overcoming barriers to success, and hold staff accountable for ensuring a positive school climate and culture. Positive outcomes from utilizing these best practices include lower suspension rates, improved peer relationships, increased follow-through and engagement by students and families, increased family participation in mental health services, and increased connections with adult role models (Stone et al, 2013; Strolin-Goltzman, 2010).

Family-School-Community Partnerships

Why We Care: Strong Family-School-Community Partnerships enables the incorporation of *all* stakeholders' perspectives – family, school and community – and the promotion of students' mental health and wellness (Center for School Mental Health, 2015). These partnerships help to ensure that the mental health and wellbeing needs of all students are met. Additionally, community partners work with schools and families to deliver services to provide integrated and coordinated care. Cross-system collaboration follows a systems of care model that can assist in bridging the gap between schools and the community (Rones & Hoagwood, 2000).

We Asked: "Do districts and schools have strong family-school-community partnerships?"

We Heard: Among the 36 informants, nearly all (86% or 31) indicated that districts/schools had some level of family-school-community partnership in place, but the strength of these ties varied considerably both in relationship to how these partnerships worked (e.g., inclusive, with shared vision and goals, and mutual respect) as well as the level of collaboration among partners (co-located, coordinated, integrated). As one informant noted, schools have traditionally been a closed system, it has only been within the past decade or so that schools have been opening their doors to others; the culture is evolving.

> *"I would have to say it really varies by school district. Some of our districts are really good about that, and others are less good. We also have community coalitions in three of our districts, and I would say in those districts that school-community-family partnership is stronger because the coalitions have focused on that... And, I think sometimes that in rural, smaller communities you get some more of that connection stuff – it's a little bit stronger." ESD-level informant*

The primary types of community-based partnerships included:

- Community coalitions;
- Collaboration with community-based mental and behavioral health service providers, and
- Cooperation with other community-based organizations (e.g., Children's Home Society, Catholic Community Services, Tribal services).

> *"The school district gets that opportunity to play that role (leader in the community) and so in a sense that's a really big strength of ours. But, it continues to be a challenge in reaching out and making sure that all of our families, and our businesses, and our faith communities and our civic organizations feel like they're a contributing member of the team." – District-level informant*

Engagement of families also varied, with this ranging from more insular engagement, typically through traditional communication strategies (e.g., newsletters, social media, parent-teacher conferences) to more intentional, collaborative involvement such as through family resource centers, family advocates, parent education programs, family game nights, and home visiting programs. In a few districts/schools, informants indicated that parents serve in leadership roles or as mentors and are directly involved in their child's school-based intervention and treatment services.

Informants shared notable examples of successful programs from districts that had strong family engagement, which included the development of a communication strategy to ensure proactive engagement with parents and supporting school-parent relations by offering basic needs or other services. In one district, this included laundry services and parent tutoring. This district also engaged parents in ethnically specific PTA groups to ensure the school was meeting the cultural needs of its population. The following are additional examples of successful family-school-community partnerships and how these worked.

> *"They create a safe supporting environment for all the students in their buildings, and that helps to engage the families. They welcome families in the building, it's not an adversarial relationship. It's not, 'Why are you here? What are you checking on?' – But, 'Come in, let's solve this issue with your child together.'" – State-level informant*

> *They recruit parents and have a pretty strong, what we call PTA/PTO or ACP, depending on the district. Those parents that they recruit, this is the idea of coalitions; you have multiple entities coming together at the table coming out to all the subgroups. Those home visitors and the counselors go out themselves and they make relationships with the parents and get that core group of ten parents at school and that group goes out and gets more parents. We see really high rates of parent involvement at that school. – District-level informant*

Barriers: Informants also acknowledged a number of barriers that may inhibit districts/schools from engaging with family and community partners in meaningful ways. The most commonly cited included:

- Lack of resources/funding
- Lack of engagement by family and community members
- Lack of family services
- Lack of trust [between school & community/families], and
- Systems-level issues; including a lack of consistency, leadership, and transparency [from the school/district to other partners].

> *"We always assume that everyone wants the best for their children. [We need to] create that kind of partnership [with parents] instead of just, 'Send us your child… stay out of the way.' …That might work in the younger years, but it will catch up with you in the middle and high school [years], because you need those families' supports and 'all hands on deck' for reaching the finish line for some of these kids." – State-level informant*

Mental Health Promotion and Awareness

Why We Care: Mental health promotion and awareness helps to reduce stigma and increase awareness of mental health issues, thus improving wellness in general. Promotion and awareness are vital in the school setting, as they provide students and adults with the knowledge and resources necessary to overcome challenges related to mental health disorders. Promotion strategies also increase protective factors that can prevent the onset of mental health issues in the first place (WHO, 2016).

We Asked: "Are there campaigns to reduce stigma and promote mental health and wellness?"

We Heard: Among the 37 informants, nearly two-thirds (63%) reported that districts/schools conducted some type of campaigns to reduce stigma and promote mental wellness. However, not all schools within a district may be involved with these types of awareness activities. Moreover, that the focus, messaging, intentionality, and implementation of these campaigns varied.

The most commonly cited activity was the delivery of Mental Health First Aid[23] (Adult and Youth versions) trainings within the schools and/or communities. In large part, this effort is driven by the Substance Abuse and Mental Health Services Administration's (SAMHSA) nationwide "Now is the Time" initiative to improve access to mental health services, including campaigns to increase mental health literacy and stigma reduction. Statewide, both OSPI, as part of Project AWARE, and the Department of Health's Division of Behavioral Health and Recovery have grant funding to support the delivery of these trainings. Although the offering of

[23] Mental Health First Aid is an 8-hour course that gives people the skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The evidence behind the program demonstrates that it does build mental health literacy, helping the public identify, understand, and respond to signs of mental illness. See www.mentalhealthfirstaide.org/faq/ for additional information.

MHFA is a step in the right direction toward building mental health literacy and reducing stigma, in and of itself, it does not meet the definition of a campaign. Nonetheless, it is included here as an example of a type of awareness strategy being implemented within districts/schools.

> *"Youth Mental Health First Aid funding allows me to offer free training, four times a year for up to 30 people. That's 120 people that I can get trained, and I got good responses from K12 staff, but mostly school counselors…I think Youth Mental Health First Aid is a really good training for people in the schools to help them be aware, to help them look for signs and symptoms, and how to respond." ESD-level informant*

Other tactics employed to help reduce stigma included the distribution of SAMHSA brochures or kits at family nights with information about how to talk to kids about mental, emotional, and behavioral health issues. In addition, some community coalitions used on-line media campaigns to inform family members and staff about depression and stigma. For example, one community partner shared:

> *"We pull data, as really kind of the bedrock for a lot of the education that we do out there. We do it targeting kids, we do it targeting parents - just so that they can understand, here's what mental health and wellness looks like in our community right now, and here are some things that you can do." County-level informant*

Another community level informant shared an example of a video that students put together about a young man who had attempted suicide, or was thinking about it, and how his friend helped him change his mind. The video was shared widely and has been nominated for a NW Emmy.

In addition, respondents indicated districts and schools focused awareness efforts on suicide prevention, ACES (Adverse Childhood Experiences), and social-emotional learning. Campaigns noted included collaborating with NAMI to deliver the "Stamp Out Stigma" initiative, the delivery of Sources of Strength (an evidence-based program) in classroom-based settings, and the conduct of schoolwide suicide prevention and mental health awareness activities.

> *"[We conduct] suicide prevention trainings to identify signs, symptoms, and then what to do, and it can be tailored anywhere from an hour to up to four hours. Its designed for people who work with youth, to recognize those signs. We've done the trainings with hospital staff, with at least two of our school districts and other kinds of community groups and organizations." Community-level informant*

One district-level informant suggested approaching this work from a public health frame. Specifically, replicating the social norms and prevention campaign that came out of the tobacco-prevention funding; a successful national and statewide effort that significantly increased awareness and showed positive outcomes in terms of reducing youth tobacco use. The replication of this same model could ultimately have similar impacts on mental health and wellness.

Barriers: Informants acknowledged two specific barriers that inhibit districts/schools from engaging in campaigns to reduce stigma and promote mental health and wellness. These are:

- Lack of resources/capacity
- Stigma

> *"If we had funding [to provide] dinner [for families] and the training materials, and to pay for the professionals, then we might be able to help out more often." –ESD-level informant*

> *"[T]rying to figure out how we are going to implement a [mental health campaign], when we are spread so thin, becomes an issue." – District-level informant*

Staff Professional Development

Why We Care: Staff professional development opportunities provide educators with the knowledge, tools, and resources they need to promote positive youth mental and behavioral development. These trainings are an important step in addressing students' needs in the areas of social-emotional learning, trauma, and the general school-based mental health system. Professional development is also crucial for effective identification and referral of at-risk students, as well as teaching staff how to talk about mental health concerns. These opportunities are also important with regard to mental health promotion and awareness, stigma reduction, universal screening, and progress monitoring of students.

We Asked: "What types of staff professional development opportunities are offered to address mental health and wellness?"

We Heard: As expected, districts/schools routinely provide a variety of trainings to school staff, with these focused on increasing knowledge and awareness as well as the practical application of programs and/or supports related to mental health and wellness.

Nearly half (47%) of these offerings were categorized as supporting the implementation of programs and/or supports across the tiered-level of services. These included:

- Positive Behavioral Intervention and Supports (PBIS)
- Signs of Suicide/Suicide Prevention
- Social-Emotional-Learning
- Check In/Check Out
- Restorative Justice
- Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

"We do a lot of professional development training. We do all the suicide prevention and intervention training. Both to faculty as well as the counseling requirements that are there. We do adverse childhood experiences and we link that to the mental health and trauma, the impact of trauma. We are actually doing a big leadership series on that this year targeting school administrators. Our districts, especially the larger districts, have brought in trainers to do that type of work and focused are focused on multi-tiered systems of support. – ESD-level informant

Knowledge and awareness offerings, identified in 45% of responses, often addressed mental, emotional, and behavioral topics such as:

- Trauma/ACEs
- Anxiety
- Depression
- YMHFA
- Co-occurring disorders
- Suicide prevention
- Stigma reduction

"We do provide awareness training and education, on overall mental health, depression, suicide ideation, signs and symptoms…We do a lot of education around trauma-informed practices and what we call Compassionate Schools - but it's really a trauma informed model. We do a lot around professional wellness and secondary traumatic stress, in education, with K-12 educators. There's just general health awareness around the physical impacts of signs of stress and mental health issues and so we do some education and training around that too, especially at our health services program." – State-level informant

Barriers: Informants also acknowledged a variety of barriers that inhibit districts/schools from providing staff professional development opportunities. These included:

- Lack of funding
- Lack of time and capacity
- Lack of workforce and outside trainers
- Union contract barriers [e.g. contracted time]

"[T]hey have 185 days contracted and that's actually a big system barrier, because planning for change takes someone who is a champion for change, and superintendents are usually all philosophically on board…But, the reality is, their staff doesn't have the time to participate in the short window that school is in session." – County-level informant

Another important aspect of professional development was not just what was being offered or how often but ensuring that all staff – at all levels – had access to professional development

learnings. Informants noted that often, school-based subject matter experts, such as school counselors and school psychologists are routinely engaged in professional development offerings. However, many other staff, too, could benefit from these opportunities. Providing school nurses training in Youth Mental Health First Aid and increasing teachers' knowledge on signs and symptoms could act as a stop gap measure, allowing for earlier identification and quicker access to services. One respondent noted that training non-educational staff, such as bus drivers, could be a huge benefit. Further noting that not only are bus drivers the first adults these students see in the morning (and the last at the end of the school day), but they also may know a lot about these students that teaching staff may not. For instance, where they are coming from (neighborhoods) and their living situation.

Another factor mentioned was the intentionality, quantity and quality of professional development opportunities. As one informant put it, *"planning for change requires someone who is a champion for change."* Without leadership and buy-in, effective changes cannot be made. In addition, training needs to be constantly assessed and re-addressed.

> *"The concern I have is that in education we tend to take an inoculation approach – if we've seen it once, its good enough… We in education need to continue to learn about trauma, about ACES, need to continue the learning and sharing the learning….that would help all of us be more effective educators. But, we tend to just do a training and then move on to whatever the next training is instead of building on the building blocks." – ESD-level informant*

Positive School Climate and Culture

Why We Care: Establishing a positive school climate and culture is an important way to increase trust and communication between students and staff, while also addressing social, emotional, and behavioral issues in the school setting (Fein et al., 2004). A school's climate and culture sets the tone for learning and teaching, and are crucial factors in students' success. Moreover, research has established a link between positive school climate and absenteeism, suspension, connectedness (teacher and student), dropout rates, motivation to learn, and staff retention (Nader, 2012; Thapa et al, 2012).

We Asked: "Do districts and schools prioritize positive school climate and culture?"

We Heard: Nearly all informants responding reported that, in general, districts/schools prioritized positive school climate and culture. This was evidenced by the implementation of programs focused on supporting a positive school climate, with Positive Behavioral Intervention and Supports (PBIS) the most often cited approach. Other strategies included adopting restorative justice practices, as well as the

> *"The majority of schools are getting to the point where they realize that this is critical, that this is work that they have to do, to create a positive culture for kids and to be able to figure out ways that they can bring behavioral health into their schools...They know if the kids are successful, it is going to change the life of that teacher…There are a few that feel like they don't need to do that, but they will come around slowly." – ESD-level informant*

implementation of a classroom-based social-emotional-learning curriculum, such as Second Step.

Additionally, districts/schools placed an emphasis on raising knowledge and awareness through professional development offerings, with these often focused on climate and culture, including trauma informed practices (e.g., ACEs) and the conduct of school climate surveys. Some districts are incorporating school climate measures into their School Improvement Plans. For example, in one district they have a goal to engage students as responsible, resilient, empowered learners. Under this goal, the school focuses on social, emotional, and behavioral learning and expectations, as well as increasing opportunities for student voice and student empowerment. Another district mentioned the "5:1 rule" where every teacher is encouraged daily to use five positive statements for every negative or corrective statement towards students to ensure the fostering a positive environment.

> *"Yes. I would almost say that the vast majority of our schools, maybe 80% or more, have had a cohort of staff who went through PBIS training and have become aware of what [positive school climate] was." – ESD-level informant*

> *"45 of our schools are PBIS schools that are doing implementation… our policies and procedures all lead with positive school climate and culture and that its absolutely essential and necessary for students to be successful in school, and that it's a responsibility of staff. We also do climate surveys."— District-level informant*

Barriers: Informants also indicated that there were a number of barriers that impeded districts/schools from prioritizing positive school climate and culture. These included:

- Lack of a social-emotional curriculum/prioritization
- Lack of data, including the use of a school climate survey
- Lack of resources and capacity
- Lack of leadership
- Lack of professional development opportunities

> *"It's very wonderful to see people say we want in on this approach, but it's very hard for our schools to embrace it in practice." – ESD-level informant*

> *"I think social emotional are the most neglected in the conversation, but can be the most damaging, because often people who are struggling with social emotional issues are also struggling with a possible behavioral health issue and aren't able to articulate that." – State-level informant*

> *"…schools are really funny because they get attracted…by the next shining thing. Right now, the focus is on attendance. I think, gosh, if we had a really positive school climate, kids would want to be here."– ESD-level informant*

Accountability Systems

Why We Care: Accountability systems assist in improving students' social, emotional, and behavioral wellbeing. When schools embed comprehensive mental and behavioral health measures into their school improvement plans, students' mental wellness can be more easily prioritized and monitored. For example, school administrators can establish systems and structures to hold school staff accountable for the attainment of social, emotional, and behavioral (SEB) learning benchmarks.

We Asked: "Are social, emotional-behavioral efforts included in accountability systems?"

We Heard: Twenty-five (25) informants addressed the question related to accountability systems, with 68% indicating that these were embedded within districts'/schools' social, emotional-behavioral efforts, although the application of those varied. Thirteen (13) informants indicated that social, emotional-behavioral accountability systems were part of both district and school-level improvement plans. Several other participants noted that these processes were more likely a part of the districts'/schools' PBIS or MTSS framework, with these focused at the student-level (e.g., classroom or schoolwide behavior expectations) and not linked to staff or administrator accountability systems.

> *"Each school has a continuous school improvement plan, a CSIP, and so they have embedded in there, social emotional and academic goals." – ESD-level informant*

These accountability systems act as the enforcement measures for ensuring program implementation, follow-through, and effectiveness. They address the issues of leadership and staff buy-in, and allow for districts to measure success from building to building and consistency throughout. Additionally, we heard that structures are put in place at all different levels of education. Elementary, middle, and high schools are able to build a robust, district wide, multi-tiered system of support and have a structure in place for the different levels of needs. These systems allow for very clear-cut procedures. The following quote not only sums up what we heard, but defines it perfectly.

> "*This is the first year that we've actually had four district goals including one around SEL development and that's the entire idea – that by having those goals everyone is held accountable to the Board, the Superintendent, but also to one another in helping achieve in their small teams. And so, principals themselves are expected in their School Improvement Plan to develop goals and then monitor the effectiveness of those goals. We break it down into professional learning communities, where small teams, whether it be grade level, or department level, have goals that then help them achieve the school goals which then helps achieve the district goals, and then we're trying to actually relate it to individual principal and teacher growth goals…I think as time goes on and we build more of a culture around this, I'm hopeful and optimistic that we will end up having it very aligned … that these are tied to social emotional, but we're not quite there yet." — District-level informant*

Barriers: Informants acknowledged several barriers that may impede districts/schools from including social, emotional-behavioral efforts in accountability systems. These included:

- Lack of a social-emotional-behavioral prioritization
- Lack of funding
- Lack of accountability

> *"We are in such an odd place in schools because there is so much pressure on the teaching staff and the administrators to get kids up to grade level and to do all these things. I feel like the administrators know this is important work, but how do they do something else with their teachers that they are accountable to, even with the social-emotional learning frame work. How do they run with that and not burn every teacher out?" –ESD-level informant*

Data-Based Decision-Making

Why We Care: Data-based decision-making enables the continuous improvement of programs and services. Ongoing, reflective data analysis also allows for the meaningful comparison between current trends and the desired state, with the adjustment of practices when necessary. Data-based decision-making is also important with regard to conducting resource inventories of existing programs and practices, analyzing students' risk and protective factors, identifying problems and gaps in services, and administering comprehensive assessments of school climate and culture.

We Asked: "Do districts and schools routinely use data-based decision-making to guide school mental health efforts?"

What We Heard: Among the 26 informants responding, the majority (54%) reported that districts/schools generally used data, of some type, to guide decision-making related to school-based mental health efforts. However, 23% of those respondents felt that, in practice, the use of data varied from district to district. For the most part, respondents indicated that academic measures were the most common data used, such as office discipline referrals, attendance, and grades. Informants also acknowledged that although districts are acknowledging the need for more comprehensive data-based decision-making more and more frequently, these systems are not standard, nor common practice.

> *"I think that there are districts that are way ahead, in terms of having integrated data systems, ways that they easily summarize data and doing universal screening to identify students, but I think that is not something that is widespread." – State-level informant*

> *"Do they use database decision making, absolutely. But it is…[o]nly for kids not meeting standards… It's only around learning, but not mental health."– ESD-level informant*

Barriers: Informants acknowledged several barriers that may prevent districts/schools from routinely using data-based decision making to guide their school's mental health efforts. These included:

- Lack of a data collection process, including the use of a universal screening tool for student identification
- Lack of data-based decision-making tool, specifically SWIS (School-Wide Information System, typically linked with schools implementing a PBIS framework)
- Lack of resources and capacity
- Lack of buy-in

> *"We've studied the data…so folks are aware of what is happening in all of our buildings, but we don't really follow that data with a diagnosis of saying – 'Ok, we've had X amount of students who are having some drug use, so let's bring in more drug counselors,' [we don't do] that kind of thing – our resources are limited." – District level informant*

> *"My sense is that there is rarely a unified, school wide approach to very deliberately identify all the kids that might be at risk and get them into the level of service that would be most indicated." – State-level informant*

MULTI-TIERED SYSTEM OF SUPPORTS: RESOURCES AND DIRECT SERVICES

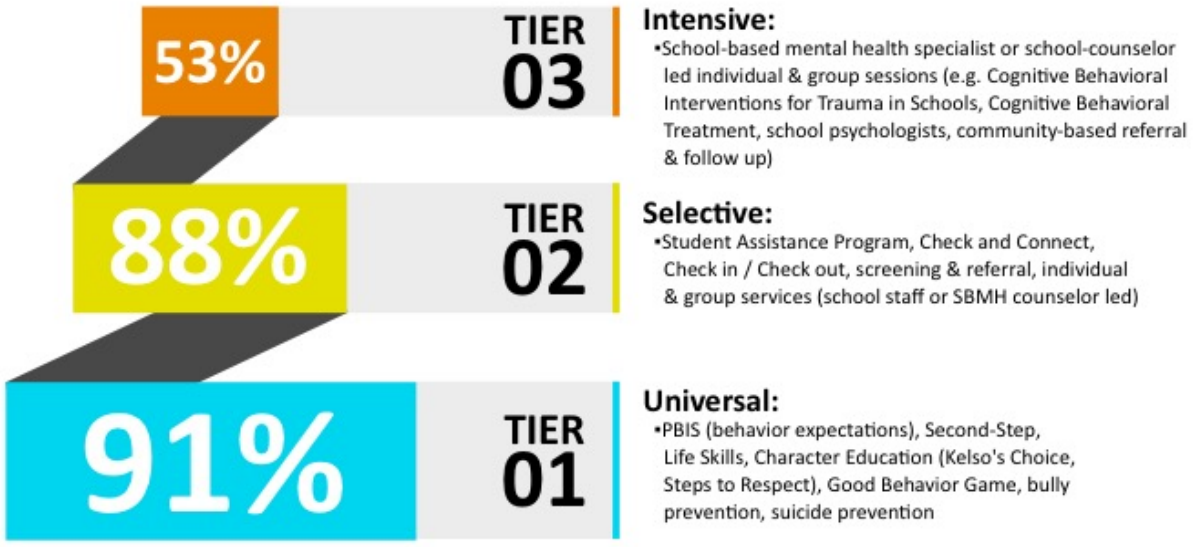
Tiered Levels of Programs, Supports and Services

Why We Care: The multi-tiered system of supports (MTSS) framework is instrumental in the prevention, early intervention, and continued development of adolescents' social, emotional, and behavioral health. Using the MTSS framework, SBMH programs, services, and supports are comprehensive, with a full array of services delivered across a continuum of tiered supports. The tiered levels of supports include: Tier 1 (Universal, *All students*) programs, assessments, and curriculum that all students receive; Tier 2 (Selective, *Some students*) services for at-risk students; and Tier 3 (Indicated, *Few students*) services for individual students in need of more intensive intervention.

We Asked: "What are the most common school mental health programs, supports and services currently in place in your schools and community related to mental health and wellness, including trauma informed practices for both students and staff?" Respondents were asked to identify these services and supports by tiered level.

We Heard: Nearly all informants (34) were able to provide information on the resources and direct services available within their districts/schools, across the three tiers of supports. Figure 3 outlines the most common services/interventions identified by tiered level.

Figure 3.5: MTSS Services and Supports Across Tiers



Ninety-one percent (91%) of informants reported that some type of Tier 1 (Universal) programs, services, or supports were in place in their schools, with these often to address issues related to school climate and safety (e.g., bullying prevention), social-emotional learning (e.g., character education, social skills), mental health awareness (e.g., suicide prevention), and trauma (ACEs, restorative justice, compassionate schools).

Informants emphasized the important role the implementation of a PBIS framework has played in creating a welcoming positive school environment for students, while also guiding a teaching approach that has helped kids grow both socially and emotionally. As one district-level informant summarized:

> *"…when we think about universal strategies, again it's that welcoming environment to students, it's building that relationship with them. It's all that preventative, kind of universal [approach] that every kid absolutely has access to. It's figuring out how your seating arrangement works in your classroom … I think the clear expectations… modeling of the expectations, practicing the expectations, making sure that we're checking for understanding of those, constantly rechecking…You know I think all of those strategies definitely help lower some of the triggers that we're seeing."*

Respondents were similarly likely (88%) to report the provision of Tier 2 (Selective) supports, with these provided as a means to address students' behaviors of concerns associated with social, emotional, and behavioral issues (e.g., behavior management, substance use, anger management) and academic support. In addition, just over half (53%) of informants identified Tier 3 (Intensive) supports, with these specifically designed to address the needs of students with more severe mental, emotional, and behavioral problems.

For those that had strong Tier 2 and Tier 3 supports, most referenced staffing a Prevention/Intervention Specialist(s) to support youth affected by substance use (either directly or indirectly), through small group work or individual intervention and treatment. Similarly, Mental Health Professionals, either ESD or community-based, and in some cases supported by the local Tribe, were in schools to provide one-on-one or group interventions and treatment to higher need youth. More unique were schools/districts that had the opportunity to staff a school social worker, a position designed, in part, to help youth and families navigate systems of care options based on individual need.

Barriers: Despite the high number of sites indicating some level of tiered services and supports, overall, there were very few sites that were at the capacity to implement a robust, comprehensive MTSS to address the social, emotional, and behavioral health needs of their students. Informants identified several barriers that may inhibit districts/schools from implementing or scaling up school mental health programs through the MTSS framework. These included:

- Lack of resources and capacity (i.e. system too overloaded)
- General lack of Tier 1, Tier 2, and Tier 3 interventions (i.e. lack of systems framework)
- Lack of a universal screening tool (behavioral) for student identification
- Lack of a referral system

"I wouldn't say we are doing a holistic, universal approach anywhere. We talk about doing it, but again, unless you are in a system like [names district], where you have services and can provide services to the kids, it creates a challenge…What if you screen 390 kids and 80 of them need intensive treatment? What are going to do? How do we help them and create a system without causing a huge challenge that we can't even address? It's one of those conversation topics that's like, is it better to do that or not?" – ESD-level informant

Comments by other informants suggested the desire for a more holistic, comprehensive approach to student mental health was fairly universal, in addition to the need for more resources (i.e. funding, workforce). Only one informant confirmed the use of a universal screening tool to identify students' behavioral health needs. However, many others mentioned the desire to implement a universal screening procedure but echoed the challenge noted above. In addition, due to the autonomy of school buildings, referral processes and procedures varied widely, with the success of these systems often dependent on the level of leadership at the building level.

Culturally, Linguistically and Developmentally Appropriate Services

Why We Care: School-based mental health services need to be responsive to the unique needs of the student, the school, and the community. This includes utilizing culturally, linguistically, and developmentally appropriate services. Ideally, students, teachers, families, community mental health professionals, district personnel, family support services staff, and anyone interested in ensuring successful mental health programming would form committees to ensure the effective coordination and integration of services. Educationally responsive, student-centered, and culturally appropriate services are essential in addressing students' unique needs (CSHA; California Community Schools Network, 2013).

We Asked: "How do you ensure that programs, supports and services are culturally, linguistically and developmentally appropriate?"

We Heard: While informants identified a variety of strategies related to the cultural, linguistic and developmental needs of students and staff, overall, knowledge in this area was lacking. Practices that were identified included professional development offerings to improve culture competency and raise awareness, the provision of language (translation) services to English as Second Language (ESL) learners and families, identification of best practices that met the needs of the district/school culture, and the review of policies and practices through an equity lens. In addition, informants noted working collaboratively with tribal and other community-based liaisons, as needed.

"We are always looking at our data and the most we can do is try to be humble; that's what I tell my staff, and to not make assumptions with the kids we are working with. Also, we are looking at data at the end of the year to see how many…majority population kids we serve vs. kids of color, do we ever have LGBT youth seek our services. You know, those kinds of questions. Just to take a look, are we serving a demographically appropriate cross section of kids, so we are not overly biased, or if we are biased, are biased in the direction of kids of color or disadvantaged youth." – ESD-level informant

However, many informants also acknowledged that they were not aware of specific steps being taken to increase cultural competency among school staff and the system in general, noting a lack of resources and capacity, including workforce, for such efforts. Many also acknowledged that school staff and educators are not often representative of the more diverse student population they serve, and more and more often, the need for cultural sensitivity/competency around the different socioeconomic situations youth are coming from is also a need. These factors have also affected the ability of schools to achieve family engagement among these populations.

"We understand some of the dynamics of 'cultures within culture'…this isn't about ethnicity necessarily, but homeless kids come from a homeless culture and there are things about that culture that are important to understand. The same with foster care kids and with institutionalized kids. We work with kids who come from cultures that aren't your traditional culture, or background….so we have a good understanding of some of the culture within culture issues. We have a good understanding of mental health and behavioral health culture, and of the substance abuse culture, but what we don't always do well is understand how ethnicity plays into those cultures and also how to teach everyone that we're teaching with a more culturally relevant lens." – State-level informant

Underdeveloped and/or Inadequate Programs, Supports and Services

Why We Care: The majority of youth with mental health diagnoses never receive treatment, or, if they do receive it, its eight-to-ten years after the onset of symptoms (Behrens, 2013; California Health Interview Survey, 2005; Gall et al., 2000; Kataoka et al., 2002). Of additional concern is the fact that many of the supports and services available to students are underdeveloped and/or inadequate. High-quality mental health programming is crucial, as unaddressed mental health issues can have an immense impact on school success, physical health, social-emotional wellbeing, and life in general. Providing adequate interventions early, and in accessible settings, greatly reduces the negative outcomes of mental health disorders (Hawkins, 2009).

We Asked: "What school mental health programs, supports, or services do you believe are underdeveloped, or inadequate in your region/district and community?"

We Heard: Areas of inadequacy fell into two broad categories: program level and systems level. Nearly two-third of informants (65%) reported that program level supports were underdeveloped or inadequate. Services for youth most at risk, Tier 3, were the least likely to be fully developed, including access to quality, intensive school-based mental health services and supports. Tier 2, selective services, were also identified as less than adequate, with informants recognizing the need for universal screening instruments and protocols, as well as evidenced-based programs to address students' needs.

> *"I really don't feel like we're reaching the whole child. And I don't think the whole child just suddenly appears when they're in middle school. The whole child happened before and all of sudden there's some holes in the whole child that manifest themselves when it's more of an intervention than prevention." – District level informant*

Informants also believed that a general lack of knowledge and awareness hampers these programs, including the need for trainings related to stigma reduction. Finally, inadequacies in professional development opportunities were identified, specifically related to cultural competency training.

> *"I think the resources kind of exist, they just need to be developed multi-culturally and linguistically. And, we need to remove the roadblocks in our structure, particularly the discipline practices, and the way that mental health is able to prioritized, which is not very high. But the schools recognize it, they seem to see it, they want it, they get it, but the structure is not there to allow for those kids to be heard very well." – ESD-level Informant*

Over one-third of informants identified systems level inadequacies, with these mostly attributed to insufficient resources (e.g., funding, workforce, services), and district's/schools' internal capacity to adequately develop school-based mental health programs, supports, and services.

> *"Our system is so broken. None of them have adequate resources; none of them have an adequate plan, adequate capacity. The universal support doesn't have adequate bandwidth to increase peoples' knowledge about how important these things are and to break down stigma." State-level informant*

Coordination and integration across systems (school and community) as well as access to services were also mentioned as being underdeveloped or inadequate to meet the needs of youth. One ESD–level informant observed, *"Students hit a roadblock the minute they ask for care…if they don't want their parents to know, maybe they're ashamed… that automatically takes them out of access to care because we cannot bill their insurance…. that to me is a huge issue…"*

In addition, a state-level informant noted that many schools seem to have an "either/or" kind of situation. For example, some schools have a strong PBIS climate and culture (Tier 1) but lack the critical supports and systems to identify Tier 2 and Tier 3 youth. Or, schools have staff in the buildings to provide Tier 2 and Tier 3 supports, but these staff are overwhelmed because of the

lack of the foundational and universal (Tier 1) programs, services, and supports. This conundrum is indicative of a broader inadequacy referenced throughout the interview process: the lack of a clear, and comprehensive systems roadmap for how to successfully implement or scale up a Multi-Tiered System of Supports.

COORDINATION AND INTEGRATION

Why We Care: It is important for service providers to serve as an ongoing resource to school staff, and for school districts to partner with community-based agencies to provide mental health services. Using a network of cross-system collaboration that follows a systems of care model can assist in bridging the gap between schools and the community (Rones & Hoagwood, 2000). Collaboration helps improve the integration and coordination of care, while also assisting in the leveraging of resources for sustainability of mental health services. Moreover, these efforts will increase the likelihood of appropriate case management for students, as well as contribute to the school's overall goals related to a positive climate.

We Asked: Three questions explored the level of coordination and integration of school-based mental health services and supports between districts/schools and other community partners. The first sought to understand what types of community-based partners, if any, were engaged in these types of services. Second, if these services and/or supports were duplicative. And finally, in cases in which these partnerships existed, were they reflective of a system of care (e.g., integrated) service delivery model.

We Heard: As with other topics throughout the interview, we found coordination and integration to be inconsistent within schools and districts. While coordination with non-school based partners was not uncommon, the level and type of engagement varied. Partnerships frequently centered around existing community-based coalitions with these mostly focused on addressing the prevention of adolescent substance use. In large part, this was due to an emphasis on adolescent substance use across the State for the past two decades. Informants agreed that integration was an important component in the effectiveness of mental health programs but indicated that successful integration was challenging.

> *"They are definitely not integrated into the system. Now, they are being welcomed by the school system absolutely because everybody recognizes that there just aren't enough services." – Community-level informant*

> *"In some areas, [the local community-based providers] have an extra body that can be there [in the school] one day a week, which is great but it's not comprehensive, it doesn't have tiers 1, 2, and 3. It's a band aid and we can't treat ourselves out of this. So, yes, I think we have to have community agencies that are coming in to do that specific treatment piece. What we really need, we need that program that has all the tiers available, that is working with our outside providers and is creating that system whether it's liaison work with the other providers, and the school based person." – ESD-level informant*

Many informants indicated a disconnect between schools and community partners with regard to language and knowledge about the mental health system. This disconnect often resulted in confusion and misunderstandings that made it difficult to coordinate/integrate school-and clinic-based care.

> *"Schools don't know the language, the system, the process to connect or they have assumptions about what is an entitled service or what is supposed to be delivered in their schools. And likewise, the clinic based facilities don't know how to embed themselves in the school buildings to be seen as a part of the cadre of resources versus just somebody who is coming to deliver a service on Tuesdays." Community-level informant*

Contrary to our expectations, few informants noted duplication of programs, supports, or services, with most respondents denoting a dearth of services across all levels of need. The vast majority of respondents did not identify duplicative services or view them as problematic. Rather, they expressed a desire for *more* services.

> *"The one thing that I ask when I go out and do my site visits…is, 'Is your need being met?' and nobody ever says yes. Everybody wants more services." Community-level informant*

Of the handful that *did* note duplication, this was likely due to a misunderstanding about services or because of a lack service of coordination, as aptly described by this state-level informant:

> *"There is often a lack of understanding that things are as duplicative as they are. Like people might see a school that is doing PBIS and SEL, and see those as being in conflict, when those don't need to be duplicative. Because you can have a PBIS framework, which within SEL is a very appropriate component." State-level informant*

Overall, "formal integration" (i.e., documented and/or established Memorandums of Agreement) of community-based providers into the school system was rare. Among informants, 11 indicated the existence of such agreements, however the formality of these varied. These types of agreements were most common among those districts/schools with community-based mental health providers engaged in the delivery of services in the school setting. One informant noted that the existence of a MOU does not necessarily indicate an integrated system, but rather, may only reflect an agreement for co-location of services.

> *"They provide the space and have agreements, but the services aren't integrated into the school system yet…" Community-level informant*

Barriers: There were several barriers identified that can make it difficult for districts/schools to partner with other agencies in the development of an integrated approach. These included:

- Lack of community partners
- Lack of resources/capacity
- Lack of access, including insurance barriers

IMPACTS

Why We Care: Measures of impact and success are an important part of the continuous quality improvement process and allow stakeholders to conduct reflective analyses of data comparing the current status of program services and supports to the desired future. Research indicates that mental health intersects with academic outcomes and school climate and culture. The frequent use and reporting of data demonstrates whether progress is being made and if that progress is consistent with expectations. Moreover, routine review of data allows for course correction or strengthening of program practices, as needed.

We Asked: To better understand informants' perceptions of the impacts of school-based mental health services and supports, we asked about program strengths and measures of success.

We Heard: In general, we found that there has been increased access to school-based mental health services in recent years. Informants embraced this, and strongly articulated their desire for increased access to high quality mental health programming. Others discussed how increased SBMH services have helped eliminate barriers to obtaining treatment (e.g., insurance, billing, family involvement).

> *"In the past it used to be, 'Oh, just send them to the mental health therapist, they'll fix them' and now it's more of, 'No, we're all a team. We're all surrounding and loving and supporting our kids and we all need to do our part to help them not only academically, but emotionally and socially.'" District-level informant*

> *"I think that the most effective thing we have is having mental health in the schools… And the reason is, I don't have to check whether or not they have insurance, I don't have to do any billing, I don't have to wonder if their parents are going to [get them to services]. If they are 13 and they say they need mental health services, our school district will help them with a mental health specialist. They don't have to do anything else or have anything else, or [depend upon] anyone else." District-level informant*

Partnerships, including community and family member engagement, as well as connection with community-based mental health providers, was recognized as a program strength. Informants also indicated that the delivery of services in an integrated approach - across the continuum of services - increased program impacts.

"The community-based mental health [providers] on their own could do it – they could just come in and provide services to Medicaid kids, right? And, so as a community we say 'Okay, that's good,' but we need to meet this other gap: What about the kids that aren't Medicaid eligible? What about those who are depressed but not suicidal, so they don't meet access to care? At that point, it's like we have really strong partnerships with the community and schools, where the school district is like, well we'll put in $20K, and then the county is going to put in $20K, and then [the agency provider] puts in $20K, and now you have a position… that's partnership and that's leveraging." – Community-level informant

It was determined that program success was frequently dependent upon buy-in (administrative and legislative), adequate funding, and the delivery of evidence-based programs. When administrative and legislative buy-in was present, programs were implemented more smoothly, and political "roadblocks" were less common. Moreover, schools were able to obtain more resources, such as necessary professional development opportunities and physical space for service delivery. Trust and effective communication between schools and community partners were also identified as crucial components of program success.

"As long as there is buy-in, as long as staff will reinforce the messaging, as long as the parents have some sense of trust and safety that their kids are engaged. As long as the kids have some sense of contribution, as long as the policies support intervention over discipline, you're going to have success." – ESD-level informant

We also gathered information related to the indicators used to measure the success of program services. In general, we identified a substantial need for more meaningful data collection and data-based decision-making with regard to program impacts and success. Of the respondents whose districts/schools measured program success, academic and behavioral indicators were reported. Academic indicators included: failure rates, graduation rates, and grades. Behavioral performance measures cited were: discipline rates, office discipline referrals, and levels of engagement (attendance). Only four informants indicated that their districts/schools routinely used school climate survey or similar types of perception data as a measure of success. Indeed, the collection of data and need for meaningful measures to assess program success were gaps in program practices.

"We don't [have measures of success], that is a big gap. We don't have a mechanism in place right now to do that. We send [students] on their way and kinda hope for the best, I guess." – District-level informant

"There needs to be some tracking over time, of some sort of outcome. Whether a more proximal social emotional behavior outcome, anxiety, depression, classroom behavioral problems, something like that, or something a little more useful, attendance, on time advancement to the next grade, graduation, etc."—State-level informant

DISCOVERY: WHAT WE FOUND

Pockets of Excellence

Throughout the interview process, key informants at every level identified regions, districts, or individual school buildings that were successfully implementing a multi-tiered system of supports (MTSS) framework to integrate social, emotional, and behavioral health services for their youth. All of these "pockets of excellence" had something in common: a foundational structure. In other words, those that were showing success had many of the foundational best practices in place, thus enabling them to successfully create a system to not only address the academic needs of students, but also the non-academic barriers to teaching and learning.

In practice, these key elements included strong district-level leadership and staff buy-in from the top down – Superintendent, Principal, Teacher, and other building-level staff. In addition, the more advanced sites explicitly prioritized social, emotional learning (SEL), developed school and/or district-level goals, and included SEL accountability measures in their school improvement planning processes. These sites embraced a MTSS framework and worked continuously to ensure resources (i.e., programs, services and supports) were available to youth at all three tiered levels of support. In addition, they had an established system in place for appropriate identification (i.e., screening) and referral of students to services.

As part of this process, school or grade level teams met regularly and utilized data to inform practices on how to best address students' varying social, emotional, and behavioral health needs. This often included the use of the SWIS (School-Wide Information System) data-management system (for schools implementing PBIS). These data were used to monitor the progress of higher need students, and as an early warning system for students at-risk. In addition, these sites also referenced conducting school climate surveys (student and staff), as well as monitoring Healthy Youth Survey data to more fully understand the needs of their students and to assess the climate of their schools.

In addition, these sites had established strong community and provider partnerships, as well as strategies to engage parents and families. The configuration of these partnerships varied by geographic location. For example, in rural areas, these partnerships were often cultivated naturally as a result of being located in a small, isolated area. Although service provider availability and general workforce issues may be a bigger challenge in these areas, those that had support from providers (whether community-based or ESD supported) referenced the importance of the school as the cornerstone of the community. In these cases, the school played a dual role – school and community – thus, it was incumbent upon them to ensure a welcoming school environment for all (students, staff, parents and community members).

There were also sites in densely populated urban settings that were creating strong family-school-community partnerships through very intentional outreach. These activities included establishing a Family-Community Resource Center model, developing a communication strategy to ensure proactive engagement with parents, and supporting school-parent relations by offering basic needs or other services. In one district, this included laundry services and parent

tutoring. This district also engaged parents in ethnically specific PTA groups to ensure the school was meeting the cultural needs of its population.

These “pockets of excellence” are encouraging and provide evidence not only of the changing state of school-based mental health programs, services and supports, but also emphasize the level of leadership and commitment needed to scale up this work across the K-12 system.

That said, there are a wide range of challenges that can hamper the development of this foundational structure and the implementation of programs, services, and supports. As noted, it takes leadership, as well as intentionality, coordination, communication, and integration to build a comprehensive system. When we peeled back the layers, even among the most successful systems, there were a number of barriers and/or challenges that all sites must overcome for this work to be successful.

OVERALL BARRIERS AND CHALLENGES

We Asked: To better understand the difficulties associated with the development and launching of school-based mental health services and supports, we asked stakeholders to tell us what they felt were the biggest challenges to implementation.

We Heard: Among the 35 (95%) participants answering, an overwhelming number of their responses (73%) fell into three broad categories: resources and capacity, knowledge and awareness, and systems barriers.

Overall, the most frequently mentioned category was related to resources and capacity (i.e. funding, workforce, time, and sustainability). However, the single most cited issue was stigma, a knowledge and awareness barrier, with 70% of respondents referencing this barrier. Stigma can impact an individual's decision to seek mental health services or supports, and can even result in judgment from peers. Informants were particularly concerned for students with internalizing mental health issues (e.g., withdrawal, depression, anxiety, trauma), as they generally do not display overt symptoms of emotional or behavioral health issues and often "fly under the radar."

Some informants even referred to stigma-related judgment on behalf of educators, who often lack knowledge and awareness of mental health issues. For example, we were told a story about a staff member who, unaware of depression's categorization as a medical illness, stated

that a particular student with depression "didn't have anything to be sad about." This sentiment was echoed multiple times throughout the interview process. Encouragingly, many informants indicated that the negative effects of stigma were lessening with each passing year, but that this progression was occurring slowly.

> *"Stigma tends to be a bigger barrier where you have the high functioning…and high standard and demands and the high anxiety kids. And, fear tends to be a bigger barrier in higher poverty areas, with more transitional youth, or undocumented youth, so it's either stigma or fear and it kind of depends on what community you're in, as to which is the bigger issue." – ESD-level informant*

Other important barriers discussed with regard to knowledge and awareness included a lack of professional development opportunities, as well as the lack of buy-in and readiness at both the school and district levels. For example, one informant stated that many teachers have a mindset of, *"I am here to teach content – let me do what I was trained to do."* Along those same lines, others argued that teachers frequently lacked the preparation, experience, and certification necessary to meaningfully address mental health issues in the school setting.

> *"I don't know that they get enough preparation in their pre-teacher pre-cert programs to prepare them for those roles, which if they did, that's like getting two people for one; you could have an academic counselor that's also trained in mental health but that's gonna have to change at the university level…" – District-level informant*

> *"I think another barrier is you have people already in school buildings with training that are being misutilized or underutilized. So, you have school counselors administering testing. Not fully using school psychologists who could support… or are experts when it comes to data and assessment. My concern is that we are passing some administrative tasks off to people in the building who could better be supporting students." – State-level informant*

However, not surprisingly, the shortage of funding available to schools/districts and lack of capacity to support SBMH and social, emotional and behavioral health was the overall most frequently cited barrier.

> *"Money. Funding is challenging, specifically related to the budget. We don't get allocated mental health therapists that all comes out of our local levy or grants, so that's a challenge. Another challenge is such a high emphasis on the accountability side of education in academics. Really, it's so hard to implement whole child education because we have to focus so much on math and literacy, it doesn't leave enough room for any explicit instruction around social emotional development, let alone trying to get kids hooked on their interests and passions that are outside math and literacy. – District-level informant*

"So, that's the other big area - funding. And, you may want to do all of these things in your school but you have to look at what is being provided for basic education, where your resources are, and if you have the capacity to fund those things in a way that is sustainable. And, that's really big because so many of the things that [the] school district has been able to [do] are really fantastic, but when they are grant funded you may be able to do some initial implementation and get some things established but to be able to sustain those things, and really embed them in what the practices are year after year after year - it becomes a challenge… You know, we really have to make sure that behavioral health and mental health are part of educating the whole child…" – District-level informant

In addition to the dearth of funding and lack of resources to implement SBMH services, as well as the perceived need to navigate through the persistent veil of stigma, stakeholders also acknowledged a number of broader, more complex systems-levels barriers. These included:

- Insurance issues (lack of access, issues of affordability, consent)
- Lack of a shared or common language (between schools and community/providers)
- Conflicting policy priorities/mandates (academic vs. SEL vs. whole child)
- No overall system coordination and integration (across all levels, from schools to state agencies)

"So, cross-system coordination is probably the second biggest barrier I see. And, at the heart for me of cross-system coordination, is people understanding what each piece of the system does and slowing down enough to have that conversation. Then, figuring out, is there a way that we can collaborate, or coordinate across systems?" – State-level informant

"The barrier is having…someone thinking systemically about how these services connect across the continuum. And, then how are they incorporated into how we do business and built [those] in to the strategic plan and delivered, so they're not an afterthought." – State-level informant

"I think in terms of those steps going forward, it just needs to continue to be a community conversation, locally, but also at the state level and national level. But I think most importantly the local and state level. We need to continue to talk about, you know, children in a way, as a whole child. We are not - we aren't siloing academics over here and behavior somewhere else. It really needs to be, when we talk about education, it needs to all be in that same sentence." – District-level informant

As a follow-up to this question, stakeholders were asked what steps they thought could be taken to reduce and/or overcome these barriers. In general, systems level solutions were the most commonly identified, including increased communication, cooperation, and community partnerships. The most common single response was *funding*, followed by increasing awareness

(of mental, emotional, and behavioral issues and responses), particularly though increased opportunities to learn.

> *"I think that OSPI coming up with those SEL benchmarks, I think if those were adopted officially into the General Ed obligation, that we would see people pushed to action and I think that that at some point we have to push them to action." – District-level informant*

> *"You know, making sure that, even the way that classrooms are set up. If it's done from a trauma informed perspective you know, make sure that the whole system of care, the school-based system is set up in a way to recognize and understand when kids start to display any type of symptoms that you can address that as early as possible." – Community-level informant*

> *"Creating a situation where kids can get services at school where parents don't have to take time off work – if transportation is an issue, they don't have to spend an hour and half on the bus to get into an appointment." – Community-level informant*

BLUE SKY

We Asked: The final question asked, "If barriers and challenges did not exist, and you had the opportunity to build a system that met the mental health and wellness needs of all students and staff, what would that ideal system look like?"

"What I would hope for, is a school district where every child, every student, every staff member, was known by name, by need, by talent, and the focus was on a very personalized approach to education." – District-level informant

We Heard: Respondents' answers to this question covered an extensive range of ideas, from practical needs (e.g. sufficient workforce and funding), to programmatic needs (e.g. implementing specific interventions and MTSS best practices), to addressing logistical issues, such as ensuring ample building space for services, or creating school-based health centers in every district. Additionally, respondents also shared aspirations that the system would be "thoughtful", "engaged" and, "joyful." The following are a few examples of informant responses.

"It would be highly trained, highly qualified, dedicated staff on both sides - the school side and the clinical side – that were paid a wage to make this a career and not something that you pass through onto something else. And, they would have plenty of time for workforce development, professional development, peer support groups – not just a weekend training somewhere. Families and youth would be engaged in planning the system and evaluating the system and we would ask preemptively, earlier, pre-school [about SEB needs]…We can meet the needs of individuals much sooner in life and prepare them for school differently – well, prepare them for the world differently." – Community-level informant

"I can't stress enough, that whatever the system is, there has to be better communication coordination, and planning...From the state level, to the regional level, to the district level, to the building level, down to the teacher. I think we need to do a better job at connecting, and reducing some of the silos and fragmentation that we have. I think that system would include better professional development, stronger training for building leaders around mental health. I think people would have a clear understanding of what it is that all kids need, how are we identifying kids that need more support, how to better connect kids to the interventions or support they need, how to progress monitor….I am thinking [a] comprehensive system, that includes a tiered continuum of support with adequate professional development, integrated data systems, strong family and community partnership, and it's all more based on some continuous improvement where we are constantly looking at what's working and what's not working and adapting and changing…. That we are not just doing things in a postmortem fashion just looking at the data, saying, 'Hmm…that didn't go so well.'" - State-level informant

"Making sure that people realize that school districts have a million policies and a million people saying 'You need to do this. You need to do that.' So, making it as easy as possible for districts. Not just saying 'Hey, you need to have this policy', but say 'You need to have this policy, and here's an example, we can provide some training on what this means, and we can help you customize it.' You know, making it really useful and making it really easy, I think, is the key." – County-level informant

"Having a comprehensive effort, where everyone is engaged, everyone is involved, that we are not there in a school building on the periphery, helping that kid in need but we are an integrated part of the school and mission, and that we have a very strong programmatic focus on what equity means in terms of service delivery and support and an equally strong focus on self-care for staff." – ESD-level informant

"I think it gets to the fact that there needs to be equal access to kids no matter whether you have insurance, Medicaid, or whatever it is, and that it really needs to be driven off of what the child needs and not what somebody wants to pay for, but really what is clinically best for the students and their family. In a perfect world, the biggest hurdle is that access to care for any student no matter what your funding is. And, high-quality services." – ESD-level informant

In the following section, we provide a summary of findings related to the current state of mental health and wellness in Washington State's K-12 education system

SUMMARY OF FINDINGS

Throughout this exploration process, we uncovered a number of key findings related to the nature, depth, and breadth of current school-based social, emotional, and behavioral strategies implemented in Washington State. We also identified specific barriers and challenges that often hinder the implementation of these services. A summary of these findings is outlined below.

Mental Health Concerns – Students

While it was a challenge for respondents to choose one pressing issue, **mental-emotional-behavioral (MEB) issues were the primary concern,** with the majority of people citing **depression and anxiety.** Many respondents also discussed sharp increases in suicide and suicide ideation in recent years. Another common concern was the lack of access and/or appropriate resources available to students.

Unmet Needs – Students

Similarly, the primary unmet needs discussed by informants were **MEB issues, including depression, anxiety, ACEs, and trauma.** It was a common argument that educators – whose primary job is to teach academics – are inadequately trained to recognize and respond to symptoms of mental health issues. As a result, mental health often takes a back seat to academics in the school setting.

Mental Health Concerns – Staff

Informants had a difficult time discussing the most pressing mental health issues facing staff in their districts/schools, primarily because staff and their wellness needs are significantly overlooked in the school setting. As with student concerns, **MEB issues were the most troubling for staff, including stress, anxiety, and burnout.** These issues were related to the high pressure of the occupation, resulting from high stakes testing, administrative demands, and increased responsibilities regarding individual students' needs. One of our more significant findings was the extent to which students' trauma takes a toll on the teachers, often resulting in compassion fatigue.

Unmet Needs – Staff

The **lack of knowledge and awareness** about mental health – including **stigma** – were crucial unmet needs. **Self-care** was also cited as a significant concern. Unfortunately, as noted, these services and supports were frequently overlooked in the school setting, and typically omitted from professional development opportunities. Half of the informants listed districts'/schools' **inadequate resources** and limited capacity to meet staff needs.

Foundational Best Practices

Family-School-Community Partnerships: Most districts/schools had **some level of family-school-community partnership** in place, but the strength of those ties varied. We found that many schools were in the process of discovering their potential as leaders in the community, and partnerships were improving with each passing year. School partnerships with the community

are a more recent trend, as schools have traditionally been a closed system. The culture is evolving, however, and schools are increasingly opening their doors to others.

Mental Health Promotion and Awareness: The majority of districts/schools conducted **some type of campaign to reduce stigma and promote mental wellness**. With that said, it was not uncommon for only some schools within a district to be involved with these awareness activities. The focus, messaging, intentionality, and implementation of these campaigns also varied from school to school. While not technically a mental health campaign, Mental Health First Aid (Adult and Youth versions) trainings within the schools and/or communities were the most commonly cited promotion activities. Additionally, we noted a special focus on suicide prevention in recent years. In general, we found that lack of funding and buy-in prevented more meaningful mental health campaigns from taking place.

Staff Professional Development: Districts and schools routinely provided a variety of trainings to school staff, focused on **increasing knowledge and awareness**, and practical application of programs/supports related to mental health and wellness. There was a need for additional ongoing trainings, however, as we noted a lack of follow-through upon completion of these programs. Just as booster shots are necessary to preserve the integrity of certain vaccines, so are refresher trainings for many mental health programs.

The majority of informants expressed a **dire need for additional professional development** opportunities related to recognizing and responding to signs and symptoms of mental illness in youth. System barriers that prevented educators from getting the mental health training they needed to be successful were also discussed, including:

- Educators often do not have the time to participate in professional development opportunities when school is in session (e.g., educators are busy teaching during the week, rendering them unavailable to attend trainings).
- Most professional development focuses on academics – not mental health.
- Professional development opportunities require a lot of planning ahead, and are scheduled far in advance (i.e., an important, relevant training may not fit into the schedule for a year or more).
- Trainings are often self-selected (i.e., educators volunteer to attend, rather than it being a requirement).

Positive School Climate and Culture: **Positive school climate and culture is becoming a higher priority** for districts/schools, with nearly all informants stating that they have seen improvement in this area. PBIS, social-emotional learning curriculum, increased professional development opportunities, and restorative justice were common methods discussed. Informants indicated, however, that despite good intentions, schools often fell short of fully implementing a positive school climate and culture.

Accountability Systems: The majority of informants stated that accountability systems were embedded within their districts'/schools' School Improvement Plan, however these, as a general rule, focused on academic improvements. Overall, **most schools did not have a**

cohesive, structured accountability system in place to address social, emotional, behavioral goals, thus, staff are not held accountable for SEB learning benchmarks.

Data-Based Decision Making: Overall, we found that meaningful **data-based decision-making was rare with regard to mental health efforts**. The use of data varied from district to district. While it was certainly common for schools to collect data, it was rare for them to use those data in making decisions. In fact, many informants stated that data were collected but never analyzed – likely because staff were not informed or trained how to do so.

Multi-Tiered System of Supports

Tiered Levels of Programs, Supports and Services: The majority of informants reported **some type of Tier 1 (Universal) and Tier 2 (Selective) programs, services, or supports** within their districts/schools. Despite this, we found a general lack of mental health interventions at all three tier levels within districts/schools. Informants also reported a lack of a universal screening tool (behavioral) for student identification and referral. In short, there was a need for a more holistic, comprehensive approach to student mental health and wellness.

Culturally, Linguistically, and Developmentally Appropriate Services: While some informants identified strategies related to the cultural, linguistic and developmental needs of students and staff, knowledge in this area was lacking overall. In fact, **the majority of informants were unaware of steps being taken in these area**s. With a general lack of mental health services for all students, culturally, linguistically, and developmentally appropriate services are frequently overlooked. Of the respondents who were aware of culturally, linguistically, and developmentally appropriate services, many maintained that language services were lacking, and that it was difficult to achieve family engagement.

It was also noted that many schools employed staff whose characteristics were not representative of the student body. That is, schools with a diverse student population often had primarily white staff. The implementation of culturally appropriate services is particularly important in these settings, as students' responsiveness to mental health programming can be impacted.

Underdeveloped and/or Inadequate Programs, Supports and Services: When asked about underdeveloped or inadequate programs, **65% of informants reported that program level supports were underdeveloped or inadequate**. Moreover, services for youth most at risk, Tier 3, were the least likely to be fully developed, including access to quality, intensive school-based mental health services and supports. Among staff, inadequate knowledge, awareness, and training – often through no fault of the educators – hampered the fidelity of programs, supports, and services.

Insufficient resources (e.g., funding, workforce, services) have hindered the quality of (and access to) mental health programming. Districts/schools often lacked the internal capacity to develop adequate school-based mental health programs, supports, and services.

Coordination and Integration

Informants regarded **coordination and integration across systems (school and community) as often underdeveloped, inadequate, and inconsistent**. While coordination with non-school based partners was not uncommon, the level and type of engagement varied. Partnerships tended to center around existing community-based coalitions with these mostly focused on addressing the prevention of adolescent substance use. Most notable, is the disconnect between schools and community providers, especially with regards to a common language and general understanding of each other's system. This disconnect often resulted in confusion and difficulty integrating/coordinating school- and community-based care. Contrary to our expectations, duplicative services were not identified or regarded as problematic for the vast majority of informants. Many informants expressed a desire for duplicative services, rather than the lack of services they were currently experiencing

Impacts

Informants reported **increased access to mental health services** in recent years. Programs utilizing the delivery of services in an integrated approach, across the continuum of services, were regarded as more successful than those without. Program success was dependent upon a multitude of issues, including:

- Buy-in (administrative and legislative);
- Adequate funding;
- The delivery of evidence-based programs;
- Access to services; and
- Trust and effective communication between schools and community partners.

As previously stated, there is a substantial need for more meaningful data collection and data-based decision making with regard to program impacts/success.

Overall Barriers and Challenges

Common barriers listed by informants included **funding**, **insurance** issues, lack of **cross-system coordination**, lack of **shared common language**, lack of **professional development**, and lack of a qualified **workforce**. The single most cited barrier, however, was **stigma**. The majority of informants reasoned that barriers could be overcome with increased funding and professional development.

NAVIGATION: BUILDING THE PATHWAY FORWARD

Despite years of positive efforts within the K-12 education system to support the mental health and wellness needs of children and adults, the gap between research and practice remains. Our findings showed that many districts/schools were ill equipped to deliver a comprehensive multi-tiered system of supports. Nevertheless, there is a path forward. Washington State has a long history of advocating for its children, and recognizes the need to develop and implement evidenced-based approaches for the delivery of services and supports to children impacted by barriers to learning and teaching. In our current study, we found evidence of this in those "pockets of excellence." More importantly, there is a general consensus – from the legislature on down – regarding the need to provide those working in the education system with the tools to improve the school environment, and to meet the mental, emotional, and behavioral health and wellness needs of children and staff.

The recommendations we present here echo, support, and build upon similar suggestions from others in the state who are also currently involved in this work. Our recommendations are made in the spirit of collaboration and hope. Hope that we in Washington State have reached the collective recognition that together we can move this meaningful work forward…our children are depending upon us.

1. Build capacity to implement comprehensive, multi-tiered, school-based mental health (SBMH) system of programs, services and support.[24]

Fund school-based pilot sites that demonstrate a level of readiness to fully implement an MTSS school-based mental health model. Build in a planning period, ideally 3 to 9 months, depending upon level of readiness, to conduct a resource inventory, needs assessment, and a well developed implementation plan.

Work collaboratively with these pilot sites to focus on implementation of foundational pillars of support.

Provide sites with technical assistance/training related to:

1) School-Family-Community partnerships and sustaining engagement;
2) Social norming campaigns for mental health promotion and awareness;
3) Staff professional development opportunities, specifically related to screening and referral, signs and symptoms of mental health issues, progress monitoring, family engagement, mental health promotion and awareness, trauma-sensitive

[24] Similar frameworks have been adopted by a number of other states, with these states laying the ground work for how to scale up this work. In addition, a number of partners within the State are, and have been, at the forefront of championing this work within the K-12 education system. These leaders include the Office of Superintendent of Public Instruction's Department of Learning and Teaching, and Department of Student Supports, the University of Washington's SMART (School Mental Health Assessment Research & Training) Center, Sound Supports, the Many Minds Collaborative, Capital Region Educational Service District 113, NorthEast Washington Educational Services District 101, the Joint Legislative Audit & Review Committee (JLARC), and the Washington State Legislature's Children's Mental Health Workgroup, among others. In addition, a number of states have adopted a similar framework, thus have established a knowledge base and the structural processes necessary to assist in the scaling up of this work in Washington State. These include the states of California, Colorado, Florida, Michigan, and Wisconsin to name a few.

and culturally responsive schools, child and adolescent development, and staff self-care;
4) Positive school climate, including how to build teams with school and community-based providers;
5) Implementing meaningful social emotional learning accountability systems (e.g., OSPI's SEL benchmarks); and,
6) Using data to drive decision-making for SBMH programs, services, and supports and examine the impacts of academic and non-academic student-level outcomes.

Work collaboratively with these pilot sites to build capacity to deliver culturally, developmentally, and linguistically appropriate services across the tiered levels of supports.

Provide sites with technical assistance/training related to:

1) Universal (Tier 1) supports including the identification and implementation of a universal behavioral health screener, development of a standardized referral process, and selection and implementation of culturally, linguistically, and developmentally appropriate evidenced-based practices (EBPs).
2) Selective (Tier 2) supports including EBPs to address identified mental, emotional, behavioral issues, and progress monitoring; and,
3) Intensive (Tier 3) supports including culturally and developmentally appropriate individual and group counseling services, re-entry and transition planning, crisis response planning, and a system of care model including MOUs, data sharing agreements and common languages between school and community-based partners.

2. Collaborate with other state level partners to expand access to a stronger, qualified, and culturally competent mental health workforce.

1) Identify workforce barriers and implement strategies to dismantle these;
2) Consider alternative credentialing options for graduate and/or professional programs; and,
3) Use graduate students, such as social workers or counselors, to deliver services while completing their degree program's practicum requirement (similar to a Chemical Dependency Trainee program).

3. Build a common language around MTSS and School-Based Mental Health.

1) Move knowledge to practice through sustained training and technical assistance offerings throughout the education system (from bus drivers to administrators);
2) Identify a team of subject matter experts that can provide training, technical assistance, and mentoring to districts/schools implementing and MTSS-SBMH structure;
3) Develop a set of modules, in collaboration with subject matters experts (SMEs), that outline the basic and next steps in the development and implementation of this framework; and
4) Collaborate with identified partners, such as OSPI, and the UW SMART Center to support a professional learning community to ensure the continued learnings of the MTSS-SBMH framework.

4. Identify others in the school system to deliver Tier 1 and Tier 2 services.

1) Utilize existing school staff such as Prevention/Intervention Specialists, Education Advocates, or para-educators to build internal capacity to deliver services; and,
2) Provide the necessary training to increase skill levels among identified staff and ensure adequate supervision, monitoring and oversight, as appropriate.

5. Advocate for meaningful family and youth engagement.

1) Provide models for replication and/or access to SMEs to build capacity in the development of this work.

6. Reduce access barriers to care.

1) Reconsider insurance and/or billing criteria to improve and expand access to care;
2) Change reimbursement structures to allow for case management, consultation, and care coordination, including problem solving teams, and wrap-around services;
3) Identify Point-of-Contact Systems Navigator in the schools, provide training in billing procedures, including accessing Title I and Medicaid funding; and,
4) Consider use of technology as an option for service delivery (e.g., telemedicine).

7. Integrate and coordinate care across systems.

1) Facilitate care coordination between community-based and school-based providers;
2) Provide opportunities for each system to learn from each other;
3) Identify common cross-systems barriers; and,
4) Provide training and technical assistance related to the development of a systems of care model.

8. Normalize mental health in the academic education system.

1) Champion the inclusion of social emotional learning and self-care as part of the pre-service curriculum in all higher education degree programs.

9. Act as a Convener.

1) Bring partners together;
2) Dismantle silos;
3) Merge parallel work;
4) Build a cohesive network of champions; and
5) Use political power to bring awareness to this issue.

10. Be the Champion of Mental Health Promotion and Awareness.

1) In collaboration with partners, conduct developmentally and culturally appropriate statewide awareness campaigns (similar to the Tobacco prevention) to reduce stigma and promote mental wellness with a strong focus on youth between the ages of 10-17;
2) In collaboration with education partners, develop and conduct self-care campaigns for education staff with a focus on reducing stress, anxiety, burnout and compassion fatigue; and,
3) Consider the development and dissemination of innovative strategies to increase self-care within the K-12 education system.

Study Limitations: Undoubtedly, environmental scans – such as the current study – can provide organizations with valuable information about their current operating environment. In turn, they can respond quickly and meaningfully to opportunities and challenges uncovered. The information presented here can inform strategic planning processes, and allow Kaiser Permanente to make informed decisions about how to advance the implementation of innovative strategies as part of the Thriving School Initiative. Through the current environmental scan, we were able to identify strengths, opportunities, weaknesses, challenges, and barriers with regard to school-based mental health programs, services, and supports in Washington State's K-12 education system.

Despite the aforementioned strengths of environmental scans, there are some limitations to current study that should be noted. Because there is such an abundance of information available on SBMH, and because we conducted this study at the statewide level in a short timeframe, it is likely that important information was overlooked at some point. Certainly, locating *all* available information sources, statewide, in a four-month period would have been nearly impossible. Moreover, best practices in the field of education and mental health are continually evolving, with promising new strategies emerging on a regular basis. It is also important to note that those identified for key informant interviews, although subject matter experts in their own right, are not necessarily representative of the K-12 education system as a whole. Rather, many of these informants represented perspectives from what termed as the "30,000- and 20,000-foot levels," with some participants more directly representative of those on the ground in the education system (e.g., school and district-level informants). Thus, the current study is reflective of the *current* state of research and best practice, and the authors stress the importance of reviewing new interventions as they transpire.

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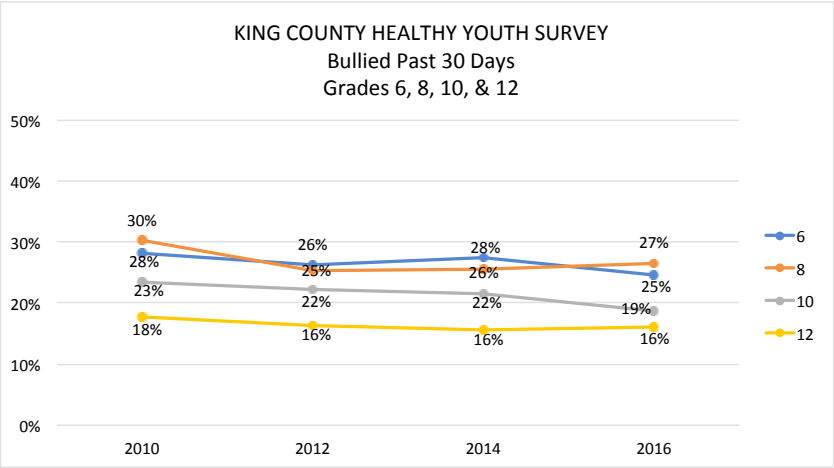
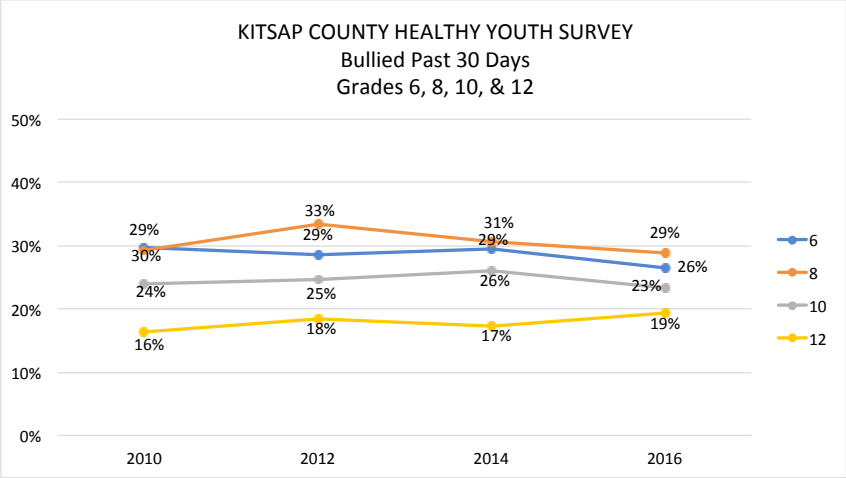
APPENDICES

APPENDIX A: HYS PAST 30-DAY BULLYING

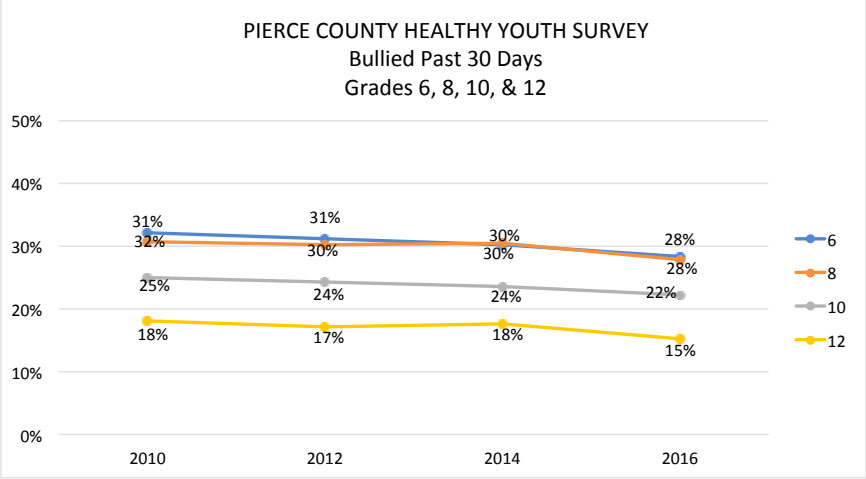
KING COUNTY



KITSAP COUNTY



PIERCE COUNTY



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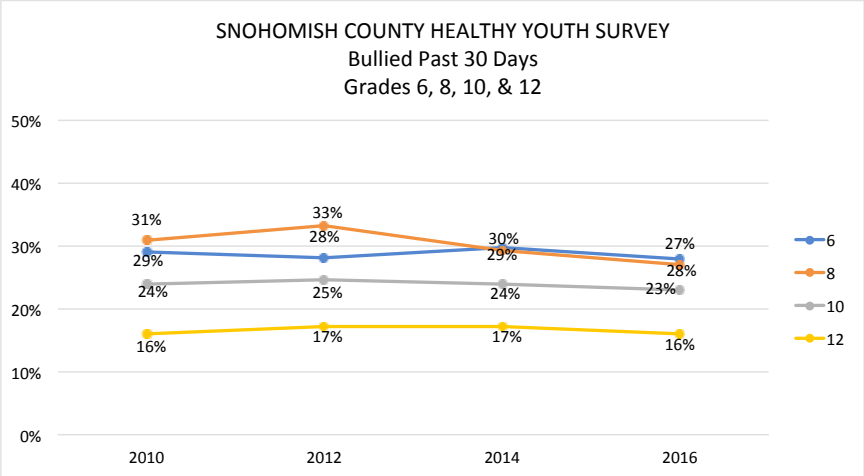

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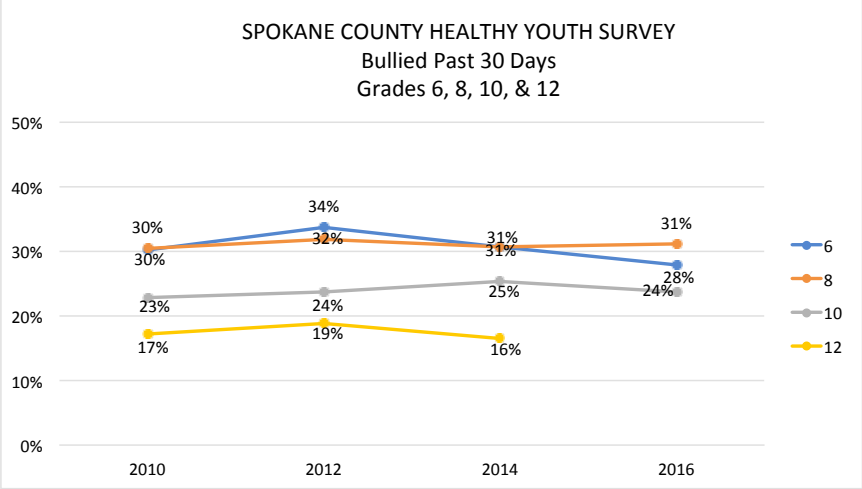

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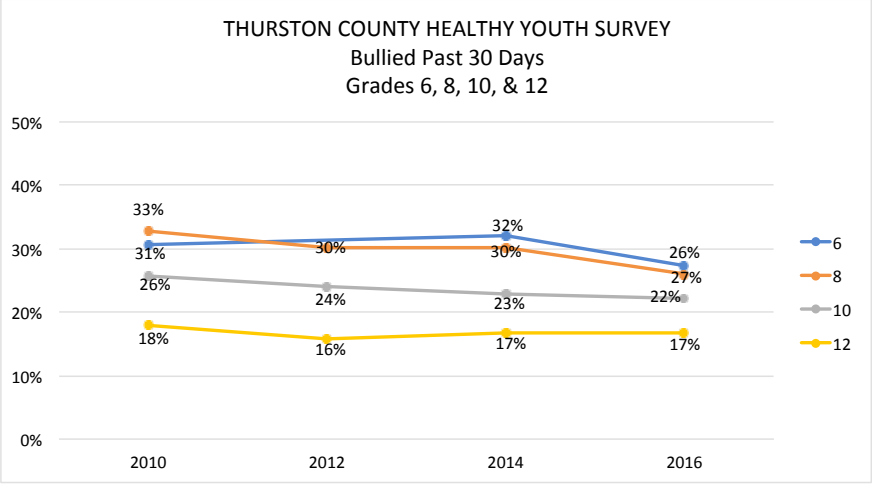
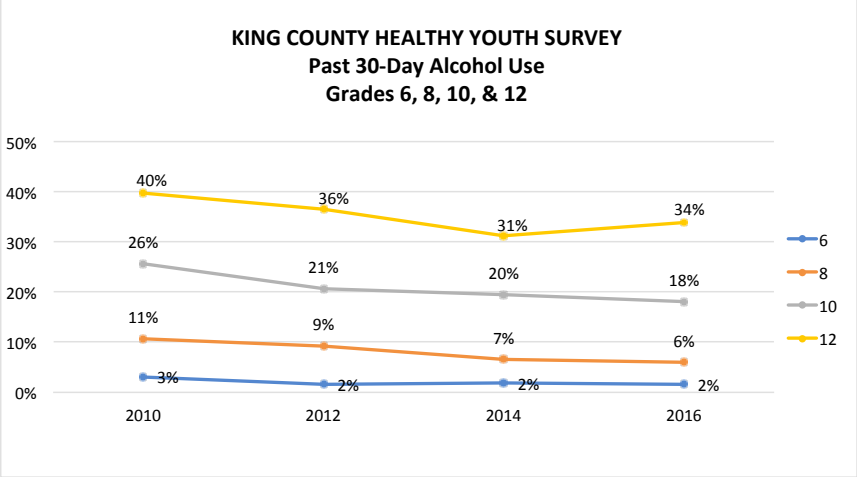


APPENDIX B: HYS PAST 30-DAY ALCOHOL USE

KING COUNTY



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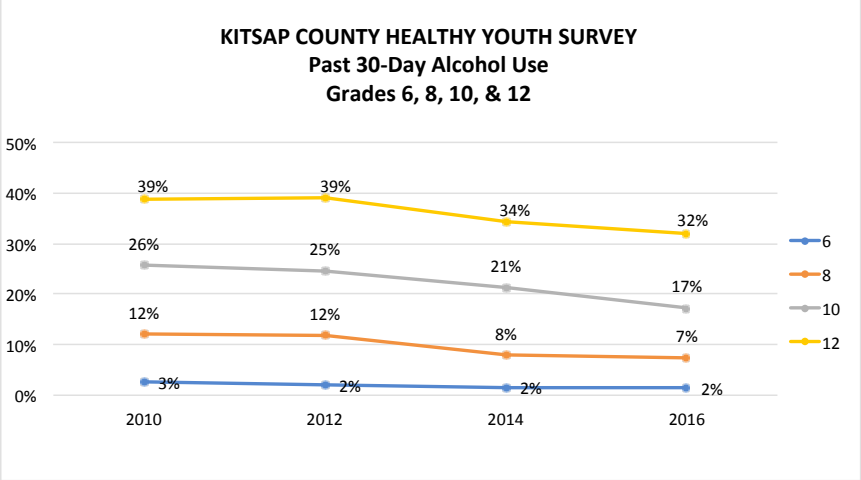

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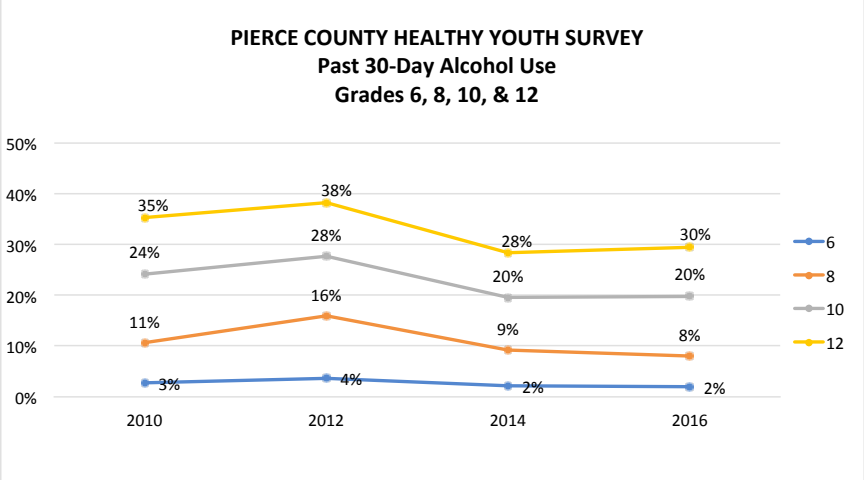

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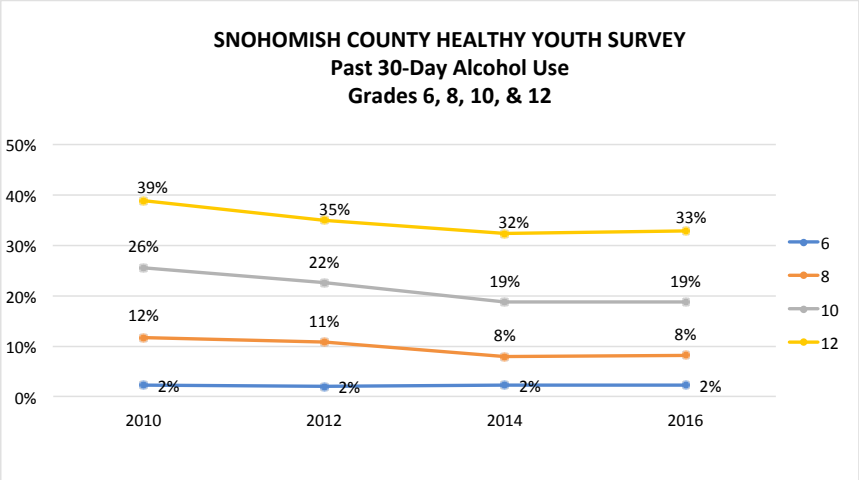

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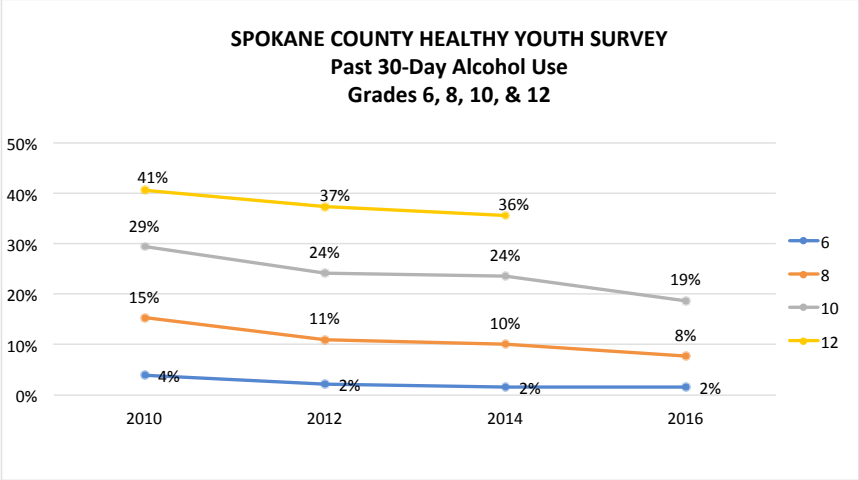
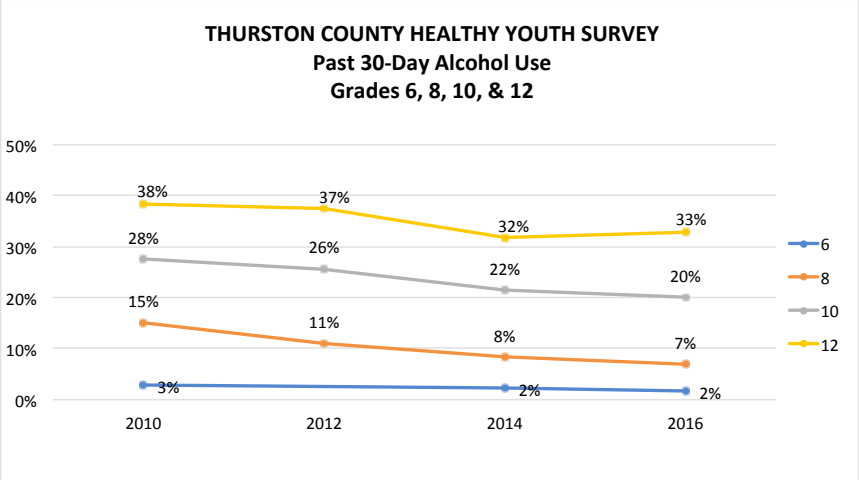
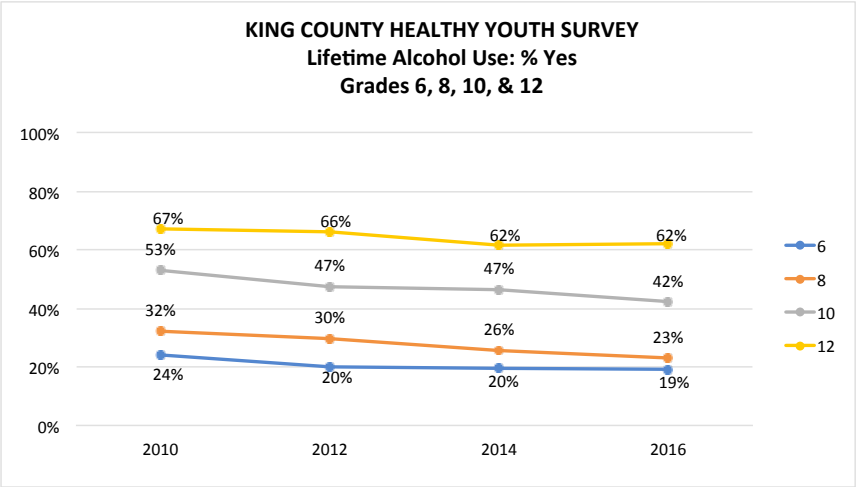


THURSTON COUNTY



APPENDIX C: HYS LIFETIME ALCOHOL USE

KING COUNTY



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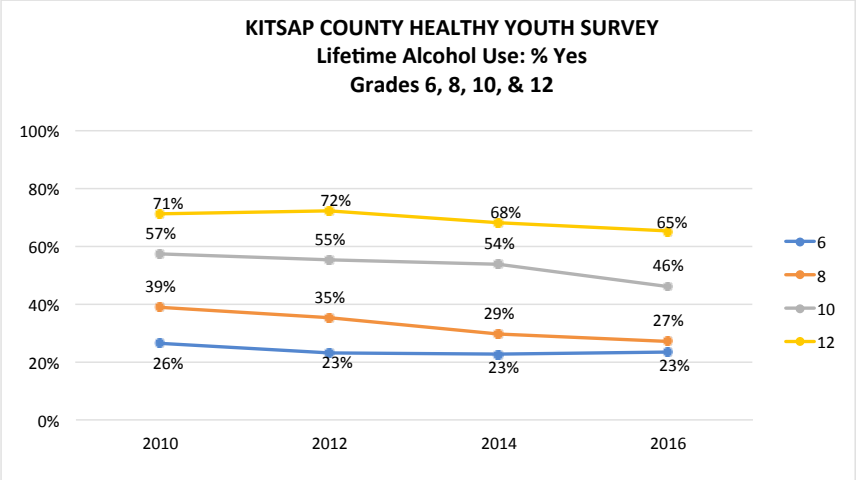

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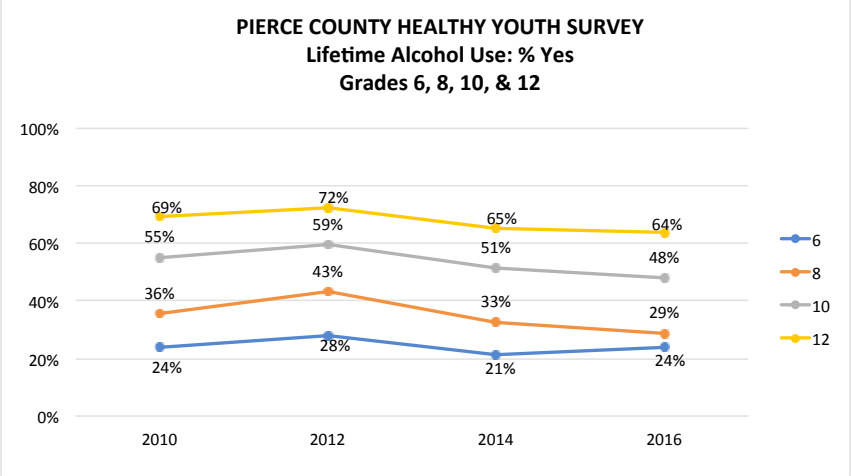

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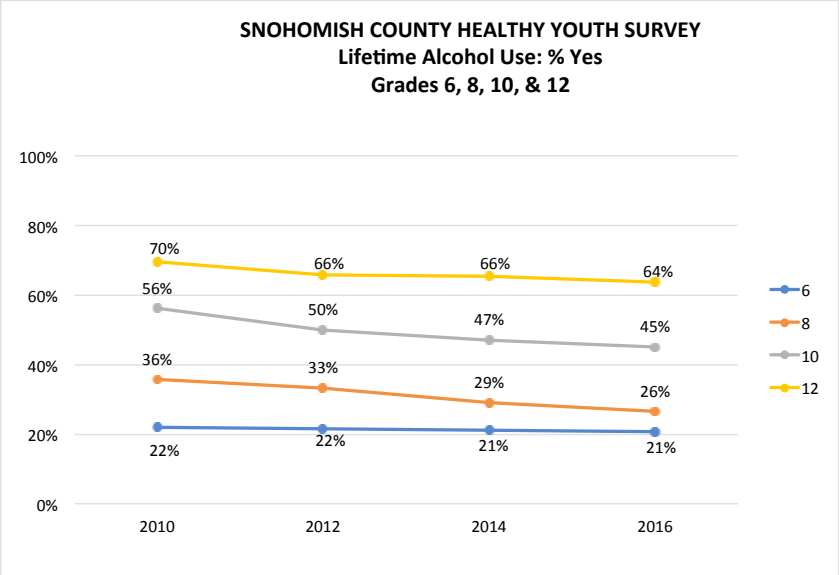

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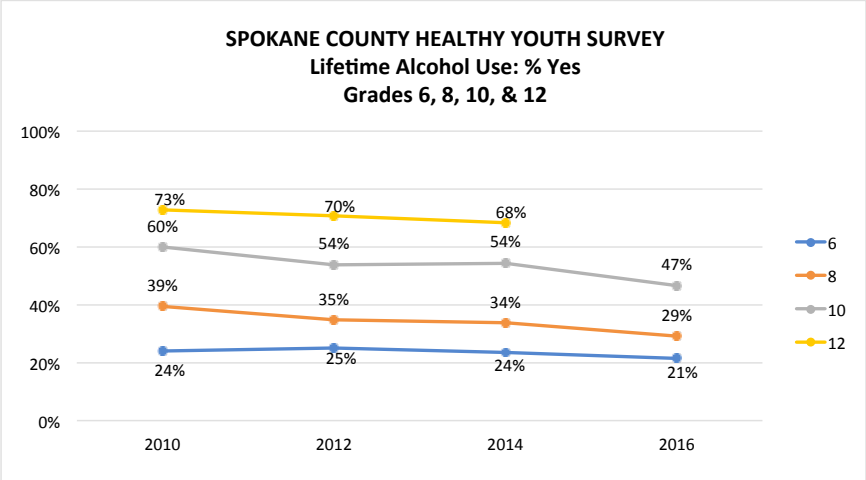

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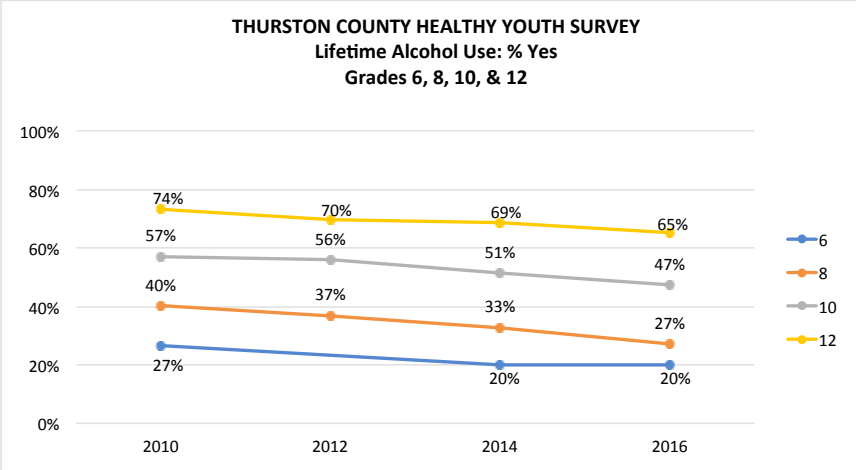
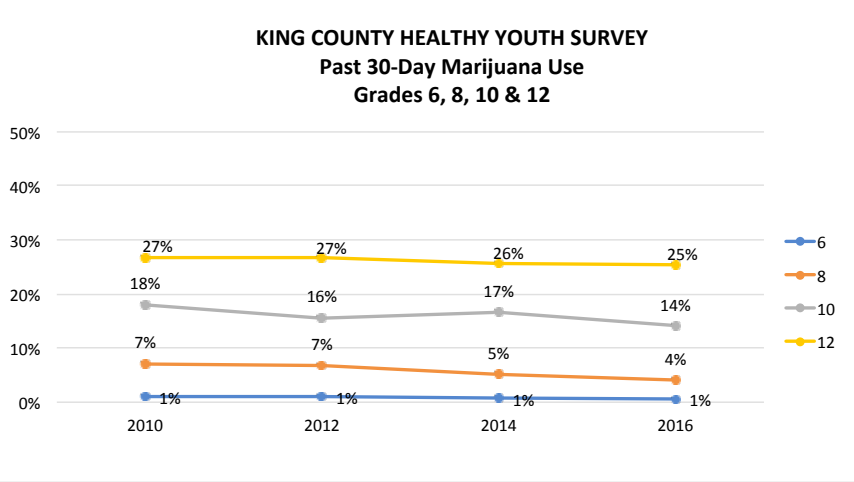


APPENDIX D: HYS PAST 30-DAY MARIJUANA USE

KING COUNTY



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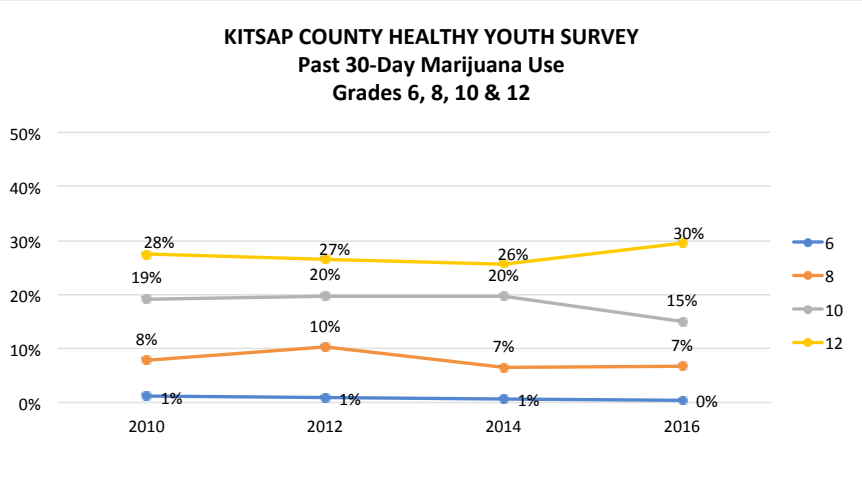

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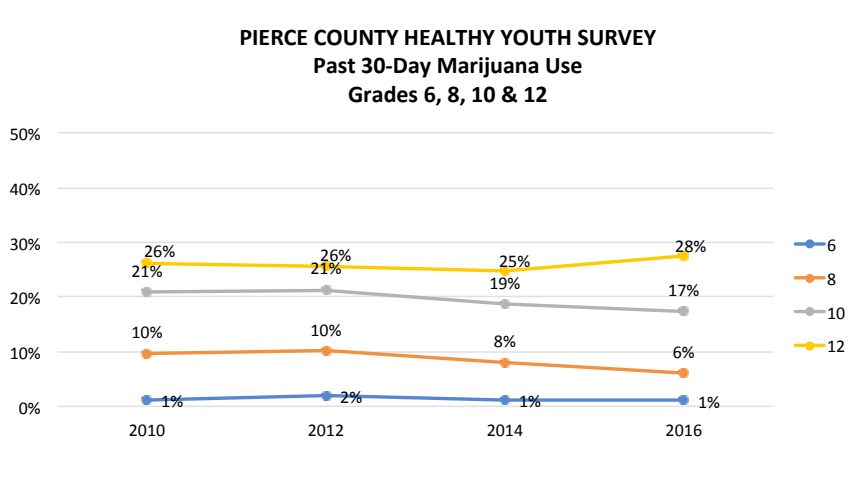

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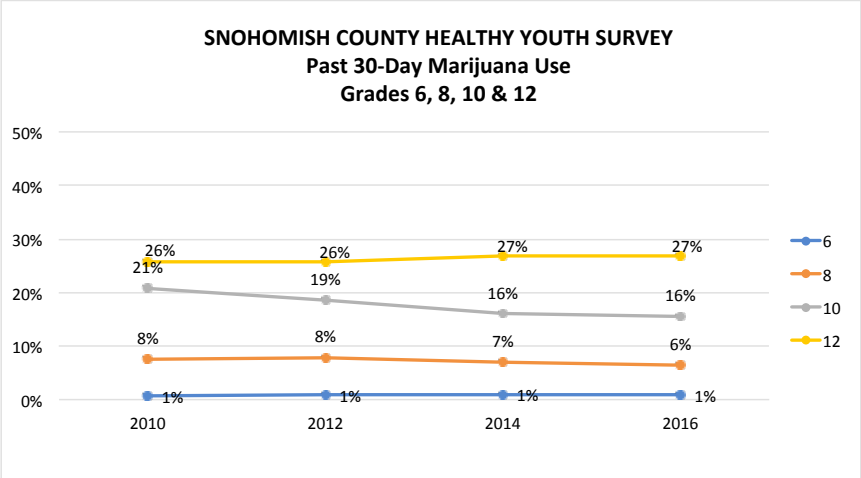

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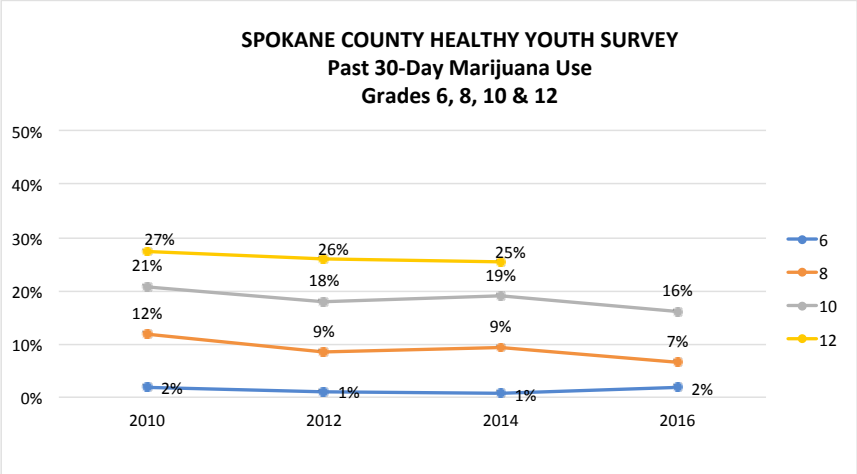

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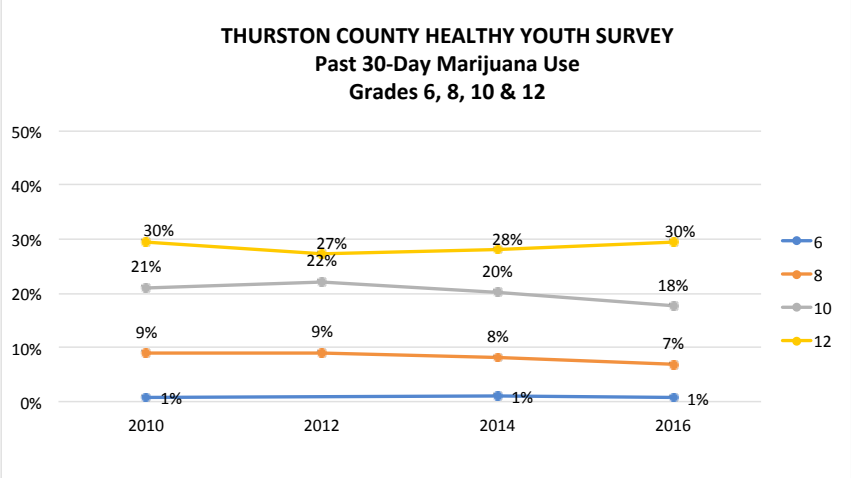
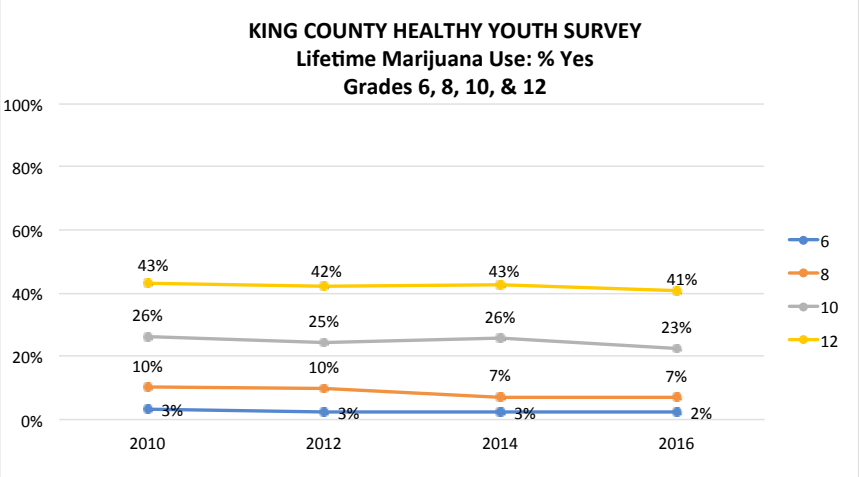


APPENDIX E: HYS LIFETIME MARIJUANA USE

KING COUNTY



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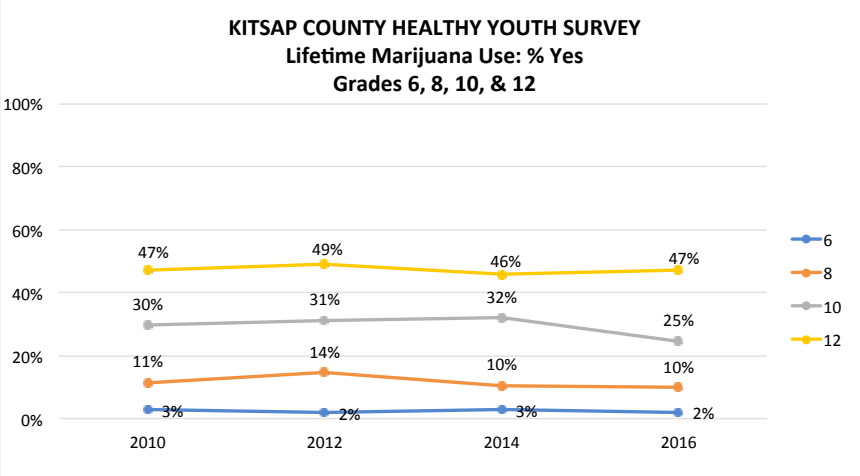

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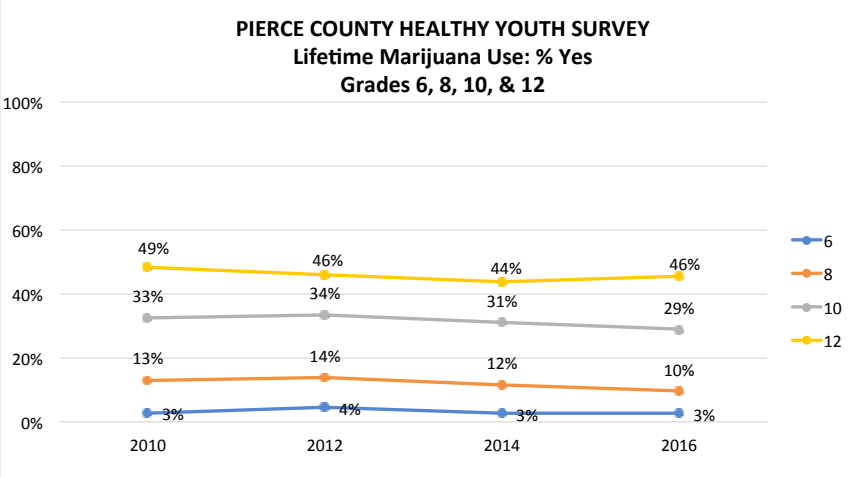

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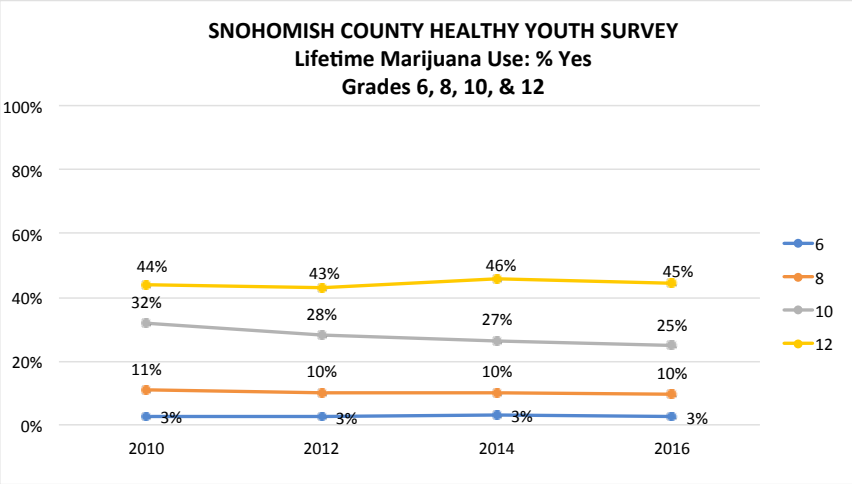

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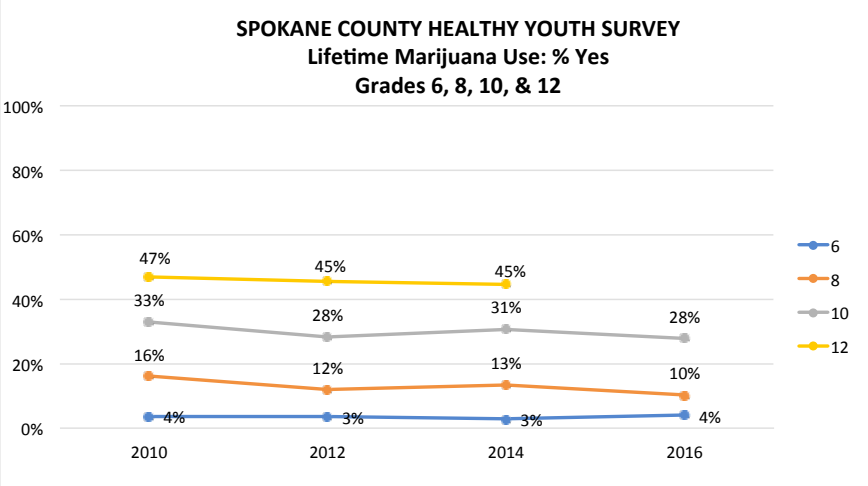

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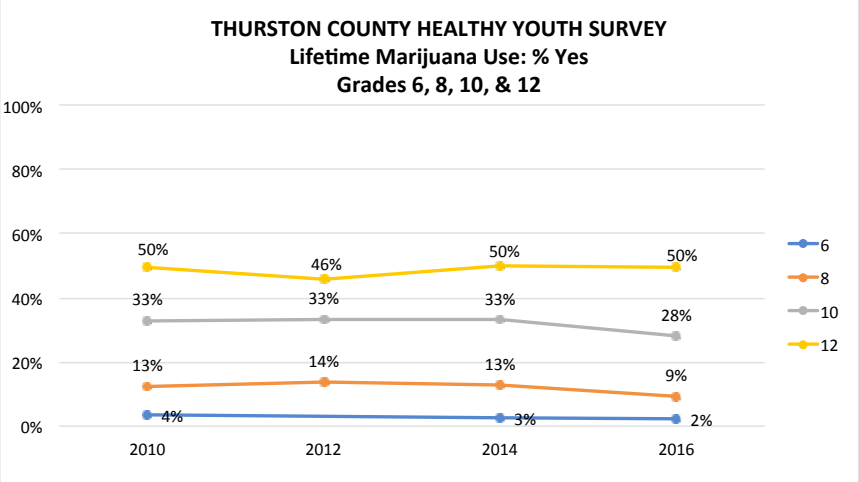
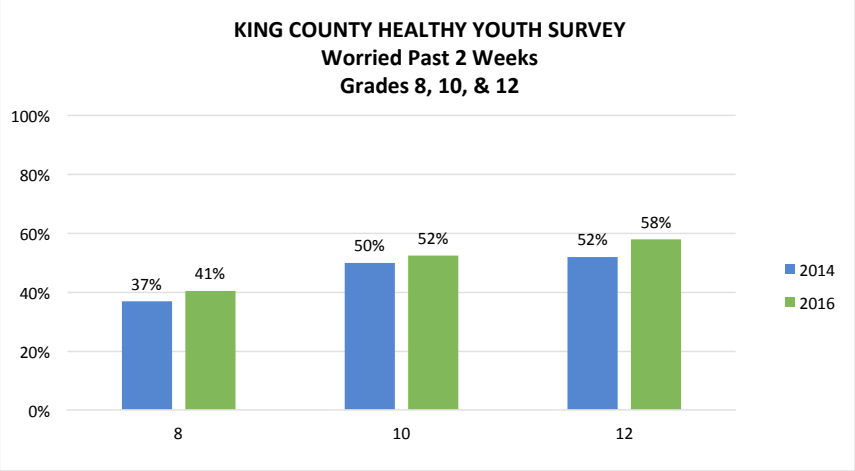


APPENDIX F: HYS WORRY PAST TWO-WEEKS

KING COUNTY



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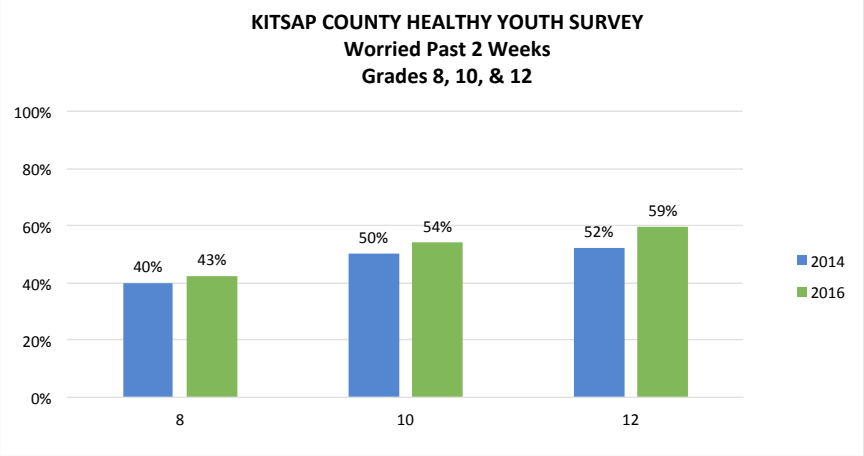
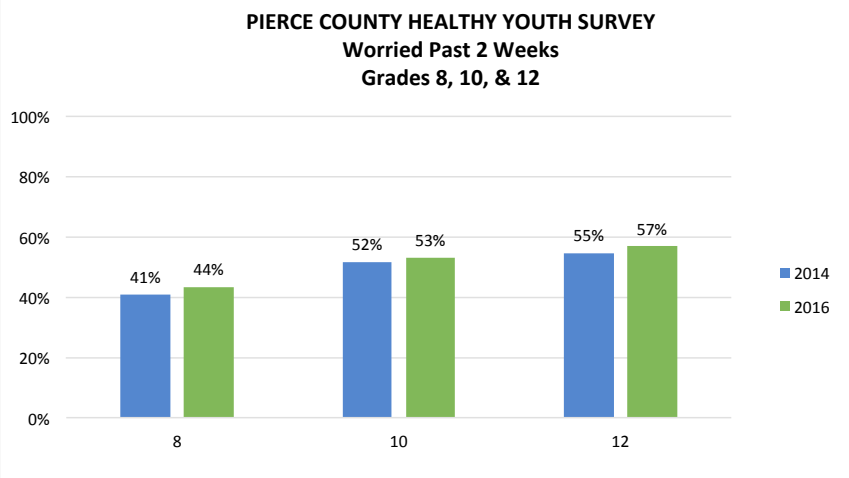


PIERCE COUNTY



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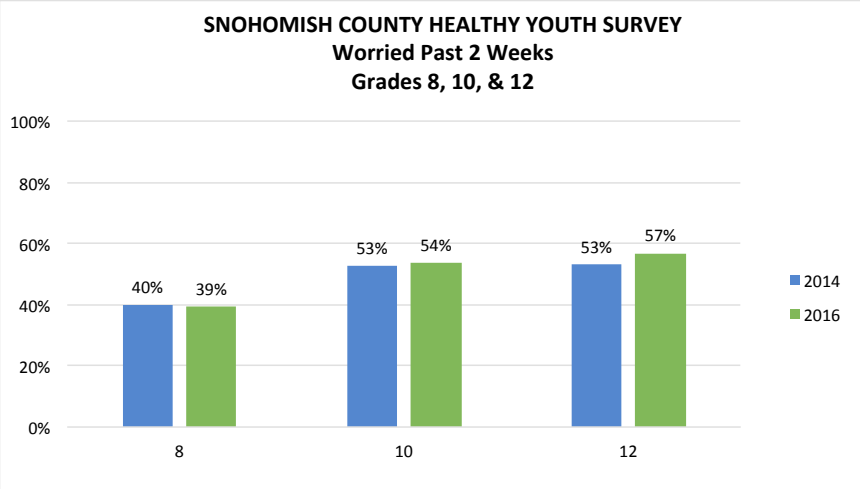

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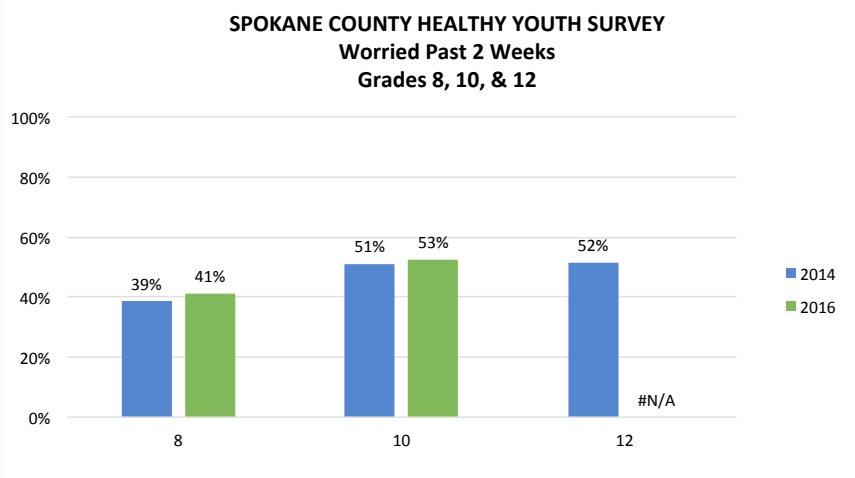

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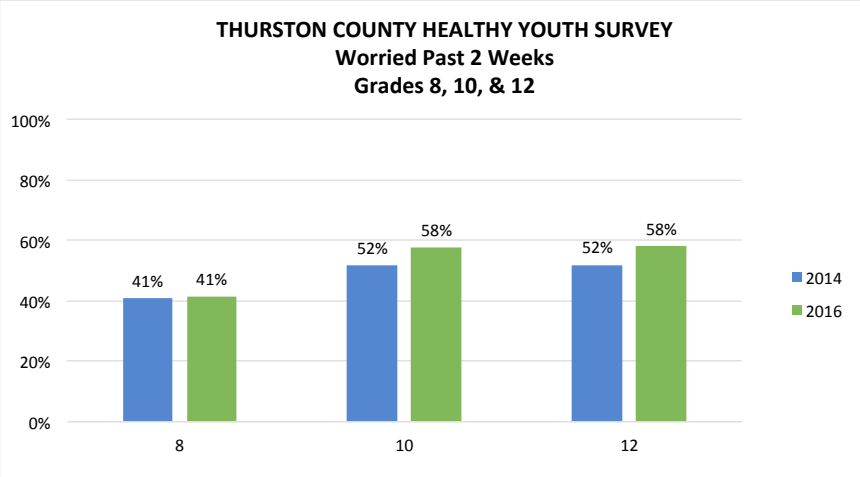
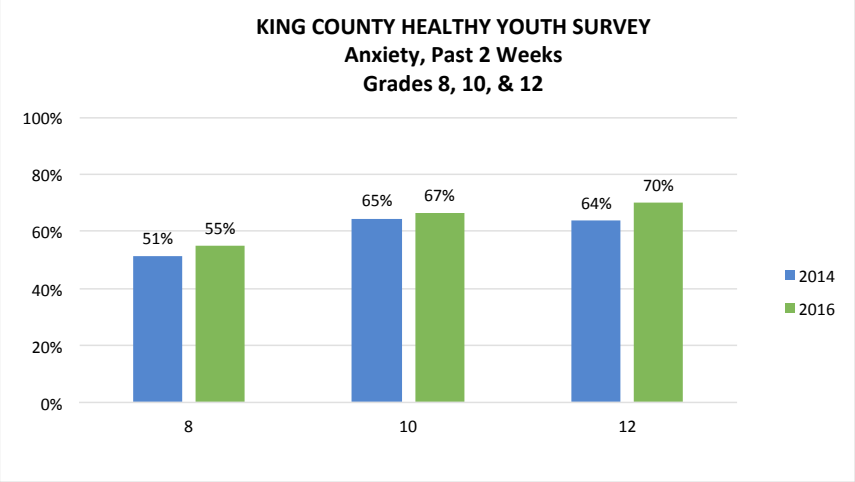
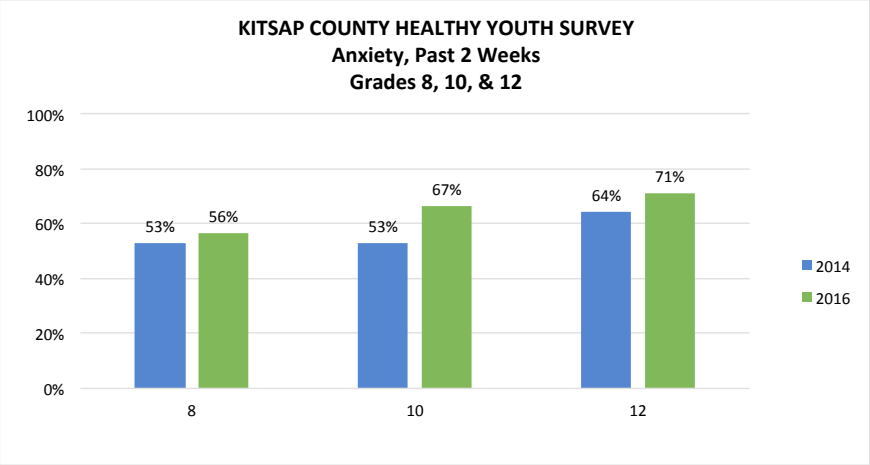


APPENDIX G: HYS ANXIETY PAST TWO-WEEKS

KING COUNTY



KITSAP COUNTY



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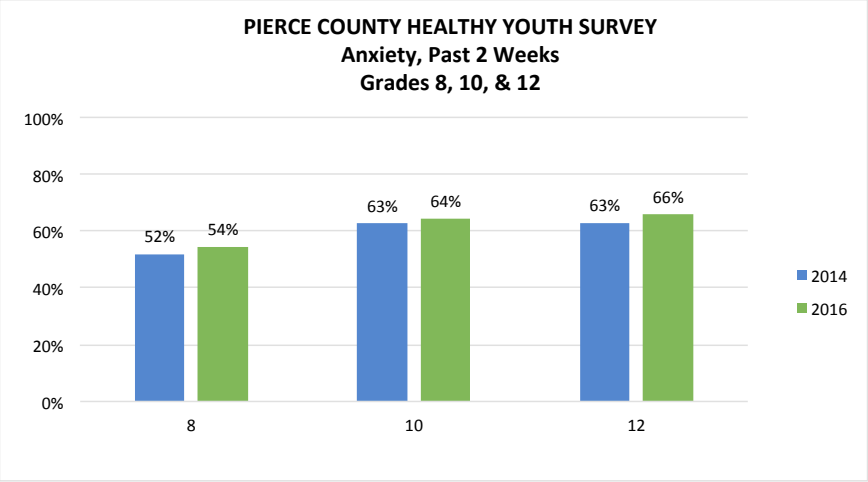

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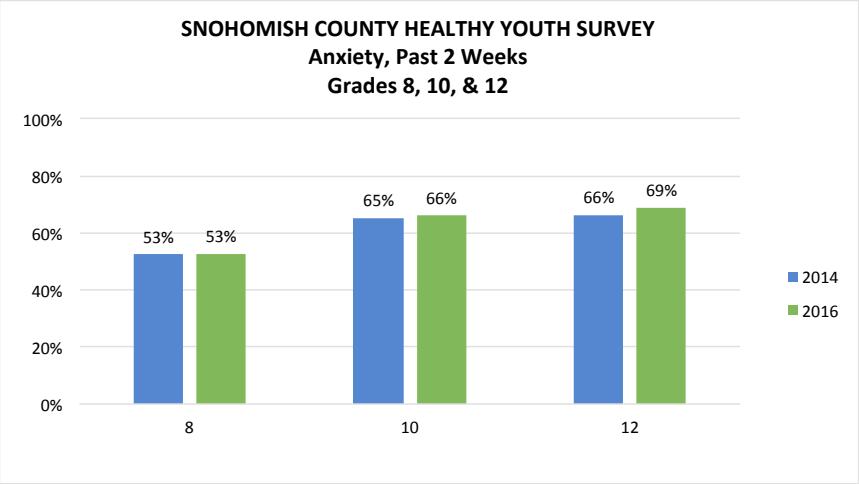

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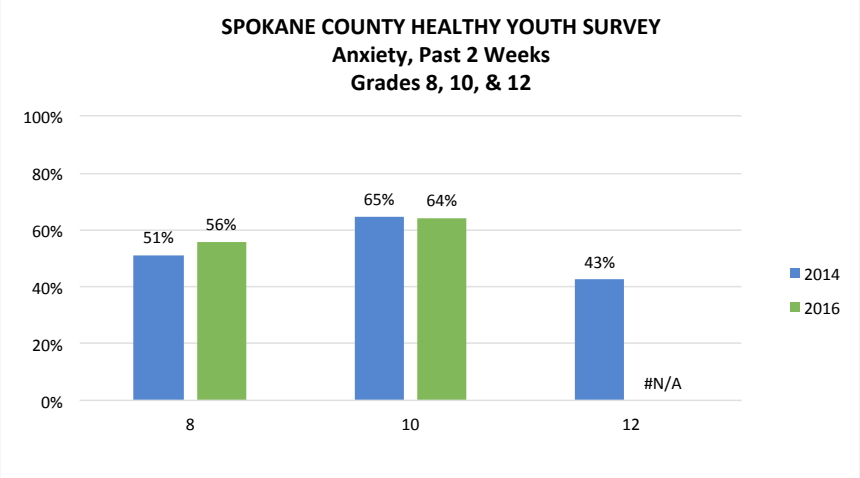

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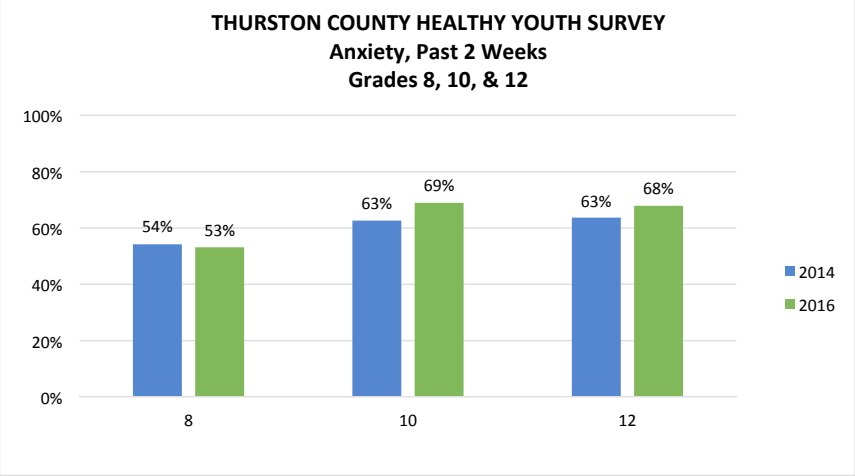
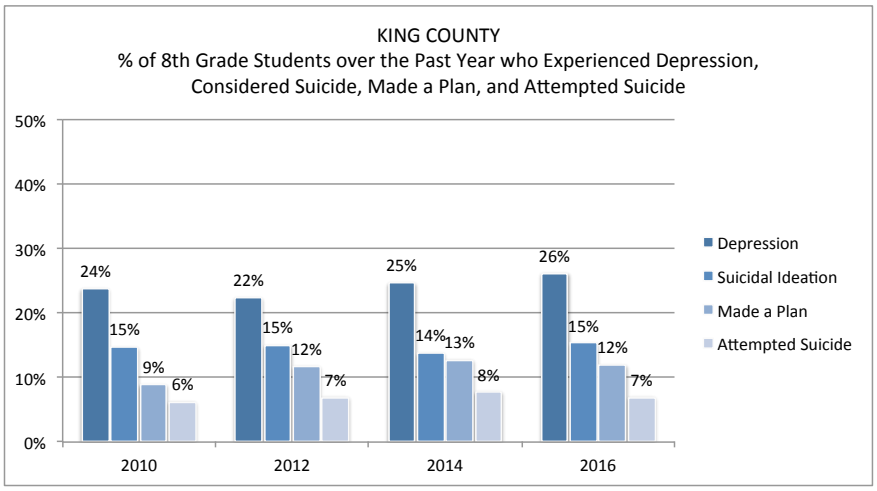
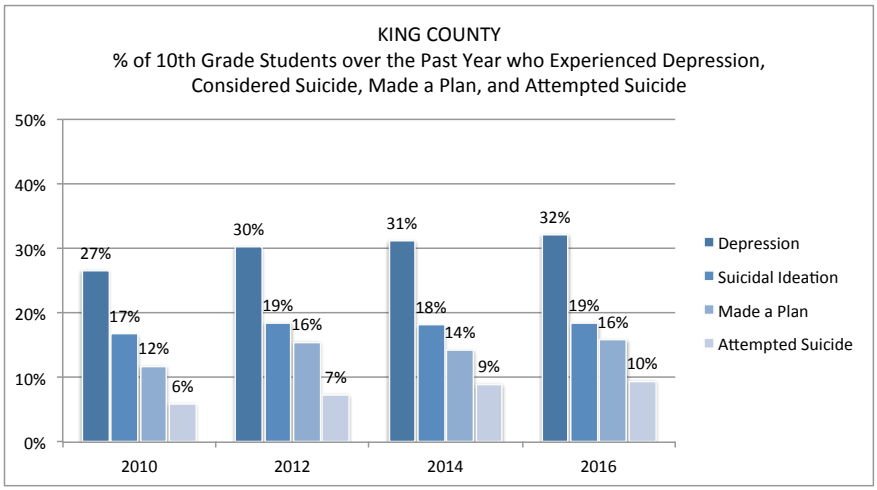
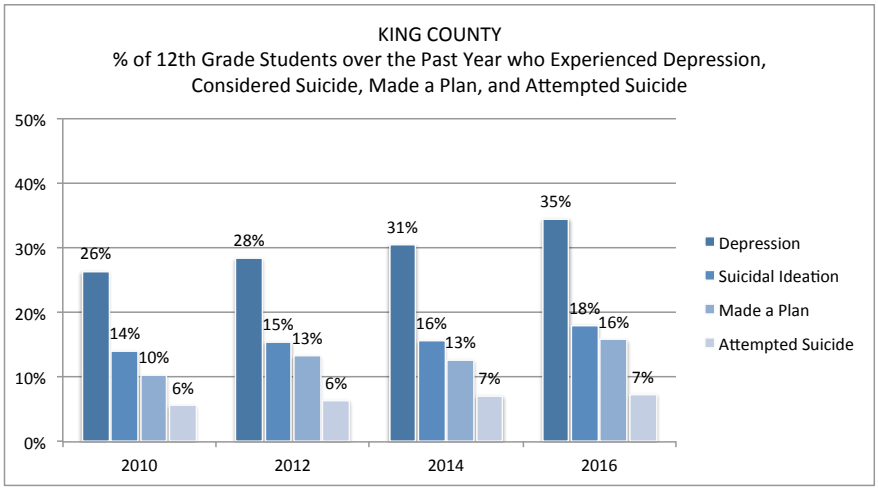


APPENDIX H: HYS DEPRESSION, SUICIDE IDEATION, PLANNING, & ATTEMPTS

KING COUNTY







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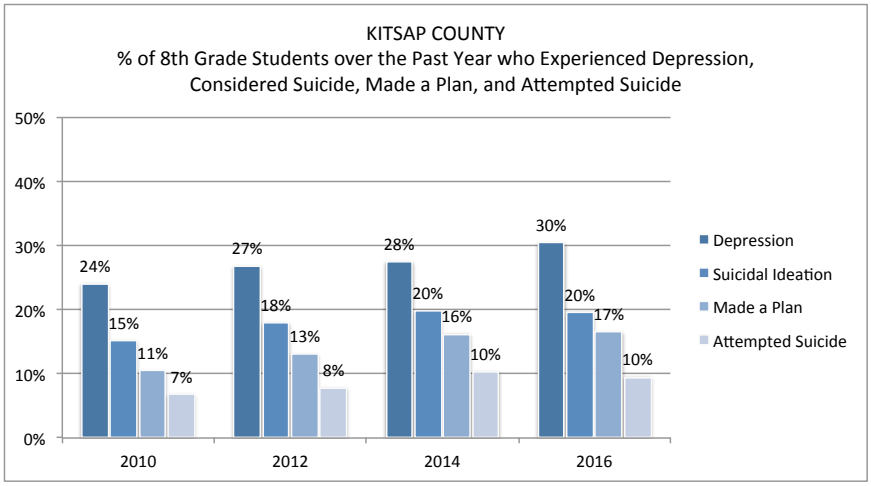
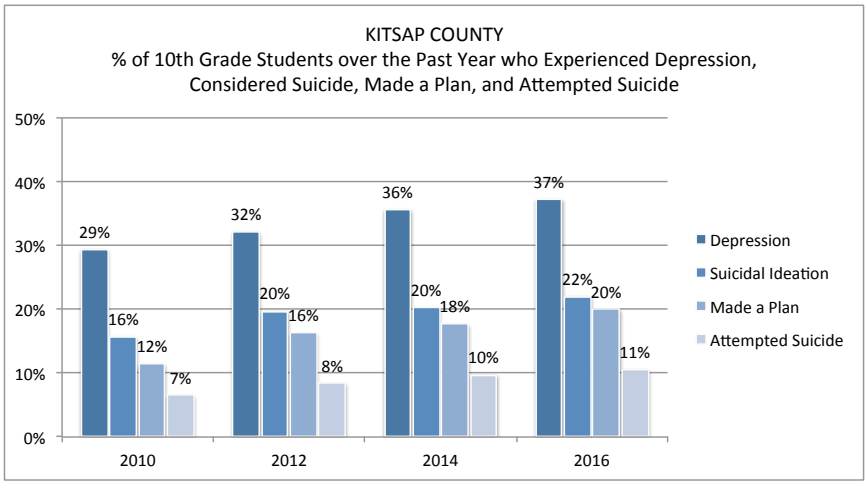
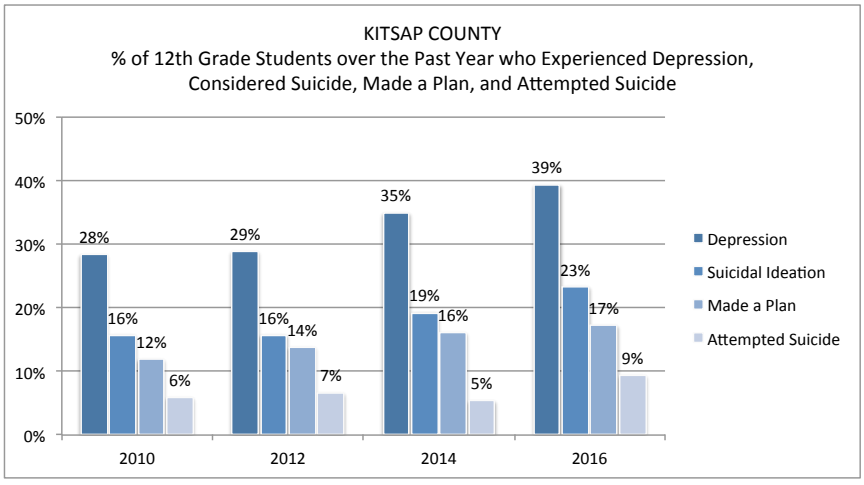
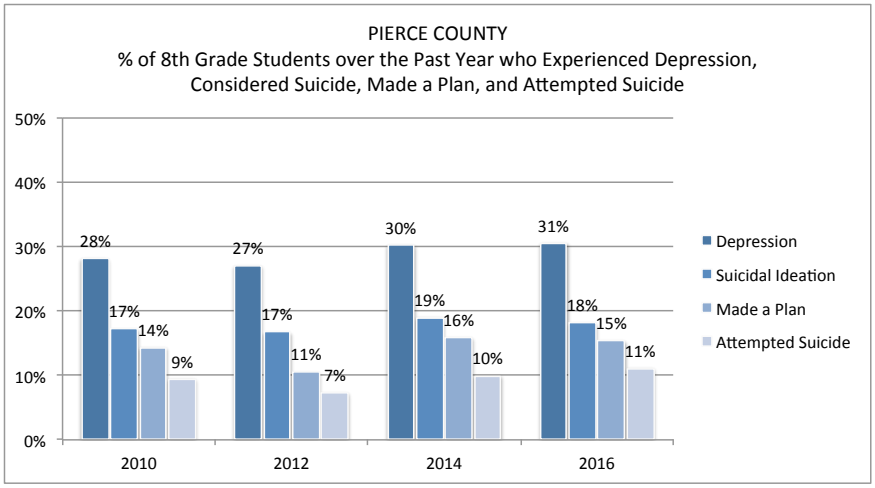
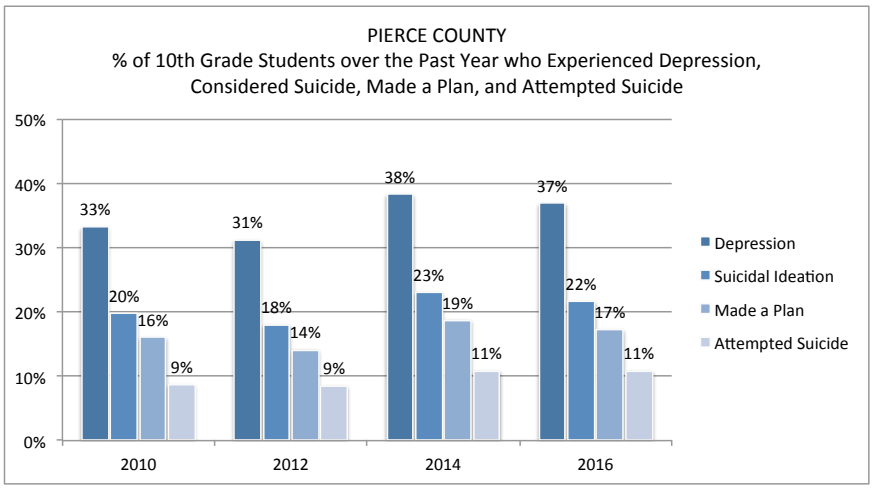


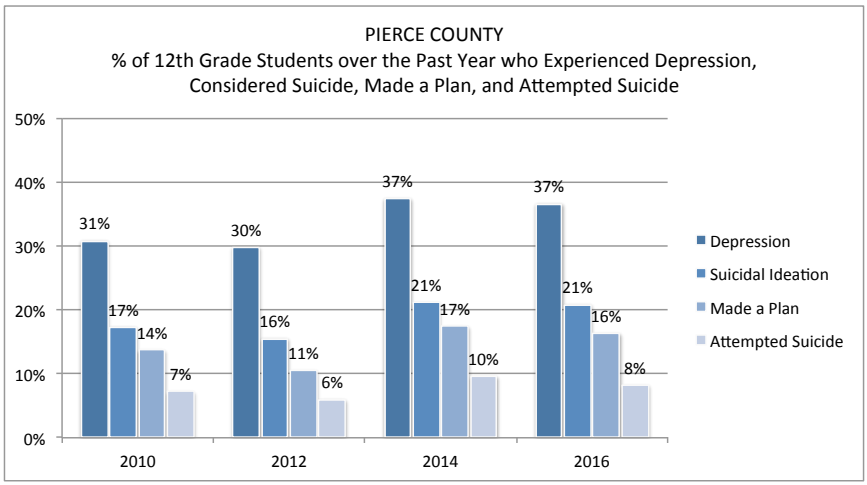




PIERCE COUNTY







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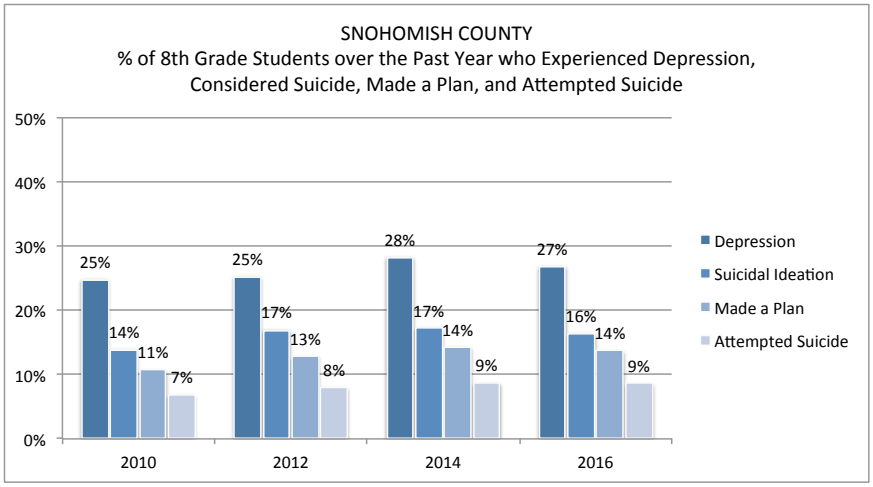

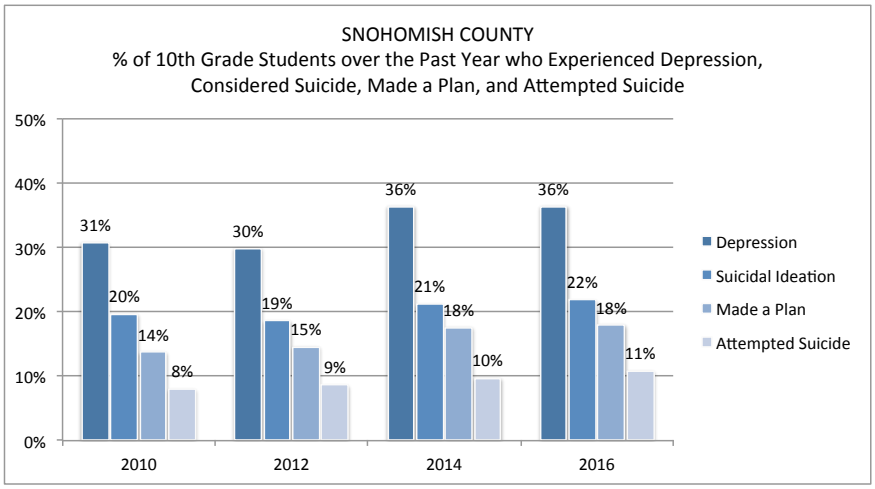

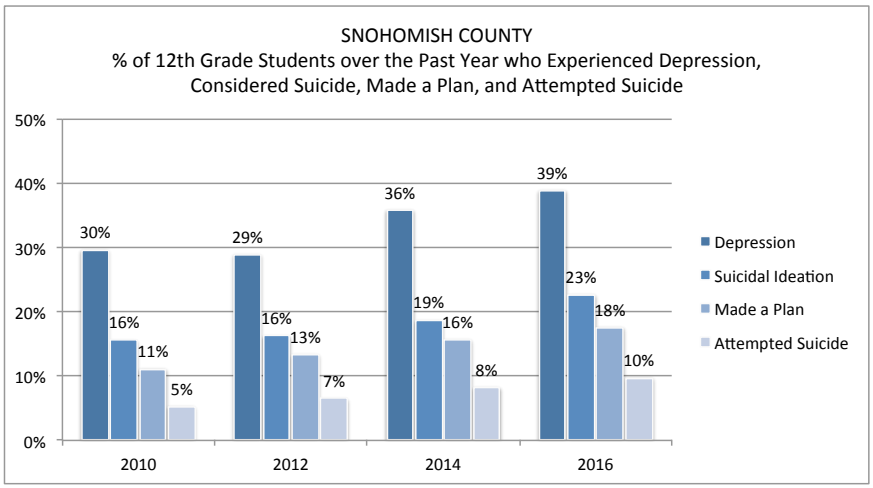

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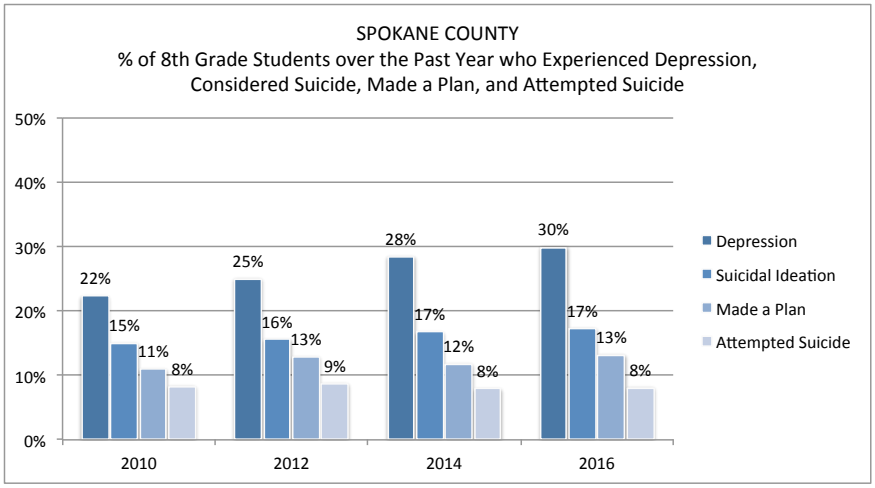

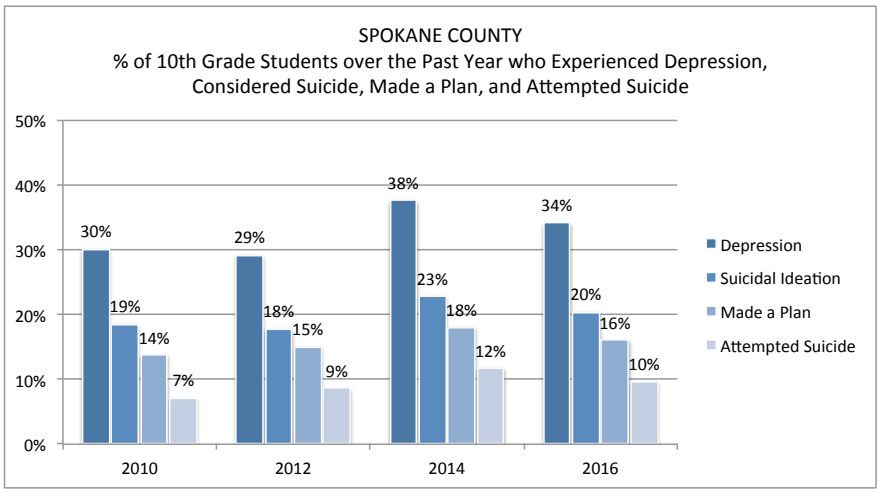

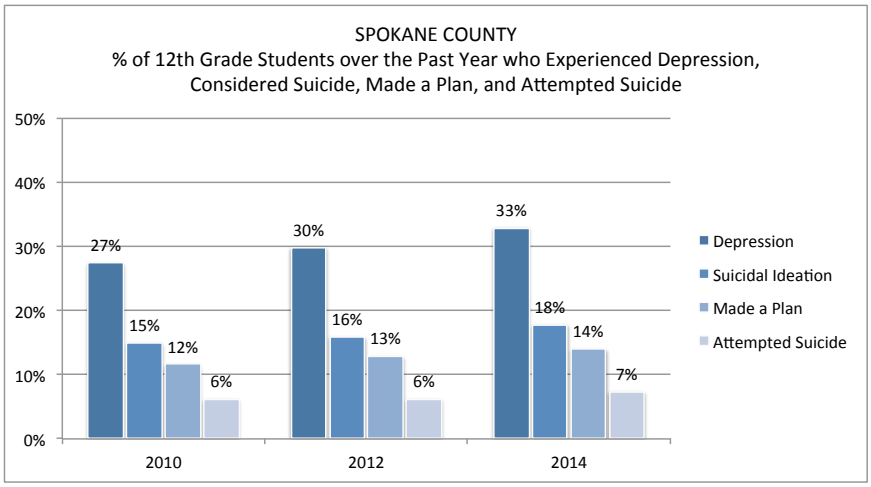

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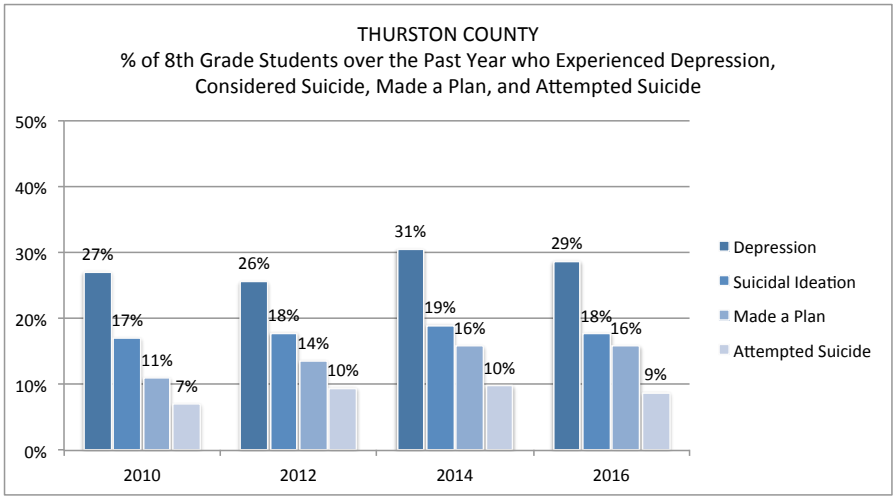
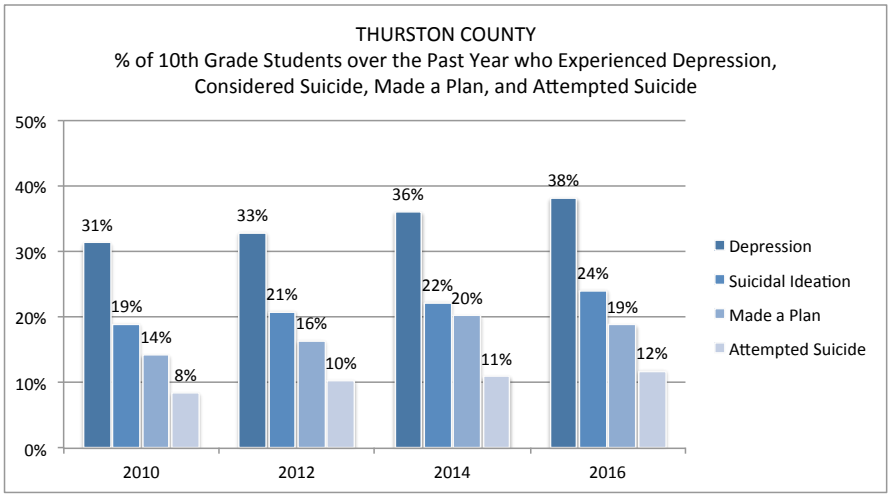
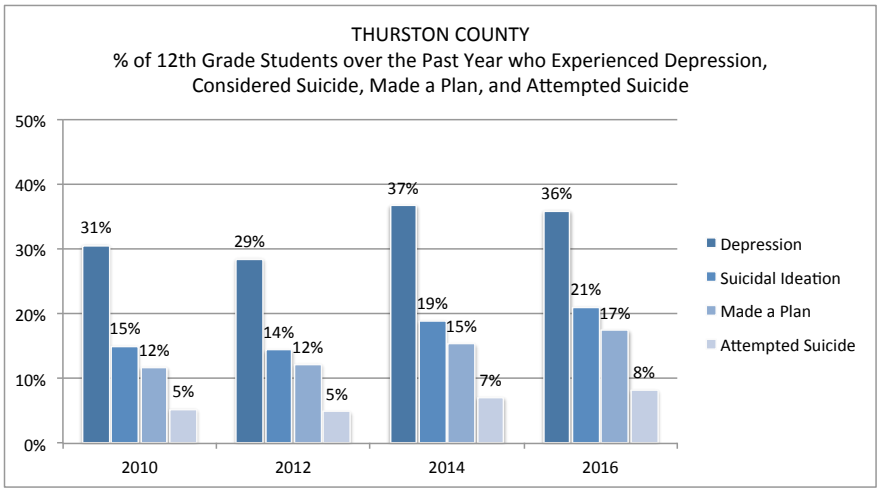
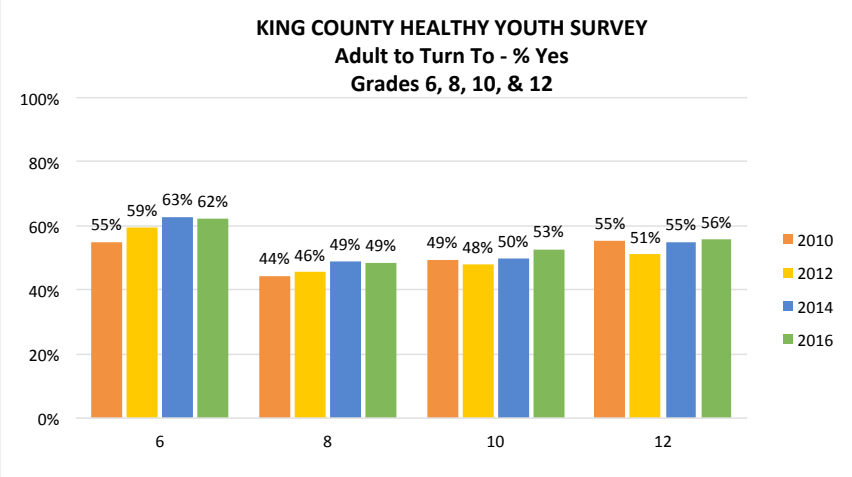




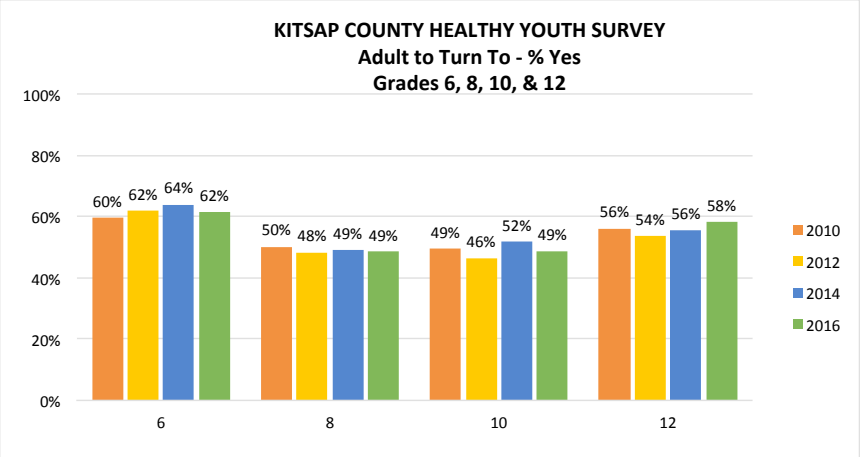


APPENDIX I: HYS ADULT TO TURN TO

KING COUNTY



KITSAP COUNTY



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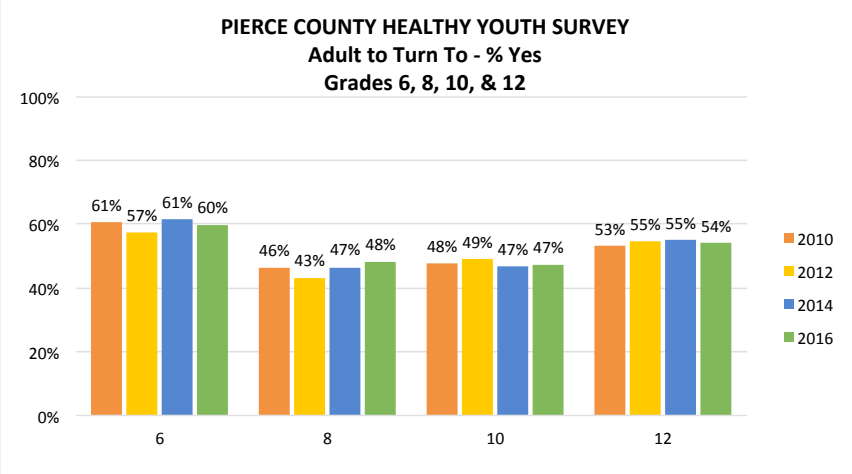

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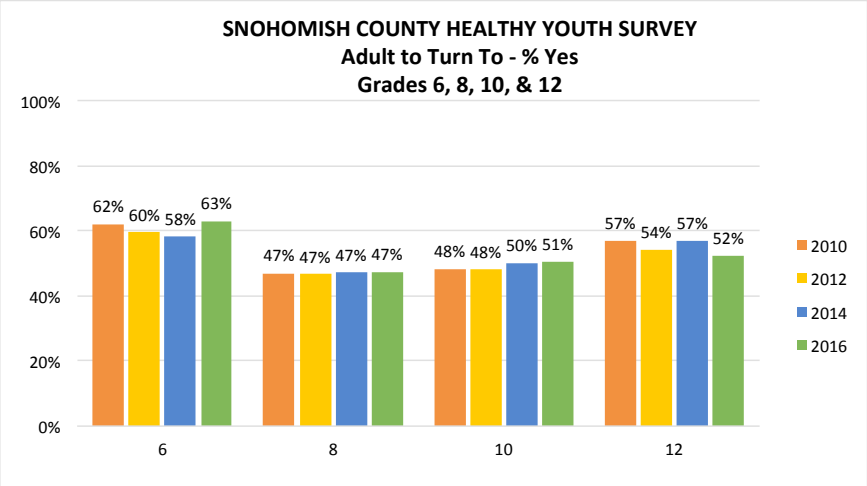
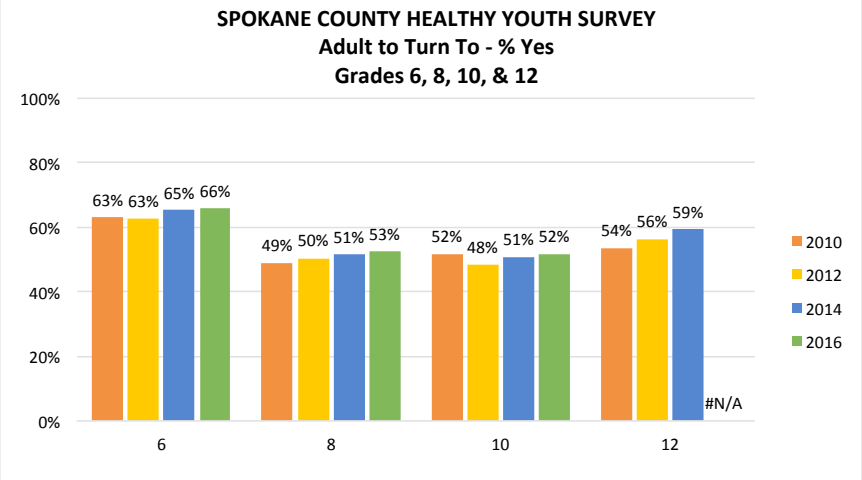


SPOKANE COUNTY



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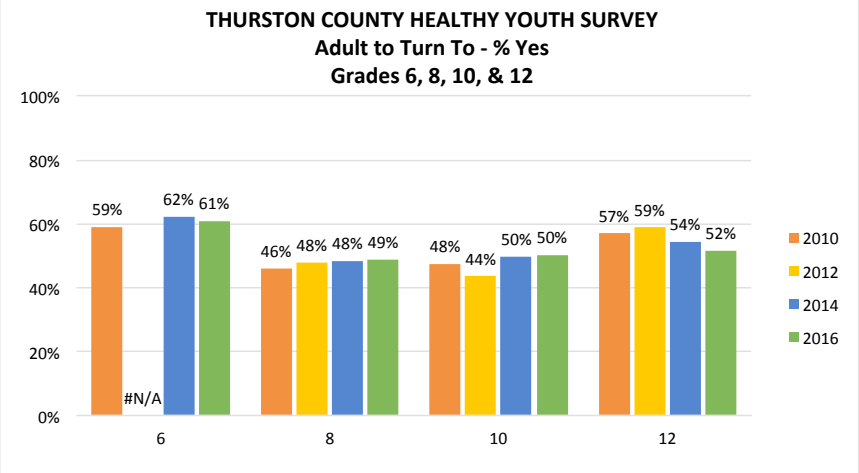

APPENDIX J: STAKEHOLDER INTERVIEW QUESTIONS

Kaiser-Permanente Environmental Scan
Key Stakeholder Interview Format
9/7/17

[Record name, location (agency), and role of person completing survey].

In August, Maike & Associates, was awarded a contract to conduct an *environmental scan of mental health and wellness of K-12 schools in Washington state for* Kaiser Permanente*.* The Kaiser Permanente-Washington region's Community Health Needs Assessment identified mental health as a priority of its community health and benefit program. The purpose of this project is to provide KP with a synthesis of existing data and perspectives from key informants that outlines current opportunities and needs related to mental health and wellness.

A major component of this work is to conduct interviews with key informants to better understand the nature, depth, and breadth of current school-based social, emotional, and behavioral strategies being implemented. As well as to identify barriers and challenges that may hinder the implementation these services.

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

Do you have any questions, before we begin?

Concerns: Mental health spans all aspects of social-emotional-behavioral development of school-age children including wellness, mental illness, substance abuse, and the effects of adverse childhood experiences and trauma.

1. Tell me what you believe is the most pressing mental health issue facing students in your schools.
2. What mental health and wellness needs of students are going unmet? Describe? < Probes: What data do you have to support this? Why do you think this might be the case?>
3. Tell me what you believe is the most pressing mental health issue facing staff in your schools.
4. What mental health and wellness needs of staff are going unmet? Describe? <Probes: What data do you have to support this? Why do you think this might be the case?>

Foundational Best Practices: The first set of questions asks about foundational elements that support school mental health services. Typically, these core elements drive the districts' and schools' abilities to engage in a comprehensive school mental health effort.

1. Do districts and schools have strong family-school-community partnerships? Describe? *<Probe: If yes, how are family and community members engaged in these efforts? How are families made aware of school mental health services? Are families routinely engaged in intervention services?>*
2. Are there campaigns to reduce stigma and promote mental health wellness? Describe*. <Probe: Who are the target audiences for these efforts? Family/Community members? Staff? Students? Is there Y/MHFA trainings?>*

3. What types of staff Professional Development opportunities are offered to address mental health and wellness? Describe. *<Probe: Does this include identification and referral? How to talk about MH and wellness with students and families? MH promotion and awareness? Stigma reduction? Trauma-sensitive and culturally-responsive? Self-care?>*
4. Do districts and schools prioritize positive school climate and culture? Describe? *<Probe: Conduct school climate surveys? PBIS?>*
5. Are social, emotional-behavioral efforts included in accountability systems? Describe? *<Probe: Are SEB strategies included as part of the districts' or schools' School Improvement Planning process? If so, how are staff/administrators held accountable for achieving these? Are there policies to support this work?>*
6. Do districts and schools routinely use data based decision making to guide school mental health efforts? Describe. *<Probe: Conduct comprehensive assessments? Use data to identify problems, analyze risk and protective factors (what types of data?), determine gaps in services and/or disproportionality (how)? Share results (with whom)? Examine outcomes?>*

Resources/Direct Services: The following questions provide a general understanding of the level of existing school mental health resources and services across a continuum of supports for school-aged children and school staff. Typically, these are integrated throughout the school community and include:

Universal strategies (Tier 1)- Mental health promotion services and supports to promote the positive social, emotional, and behavioral skills and wellness which are designed to meet the needs of all students regardless of whether or not they are at risk for mental health problems. These activities can be implemented school-wide, at the grade level, and/or at the classroom level e.g., school-wide assemblies, grade level or classroom awareness presentations or trainings (e.g., PAX Good Behavior Game, Second Step, PATHS, Project SUCCESS, Signs of Suicide, or Life Skills, etc.).

Selective services and supports (Tier 2) - Brief strategies to support students at risk of or with mild mental health challenges often provided to groups of students who have been identified through needs assessments and school teaming processes. When problems are identified early and supports put in place, positive youth development and academic success are promoted and problems can be eliminated or reduced. Sometimes these are referred to as mental health "prevention" or "secondary" prevention services (e.g., Check In/Check Out, Social Skills Groups, Student Assistance Program, school-based MH counseling/treatment).

Indicated services and supports (Tier 3) – Ongoing strategies to support those with significant needs, including a streamlined referral process with community mental health providers to create a seamless service delivery model for children, adolescents, and their families. Sometimes these are referred to as mental health "intervention" or "tertiary" or intensive services (e.g., Trauma-focused Cognitive Behavioral Therapy, Coping Cat, Cognitive Behavioral Intervention for Trauma and Schools (CBITS), Multisystemic Therapy, and high-quality Wraparound planning).

Following the interview, you will be requested to fill out a more extensive resource inventory. For now, I want to focus on a few of the specific programs and strategies that may be in place in your region/district.

1. What are the most common school mental health programs, supports and services that are currently in place in your schools and community related to mental health and wellness, including trauma informed practices for both students and staff? Describe (by tiered level) and include services provided by school-employed and community-employed, school-based professionals. *<Probe re: referral – How are students identified for services? What is the referral*

mechanism? Is there a standard procedure/form? Who can refer students e.g., staff, parents, self, community? Probe: re: screening – What is the screening process? Is there a standardized (Universal) tool? How do students get into services school-based and/community-based? Probe re: effectiveness. Are these processes (referral and screening) effective? How do you know? What data do you have to support this belief?>

2. How do you ensure that programs, supports and services are culturally, linguistically and developmentally appropriate? Describe. *<Probe: Are programs meeting the needs of all children (culturally, linguistically, developmentally)? How do you know? Probe: Are there any groups with disproportionate need? If so, are services available to them? Describe.>*
3. What school mental health programs, support, or services do you believe are underdeveloped, or inadequate in your region/district and community? Please explain*. <Probe: Ask this for both students and staff.>*

Coordination: These next questions focus on the coordination and integration of school mental health services and supports.

1. Is there anyone else in the school and/or community e.g., community partner, that is addressing or attempting to address these issues? Please explain. *<Probe: How are efforts coordinated? Is there a team approach e.g., Wrap around? Who are other partners?>*
2. Are there duplicative programs, supports and services? If so, please describe duplication. If there are duplicative services, which do you think are more effective and which are less so? Describe.
3. Are there interagency partnerships to support the integration of school mental health service delivery? If so, please explain*. <Probe: Are these formal e.g., MOU/MOA's or informal? Does this integration go beyond sharing space? Does this follow a systems of care model?>*

Impacts: We are also interested in knowing about the impacts of school mental health services and supports. Can you tell me….

1. Are there certain programs, support, and services that are more effective than others? Describe. *<Probe: How do you know? What data do you have to support this belief?>*
2. What are the strengths of the school mental health programs, services, and supports? Explain. *<Probe: What are the key supports or factors that are contributing to the success of the program?>*
3. What are your measures of success? Explain*. <Probe: What data are you using? Are these effective? What's missing? Is this information shared? Are there any evaluation efforts related to the program/services? Are you are collecting or tracking any data, what type?>*

Barriers/Challenges: The next two questions seek to better understand what challenges and/or barriers exist that may impede the implementation of school mental health services and supports within the K-12 system.

1. What are the barriers or challenges to implementing and/or delivering these types of services in your region/district/school and community? Explain*. <Probe: If these topics are not brought up prompt for stigma, workforce, knowledge and awareness of MH issues, financing/funding, and existing policies/practices (local, state, national)>.*
2. What steps can be taken to reduce and/or overcome these challenges/barriers?

Blue Sky Question: If barriers and challenges did not exist, and…..

1. If you had the opportunity to build a system that met the mental health and wellness needs of all students and staff, what would that ideal system look like?

Finally, are there other things you think are important about school mental health efforts happening within your region/district that that I've not covered?

[Thank you for taking the time to support this critical work. Later today, you will receive an email with a link to a ES-Resource template. Please take the time to complete this information to the best of your knowledge and feel free to ask others in your organization for assistance should you need it. Over the next month or so we will be compiling your responses with other key stakeholders as well as the information obtained through the ES template. Once completed a summary report of findings with recommendations will be submitted to the KP team. This information will be used to inform KP about the needs of SMH services and supports in their region and to guide decisions related to how best to support the K-12 system to implement trauma-informed strategies as part of the KPWA Thriving Schools Initiative.]

[For ESD 101, ESD 113, ESD 114, ESD 123, and ESD 189 participants only: Before I let you go, I'd like you to nominate 2-3 others in the education system either at the ESD or district level who are knowledgeable of school-based mental health services that we can also interview. Would you be willing to provide a name and contact information for these people? You can give that to me now, or you can email Michelle at mmaike@olypen.com.]

APPENDIX K: CONTENT ANALYSIS CODE BOOK

Data-Driven Codebook for KP Project

Assigning Keywords

After the completion of 37 interviews, each interview was transcribed into word documents. In order to make sense of and analyze the interviews, the raw transcriptions needed to be coded and input into an excel documentation for further analysis.

Step 1: Using the transcribed interviews, each question asked was numbered (1 – 23).

Step 2: An excel document was created to house the keywords found and create unique variables to allow for future analysis of the raw data. This process allowed for simplification, data reduction, and data consistency across all interviews and questions. Interviews were coded into raw data using the example excel table in Figure 1.

QUESTION	AGENCY	LEVEL	NAME	KEYWORD	YES / NO / IT VARIES	QUOTE	NOTES
Question number and question asked	Agency name of person interviewed	Level of person interviewed, as determined by their position and agency. Input as either 1, 2, or 3	Name of person interviewed	Keyword (tag or label) given to specific words or quote(s) within the transcribed interview	If the question asked a yes/no, either 0, 1, or 2 were input. 0 = No, 1 = Yes, 2 = It varies	Notable quote pertaining to the keyword	Note to help guide understanding of the keyword or quote

Figure 1. Excel table for coding transcribed interviews into raw data

Step 3: Each transcribed interview was read and keywords (tags or labels) were given to specific words or quote(s) found within each answer to each question. These keywords were assigned based on specific words mentioned by the person interviewed or from phrases, sentences, or paragraphs that are connected in context. Some answers contained more than one keyword. Figure 2. is an example of the coding process for keywords.

KEYWORD	TRANSCRIBED QUOTE	EXPLANATION
Suicide	*"...we are seeing higher rates of <u>suicide</u> attempts / completions…"*	Specific word used in the interview
Family Engagement	*"They will continue to work with the child to continue to get them to find a relief and get their families into the fold, at whatever level the child is partnering with."*	Summarized quote turned into a keyword based on the context of the answer given
Funding Needs	*"...if it is not <u>funded</u> through a grant that service isn't happening… not that there isn't some type of support of <u>funding</u> that's coming from community partners…"*	Keyword based on specific word used in the quote but changed for data-consistency purposes

Figure 2. Explanation of coding process of transcribed interviews into keywords

Cleaning Keywords

The keyword was the level of analysis and every keyword was a unique observation in this dataset. After each keyword was input into the excel document and all other coinciding data was input as well (question number, agency name, name person interviewed, etc.), the excel document contained 2,458 rows of data (or 2,458 unique keywords). These keywords needed to be cleaned of any duplicates, errors, or misspellings. Additionally, similar meaning keywords needed to be changed and a single label decided upon for the purpose of consistency. This process was done by splitting the questions into themes and cleaning the keywords based on theme.

THEME	QUESTIONS
Concerns	1 - 4
Best Practices	5 - 9
Resources & Direct Services	11 - 13
Coordination	14 - 16
Impacts	17 - 19
Barriers & Challenges	20 - 21
Blue Sky	22 - 23

Figure 3. Themes and grouping of questions

Prior to cleaning the data, there were 1,600 distinct (all unique keywords counted only once). After cleaning, the distinct keyword count was 895. Figure 4. is an example of the cleaning process for keywords.

QUESTION	ORIGINAL KEYWORD	CLEANED KEYWORD	EXPLANATION
1	ANXIETY	ANXIETY	Match
1	Anxiety	ANXIETY	Contains a space at the end of the keyword
1	BI-POLAR	BIPOLAR DISORDER	Cleaned for consistency
1	BIPOLAR DISORDER	BIPOLAR DISORDER	Misspelling
2	STAFF DEVELOPMENT NEEDS	PROFESSIONAL DEVELOPMENT	Cleaned for consistency
2	Staff training (need)	PROFESSIONAL DEVELOPMENT	Cleaned for consistency

Figure 4. Cleaning process and explanation of common reasons

In order to clean the keywords, a =VLOOKUP equation was used and input into a new column in the working data sheet of the raw data.

Categorization

Following the cleaning of keywords, a categorization process took place. This consisted of grouping the keywords by themes (see Figure 3.) and then based on commonalities in the keywords, grouping them into relevant categories.

Q#	VLOOK KEYWORDS	VLOOK CATEGORY THEMES
1	ACCESS	ACCESS
1	ADD/ADHD	MENTAL, EMOTIONAL, BEHAVIORAL ISSUES
1	ADVERSE CHILDHOOD EXPERIENCES	ADVERSE CHILDHOOD EXPERIENCES
1	ANGER ISSUES	MENTAL, EMOTIONAL, BEHAVIORAL ISSUES
2	ANXIETY	MENTAL, EMOTIONAL, BEHAVIORAL ISSUES
2	AWARENESS	KNOWLEDGE/AWARENESS
1	BIPOLAR DISORDER	MENTAL, EMOTIONAL, BEHAVIORAL ISSUES
1	BULLYING	MENTAL, EMOTIONAL, BEHAVIORAL ISSUES
1	CAPACITY	RESOURCES/CAPACITY
3	CULTURAL COMPETENCY	KNOWLEDGE/AWARENESS
2	DEPRESSION	MENTAL, EMOTIONAL, BEHAVIORAL ISSUES
1	FAMILY ENGAGEMENT	KNOWLEDGE/AWARENESS
4	FUNDING	RESOURCES/CAPACITY
4	HIGH RISK NORMS	-
1	HOMELESSNESS	BASIC NEEDS
1	INSURANCE	ACCESS

Figure 5. Categorization process of keywords grouped by theme

Similar to the keyword cleaning process, a =VLOOKUP equation was used and input into a new column in the working data sheet of the raw data. For the categories =VLOOKUP, because the questions were grouped by theme, a =CONCATENATE equation of the question number and the keyword was necessary to distinguish between keywords that were the same, but had differentiating categories based on the themes they belonged to. An example of this: ACES falls under the TIER 1 SUPPORT category in one theme, but under the KNOWLEDGE/AWARENESS category of another. In this instance, the =CONCATENATE equation would combine the two cells QUESTION and KEYWORD, to create a new unique keyword specific to that theme. So, the ACES keyword would be turned into “11ACES” for question 11 and “7ACES” for question 7. This would allow the =VLOOKUP to differentiate between the two and provide the correct category.

This step completed the cleaning and a new “cleaned data” tab was created which removed extra columns and equations for simplicity sake.

Data Analysis

The final analysis used the creation of a pivot table in order to evaluate the data points. Using the pivot, multiple tables were created to examine the data from numerous levels of analysis. The following figures are final products of the pivot table outcome.

DESCRIPTIVE STATISTICS – Q1	
UNIQUE KEYWORDS (TOTAL)	143
KEYWORDS	44
CATEGORIES	6
RESPONDENTS	37

Figure 6a. Descriptive statistics example

KEYWORD		PERCENT
DEPRESSION	16	11%
ANXIETY	12	8%
…	…	…
Grand Total	**143**	**100%**

Figure 6b. Keyword count and percent of total

CATEGORY			PERCENT	RESP %
MENTAL, EMOTIONAL, BEHAVIORAL ISSUES	72	50%	23	62%
RESOURCES/CAPACITY	22	15%	15	41%
KNOWLEDGE/AWARENESS	16	11%	14	38%
ADVERSE CHILDHOOD EXPERIENCES	16	11%	13	35%
ACCESS	15	10%	14	38%
-	2	1%	2	5%
Grand Total	**143**	**100%**		

Figure 6c. Category count/percentage and respondent count/percentage

CATEGORY	KEYWORD	COUNT	PERCENT
-	MENTAL HEALTH AND WELLNESS	100%	50%
	HIGH RISK NORMS	100%	50%
- Total		**2**	**1**
ACCESS	ACCESS	12	80%
	TRANSPORTATION	2	13%
	INSURANCE	1	7%
ACCESS Total		**15**	**1**

Figure 6d. Keywords by category count and percentage of category total

LEVEL	CATEGORY	COUNT
1	ADVERSE CHILDHOOD EXPERIENCES	8
	MENTAL, EMOTIONAL, BEHAVIORAL ISSUES	7
	RESOURCES/CAPACITY	5
	ACCESS	4
	KNOWLEDGE/AWARENESS	4
	-	1
1 Total		14
…	…	…

Figure 6e. Category by level and count

LEVEL	POSITION	COUNT
1	SCHOOL DISTRICT EMPLOYEE	7
	SUPERINTENDENT	4
	COUNTY PUBLIC HEALTH DIRECTOR	1
	PRINCIPAL	1
	SCHOOL BOARD MEMBER	1
1 Total		14
2	ESD DIRECTOR	9
	…	…

Figure 6b. Position by level and count

APPENDIX L: RESOURCE TEMPLATE RESULTS

Kaiser Permanente - Environmental Scan Resource Template
for School-based Mental Health Supports and Services: Results

Interview participants were also asked to complete an on-line Environmental Scan Resource Template. The purpose of the scan was to answer the following questions: What programs, services, supports, and other resources exist in the school and/or community that serve the metal health and well-being of students and staff in the K-12 education system? Who provides them? Where to gaps exist? And, are there duplicative efforts that can be merged or otherwise coordinated? The information was collected along tiered levels of supports. A total of 17 stakeholders completed the Resource Template.

Universal strategies (Tier 1)- *Mental health promotion services and supports to promote the positive social, emotional, and behavioral skills and wellness which are designed to meet the needs of all students regardless of whether or not they are at risk for mental health problems. These activities can be implemented school-wide, at the grade level, and/or at the classroom level e.g., school-wide assemblies, grade level or classroom awareness presentations or trainings. Please include services provided by school-employed and community-employed, school-based professionals.*

UNIVERSAL STRATEGIES – TIER 1 (include strategies provided by both school-based and community-based providers/systems)[25]

Respondent Organization	Organization or Agency	Programs, Services, or Supports (Universal)	Evidence Based	Population Served	Funding & Funding Streams	Policies	Systems Integration Activities (Partnerships)
Who provided the answers to this survey?	***Who provides these services or programs (e.g., district/school, ESD, community-based agency, etc.)?***	***UNIVERSAL STRATEGIES – TIER 1 (include strategies provided by both school-based and community-based providers/systems)***	***Is this an evidence-based practice?***	***Who is the target population for the services or programs (e.g., K-3, trauma-impacted students, etc.)?***	***How is the program funded? Are there blended funds? If so, what are these (e.g., state, federal, local)?***	***Are there existing policies that are aligned with the service or program or a governing board that oversees the service? (For example, for suicide prevention programs, a written suicide prevention policy is in place).***	***Are there interagency partnerships to support the integration of service delivery? If so, list partners.***
ESD112	ESD	Project Success universal substance use prevention	Yes	Middle and High School Students	Federal substance use prevention block grant	No	School districts and ESDs
	ESDs, counties, school districts, community coalitions, State agencies	Community based substance use prevention through coalition work and 12 sector model of environmental strategies	Yes	All youth residing in a community	Federal block grant dollars and federal drug free communities	No	13 sectors are required in this work: youth, parents, schools, govt, law enforcement, media, business, faith communities, civic groups, health care, treatment, and youth serving organizations

[25] NOTE: "N/A" indicates respondent did not answer question.

UNIVERSAL STRATEGIES – TIER 1 (include strategies provided by both school-based and community-based providers/systems)[25]							
Respondent Organization	**Organization or Agency**	**Programs, Services, or Supports (Universal)**	**Evidence Based**	**Population Served**	**Funding & Funding Streams**	**Policies**	**Systems Integration Activities (Partnerships)**
	ESDs, state agencies, community partners offer training to schools in the curriculum	Mental health high school curriculum	No	9th and 10th graders	None	No	School districts, OSPI, community based organizations to support the trainings of teachers
PSESD	PSESD to Foss High School	PAX Good Behavior Game	Yes	N/A	N /A	N /A	N /A
	PSESD to Cascade MS/Auburn SD	Life Skills	Yes	N/A	N /A	N /A	N /A
	PSESD to Cedarcrest MS, Bethel	Positive Action	Yes	N/A	N /A	N /A	N /A
PSESD	PSESD to Auburn (Auburn High, Cascade MS), Bethel (Cedarcrest MS), Clover Park (Lochburn MS, CP High), Franklin Pierce (Washington High, Perry Keithly MS), Highline (Cascade MS), Seattle (Aki Kurose MS, Denny MS, Chief Sealth High, Garfield High), Tacoma (Foss High)	Project SUCCESS	Yes	Middle and High School Students	N /A	N /A	N /A
	Regional PD to ESA staff	Networks for Life Suicide Prevention Training (3 hr)	Yes	ESA Staff	N /A	N /A	N /A
	Regional PD to ESA staff	Signs of Suicide Training (3 hr)	Yes	ESA Staff	N /A	N /A	N /A
	PD offering across the region	Youth Mental Health First Aid (8 hr)	No	Open to all adults in the region	N /A	N /A	N /A
	PD offering across the region	Trauma Informed Educational Practices (1-6 hours	No	Open to all adults in the region	N /A	N /A	N /A
	PD offering across the region	Motivational Interviewing	No	Open to all adults in the region	N /A	N /A	N /A
ESD 105	ESD 105	PAX Good Behavior Game	Yes	K-5	N /A	N /A	N /A
Washington State Association of School Psychologists	Committee for Children Curriculum, delivered in all classrooms through the school building staff	Second Step	Yes	All students K-5	General Education funding to my knowledge	N /A	No
	Districts/schools	PBIS	Yes	All students	General education funding to my knowledge, potentially some title funding	Varies district to district, FPS does have a policy about PBIS	N /A

UNIVERSAL STRATEGIES – TIER 1 (include strategies provided by both school-based and community-based providers/systems)[25]							
Respondent Organization	**Organization or Agency**	**Programs, Services, or Supports (Universal)**	**Evidence Based**	**Population Served**	**Funding & Funding Streams**	**Policies**	**Systems Integration Activities (Partnerships)**
	Randy Sprik is the author of CHAMPS, a PBIS system	CHAMPS	Yes	All students	General education	Varies district to district, FPS does have a policy about PBIS	The author works with the district on training and such
Pacific County	Pacific County Health Dept, Raymond School District, South Bend School, Naselle School, Teen Advocacy Coalition	Source of Strength	Yes	JR and SR high students county wide	DOH Suicide prevention grant, Drug Free Communities Grant	No	TAC, schools, health dept
Pacific County	Pacific County Health Dept, Raymond School District, South Bend School, Naselle School, Teen Advocacy Coalition	Peer Helpers Program	Yes	JR and SR high students county wide	Drug Free Communities Grant	No	TAC, schools, health dept, WellSpring Community network
	Ocean Beach School District	Safe Space Room	No	OBSD JR/SR high	WellSpring Community Network (initially)	Yes	OBSD, Health Dept, WellSpring
	Willapa Beahvioral Health, Schools	School Based Mental Health Counselors	No	K-12 at all districts (varying level depending on district)	.1% Sales Tax (County), school district funds, Medicaid	No	School districts and Willapa Behavioral Health
	Raymond School District, Ocean Beach school district	Second Step	Yes	K-12	School district on-going, .1% sales tax used to purchase curriculum at Raymond	N /A	No
	Ocean Beach School District, South Bend Early childhood coalition	Trauma Informed practices and training on ACEs (various)	No	K-12 at OBSD, 0-5 at south bend	District, WellSpring Community Network	No	Wellspring Community Network, OBSD, know & grow coalition
NEWESD 101	Washington State University	CLEAR	No	K-12 schools	SAMSHA (formerly)	N /A	N /A
NEWESD 101	Prevention Specialists are hired by NEWESD 101 and are placed in 9 schools in our service area; their focus is on universal prevention efforts and interventions that identify and support students who are using illegal substances or who are affected by family members who are doing so. The framework for this work is Project Success	CPWI Communities and Prevention Specialties	Yes	K-12 schools: Tekoa/Oakesdale; Republic/Curlew; Reardan; East Valley High School; North Central High School; Mary Walker High School; Cusick School District	Combination of state/federal and school district funds	N /A	N /A

UNIVERSAL STRATEGIES – TIER 1 (include strategies provided by both school-based and community-based providers/systems)[25]							
Respondent Organization	**Organization or Agency**	**Programs, Services, or Supports (Universal)**	**Evidence Based**	**Population Served**	**Funding & Funding Streams**	**Policies**	**Systems Integration Activities (Partnerships)**
NEWESD 101	Eight mental health therapists were hired by NEWESD 101 to provide mental health services to students in designated schools in designated schools districts: West Valley; Medical Lake; Cheney; Riverside. Students are served without regard for their need to pay. The focus is one preventing students from moving from Tier 1 to Tier 2. CBT is utilized often in working with students.	Project Prevent	Yes	K-12	Federal grant funding	N /A	N /A
	Some school districts in our service area are served by mental health resource individuals who go to the schools to provide those services. While this overcomes the barrier of transportation and time, there is an ongoing concern about continuity of personnel and service.	Mental Health Services provided by agencies in school settings	No	K-12	State and county/Medicaid	N /A	N /A
	Families can access services based on their insurance support, transportation availability, time availability.	Mental Health Services provided by agencies to school-aged children and their families at the agency site	No	K-12	State and county/Medicaid/insurance	N /A	N /A
ESD 114	Teacher/counselor in the school	Second Step	Yes	K-6	School revenue	N /A	N /A
	Teacher in the school	Good Behavior Game	Yes	K-6	Marijuana tax to train teachers and purchase curriculum.	Yes	N /A
	OESD staff to train schools and community	Signs of Suicide	Yes	Adults targeting K-12	Grant or fee for service	Yes	N /A
	OESD staff to train schools and community	Networks for Life	Yes	Adults targeting K-12 and peer to peer middle/high school	Grants or fee for service	Yes	N /A
	Schools	PBIS	Yes	K-12	School/district revenue	Yes	School districts and some MH partnerships

UNIVERSAL STRATEGIES – TIER 1 (include strategies provided by both school-based and community-based providers/systems)[25]							
Respondent Organization	**Organization or Agency**	**Programs, Services, or Supports (Universal)**	**Evidence Based**	**Population Served**	**Funding & Funding Streams**	**Policies**	**Systems Integration Activities (Partnerships)**
ESD 114	OESD staff to train schools and community	MHFA	Yes	Adults targeting youth	Grants or fee for service	Yes	School districts and some MH partnerships
	SAP's	Towards no Drug Use	Yes		State marijuana tax revenue and federal DBHR prevention funding	Yes	School districts and some MH partnerships
	SAP's	Project Success	Yes		State marijuana tax revenue and federal DBHR prevention funding	N /A	N /A
OSPI	Some Districts	PBIS	Yes	All students and staff	Each district identifies their fund sources differently; this is not tracked by OSPI to my knowledge	N /A	N /A
	Some Districts	Compassionate Schools	No	All students and staff	Each district identifies their fund sources differently; this is not tracked by OSPI to my knowledge	N /A	N /A
	Some Districts	Good Behavior Game, Second Step	Yes	All students	Each district identifies their fund sources differently; this is not tracked by OSPI to my knowledge	N /A	N /A
	Some Districts (mostly CPWI)	Project Success--prevention ed series	Yes	All students receive at least one series of prevention ed at grade 6-12	SAMHSA Prevention/Treatment Block Grant	N /A	Local community coalition linked to the funding source (CPWI)
	Schools	Life Skills	Yes		N /A	N /A	N /A
	Some Districts/schools	Mental Health In High Schools		High school teachers and students	Project AWARE	N /A	N /A

UNIVERSAL STRATEGIES – TIER 1 (include strategies provided by both school-based and community-based providers/systems)[25]							
Respondent Organization	**Organization or Agency**	**Programs, Services, or Supports (Universal)**	**Evidence Based**	**Population Served**	**Funding & Funding Streams**	**Policies**	**Systems Integration Activities (Partnerships)**
DOH	YSPP	The Youth Suicide Prevention Program (YSPP)	Yes	YSPP field coordinators lead suicide prevention coalitions in Yakima County, Spokane County, Clark and Cowlitz counties, and Benton and Franklin counties. Field coordinators brought community partners together to strengthen community collaboration.	The Department of Health receives state funds designated for youth suicide prevention.	N /A	No
	N /A	Networks for Life	Yes	N /A	N /A	N /A	N /A
	N /A	ASIST	Yes	N /A	N /A	N /A	N /A
	N /A	SafeTalks	Yes	N /A	N /A	N /A	N /A
	N /A	OUTloud Training Series	Yes	N /A	N /A	N /A	N /A
North Thurston School District	North Thurston School District Schools	Second Step	Yes	N /A	N /A	N /A	N /A
	North Thurston School District Schools	Skills Streaming	Yes	N /A	N /A	N /A	N /A
	North Thurston School District Schools	Safe and Civil Schools/CHAMPS	No	N /A	N /A	N /A	N /A
	North Thurston School District Schools	Zone of Regulation	No	N /A	N /A	N /A	N /A
	North Thurston School District Schools	PBIS	No	N /A	N /A	N /A	

Gaps: Briefly describe, in general, any gaps in programming related mental health promotion and awareness (Universal strategies) Do strategies address both students and adults? Are there issues with implementation and/or fidelity? Are there duplicative efforts that can be merged or otherwise coordinated?

- We do not have funding support at the ESD to provide training and support to the districts to implement universal prevention programming in each district.
- Coordination challenges and funding is competitive. Fidelity is tied to funding.
- I do not see much instruction on actual mental health and wellness, and nothing on suicide prevention on a broad scale.
- Best practices are implemented sporadically throughout the county- for example, OBSD has 2 FTE school based therapists. Other districts have .50 FTE or less. ACEs trainings and trauma informed care is not implemented across all districts. Some districts have held one training, some have held multiple and are implementing practices. It really varies from school to school.

- There are not adequate resources to serve all those who have needs, i.e., qualified therapists. The strategies I listed are focused largely on students. My belief is that our mental health system was designed for adults and work with those under 18 does not always happen without "bumps." I don't believe there are duplicative efforts, but I also believe there is minimal coordination by our BHO.
- Not all schools are able to implement due to lack of funding, ability to train staff and other priorities as per state requirements/initiatives.
- There are major inconsistencies across the state in terms of mental health promotion programming. District's use local control to prioritize their focus, and some districts are heavily focusing on promotion, and others are not at all. Districts who are recipients of grant funds through OSPI and DSHS are more likely to be doing some of this work, but that is not happening statewide. The recommended health standards from OSPI include mental health, suicide prevention, depression, etc. However, these standards are recommendations, and each district has the autonomy to determine if and how the content is covered.

Barriers/Challenges: What challenges or barriers prevent the delivery of services or programs (e.g., policies, systems, turf issues)?

- Funding for capacity to do the work helping school districts understand the need to make time to provide the SEL work in the classrooms when there are multiple competing priorities.
- Disciplinary policies, coordination across multiple agencies all with a specific agenda prohibiting ease of coordination, race equity not a priority in most program design, parent engagement is fragmented in terms of priority, policies related to confidentiality re: HIPPA, FERPA and the WACs.
- Resources: Staff, funding, training, re-training new staff, etc.
- 6 districts in a small county (20,000 population total) makes it difficult. While our districts are easy to work with and willing partners, it is cumbersome to have to repeat the process of implementing programs/policy change across so many school districts. Also, funding is an issue- especially flexible funds. Grants come and go and usually are restrictive. We have the 1% sales tax that is very flexible, but that is limited.
- School districts lack adequate funding for mental health therapists in their schools. Agencies are restricted by Medicaid requirements and reporting requirements that limit the actual time that therapists have to do therapy. See above--coordination of services does not seem to be efficient or effective.
- Funding and allocation of time there are competing needs.
- District leaders must prioritize this subject matter and make space for it in PD and health classes. Instructors of the content need intensive training to familiarize themselves with the sensitive subject matter so they are able to competently and confidently teach classroom mental health promotion. Internal counseling supports should be mobilized by the school when these subjects are covered to anticipate any student who experiences distress because of the topic discussion. Teachers should know the signs of distress and know how to refer them for help.
- The biggest challenge was that there wasn't evidence to show that the work was making an impact in the communities served.

Selective services and supports (Tier 2) - *Brief strategies to support students at risk of or with mild mental health challenges often provided to groups of students who have been identified through needs assessments and school teaming processes. When problems are identified early and supports put in place, positive youth development and academic success are promoted and problems can be eliminated or reduced. Sometimes these are referred to as mental health "prevention" or "secondary" prevention services (e.g., Check In/Check Out, Social Skills Groups, Student Assistance Program, school-based MH counseling/treatment). Please include services provided by school-employed and community-employed, school-based professionals.*

For the following, please complete these questions for the **LAST SCHOOL YEAR**.

SELECTIVE SERVICES & SUPPORTS – TIER 2 (include strategies provided by both school-based and community-based providers/systems)							
Respondent Organization	**Organization or Agency**	**Programs, Services, or Supports (Students At Risk)**	**Evidence Based**	**Population Served**	**Funding & Funding Streams**	**Policies**	**Systems Integration Activities (Partnerships)**
Who provided the answers to this survey?	***Who provides these services or programs (e.g., district/school, ESD, community-based agency, etc.)?***	***What programs, services, supports, and other resources exist that serve children, K-12, teachers, and staff related to mental health and wellness including trauma informed practices? Provide a brief description of the program, including hours of service, goal/purpose (e.g., cognitive behavioral therapy), as appropriate. an evidence-based or evidence-informed program, as appropriate.***	***Is this an evidence-based practice?***	***Who is the target population for the services or programs (e.g., K-3, trauma-impacted students, etc.)?***	***How is the program funded? Are there blended funds? If so, what are these (e.g., state, federal, local)?***	***Are there existing policies that are aligned with the service or program or a governing board that oversees the service? (For example, for suicide prevention programs, a written suicide prevention policy is in place).***	***Are there interagency partnerships to support the integration of service delivery? If so, list partners.***
ESD 112	ESD staff and community partners	Youth Mental Health First Aid training	Yes	Adults in the community and schools who work with youth	Federal Project AWARE	No	OSPI, King County Behavioral Health and Recovery, all 9 ESDs
	ESD staff	Project Success	Yes	Middle and High School Students who need early intervention services for substance use issues	Federal Substance Abuse Prevention Block Grant. Also school districts provide funding match and sometimes fund 100% of the services	School district discipline policies	Yes, in our communities with DBHR funding, there are community coalitions doing environmental work to compliment the work in schools
	ESD staff	Student Threat Assessment	No	K-12 students who are at possible risk to others	School districts	No	We have law enforcement, DCFS, mental health participate in our level 2 assessments
	ESD staff	Truancy Project	No	K-12 students who are referred to the court for being truant as per the Becca bill	School districts and juvenile courts	RCW 28A.225.025 and school district policies written to reflect this law	Juvenile court

SELECTIVE SERVICES & SUPPORTS – TIER 2 (include strategies provided by both school-based and community-based providers/systems)							
Respondent Organization	**Organization or Agency**	**Programs, Services, or Supports (Students At Risk)**	**Evidence Based**	**Population Served**	**Funding & Funding Streams**	**Policies**	**Systems Integration Activities (Partnerships)**
PSESD	Renton Middle Schools and Tukwila Showalter Middle School (King County MIDD Funded)	MIDD 4C: Student Assistance through Trauma informed practices	No		N /A	N /A	N /A
	Same as Tier 1 sites. Provide GAIN SS, SBIRT (Teen Intervene) and educational support groups	Project SUCCESS	Yes	Middle & High School Youth	N /A	N /A	N /A
Washington State Association of School Psychologists	Some are connected to UW or CHAMPS, or may be independent	Check In Check Out, Connections, Check and Connect (lots of names)	Yes	All students not responding to Tier 1	General education	Varies district to district, usually would not be in a specific policy though	Depends on the place, some are in partnership with UW or Randy Sprick
	Usually in house school staff	Small group instruction	No	Tier 2 identified kids in need	General education	None that I am aware of, but it is part of ASCA's practice model	None that I am aware of
Pacific County	ESD 113- True North Student Assistance Program	Prevention/Intervention (using Project Success)	Yes	JR/SR high. 1.0 FTE each at Ocean Beach, Raymond, and South Bend school districts, .50 at Naselle and .50 at Valley	Great Rivers Behavioral Health, DBHR, .1% Sales Tax	School based treatment and early intervention	School districts, funders (GRBHO, health dept, DBHR), and ESD 113 (provider)
	Big Brothers Big Sisters of SW Washington	Big Brothers Big Sisters mentoring program	Yes	K-8 at Raymond, Ocean Beach, Valley, and South Bend	DBHR, County Millage Funds, AmeriCorps, wellspring community network	Yes	Schools provide office space and match meeting space, refer kids (both bigs and littles), health dept/wellspring provide funding
NEWESD 101		All of the services and supports previously mentioned also serve this population.	No		N /A	N /A	N /A
	Sacred Heart Hospital	Sacred Heart BEST program (day treatment program)	No	K-6	N /A	N /A	N /A
	Sacred Heart Hospital	Sacred Heart PCCA (adolescent psychiatric unit)	No	13-18	N /A	N /A	N /A

SELECTIVE SERVICES & SUPPORTS – TIER 2 (include strategies provided by both school-based and community-based providers/systems)							
Respondent Organization	**Organization or Agency**	**Programs, Services, or Supports (Students At Risk)**	**Evidence Based**	**Population Served**	**Funding & Funding Streams**	**Policies**	**Systems Integration Activities (Partnerships)**
NEWESD 101	Kootenai Behavioral Health	Kootenai Behavioral Health	No	Overflow referrals from Sacred Heart are sent to Kootenai in Coeur d'Alene which is 40 miles from Spokane WA	N /A	N /A	N /A
	Spokane Public Schools	MAP	No	High school students are referred to this school program based on their mental health diagnosis and their inability to function in a mainstream school setting. Students from Spokane County are eligible for placement	N /A	N /A	N /A
	Spokane Public Schools	Eagle Peak	No	K-12 students from Spokane County are referred to this program based on their inability to function in a mainstream school setting; most participants have a 504 or IEP that addresses behavioral issues.	N /A	N /A	N /A
ESD 114	OESD and some schools hire their own	Student Assistance/ Project Success	Yes	Secondary	School District revenue; County, State, and Federal grants	Yes	School districts
	OESD and some schools contract with MH on their own	SBMH	Yes	K-12	School District revenue; County, State, and Federal grants	Varies	School district and MH agencies
	OESD and school districts and schools	Threat Assessment screening	Yes	K-12	School District Cooperative	Yes	Law enforcement, school districts, and Mental Health

SELECTIVE SERVICES & SUPPORTS – TIER 2 (include strategies provided by both school-based and community-based providers/systems)							
Respondent Organization	**Organization or Agency**	**Programs, Services, or Supports (Students At Risk)**	**Evidence Based**	**Population Served**	**Funding & Funding Streams**	**Policies**	**Systems Integration Activities (Partnerships)**
ESD 114	OESD	Education Advocates	No	Secondary	Federal Title I D. funding through OSPI	No	Juvenile Justice, detention schools and school districts
	OESD and some schools contract on their own	Trauma informed/sensitive schools (this should go under universal forgot to add it)	No	K-12	School District revenue; County, State, and Federal grants	No	No
OSPI	Some districts	Project Success Education Groups	Yes	Students identified to have a behavioral health risk	SAMHSA Block Grant	N /A	N /A
	Some districts	Prevention Clubs	No	Students who want to promote wellness in school	Unknown	N /A	N /A
	Some ESDs, Districts, and community based providers of services	School-based Health Services	No	Students with an IEP or IFSP who are Medicaid eligible	Medicaid	N /A	N /A
	Some Schools (mostly in King County)	School-based Health Centers	No	Depending on the community sponsor and insurance availability for students, Medicaid eligible students	Private insurance, Medicaid, county funding in some cases	N /A	N /A
	Amerigoup, Community Health Plan, Coordinated Care, Molina Healthcare, United Healthcare	Managed Care Organizations (Medicaid provider groups)	No	Medicaid eligible	Medicaid	N /A	N /A
North Thurston School District	North Thurston School District Schools	SWIS	N /A	N /A	N /A	N /A	N /A
	North Thurston School District Schools	Check in Check Out	N /A	N /A	N /A	N /A	N /A
	North Thurston School District Schools	Check and Connect	N /A	N /A	N /A	N /A	N /A
	North Thurston School District Schools	Organizational Bootcamp	N /A	Secondary	N /A	N /A	N /A

Gaps: Briefly describe, in general, any gaps in programming related to the selective services and supports (Tier 2). For example, who should be served that is not receiving services? Are services developmentally, culturally, and gender specific? Is access an issue? Are there issues with implementation and/or fidelity? Are there duplicative efforts that can be merged or otherwise coordinated?

- Our school-based tier 2 services are only substance abuse intervention focused, so the work needs to be expanded to include mental health. The programs are only in select school districts - 15 of our 30.
- Cultural specific support services are lacking in numerous sites, creating accessibility challenges. In some (Seattle and Vashon) sites, the coordination between multiple agencies are challenging at best and duplicative, turf based and agency over family service supported at worse. GAIN SS is not used reliably with ELL students in crisis.
- Tier 2 is often the weakest area. We need more evidence based practices here I think.
- Yes- we would like to establish a mentoring program at Naselle. We'd also like to increase FTE of Prevention/Intervention staff at Valley and Naselle.
- Not all of these programs are well known so there is a lack of understanding of what resources are available to schools and families. This is definitely an access issue. Families are required to provide their own transportation to most of these programs which is a significant barrier in terms of time and financial resources. I don't believe there are duplicative efforts; my belief is that the efforts are not coordinated and are insufficient.
- Limited number of schools have the services (approximately 1% in OESD region) in place and it is grant dependent. Therefore, when funding goes away positions are eliminated. Students who live in rural communities have a hard time accessing services at a community MH or SUD treatment center and transportation is not easily accessible.
- Behavioral health service interventions are not available to all students in schools. This is a major health disparity and equity issue.

Barriers/Challenges: What challenges or barriers prevent the delivery of services or programs (e.g., policies, systems, turf issues)?

- Funding
- Coordinated care in which there is no 'wrong door.' CWPI constraints on how much FTE per site, how many students per site. Multiple agencies not coordinating well within a school (often due to turf issues and often at the higher systemic level where coordination was not established well. School Discipline policies and practices.
- Resources! Here though, a lot of those resources are about when and where the service happens.
- Funding.
- Not having the funding to support the services.
- School based health services including behavioral health services are primarily only available for Medicaid eligible youth with an IEP or IFSP. Students who are Medicaid eligible, but not on an IEP/IFSP cannot get behavioral health services in schools unless the school is in a contracting relationship with a Managed Care Organization, and works with that MCO to coordinate care.

Indicated services and supports (Tier 3) – *Ongoing strategies to support those with significant needs, including a streamlined referral process with community mental health providers to create a seamless service delivery model for children, adolescents, and their families. Sometimes these are referred to as mental health "intervention" or "tertiary" or intensive services (e.g., Trauma-focused Cognitive Behavioral Therapy, Coping Cat, Cognitive Behavioral Intervention for Trauma and Schools (CBITS), Multisystemic Therapy, and high-quality Wraparound planning). Please include services provided by school-employed and community-employed, school-based professionals.*

For the following, please complete these questions for the **LAST SCHOOL YEAR**.

INDICATED SERVICES & SUPPORTS (TIER 3) (include strategies provided by both school-based and community-based providers/systems)							
Respondent Organization	**Organization or Agency**	**Programs, Services or Supports (Students displaying mental health concerns)**	**Evidence Based**	**Population Served**	**Funding & Funding Streams**	**Policies**	**Systems Integration Activities (Partnerships)**
Who provided the answers to this survey?	***Who provides these services or programs (e.g., district/school, ESD, community-based agency, etc.)?***	***What programs, services, supports, and other resources exist that serve children, K-12, teachers, and staff related to mental health and wellness including trauma informed practices? Provide a brief description of the program, including hours of service, goal/purpose (e.g., cognitive behavioral therapy), as appropriate. an evidence-based or evidence-informed program, as appropriate.***	***Is this an evidence-based practice?***	***Who is the target population for the services or programs (e.g., K-3, trauma-impacted students, etc.)?***	***How is the program funded? Are there blended funds? If so, what are these (e.g., state, federal, local)?***	***Are there existing policies that are aligned with the service or program or a governing board that oversees the service? (For example, for suicide prevention programs, a written suicide prevention policy is in place).***	***Are there interagency partnerships to support the integration of service delivery? If so, list partners.***
ESD 112	Community Behavioral Health agencies	School based mental health and substance use treatment services	No	K-12 students assessed to qualify for services and who also have Medicaid insurance	Medicaid	No, except federal Medicaid rules and state rules guiding those funds	ESD 112, school districts, managed care orgs and community providers
PSESD	Support provided as requested around the region	Suicide Intervention	No	N/A	N/A	N/A	N/A
	Support provided as requested around the region	Crisis response and flight teams	No	N/A	N/A	N/A	N/A
Washington State Association of School Psychologists	Typically, district/school	Behavior Intervention Plan	Yes	Targeted individuals in need	Could be general education or special education	IDEA covers some, otherwise, not that I know of	Sometimes outside behavior therapists are involved, but this is not common.
	Could be school staff or outside providers coming in	Individual counseling	No	Targeted individuals in need	Could be general education or special education, or even community/insurance funding	N/A	Greater Lakes Mental Health is one I know of, also sometimes Catholic Community Services.
Pacific County	ESD 113 True North Student Assistance Program	School based SUD counselling	N/A	7-12 at OBSD, South Bend, Raymond, Valley, and Naselle	.1% Sales Tax, GRBHO, Medicaid, DBHR/OSPI	Yes	Districts and funders. ESD 113 provides services

INDICATED SERVICES & SUPPORTS (TIER 3) (include strategies provided by both school-based and community-based providers/systems)							
Respondent Organization	**Organization or Agency**	**Programs, Services or Supports (Students displaying mental health concerns)**	**Evidence Based**	**Population Served**	**Funding & Funding Streams**	**Policies**	**Systems Integration Activities (Partnerships)**
	Willapa Behavioral Health	School based mental health counseling	N/A	K-12 county wide	.1% Sales Tax, GRBHO, Medicaid	Yes	Districts and funders. WBH provides services
NEWESD 101	Sacred Heart	PCCA (Adolescent Psychiatric Unit)	N/A	Ages 13-18	N/A	N/A	N/A
	Sacred Heart	BEST (day treatment program)	N/A	K-6	N/A	N/A	N/A
		Tamarack (psychiatric in-patient long-term treatment center for adolescents)	N/A	Ages 13-18	N/A	N/A	N/A
		Excelsior (placement usually is done by court systems of students who have not been successful in any other setting; the majority of students placed here are in state custody)	N/A	Ages 13-18	N/A	N/A	N/A
ESD 114	OESD	Teen Intervene	Yes	Grades 9-12	County, State and Federal grants	Yes	School districts
	OESD	Coping and Support Training	Yes	Grades 9-12	County, State and Federal grants	No	School districts
	OESD and MH	CBT	Yes	Grades K-5 and 9-12	County, State and Federal grants	No	School districts & Mental Health

Gaps: Briefly describe, in general, any gaps in programming related to indicated services and supports (Tier 3). For example, who should be served that is not receiving services? Are services developmentally, culturally, and gender specific? Is access an issue? Are there issues with implementation and/or fidelity? Are there duplicative efforts that can be merged or otherwise coordinated?

- School based services only available to Medicaid eligible.
- School based services are often missing.
- Need more consistent/greater quantity of mental health counseling at outlying schools (nacelle and valley).
- There are in adequate spaces for the students who need this type of extensive support.
- Limited number of schools have this service in place about 1% in our region and limited access to services outside the schools do to ability to travel to services and afford services.

Barriers/Challenges: What challenges or barriers prevent the delivery of services or programs (e.g., policies, systems, turf issues)?

- Continuing to support schools in understanding the behavioral health funding and agency needs, and likewise assisting agencies in understanding best way to provide school based services
- Resources: staff, training, time, space, etc.
- Hiring- it is VERY difficult to hire and maintain all positions- especially qualified mental health counselors.
- Relying on grants makes it challenging to sustain. Rarely do we run into policy, systems or turf issues to provide MH an SUD counseling support especially for Tier 3.
- School based health services including behavioral health services are primarily only available for Medicaid eligible youth with an IEP or IFSP. Students who are Medicaid eligible, but not on an IEP/IFSP cannot get behavioral health services in schools unless the school is in a contracting relationship with a Managed Care Organization, and works with that MCO to coordinate care.