K-12 Student Behavioral Health in Washington

Opportunities to improve access to needed supports and services

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Executive Summary

Background (page 6)

Schools can play a critical role in providing behavioral health prevention activities, and identifying and connecting students to early intervention services. National education and healthcare organizations now recommend schools address student behavioral health in addition to physical health, although historically these services have not been provided in schools. In Washington, the behavioral health and education systems operate separately: the state Health Care Authority (HCA) and Office of Superintendent of Public Instruction (OSPI) both play significant but distinct roles, as do local school districts and regional educational service districts. This audit therefore looked at both how public K-12 school districts are addressing student behavioral health prevention and early intervention, and the larger state system in place to coordinate and support these services.

The behavioral health supports and services that are available to students depend on what schools are able to provide at the local level (page 14)

Effective school-based behavioral health systems include the full continuum of student supports and universal screening. However, few schools have adopted all core elements recommended as leading practices. Most schools have not implemented a full continuum of supports, but many provide at least some services. In addition, few schools systematically screened students. Nearly all schools trained their employees, and had dedicated staff to respond to concerns. Most schools monitored student data. Schools said the lack of providers and transportation were barriers for students to access services.

The state's approach to student behavioral health is fragmented and lacks sufficient resources (page 21)

The state's current approach is fragmented, with roles and responsibilities assigned across several local and state agencies. Washington's decentralized approach has relied on school districts to develop behavioral health plans without oversight.

Furthermore, educational service districts can only provide limited support to school districts as they develop those plans. Gaps in the current oversight and guidance structure requires improved state-level coordination to help schools better identify and connect students to behavioral health supports. Insufficient state-level direction and oversight results in students having uneven access to behavioral health supports. Leading practices suggest greater state-level direction and coordination can help schools and districts better address students' needs. Washington's current workgroup around student behavioral health services is limited to making recommendations to the Legislature. The Legislature can promote greater state-level direction and coordination through establishing a lead agency and an advisory council. The state's current approach to behavioral health in schools lacks the resources needed to adequately identify and refer students to needed services.

Although fundamental changes are needed to address issues with the current structure, state and local agencies can make incremental changes to improve student access to services (page 31)

HCA can take steps to help education agencies better access Medicaid to help pay for services. Medicaid allows education agencies to become providers and deliver behavioral health services in schools. As the state's Medicaid agency, HCA is positioned to help education agencies with challenges they face when contracting with the state's managed care organizations. HCA could provide better guidance around reimbursable services as well as contracting and billing with managed care organizations. Other states help education agencies with coordination, guidance and financial support.

Though it might be controversial, HCA could also seek a federal waiver to expand student eligibility for Medicaid to cover confidential behavioral health services for students age 13 years and older, as it has done for reproductive health services. In addition, it should monitor providers to ensure Medicaid-enrolled school-age children receive required screenings. Despite their limited resources and expertise, some school districts have found creative ways to provide behavioral health services.

State Auditor's Conclusions (page 42)

Nearly half of all people with mental health disorders begin exhibiting symptoms by the time they start high school. Left unaddressed, these disorders can lead to lifelong problems, including homelessness and incarceration, and in some cases can lead to death by suicide. Even before the start of the pandemic, Washington students experienced these issues at a higher rate than national averages. The disruption and social isolation of the pandemic have only made the problem more intense.

Addressing the broader issue of behavioral health disorders goes beyond what schools can reasonably solve. Nonetheless, because schools are a hub for the vast majority of children who might begin to exhibit symptoms, schools are a natural setting for prevention and early intervention efforts. However, as this audit shows, the system to both support and hold schools accountable for these efforts is highly fragmented, with the result being uneven and often inadequate availability of services.

Truly fixing the system for prevention and early intervention efforts will be no small undertaking. It will require both structural changes to place someone in charge of the system, as well as additional resources for schools. While this audit also highlights some steps the state and schools could take to make incremental improvements, a coherent system to give Washington's youth the supports they need to address behavioral health concerns early on should be the state's long-term goal.

Recommendations (page 43)

We made recommendations to the Legislature to address the fragmentation in the existing structure to provide greater state-level coordination and direction. We also made a series of recommendations to the Health Care Authority to improve the existing state system's ability to connect students with behavioral health prevention and early intervention services. In addition, we also made a recommendation to the Office of Superintendent of Public Instruction to address the shortcomings of its model plan.

Next steps

Our performance audits of state programs and services are reviewed by the Joint Legislative Audit and Review Committee (JLARC) and/or by other legislative committees whose members wish to consider findings and recommendations on specific topics. Representatives of the Office of the State Auditor will review this audit with JLARC's Initiative 900 Subcommittee in Olympia. The public will have the opportunity to comment at this hearing. Please check the JLARC website for the exact date, time and location (www.leg.wa.gov/JLARC). The Office conducts periodic follow-up evaluations to assess the status of recommendations and may conduct follow-up audits at its discretion. See **Appendix A**, which addresses the I-900 areas covered in the audit. **Appendix B** contains information about our methodology. See the **Bibliography** for a list of references and resources used to develop our understanding of student behavioral health issues.

Background

Many K-12 students need behavioral health supports and services

Behavioral health is an overarching term used in both medical and educational settings, encompassing mental health, mental health disorders and substance use disorders. Behavioral health disorders can interfere with the way an individual thinks, feels and acts. For this report, we define these terms this way:

- **Mental health** is a person's social, emotional and behavioral well-being that affects their ability to learn, handle challenges and make decisions.
- **Mental health disorders** can interfere with all aspects of daily life, as well as a person's sense of hope and the way they look at themselves. Examples of mental health disorders are depression and anxiety.
- **Substance use disorder** is the excessive use of alcohol or other drugs that can lead to dependence on an addictive substance.

Half of those with mental health disorders will show symptoms by age 14, but treatment often does not occur until years later. Untreated behavioral health issues have negative short and long-term effects. Identifying problems early on and intervening appropriately are essential to improve students' overall well-being and educational outcomes. Students whose needs for behavioral health supports go unmet can suffer from poor academic performance, including behavioral issues, school violence, criminal activity and dropping out of school. These issues can have lifelong ramifications for students when they are left unaddressed, including homelessness, incarceration and even suicide.

Steps can be taken either to prevent behavioral problems from arising in the first place or to intervene early on so that an individual's condition does not progress.

- **Prevention** seeks to promote positive social, emotional and behavioral skills. It focuses on overall well-being and seeks to prevent problems from occurring.
- **Early intervention** is targeted to people displaying early signs and symptoms of a behavioral health problem or disorder. It focuses on mitigating risk factors and preventing early symptoms from progressing into a diagnosable disorder or reducing the impact of the disorder.

Meeting students' needs can improve their academic and health outcomes into adulthood

Research shows that students who receive supports and services to address their behavioral health needs have better academic and health outcomes. The most powerful influences over students' achievement in school are social and emotional factors, with a direct link between the academic success of students and their behavioral development. Interventions that strengthen students' social, emotional and decision-making skills also positively affect their academic outcomes. Prevention and early intervention supports, such as informal peer-group discussions or other low-intensity classroom-based supports, can reduce the severity of students' potential disorders or prevent them entirely. Early action to support students can reduce rates of suicide, incarceration and abandoning education before graduation.

Washington students experience higher rates of behavioral health disorders than national averages

Mental health and substance use disorders are more common among Washington youth than the national average. The 2018 National Survey of Children's Health data showed that the mental health disorder prevalence rate among 5- to 17-year-olds in Washington is 17.5 percent compared to the national average of 14.9 percent. For substance use disorders, the 2018 National Survey on Drug Use and Health showed that 5 percent of Washington youth experienced at least one substance use disorder in the past year compared to the national average of 3.8 percent.

View the Healthy Youth Survey on the publisher's website here: https://www.askhys.net/

The state's own Healthy Youth Survey shows examples of behavioral health concerns that Washington's students experience. For example, around one in ten students in the 8th, 10th and 12th grades said they had attempted suicide in the past year, while four in ten students in the 10th and 12th grades felt so sad and hopeless for two weeks or more that they stopped doing their usual activities. Responses about substance use were also troubling: more than a quarter of 12th graders reported using alcohol in the last 30 days, and two out of ten 12th graders used more than one substance in the last 30 days. This survey is conducted every two years through a collaborative effort between four agencies: the Health Care Authority (HCA), the Office of Superintendent of Public Instruction (OSPI), the Department of Health, and the Liquor and Cannabis Board. It is administered in schools for students in grades 6, 8, 10 and 12.

Schools can play a critical role in providing behavioral health prevention and early intervention services

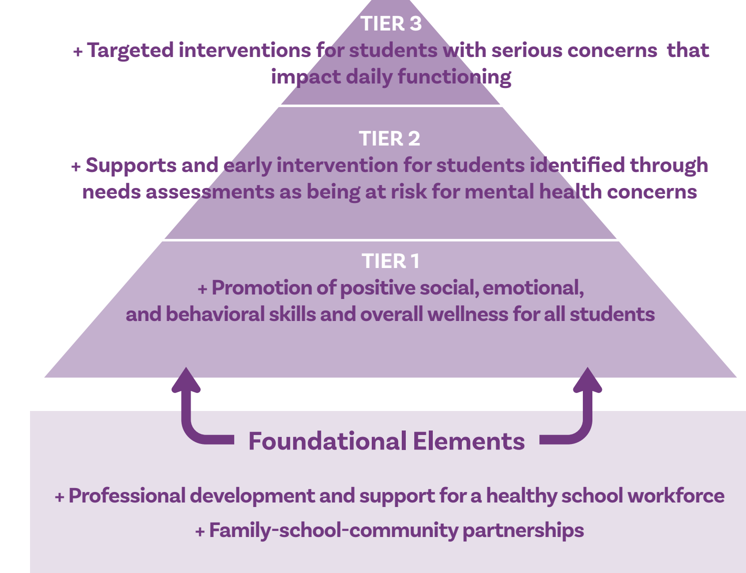
National experts recognize that schools are a natural setting to promote student well-being, identify behavioral health concerns and offer necessary interventions. Students spend a large portion of their days at school, so teachers and other school staff play an integral role in identifying and supporting students with behavioral health needs. Offering students services in school settings can reduce barriers to accessing care and stigma related to mental illness and substance use disorders. These services can be provided by qualified staff hired by the district, through community partnerships with behavioral health professionals, or in co-located school-based health centers. National education and healthcare organizations now recommend schools address student behavioral health in addition to physical health, although these services have not been historically provided in schools.

In Washington, school districts and schools play a key role in identifying and supporting students with behavioral health needs, while educational service districts provide some supports and training

School districts and schools play a key role in identifying and connecting students to behavioral health supports and services. School districts must usually work within their existing state and local funds – or seek additional external grants – to provide behavioral health programs.

In school settings, educators and health care providers use a framework referred to as the Multi-Tiered System of Support. The pyramid in **Exhibit 1** shows the three different levels of supports and services, which include prevention, early intervention and referrals for treatment. Through this framework, schools can offer a seamless continuum of supports to students from universal prevention in tier 1 to more intensive interventions in tier 3.

Exhibit 1 – The Multi-Tiered System of Supports



Source: *Advancing Comprehensive School Mental Health: Guidance From the Field*. National Center for School Mental Health. University of Maryland School of Medicine.

- **Prevention activities (tier 1)** are directed at all students. They include educational programs to increase students' awareness of mental health and substance use issues, social-emotional learning that helps students build healthy coping skills, and student-led support groups.
- **Early intervention activities (tier 2)** are for students who have early symptoms or are at risk of behavioral health problems. They can include regular check-ins with a trained school professional and small group interventions with students who have similar needs.
- **Referrals for treatment and more intensive interventions** (**tier 3**) are for students with more serious behavioral health concerns. Schools can refer students to community health professionals who partner with the school to provide services off-campus or on-campus, or to school-based health centers that provide a full range of health services for students and their families.

The foundational component of this framework recognizes the key role school staff play in addressing students' needs at all three tiers. National experts stress the importance of adequately training educators and administrators on social and emotional skills and mental health literacy through professional development courses or programs. Well-equipped teachers and other staff on the front lines form a healthier workforce, and one that is better prepared to respond to the needs of students.

Washington's nine **educational service districts** (referred to in this report as service districts) support school districts in their regions. In the case of behavioral health, service districts provide professional development opportunities that address how to recognize, screen for, and respond to emotional or behavioral distress in students. These trainings are run either by their own staff or by contracted outside professionals. Service districts also participate in the community coalitions that make up the state Community Prevention and Wellness Initiative, described below.

In fiscal year 2021, the Legislature allocated funding to place behavioral health navigators in all nine service districts. Navigators' duties include facilitating partnerships between school districts and community mental health agencies, coordinating Medicaid billing, and helping districts develop their required plans for recognizing and responding to emotional and behavioral distress. They also lead suicide prevention and response efforts in their service district and serve as trainers for required suicide prevention training.

The K-12 education system seeks to serve all students regardless of the student's insurance status

Service districts, schools districts and school representatives said that they seek to serve all students with behavioral health needs. Some schools are able to provide in-school supports for students. However, schools can find connecting students to community providers challenging, because it requires them to go through students' health care insurance. Doing so can result in high deductible costs, making it challenging for students and their families to pay for services. When students are uninsured, schools face another layer of difficulty in making community connections.

State agencies have limited resources to provide funding and guidance for schools, districts and other local organizations

OSPI is the state education agency with general oversight responsibility for school districts. It is required to help schools implement suicide prevention activities and to identify resources related to social-emotional learning and other behavioral health prevention topics. HCA contracts with OSPI and educational service districts to administer the Student Assistance Prevention and Intervention Services Program, which is funded by HCA through the Community Prevention and Wellness Initiative (described below). This program places Prevention and Intervention Specialists within selected schools.

HCA is the state's designated Medicaid agency. It is responsible for purchasing health care services, including behavioral health services, for Medicaid-eligible Washingtonians. In 2016, the Legislature also made HCA the state's behavioral

health authority, responsible for oversight of all behavioral health services. The agency's transition into this role, which was formerly assigned to the Department of Social and Health Services, was completed in July 2018. In its new role, HCA also monitors the managed care organizations that provide behavioral health services for the state's Medicaid population — including the more-than-550,000 school-age children enrolled in Medicaid. HCA's primary prevention program for school-based behavioral health is the Community Prevention and Wellness Initiative.

The state's main school-based program focuses on preventing substance use in high-need communities through community coalitions

HCA established the Community Prevention and Wellness Initiative in 2011 to implement effective prevention strategies, create greater positive community level outcomes, and leverage federal, state and local funding. The initiative's 2019-2021 biennial budget – nearly $32 million – was funded primarily through federal grants from the Substance Abuse and Mental Health Services Administration, with some money from the state's Dedicated Marijuana Account.

The initiative provides communities that have high levels of underage drinking, marijuana, tobacco and opioid use, school failure rates, mental health challenges and crime the funding, training and technical assistance they need to conduct effective strategies to prevent and reduce substance use disorders. The initiative was designed to address the needs of an entire community; participants work together to establish a community coalition in their area. Coalition representatives can include volunteer organizations, law enforcement, health care professionals, schools and local governments. In 2021, more than 80 community coalitions have been set up, in all 39 counties. Their key duties are to strategize and put into action community-wide activities around substance use prevention. However, because funding is limited, HCA has prioritized funding to high-need communities using a data-informed process. As funding opportunities allow, HCA indicated that it will further expand the initiative into the highest need communities around the state. The initiative also funds some school and community-based programs. Such programs include the evidence-based, school-climate-change program called PAX Good Behavior Game, which addresses substance-use disorder prevention and mental health promotion in schools.

In the past, HCA contracted with OSPI to administer the school-based portion of the initiative, known as the Student Assistance Prevention and Intervention Services Program, as Washington's primary substance use prevention program in K-12 education. Under the contract, HCA provided funding to place a specialist in a school within the boundaries of each community coalition; it served more than 120 of the state's 2,000-plus schools. The specialists conducted prevention activities and student screenings, and provided early intervention supports and community referrals for students with substance use concerns. After its contract with OSPI expires on June 30, 2021, HCA will instead contract directly with the state's educational service districts to provide the initiative's services.

This audit asked how local and state agencies can better coordinate to identify and connect students to needed services

We conducted this audit due to the critical role schools can play in providing behavioral health prevention activities, and identifying and connecting students to early intervention services. We looked at how public K-12 school districts are addressing student behavioral health prevention and early intervention, as well as the larger state system in place to coordinate and support these services. The audit answers the following questions:

> Are there opportunities for state agencies, educational service districts and school districts to better identify and connect Washington students to needed services?
>
> Can state agencies, educational service districts and school districts reduce barriers to accessing these services and improve coordination of them?

To answer these questions, we needed to understand what schools, school districts and service districts were currently doing to identify and connect students to needed services. Using the Multi-Tiered System of Support framework (illustrated in Exhibit 1), we focused our review on activities that identified and connected students. Aside from that focus, our work also identified additional improvement opportunities that bridged multiple tiers of supports and services.

We first judgmentally selected 50 of the state's 295 school districts to survey about their behavioral health practices. We selected districts to create a balance across regions of the state, rural and non-rural areas, and participation in the state's Community Prevention and Wellness Initiative.

Nearly 400 schools in these districts responded to our survey, representing one fifth (20 percent) of all K-12 students in Washington (228,000 students). Although the results are not statistically projectable to the state as a whole, we believe the mix of schools gives us a sample that is representative enough to draw general conclusions about schools' practices. The results in the first chapter of this report summarize schools' responses regarding these practices, but additional detail is available in **Appendix C**. Because the survey design took place before the beginning of the COVID-19 pandemic, we did not include questions about the impact of virtual schooling on students' behavioral health.

We also met with the state's nine educational service districts and state agencies to learn about how they currently support schools and districts with behavioral health programming. State agencies included OSPI, HCA, the Department of Health, and the Department of Children, Youth and Families. We limited the scope of our audit to these government agencies, focusing on what they can do to help

students in schools. For example, Medicaid services are under the authority of HCA, and therefore within the scope of this audit. Opportunities for uninsured students or those with private health insurance outside of schools were beyond the scope of our work.

We also reviewed state laws to better understand requirements state agencies, service districts and school districts must meet pertaining to behavioral health care in K-12 education. We then tested three areas for compliance: OSPI's model plan; the service districts' regional safety centers; and school districts' plans to recognize and respond to student emotional distress.

We looked to leading practices and other states to gain a broad understanding of opportunities to improve student access to behavioral health prevention and early intervention. We selected Michigan and South Carolina to learn about practices they implemented to support education agencies in providing Medicaid behavioral health services in school settings. We also met with Washington school and district representatives to learn about how they have implemented practices to identify and connect students to needed services, even with limited resources. Appendix B has more detailed information about our audit methodology. See also the selected bibliography at the end of this report.

Audit Results

The behavioral health supports and services that are available to students depend on what schools are able to provide at the local level

Results in brief

Effective school-based behavioral health systems include the full continuum of student supports and universal screening. However, few schools have adopted all core elements recommended as leading practices. Most schools have not implemented a full continuum of supports, but many provide at least some services. In addition, few schools systematically screened students. Nearly all schools trained their employees, and had dedicated staff to respond to concerns. Most schools monitored student data. Schools said the lack of providers and transportation were barriers for students to access services.

Effective school-based behavioral health systems include the full continuum of student supports and universal screening

Schools play a critical role in supporting students' well-being and identifying behavioral health concerns. Not only do students spend much of their time in school, researchers have found positive interrelationships between good behavioral health support and academic outcomes. An effective system of behavioral health support in schools incorporates certain core features, such as those identified in a guide published by the National Center for School Mental Health. The guide, "Advancing Comprehensive School Mental Health," incorporates issues around social, emotional and behavioral health of students, including substance use. It

contains contributions from a range of federal, state and local organizations. Its core features are widely accepted nationally as leading practices. **Exhibit 2** lists five that the audit used to evaluate Washington's school-based behavioral health system.

Exhibit 2 – Selected core elements for effective school-based behavioral health systems

A	Behavioral health supports that cover the full continuum of intensities and needs, from universal preventive activities through more intensive interventions for students with mild-to-significant behavioral health needs
B	Screening students universally or in subsets to identify those who need behavioral health supports
C	Having well-trained staff who can support behavioral health needs
D	Collaborative team approach that works across the school, family and community organizations
E	Tracking data on behavioral health outcomes and needs to facilitate data-driven decision-making

Source: "Advancing Comprehensive School Mental Health: Guidance From the Field." National Center for School Mental Health. University of Maryland School of Medicine.

The first core element recommends providing a multi-tiered system of supports that will address the full continuum of students' needs. While this audit focused on prevention and early intervention, research indicated that effective school-based behavioral health systems include the full continuum of supports. This approach (described in more detail in the Background section of this report) incorporates prevention activities for all students, early intervention activities for students with mild distress or impairment, and targeted interventions for those with more severe needs. These layered interventions – from universally beneficial activities to targeted programming – help ensure all students can access services that best address their needs. This approach has been adopted by a variety of national and state organizations, including the federal Substance Abuse and Mental Health Services Administration and Washington's Office of Superintendent of Public Instruction.

The remaining core elements cover activities that help reinforce schools' ability to meet their students' behavioral health needs. Universal screening helps ensure that students with a high risk of developing or already displaying early warning signs of behavioral health problems are identified and connected to appropriate supports. Trained staff and working in collaborative teams help ensure the system works as intended and meets the specific needs of individual communities. Finally, school administrators armed with data from thoughtfully selected program measures can make better decisions and ensure the system continues to improve.

Few Washington schools have adopted all core elements recommended as leading practices

To find out more about the ways schools and school districts support students with behavioral health needs, we first conducted a survey. Aligning with leading practices around the continuum of supports, the survey asked broad questions about how students are identified and connected to services, such as early intervention and treatment services. Survey results thus illustrate the full continuum of supports schools make available to students. We then held follow-up conversations with selected school administrators. It became clear from these discussions that while schools may want to offer more and better behavioral health supports to their students, their ability to do so varied widely. Although nearly all surveyed schools reported they offered at least some level of support, only 13 percent of responding schools had practices in place covering all five core areas. Even among the majority of schools offering some supports, the supports they could provide varied from school district to district. In the following pages, we discuss the five core elements and how many schools said they fully provided each. Overall, these results show there is significant room for improvement across Washington to fully adopt the leading practices necessary for effective school-based behavioral health systems. (See Appendix C for more detail about the survey questions and results.)

A. Most schools have not implemented a full continuum of supports but many provide at least some services

Only 42 percent of schools said they provided in-school supports that covered the full continuum of prevention and early intervention activities. The remaining 58 percent said that they did not offer at least one activity or service in each of the three tiers: prevention, early intervention, and targeted intervention. Offering the full continuum of supports is a key element of an effective school-based behavioral health system. This is because the layered interventions from universal approaches to targeted programming help ensure all students can access services that address their needs and receive exposure to universal supports.

Exhibit 3 shows the percentage of schools offering the recommended type of support in each of the three tiers. (Note that because schools could select multiple 'yes' answers in each area, percentages in this table do not add to 100 percent.)

Exhibit 3 – Multi-tiered systems of support activities

Reported activities	Percent of schools reporting this activity in place
Prevention activities	
Behavioral health-related curriculum	76%
Behavioral health-related campaigns, initiatives or events	15%
Early intervention services	
Low-intensity classroom supports	83%
Brief individualized student interventions	83%
Small group student interventions	81%
Student mentoring programs	35%
Targeted intervention services	
Intensive individualized student interventions	47%
School-based health center	14%

Note: Because districts could choose multiple answers, these totals add to more than 100%.
Source: Auditor analysis of survey responses from selected Washington K-12 schools.

Most of the surveyed schools offered at least one recommended activity in each tier, although this varied across tiers. Almost 80 percent of schools said they offered at least one prevention activity. These activities could include school-wide lessons or classroom presentations to help build awareness of behavioral health for students and promote positive behaviors like self-awareness and relationship skills that can mitigate behavioral health risk factors. Nearly all schools said they offered at least one early intervention service. Early intervention services such as classroom-based supports, which could include a daily report card or teacher check-in, help address mild behavioral health distress and reduce the likelihood that problems will get worse. Half of schools said they offered at least one targeted intervention service. Targeted interventions, such as group or family therapy, help meet the needs of students with significant distress or functional impairment.

Nonetheless, one in five schools did not report having any prevention activities in place. In-school universal prevention activities are important because they support healthy behavioral development in all students. Because it is easier and more cost-effective to prevent behavioral health problems rather than treat them after they have developed, schools' responses suggest the state should place greater emphasis on prevention.

B. Few schools systematically screened students

Screening students for behavioral health needs allows school professionals to intervene early, when issues are easier to address. Universal screening is best because it helps ensure schools identify not only students with the most disruptive problems but also those with milder issues who could benefit from early help. If universal screening is not practicable/possible, leading practices acknowledge that screening a sizeable subset of students, such as by grade, is also useful. Only 32 percent of schools said they screened either all students or a subset of students to identify behavioral health needs. An additional 28 percent of schools said they screened students only on an individual basis when there was cause for concern. In total, 60 percent of schools said they conduct some sort of behavioral health screening of their students, as shown in **Exhibit 4**.

Exhibit 4 – Extent of behavioral health screening varies across schools

*Note: "Other" responses totaled 3%; these answers could not be quantified as conducting any type of screening.

Source: Auditor analysis of survey responses from selected Washington K-12 schools.

Universal screening is the basic foundation for behavioral health systems because screening identifies needs and early symptoms before they become disruptive to the student's life and harder to treat. With less than a third of schools reporting they conduct broad-based screening as leading practices recommend, the state should emphasize behavioral health screening.

C. Nearly all schools trained their employees

Educators, student support staff and other school-based staff play an integral role in identifying and connecting students with behavioral health concerns with services. For this reason, they need adequate training to recognize and respond to them. Proper training includes the social and emotional skills that will help staff foster a school climate that supports good mental health. As **Exhibit 5** shows, while only about a fifth of schools said they trained all staff, 90 percent of schools said they train all or some of their staff on these issues. For schools that trained some staff, those most likely to be trained included administrators, counselors, teachers, and para-educators. More than 75 percent of the schools trained staff on how to respond to a student in emotional or behavioral distress, and who to contact when they suspect a student might have a behavioral health concern.

Exhibit 5 – Staff training activities

Activity	Percent of schools reporting this activity in place
Trained all staff	19%
Trained some staff	71%
Don't train staff/Don't know	10%

Source: Auditor analysis of survey responses from selected Washington K-12 schools.

D. Most schools had dedicated staff to respond to concerns

Successful school behavioral health systems require a commitment to integrating academic and health supports. This in turn requires dedicating some school staff to determine how to respond to concerns about student behavioral health issues. Ideally, a school or district works with a collaborative team that brings in community partners such as behavioral health providers and parents. As **Exhibit 6** shows, 72 percent of schools said they had a dedicated person, 69 percent said they had an intervention team, and 58 percent said they had both. In all, 83 percent of schools said they had either a dedicated person or team.

Exhibit 6 – Dedicated staff or behavioral health team

Dedicated staff or team (check all that apply)	Percent of schools answering yes to the question*
Dedicated staff person	72%
Dedicated team	69%
Both dedicated staff person and team	58%

*Note: Because districts could choose multiple answers, percentages do not total 100%.
Source: Auditor analysis of survey responses from selected Washington K-12 schools.

E. Most schools monitored student data

Schools need data about behavioral health needs and outcomes, so they can make informed decisions about resource allocation, staffing and program refinements. This does not necessarily mean they must devise all new systems: schools can use existing data collection systems, such as those used for attendance and grades. As **Exhibit 7** shows, 82 percent of schools said they routinely monitor student data to identify potential behavioral health concerns for all or at-risk students, with 54 percent reporting they did this for all students. The most common metrics schools said they monitored routinely were discipline referrals and attendance. Slightly more than half said they routinely monitored changes in grades. Less than half said they routinely monitored school nurse visits.

Exhibit 7 – Schools that monitor behavioral health indicators for some or all students

Data monitoring	Percent of schools reporting this activity in place
Monitor data for all students	54%
Monitor data for at-risk students	28%
Don't monitor data/Don't know/ No response	18%

Source: Auditor analysis of survey responses from selected Washington K-12 schools.

Schools said the lack of providers and transportation were barriers for students to access services

Survey respondents said they face barriers outside their control when it comes to connecting students to needed services. Schools identified the limited number of nearby and available mental health providers as the most pressing barrier: almost two-thirds said this significantly or very significantly affected their ability to connect students to services. Transportation was also a problem. Half of schools said students' lack of transportation to a provider had a significant or very significant effect on successfully connecting the student to services. Finally, almost half of schools said that parents' reluctance to access services for their child was a significant or very significant concern. While there may be a number of reasons for this reluctance, it may hinder a student's ability to access behavioral health services.

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

Results in brief

The state's current approach is fragmented, with roles and responsibilities assigned across several local and state agencies. Washington's decentralized approach has relied on school districts to develop behavioral health plans without oversight. Furthermore, service districts can only provide limited support to school districts as they develop those plans. Gaps in the current oversight and guidance structure require improved state-level coordination to help schools better identify and connect students to behavioral health supports. Insufficient state-level direction and oversight results in students having uneven access to behavioral health supports. Leading practices suggest greater state-level direction and coordination can help schools and districts better address students' needs. Washington's current workgroup around student behavioral health services is limited to making recommendations to the Legislature. The Legislature can promote greater state-level direction and coordination through establishing a lead agency and an advisory council. The state's current approach to behavioral health in schools lacks the resources needed to adequately identify and refer students to needed services.

The state's current approach is fragmented, with roles and responsibilities assigned across several local and state agencies

Many students lack access to a full range of in-school supports due to Washington's fragmented approach to behavioral health, compounded by limited state-level support and oversight. Although HCA and OSPI provide programming and resources around student behavioral health, these efforts are not comprehensive. For example, Medicaid services, which are the responsibility of HCA, are limited to those students who are eligible for Medicaid. Uninsured students or those with private health insurance are not eligible to be served by Medicaid-funded programs. Furthermore, the fragmented and decentralized system relies heavily on school districts and educational service districts (referred to in this report as service districts) to develop, fund and provide these services themselves.

State laws direct local and state agencies to implement behavioral health services and supports with no clear lead state agency to coordinate the resulting patchwork of efforts. Although the roles and responsibilities assigned to these agencies include important components of a comprehensive system of behavioral health for students, existing laws do not actually deliver such a system. A truly comprehensive system would ensure students can access the full continuum of services – from prevention through early interventions and referrals for treatment. This section of the report sets out the gaps identified during the audit.

Washington's decentralized approach has relied on school districts to develop behavioral health plans without oversight

The audit found no one currently reviews the plans school districts must make to identify and respond to students who might need behavioral health services. The state relies on districts to develop and implement these plans, but until recently the state did not require oversight to help ensure they can and do. State law requires districts to develop these plans to ensure staff can recognize and respond to students in emotional or behavioral distress. Plans should include teaching school staff how to respond when a student needs help. The law requires that the plan cover four areas relevant to prevention and early intervention, as listed in **Exhibit 8.**

Exhibit 8 – What the law requires

1. Identifying staff training opportunities for recognizing, screening and referring students for behavioral health services
2. Addressing how to make use of district staff who are specially trained in recognizing, screening and referring students
3. Detailing how staff should respond to concerns or warning signs of emotional or behavioral distress in students
4. Developing partnerships with community organizations students can be referred to for behavioral health services

RCW 28A.320.127

Of the 20 district plans we reviewed, only three fully met the requirements in state law, while eight were partially complete. Nine other districts either said they had not developed a plan or did not respond to our requests.

In 2019, the Legislature assigned responsibility for monitoring these plans for compliance with state law to OSPI, and set a deadline of December 1, 2020, for OSPI to report on how it intended to do so. While OSPI has reported on its monitoring plan as directed, the agency is not currently monitoring individual district plans. OSPI officials told us their goal is to begin collecting data from school districts during the 2021-22 school year.

In addition, service districts can only provide limited support to school districts as they develop plans

Service districts have limited capacity to provide required behavioral health supports to help school districts – for example, by facilitating school-provider partnerships and providing suicide prevention training – even though doing so is part of their legal obligation. In 2019, state law required service districts to establish regional school safety centers as part of a statewide network for school safety. Regional safety centers are responsible for many aspects of behavioral health coordination for school districts, such as:

- Helping districts develop and implement their required plans
- Offering training opportunities for district staff
- Facilitating partnerships with community providers

However, service district officials said that they have not fully met these requirements due to limited capacity because the legislative bill was not fully funded prior to July 2020. Instead, they have focused on helping schools with the development of threat assessments to respond to potentially threatening student behavior. From July 1, 2020, the Legislature allocated funding to place behavioral health navigators in all nine service districts. These navigators will help regional safety centers meet their responsibilities.

Gaps in the current oversight and guidance structure require improved state-level coordination to help schools better identify and connect students to behavioral health supports

State law does not designate a state agency to oversee behavioral health services in K-12 education. Instead, HCA and OSPI must find ways to fulfill or oversee the patchwork of behavioral health requirements. Neither agency is able to provide programming and resources sufficient to help schools and districts actually implement comprehensive behavioral health systems that address the full continuum of services and supports. Representatives from both HCA and OSPI said that while they would like to support more school districts in their efforts, their resources are too limited to do so.

State law directs OSPI to develop a model plan to guide school districts as they develop their plans for recognizing and responding to students in emotional distress. However, our review of OSPI's model plan found it does not fully meet legal requirements. It focuses on suicide prevention rather than broader behavioral distress as the law directs, and lacks suggested trainings on screening students. Staff at OSPI said that when they first developed the model, they were responding to the Legislature's focus on suicide prevention. As a result, school districts use a model plan that is not fully compliant with requirements.

Furthermore, OSPI as an agency does not have a behavioral health program that can give districts all the technical assistance and training they need to set up comprehensive behavioral health systems. OSPI staff give districts some guidance around a limited set of behavioral health activities, such as social-emotional learning and suicide prevention activities.

Although HCA is the state's behavioral health authority, it is not required to ensure an adequate school-based behavioral health system is in place. The agency is allocated funding for substance use disorder prevention, primarily through the Community Prevention and Wellness Initiative that focuses on selected, high-need communities across the state. Even though HCA has worked with OSPI and service districts to support the school-based portion of the initiative, limited funds mean the initiative can serve only 6 percent of public schools. In addition, the funding sources specify that the initiative must focus on substance use disorder prevention. This produces an additional gap in funding available to meet the communities' needs for mental health promotion and intervention services. Finally, as the state's Medicaid authority, HCA is required to ensure that medically necessary services are provided to people eligible for Medicaid, a group that includes a significant subset of Washington students.

Insufficient state level direction and oversight results in students having uneven access to behavioral health supports

This lack of comprehensive state direction has resulted in a system in which schools vary considerably in the level of behavioral health support they can give their students. As set out in the previous chapter, few Washington schools have adopted important leading practices to ensure they can effectively support their students' needs. Furthermore, nearly 40 percent of schools said they did not provide any kind of behavioral health screening, or did not know for sure if they did.

State law does not assign responsibility for ensuring that school districts provide a baseline of behavioral health support in schools, such as universal screening and behavioral health curriculum for students. Furthermore, no agency is tasked with giving districts broad strategic direction on how to meet the state's expectations.

Other factors contribute to the challenges in the system, including insufficient guidance, monitoring and training. OSPI's model plan does not address all legal requirements. In addition, because OSPI has yet to review districts' behavioral health plans, districts lack guidance on what improvements they must make to ensure plans meet state requirements. The limited capacity of service districts to help school districts develop those plans and to facilitate community partnerships in turn limits what districts can achieve to widen the reach of existing services or put new ones in place.

Even if all these components functioned as the Legislature intended, the state still lacks a strategic, comprehensive direction on the minimum level of support schools are expected to provide students, and oversight to ensure it takes place. Stronger state oversight can help ensure that consistent minimum level of support. Without stronger direction from the state, students' uneven access to behavioral health supports will continue to be a persistent, systemic issue.

Leading practices suggest greater state-level direction and coordination can help schools and districts better address students' needs

Guidance published by the National Center for School Mental Health recognizes that schools and school districts need state-level support, such as technical assistance and training, to help them establish effective behavioral health systems in schools. Leading practices advise that state-level coordination is key to successfully promoting engagement and goal setting across education and health agencies.

The Center and other leading practices also recommend that states consider convening an advisory council made up of relevant parties in the behavioral health and education systems. Among the responsibilities members of an advisory council could assume are:

- Establish the state's strategic direction in student behavioral health. This includes building out evidence-based programming, such as social-emotional learning curriculum, for school districts to use in their own schools.
- Establish and monitor school-based behavioral health activities, using performance measures to track outcomes
- Oversee and provide guidance to school districts on how they can use allocated funds to implement programs

Such councils ideally work closely and collaboratively with their state's designated lead agency, with the joint goal of helping school districts establish more consistent prevention through early intervention services across the state.

Washington's current workgroup around student behavioral health services is limited to making recommendations to the Legislature

Washington has made progress toward the leading practice of an advisory council, by setting up a workgroup that has some responsibilities that resemble those of an advisory council. In 2016, the Legislature established the Children and Youth Behavioral Health Workgroup to identify barriers to accessing behavioral health services for children and families. However, this workgroup's authority is limited to making recommendations to the Legislature, and it cannot make changes to the system on its own. Nor was the workgroup tasked with providing strategic direction for school districts around prevention and early intervention or helping them implement services.

Michigan's legislature took a different approach to developing strategic direction and oversight for behavioral health services in schools. It established an advisory council, made up of members from health and educational organizations, and provided both funding and authority to the council. The council was specifically tasked with establishing goals for program implementation, overseeing allocated funding, and establishing and tracking performance measures. (See page 34 for more information on Michigan's approach.)

The Legislature can promote greater state-level direction and coordination by establishing a lead agency and an advisory council

Washington can do more to alleviate current fragmentation and the lack of state-level direction around student behavioral health by designating one agency to lead the state's efforts. This agency would be responsible for coordinating strategic direction and local activities with representatives from HCA, OSPI, service districts and other key partners such as managed care organizations. The lead agency would be made responsible for providing key technical support to school districts for program implementation and reporting outcomes to the Legislature.

Working with an advisory council is an important component of that coordination. In establishing the lead agency, the Legislature should also task it with setting up an advisory council. The lead agency should facilitate the council's meetings and ensure its recommendations are incorporated into state-level guidance and programs.

The Legislature could designate a state lead agency from its two strongest candidates:

- HCA, because it is the state's behavioral health authority and has the greater depth of resources in this field. It also has direct relationships with others in the health care systems, including expertise in medical billing. HCA also has some established channels of communication with service districts and schools.
- OSPI, because it is the lead agency on K-12 education and has direct relationships with schools and districts. It serves all students regardless of whether they qualify for Medicaid or state-assistance.

Exhibit 9 outlines each agency's strengths and challenges as the potential lead agency.

Exhibit 9 – Strengths and challenges for OSPI and HCA

	Strengths	Challenges
HCA	• Behavioral health expertise • Established relationships with managed care organizations • Oversees the state's primary substance-use prevention program • Oversees Medicaid services provided to students enrolled in Medicaid	• Does not have a primary focus or expertise in K-12 education • Some communication with schools, districts and educational service districts • No jurisdiction over educational settings
OSPI	• Established channels of communication and relationships with schools, districts and educational service districts • K-12 education expertise and understanding of what behavioral health practices schools and districts can realistically adopt	• Does not have a primary focus or expertise in behavioral health services and medical billing • Focused on providing local control to districts, limiting its authority to implement efforts across the state

Source: Auditor prepared based on interviews and agency documentation.

Each agency has strengths that could advance the coordination of behavioral health prevention and early intervention services for students in K-12 schools. The special expertise HCA has in working with health care providers, managed care organizations and medical billing is a particular advantage. It can work with OSPI to leverage the latter's closer relationships with schools in order to bring services closer to students who need them.

The state's current approach to behavioral health in schools lacks the resources needed to adequately identify and refer students to needed services

Washington directs behavioral health funding to specific activities and issues, rather than across the full continuum of services in a comprehensive, school-based behavioral health system.

Piecemeal state funding is likely inadequate to meet the needs of all students

The state allocates funding to help education agencies and HCA implement behavioral health prevention and early intervention activities, but current funding appears inadequate to meet the needs of all Washington students. This audit did not include an in-depth analysis to determine the cost of funding a comprehensive system.

HCA receives state funding aimed at student behavioral health programming, with roughly $4.4 million used to implement the Community Prevention and Wellness Initiative in the 2019-2021 biennium. Many representatives from HCA, OSPI, service districts and school districts said that although they wanted to provide greater behavioral health supports for students, limited resources constrained their ability to do so. For example, in the same biennium, OSPI received just under $400,000 to establish the state safety center, which supports the service districts' regional school safety centers. While all nine service districts received funding to hire behavioral health navigators, these employees are tasked with supporting numerous school districts, representing thousands of students.

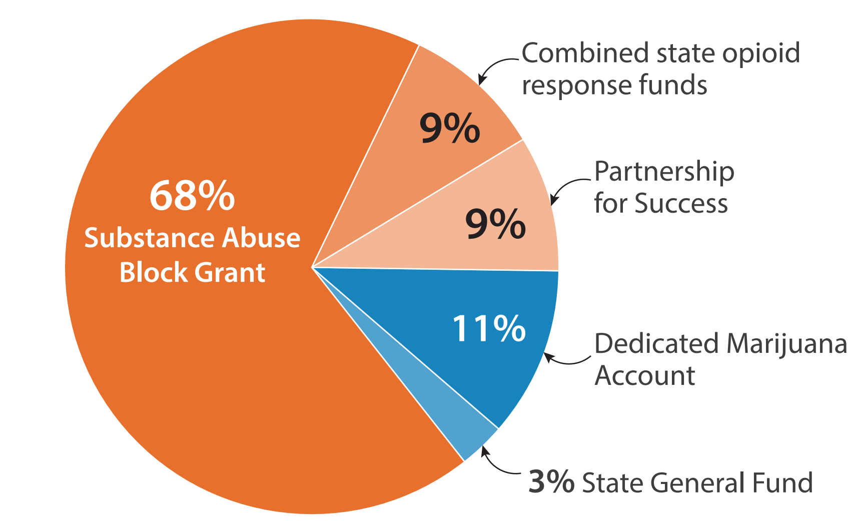
Additionally, the state's school funding formula – which is used to calculate resource funding for schools – requires a large number of students in order to fund behavioral health personnel. For example, a district must serve around 23,500 elementary students to receive funding for one school psychologist, and around 9,500 elementary students for a school social worker. Districts need even higher numbers of middle- and high-school students for such positions to be funded. This means that many school districts, especially smaller ones, must find other funding sources to hire behavioral health personnel.

The amount of funding and restrictions on its use also hinder the reach of the state's main prevention program

HCA's Community Prevention and Wellness Initiative has placed Prevention and Intervention Specialists in barely 6 percent of public schools due to limited funding. OSPI officials pointed out that because specialists funded through the initiative are assigned to a specific school, they cannot help other schools outside their community coalition boundary, even if they had the time to do so. In addition, the initiative primarily focuses on middle and high schools, not elementary schools. This limited coverage means that most schools must develop behavioral health programs on their own.

HCA has sought out and received additional funding to expand the program over the years; the 2019-2021 biennial budget of nearly $32 million includes both federal and state funding sources. Even with the higher budget, HCA said that more schools would like to participate in the program than it can fund. Furthermore, funding restrictions mean the money is limited to spending on substance use prevention even though mental health disorders are more prevalent. Federal grants designated for substance use disorder prevention pay for roughly 86 percent of the program, as shown in **Exhibit 10**, and stringently restrict how HCA may use the money. Although the initiative includes practices that have positive mental health outcomes, the primary focus of the program is around substance use prevention. The audit could not find any state-level program that directly supports mental health prevention and early intervention in schools.

Exhibit 10 – Community Prevention & Wellness Initiative funding sources
2019-2021; Federal funds in orange; State funds in blue



Source: Reported by HCA.

School districts and service districts must work within their means or seek other funding sources to meet student needs

Educational service districts and school districts acknowledged the limitations of current funding streams to support their behavioral health efforts. Instead, they turned to other funding sources, such as grants and local levies. However, relying on these sources poses its own challenges. For example, a district might lack staff to research and write grant applications. In one case, a district was unable to fund a school-based health center due to a failed levy in its region.

OSPI has helped direct grant funding to a selected number of districts. For example, through the Project AWARE federal grant from the Substance Abuse and Mental Health Services Administration, three school districts received funding to develop mental health services and behavioral health education programs over a five-year period. Once the development period ends, however, the districts must find new money to sustain their programs. OSPI also receives a limited amount of dedicated marijuana account funding from HCA, which districts can use to start a LifeSkills program within their schools. However, OSPI officials said that districts are often hesitant about applying for these funds due to the numerous program requirements.

Overall, sources of funding are both modest and restricted in uses. Such money as there is can help districts in the short term, but sustaining programs once they are established can be challenging.

Although fundamental changes are needed to address issues with the current structure, state and local agencies can make incremental changes to improve student access to services

Results in brief

The Health Care Authority (HCA) can take steps to help education agencies better access Medicaid to help pay for services. Medicaid allows education agencies to become providers and deliver behavioral health services in schools. As the state's Medicaid agency, HCA is positioned to help education agencies with challenges they face when contracting with the state's managed care organizations. HCA could provide better guidance around reimbursable services as well as contracting and billing with managed care organizations. Other states help education agencies with coordination, guidance and financial support.

Though it might be controversial, HCA could also seek a federal waiver to expand student eligibility for Medicaid to cover confidential behavioral health services for students age 13 years and older, as it has done for reproductive health services. In addition, it should monitor providers to ensure Medicaid-enrolled school-age children receive required screenings. Despite their limited resources and expertise, some school districts have found creative ways to provide behavioral health services.

HCA can take steps to help education agencies better access Medicaid to help pay for services

As the state's Medicaid agency, HCA is responsible for providing health care services for Washington's Medicaid population—including more than 550,000 school-age children that are enrolled in Medicaid. Part of the agency's responsibilities include monitoring managed care organizations and their service providers to ensure they meet agency standards. HCA can also pursue innovative approaches to improve its own services.

Medicaid allows education agencies to become providers and deliver behavioral health services in schools

In 2014, the Centers for Medicare and Medicaid Services (CMS) – the federal agency that oversees Medicaid – clarified that schools could seek reimbursement for children's health services they provide in school settings. A national organization

called the Healthy Schools Campaign tracks states that expanded Medicaid services in school settings following the CMS clarification. Of the 16 states that have already expanded school-based services, 12 included behavioral health.

In Washington, only two education agencies – Spokane Public Schools and Capital Region Educational Service District 113 (ESD 113) – serve as Medicaid-qualified providers that contract with managed care organizations to provide services in schools. The services provided include behavioral health screenings, early intervention and treatment services. These education agencies each assigned behavioral health professionals to specific schools to serve the Medicaid-enrolled students referred to them. Education agencies said they found that doing so allowed them to better connect students to services and address student behavioral health concerns. In addition, they said that becoming Medicaid-qualified providers allowed them to better coordinate services across their regions.

As the state's Medicaid agency, HCA is positioned to help education agencies with challenges they face when contracting with managed care organizations

Educational service districts and school districts have the option to provide behavioral health services to Medicaid-enrolled students. To do so, education agencies must go through a long and complex process, illustrated in **Exhibit 11**. They must first go through an agency licensing and staff credentialing process with the Department of Health. Once achieved, they must work with HCA to learn about reimbursable services, staff credentialing and negotiating contracts with the state's multiple managed care organizations.

Exhibit 11 – Education agencies face a complex process to become a Medicaid provider

Become licensed provider through the Department of Health. Includes credentialing for behavioral health staff to ensure they meet requirements.

Undergo a credentialing process with each managed care organization in the region

Determine which behavioral health services HCA will reimburse, and which professionals can provide those services

Negotiate contracts with each managed care organization in the region. Contracts must include services the district wants to provide and how the organization will pay them for delivering those services.

Train school staff to identify students with behavioral health concerns. Establish referral process to address student needs. Hire billing staff to bill Medicaid managed care organizations for services provided.

In addition to the two existing providers, four educational service districts are currently endeavoring to become Medicaid providers by contracting with managed care organizations. They described a variety of challenges to completing the process.

- **Lack of expertise in the medical field, affecting clear communication.** Education agencies said that education and health agencies use different definitions for the same terms. For example, "policy" and "case manager" mean one thing to an educator and something quite different to a managed care organization. Furthermore, ESD 113 also said that because Medicaid uses many billable codes, it was burdensome for staff to identify all the codes as providers.
- **Time and costs involved in billing multiple managed care organizations.** Because multiple managed care organizations serve Medicaid enrollees in the state, ESD 113 and Spokane Public Schools found they had to contract with each of them as well as bill each separately in their region. Managed care organizations each use their own documentation and reporting processes, as well. ESD 113 and Spokane Public Schools expressed their appreciation for the managed care organizations' attempts to standardize some forms, which has helped streamline the billing process. However, both found that reporting differences at managed care organizations were challenging. These differences added time to their process and affected their ability to implement a standardized system within their own organizations. ESD 113 said that behavioral health staff spent around half their time documenting their work.
- **Lack of resources to complete the process.** Education agencies must make an initial investment of time and money to become Medicaid providers before they can begin to offer services to students. For example, Educational Service District 112 (ESD 112) relied on a grant to hire school-based personnel to deliver services. It must begin billing to maintain these positions but it cannot do so until it has established its contracts with managed care organizations. Additionally, ESD 113 said a lot upfront work and costs were associated with establishing contracts with four managed care organizations.

HCA could provide better guidance around reimbursable services as well as contracting and billing with managed care organizations

Without specific guidance, school districts and service districts must try to navigate a system in which they lack knowledge and expertise. HCA does not have a specific guide for education agencies seeking to become Medicaid behavioral health providers under the managed care model.

HCA does have numerous billing guides for physical and behavioral health care that contain useful information around specific sets of services. The guides typically contain information about client eligibility, covered services, provider qualification, needed documentation, and the billing and payment process.

Although HCA has a school-based health services billing guide, it primarily focuses on special education services that are billed directly to HCA under the fee-for-service model. Education agencies cannot use this guide because it is not relevant to behavioral health services and billing through managed care organizations. This requires a different process than billing directly to HCA, as seen in **Exhibit 12**.

Exhibit 12 – Differences in billing models

Managed care: State Medicaid agencies contract with several managed care organizations to oversee services. Community providers must contract with individual managed care organizations to become Medicaid providers and bill to each organization.

Fee-for-service: Community providers contract directly with state Medicaid agencies to become Medicaid providers and bill for services they provide.

To address some of these barriers, HCA could adopt approaches implemented by other states that support their education agencies seeking reimbursement for behavioral health services.

Other states help education agencies with coordination, guidance and financial support

Michigan and South Carolina both offer approaches that HCA could consider. Michigan has established comprehensive behavioral health services in school settings; it has regional school districts – comparable to Washington's educational service districts – that support local school districts. South Carolina was an early adopter of CMS' revised guidance; when it brought behavioral health services into managed care, it included school districts among those that could contract directly with managed care organizations. Both states' Medicaid agencies provided guidance documents tailored to local education agencies and offered extra coordinated support as they expanded behavioral health services into school settings.

Michigan expanded behavioral health services in school settings and provided guidance and funding to regional school districts

Michigan policymakers recognized the critical role schools play in connecting students to needed services. The Michigan legislature directed its state Medicaid agency, the Department of Health and Human Services, to seek federal approval to expand the state's school-based services to include behavioral health services. With guidance from the legislature, the state's Medicaid agency took the following steps.

1. **Received federal approval to provide behavioral health services in schools and streamline the billing process.** The approval covered comprehensive behavioral health services, from universal screening to treatment services, reimbursable in school settings. The approval also allowed regional school districts to use one billing process to bill for both behavioral health services

and administrative services (for example, scheduling appointments) directly to the state's Medicaid agency.

2. **Developed a program guide for school-based services.** The new program guide explained key program components regional school districts needed to start their programs. It addressed student eligibility criteria, the provider enrollment process, professional qualifications for behavioral health personnel, covered services, and the reimbursement process.
3. **Supported program implementation and provided funding oversight.** The legislature provided around $16.5 million during the 2018-2019 school year to help regional school districts implement the new program. The Medicaid agency and the Department of Education established an advisory council to oversee the funds and establish performance metrics. Council members represent a variety of education and health experts as well as state and local officials. The advisory council developed guidance for regional school districts on how funding could be used. Regional school districts then used the money to provide trainings and to hire behavioral health professionals.
4. **Provided ongoing collaboration and established responsibilities.** The Medicaid agency works with the Department of Education to support regional school districts. For example, representatives from the state Medicaid agency said that they implement policy and program updates, while the Department of Education communicates changes to regional school districts. Representatives from the Department of Education said they also conduct trainings and provide technical assistance for regional school districts.

South Carolina facilitated coordination for managed care contracting and billing to help reduce school districts' administrative burden

South Carolina, like Washington, brought Medicaid's behavioral health services under its managed care organizations. To help school districts contract with managed care organizations, South Carolina's Medicaid agency and Department of Education took these steps.

1. **Facilitated collaboration before the transition to managed care.** The state Medicaid agency brought together representatives from the Department of Education, managed care organizations and school districts. Doing so allowed the various stakeholders to collaborate during the process of adding school behavioral health services to managed care. The Medicaid agency also created new policies and procedures for school districts to follow.
2. **Standardized contracting and forms with managed care organizations.** Working together, the two agencies developed a boilerplate contract for managed care contracting and a sample list of fee-for-service reimbursement rates to help school districts' negotiation process with managed care organizations. Additionally, the Department of Education worked with managed care organizations to standardize the service forms school districts

would use. Standardizing forms across managed care organizations helped reduce the administrative burden for school districts that would now need to bill several different managed care organizations.

3. **Prepared school districts to bill managed care organizations.** The Medicaid agency transitioned to managed care over the course of six months. During this time, the agency held periodic joint meetings with the Department of Education, managed care organizations and the participating school districts to talk about a variety of issues around managed care. Managed care organizations also provided trainings to school districts about documentation and care coordination.
4. **Provided ongoing collaboration and established responsibilities.** The two agencies continue to coordinate with the managed care organizations around program and policy updates. Representatives from the Department of Education said that it serves as the liaison between the managed care organizations and the participating school districts. They also said they offer school districts ongoing training opportunities on documenting and billing for services.

In both Michigan and South Carolina, the Department of Education and other stakeholders led some aspects of these efforts, but the work was directed by their respective Medicaid agencies. In Washington, HCA oversees the state's Medicaid services and its leadership would be needed to make similar changes here. Also, Michigan's legislature allocated financial resources to support these changes. Washington's Legislature would have to consider providing similar financial resources for education agencies to cover startup costs, as well as maintaining these efforts after start-up.

Though it might be controversial, HCA could also seek a federal waiver to expand student eligibility for Medicaid to cover confidential behavioral health services for students age 13 years and older, as it has done for reproductive health services

School officials identified parental inability or reluctance to access services for their student as a barrier to connecting students to behavioral health services. More than 40 percent of surveyed schools said unwillingness posed significant or very significant barriers. This is a problem because it can leave youth unable to access services they need and are legally entitled to, which may result in their needs becoming more severe and harder to treat. Even students with health insurance that can cover behavioral health services may be unable to access those services. If students want to keep their behavioral health needs confidential from their parents, or if their parents do not want them to receive services for any reason, students may be unable to use their insurance benefits.

A federal waiver program presents an opportunity for HCA to expand Medicaid eligibility to more students with behavioral health needs who are not currently eligible for Medicaid. Through the 1115 demonstration waiver, HCA could seek to expand Medicaid behavioral health coverage to all students age 13 years and older. This would allow all youth, even those covered by private insurance or uninsured, to access confidential behavioral health services through Medicaid. Although using this waiver may be controversial, it is not unprecedented.

The existing reproductive health waiver program could serve as a model

HCA has already used a Medicaid waiver to expand eligibility to all students age 13 years and older who need confidential reproductive health services. The Family Planning Only program is intended to help prevent unintended pregnancies; it allows all youth, even those covered by private insurance or uninsured, to access confidential reproductive health services through Medicaid. HCA anticipates that the important long-term benefit of this program is that the reproductive health services provided today avoid future Medicaid costs.

State law already allows students age 13 years and older to receive behavioral health services without parental consent. Although students have the legal right and may want to seek help, there are many reasons why they might not get it. They may wish to keep their need for services confidential from their parents, and fear appointments would appear on insurance statements. Parents themselves may be uncomfortable with their children accessing services for many reasons, such as stigma around behavioral health needs or concern about ability to pay for services. Uninsured students may abandon treatment because they cannot pay out-of-pocket costs.

Provisions in this waiver could reduce some or all of those barriers to access by guaranteeing students confidential, cost-free access to needed behavioral health services. Officials at OSPI recommended this model to HCA as a way to expand access, especially for early intervention and more intensive services. However, HCA has not studied the costs and benefits of using this approach for behavioral health because there have been multiple competing recommendations for waiver programs. HCA has important steps to take before it can submit a request to CMS:

- Evaluating the work required to establish such a waiver program for behavioral health
- Identifying ways to address system limitations that will mitigate the risk of parents discovering that their children have applied for confidential services

HCA should monitor providers to ensure Medicaid-enrolled, school-age children receive required screenings

Although HCA is responsible for ensuring health care providers deliver required Medicaid services, it does not monitor primary care providers to ensure school-age children receive behavioral health screenings at their well-child checkups. Children covered by Medicaid are eligible for these periodic checkups, which are intended to identify physical, developmental or behavioral health problems so they receive prompt treatment. Although HCA monitors certain aspects of well-child checkups, it does not monitor whether well-child visits actually include the performance of a behavioral health screening. Without establishing a regular monitoring process that includes behavioral health screenings, HCA lacks full assurance that eligible children are receiving the behavioral health screenings they are entitled to.

The audit examined 2018 and 2019 data around well-child checkups. In those years, about 690,000 schoolchildren were enrolled in Medicaid and may or may not have received a well-child checkup during this period. Of these children, about 426,000 had a documented well-child checkup; the remaining 264,000 did not.

Of the 426,000 children who had well-child checkups, our analysis could confirm only 45 percent had received a separately identifiable behavioral health screening or were already identified as receiving treatment or medication. A separately identifiable behavioral health screening code was not billed for the remaining 55 percent. One reason for this is because providers can only bill for screenings conducted using a standardized screening tool; all other screenings – such as those conducted through interviews – are simply recorded by the provider in the patient's record and included in the well-child checkup billing codes. These children may have received behavioral health screenings, but HCA cannot determine this without reviewing their medical records.

HCA contracts with an outside company to monitor whether managed care organizations provide well-child checkups, but the contractor does not currently review the medical records to determine that a behavioral health screening was performed as part of the checkup. Therefore, HCA lacks full assurance that providers are regularly conducting these required screenings to ensure children's behavioral health needs are addressed early on.

Despite their limited resources and expertise, some school districts have found creative ways to provide behavioral health services

Despite minimal state-level funding and other resources, some schools and districts we interviewed have found ways to address student behavioral health needs. They perform regular screenings using teachers and classroom time, and have established community partnerships and school-based health centers to provide early intervention and treatment services on campus.

Schools built in time for screenings

Only 32 percent of surveyed schools said they screened either all students or a subset of students. When schools conduct behavioral health screenings they are able to identify and support students with behavioral health concerns — especially students that internalize symptoms, making it difficult for others to detect. The purpose of behavioral health screening is to identify students that might not otherwise have been recognized as needing help. Schools that are diligent about screenings can provide more proactive interventions, rather than reactive interventions, for students. Interviews with officials at seven such schools revealed that most had an established process in place, summarized in **Exhibit 13**.

Exhibit 13 – Typical screening process used by schools interviewed during the audit

Steps and actions		Comments about the process
1	Train teachers to administer the screening	Ensure they are comfortable with the process before rolling out to students
2	Teachers administer the screening, mostly in class, at least once a year	Teachers help young children fill in the form, while older students do it themselves
3	School behavioral health teams review screening results	Teams also review supplemental student data such as attendance and disciplinary records
4	Behavioral health teams develop individual intervention plans for identified students	Students receive help in school settings or through providers in the community

Source: Auditor prepared from interviews with schools.

For each step in the typical procedure, some schools offered additional helpful insights. For example, most schools had teachers conduct the screening during classroom time—some referenced needing substitute teachers or using professional development days to do this work. Teachers filled out the screening form for younger students, while older students filled it out on their own. All schools we interviewed conduct at least one screening a school year.

Many schools had established behavioral health teams that were tasked with reviewing the screenings and developing intervention plans. These teams typically included staff such as counselors, teachers, para-educators and behavioral health specialists. While reviewing screening results, they also considered other student information, such as attendance and disciplinary data, to better understand students' level of need.

However, even with an established process to screen and support students, schools reported some challenges, such as building school staff buy-in and ensuring they felt comfortable doing work in behavioral health. They also reported not being able to meet all students' needs.

School districts worked with their communities to improve access to early intervention and more intensive treatment services in schools

Community partnerships between school districts and behavioral health providers can bring services right into schools. On-site behavioral health services make it easier to refer students displaying behavioral health concerns to professional help without delay.

In most cases, district staff crafted formal agreements with several providers in their area. District staff then shared with schools the list of providers and the services they offered. This menu of options reduced the administrative burden on schools, sparing them the effort of finding providers willing to take on new clients and deliver services in schools. Furthermore, because providers are based on campus, significant barriers to care are eliminated, such as transportation to and from appointments. Parents who would have struggled to take time off work to address their children's needs can now rely on schools to help. The school's behavioral health team, having developed the student's intervention plan, is responsible for deciding which community partner is best suited to address identified needs.

Districts we interviewed reported two key barriers they encountered when working with behavioral health providers that affected their ability to meet students' needs: dealing with students' insurance types and limited providers in the region.

Some school districts opted to develop a school-based health center to provide a very wide range of services, including physical and behavioral health care, on the school's campus or very close by. Doing so solves many of the same problems as bringing behavioral health care providers into schools, particularly transportation to appointments. These health centers are typically partnerships between schools and a health care sponsor, such as a local behavioral health provider or county public health department. Similar to the community partnership model, districts establish formal agreements and other policies with school-based health centers.

School and district officials noted there is no singular approach to establishing a school-based health center. For example, Yakima School District officials said that a behavioral health provider the district partnered with expanded its services to establish itself as a school-based health center. They encouraged other districts to evaluate the types of partnerships available in their particular community. They emphasized the importance of having the right people at the table dedicated to establishing a school-based health center. Providers must be able to build trust with school staff and students so they can begin to work more collaboratively and encourage students to self-refer themselves for care. School officials also said that once teachers found themselves with better behavioral health supports in schools, they experienced a changing mindset around discipline: from suspending students they believed were “acting up” to referring them to services.

Schools and districts were creative about seeking funding for their programs

School and district leaders described several ways of finding additional money to ensure funding for their behavioral health programs. For example, school officials described sourcing funds for screening programs from grants, district behavioral health funds and other school funds.

When it came to funding a community partnership in behavioral health, some school districts were able to access grants, while another was able to use state funding from the Learning Assistance Program. In one case, a district and provider combined their own funds to hire a behavioral health professional to be full-time in a school to deliver services to students.

State Auditor's Conclusions

Nearly half of all people with mental health disorders begin exhibiting symptoms by the time they start high school. Left unaddressed, these disorders can lead to lifelong problems, including homelessness and incarceration, and in some cases can lead to death by suicide. Even before the start of the pandemic, Washington students experienced these issues at a higher rate than national averages. The disruption and social isolation of the pandemic have only made the problem more intense.

Addressing the broader issue of behavioral health disorders goes beyond what schools can reasonably solve. Nonetheless, because schools are a hub for the vast majority of children who might begin to exhibit symptoms, schools are a natural setting for prevention and early intervention efforts. However, as this audit shows, the system to both support and hold schools accountable for these efforts is highly fragmented, with the result being uneven and often inadequate availability of services.

Truly fixing the system for prevention and early intervention efforts will be no small undertaking. It will require both structural changes to place someone in charge of the system, as well as additional resources for schools. While this audit also highlights some steps the state and schools could take to make incremental improvements, a coherent system to give Washington's youth the supports they need to address behavioral health concerns early on should be the state's long-term goal.

Recommendations

For the Legislature

To provide greater state-level coordination and promote equitable access to students across the state, as described on pages 25-27, we recommend the Legislature:

1. Designate either the Health Care Authority (HCA) or the Office of Superintendent of Public Instruction (OSPI) as the lead state agency tasked with ensuring student access to the continuum of behavioral health services in school settings.

   This legislation should reference existing laws and requirements to prevent any duplication, overlap or fragmentation of duties related to student behavioral health services. It should also include language to ensure school districts and educational service districts comply with all requirements.

2. Allocate funding to the lead agency with requirements to:
   - Establish and maintain an advisory council with representatives from HCA, OSPI, educational service districts, school districts, and other key partners such as managed care organizations and community providers. The council's responsibilities should include:
     - Establishing strategic direction and goals for programming around the full continuum of services funded under this legislation
     - Developing outcome and performance measures and reporting them to the Legislature annually
     - Providing guidance to school districts and service districts on how funds can be used
   - Provide flexible funding to service districts and school districts that will help them develop comprehensive behavioral health services to address the needs of their students, either directly in schools or through community partnerships.
   - Provide upfront funding to service districts and school districts seeking to become Medicaid behavioral health providers, as described on page 35.

For the Health Care Authority

To make greater use of Medicaid services and funding to support student behavioral health, as described on pages 31-36, we recommend the Health Care Authority:

3. Create guidance for educational service districts and school districts interested in contracting with managed care organizations to provide behavioral health services to students. HCA should work with representatives from education agencies and managed care organizations to develop this guidance. At a minimum, the guidance should:

    - Refer to DOH resources on becoming a licensed behavioral health provider
    - Describe how to contract with managed care organizations, which should also list designated contact staff at the organizations and at HCA
    - Provide a comprehensive list of behavioral health services, from screening through treatment, for school-age children
    - Identify behavioral health professionals who can deliver the listed services

    As an alternative to developing guidance, HCA could consider conducting a cost-benefit analysis to determine if a new billing guide would more effectively help education agencies interested in becoming Medicaid providers.

    Collaborate with OSPI, service districts, managed care organizations and school district representatives to reduce administrative burdens on service districts and school districts. This includes, but is not limited to:

    - Standardizing forms
    - Creating boilerplate language for contracts between managed care organizations and education agencies. It should include the services and reimbursement methodology, such as setting a minimum fee schedule to establish the reimbursement to expect for services

    Conduct a study to evaluate what would be needed to establish an 1115 waiver program for behavioral health services and request approval from the Center for Medicare and Medicaid Services, using the Family Planning Only program as a model.

To ensure Medicaid-enrolled students are receiving behavioral health screenings, as described on page 38, we recommend the Health Care Authority:

6. Incorporate a review of children's behavioral health screenings into HCA's current monitoring process to ensure beneficiaries receive screenings to which they are entitled.

For the Office of Superintendent of Public Instruction

To address the shortcomings of its model plan template and low district compliance with requirements, as described on page 23, we recommend the Office of Superintendent of Public Instruction:

7. Revise its district plan template to more closely follow state requirements. To achieve this, it should address a broader understanding of "emotional or behavioral distress" beyond suicidality. OSPI should then communicate the change to school districts.

Agency Response

STATE OF WASHINGTON

June 14, 2021

The Honorable Pat McCarthy
Washington State Auditor
P.O. Box 40021
Olympia, WA 98504-0021

Dear Auditor McCarthy:

Thank you for the opportunity to review and respond to the State Auditor's Office performance audit on K-12 student behavioral health in Washington. The Health Care Authority and Office of Financial Management worked together to provide this response.

We share the SAO's desire to address the behavioral health needs of children and youth in a timely and efficient manner. We also support a comprehensive approach to K-12 student behavioral health, which includes primary prevention, intervention, treatment and recovery support services.

This performance audit began as an audit of behavioral health prevention and intervention services. However, the audit scope was expanded to include a limited review of behavioral health treatment services. The final audit recommendations focus predominately on Medicaid-funded screening and treatment services, with little mention of prevention and intervention services, as was originally planned and where the bulk of HCA and SAO discussions were spent.

While we support a full continuum of behavioral health services for every student and child in Washington, we believe this performance audit falls short of making comprehensive recommendations to significantly improve access to these services. Specifically:

- To best meet the behavioral health needs of all students, it is imperative that we fully fund prevention, intervention, treatment access and recovery support services in each school district, and provide age-appropriate services in each school building. It is also important to engage Medicaid *and* commercial insurance plans, which cover behavioral health treatment services for many students in our state. The audit report concludes Washington has a fragmented response to student behavioral health. We do not believe this is a totally accurate conclusion.

  While not every school building in our state provides a full continuum of behavioral health services today, we do have a system that is well-regarded nationally, and we have a number of collaborative efforts under way to address gaps. A key effort is the Children and Youth Behavioral Health Work Group created by the Legislature. The work group convenes representatives from the Office of the Superintendent of Public Instruction, HCA, providers, legislators and advocates to identify and support system changes and service enhancements. A sub-group addresses school-based behavioral health services. We believe this structure is the appropriate mechanism for continued collaboration.

- Not all school districts wish to offer behavioral health treatment services on site. While most schools could provide prevention, intervention, screenings and recovery support services with adequate training and funding, on-site treatment challenges include building space, risk, certification, staffing, program knowledge and billing capacity.

School districts interested in offering on-site treatment services would need enhanced infrastructure resources to develop and operationalize treatment programs (for example, staff to do insurance billings). For many schools, fully funded prevention and intervention programs can reach all students and make appropriate community-based treatment referrals. Those same school districts could offer ongoing recovery support services on-site to support the student recovery goals.

We believe public funds, including Medicaid, play an important role in supporting behavior health services for Washington youth in schools and in the community at large. We also know that approximately half of students are covered by commercial health care plans. Continued development of a robust system for all must include public and privately funded resources, and school and community-based providers need to know how to access and leverage both.

Please thank your team for its commitment and effort over the past couple of years as we partnered on this performance audit.

Sincerely,

Sue Birch
Director
Health Care Authority

David Schumacher
Director
Office of Financial Management

cc: Jamila Thomas, Chief of Staff, Office of the Governor
Kelly Wicker, Deputy Chief of Staff, Office of the Governor
Keith Phillips, Director of Policy, Office of the Governor
Amber Leaders, Senior Policy Advisor, Office of the Governor
David Schumacher, Director, Office of Financial Management
Christine Bezanson, Director, Results Washington, Office of the Governor
Tammy Firkins, Performance Audit Liaison, Results Washington, Office of the Governor
Scott Frank, Director of Performance Audit, Office of the State Auditor
MaryAnne Lindeblad, State Medicaid Director, Health Care Authority
Keri Waterland, Director, Division of Behavioral Health and Recovery, Health Care Authority
Lynda Karseboom, Manager, Audit & Accountability, Health Care Authority

Official State Cabinet Agency Response to the Performance Audit on K-12 Student Behavioral Health in Washington – Opportunities to improve access to needed supports and services – June 14, 2021

The Health Care Authority and the Office of Financial Management provide this management response to the State Auditor's Office performance audit report received on May 24, 2021.

SAO Performance Audit Objectives:

The purpose of this performance audit was to evaluate current prevention and early intervention efforts in behavioral health for students by asking these questions:

- Are there opportunities for state agencies, educational service districts and school districts to better identify and connect Washington students to needed services?
- Can state agencies, counties, educational service districts and school districts reduce barriers to accessing these services and improve coordination of them?

SAO recommendations 1-2 are for the Legislature. Recommendations 3-6 are for the Health Care Authority. Recommendation 7 is for the Office of Superintendent of Public Instruction.

For the Health Care Authority

To make greater use of Medicaid services and funding to support student behavioral health, as described on pages 31-36, we recommend the Health Care Authority:

SAO Recommendation 3: Create guidance for educational service districts and school districts interested in contracting with managed care organizations to provide behavioral health services to students. HCA should work with representatives from education agencies and managed care organizations to develop this guidance. At a minimum, the guidance should:

- Refer to DOH resources on becoming a licensed behavioral health provider
- Describe how to contract with managed care organizations, which should also list designated contact staff at the organizations and at HCA
- Provide a comprehensive list of behavioral health services, from screening through treatment, for school-age children
- Identify behavioral health professionals who can deliver the listed services

As an alternative to developing guidance, HCA could consider conducting a cost-benefit analysis to determine if a new billing guide would more effectively help education agencies interested in becoming Medicaid providers.

STATE RESPONSE: We thank SAO for the recommendation to provide additional guidance. The barriers to increasing the use of Medicaid funding and support in schools, however, are more complex and foundational than a lack of guidance documents. While many school districts do provide behavioral health prevention, early intervention and recovery support services, not all schools can afford to offer these services. Furthermore, the primary function of schools is not providing behavioral health treatment services, and it is not a simple undertaking. Therefore, schools must first have the desire to commit to becoming behavioral health treatment providers, and then need the resources and capacity to undertake this work.

To work toward the shared goal of increasing student access to behavioral health services, HCA is developing a work group to improve opportunities for schools to bill Medicaid through managed care organizations. These efforts may also encourage schools to explore billing private insurance, helping expand access to services for all students. Goals of the work group will include efforts to:

- Explore standardizing contracts between the health plans and schools/educational service districts (ESDs);
- Explore the option of schools/ESDs using billing agents or clearinghouses to bill for services;
- Provide information about becoming a licensed provider through the Department of Health;
- Partner with OSPI/ESDs/schools to better understand challenges;
- Explore the creation of a school behavioral health billing guide; and
- Collaborate with the School-based Behavioral Health & Suicide Prevention Subgroup of the Children and Youth Behavioral Health Work Group.

To further increase support for students and behavioral health care access, HCA will continue to work with OSPI, ESDs and districts to explore options that include:

- Partnering with local mental health and substance use prevention, early intervention, treatment and recovery providers already in the community; and
- Contracting and developing school-based health centers that include mental health and substance use prevention, early intervention, treatment and recovery supports in their service design.

Because Medicaid covers roughly half of all students statewide, there is an ongoing need to explore opportunities in regions with a variety of medical coverages. This may include regional purchasing agreements so schools can serve all students in partnership with local service providers.

HCA will encourage our five Medicaid managed care organizations to incentivize providers serving school-age children to serve more Medicaid-enrolled children and/or contract with their local schools to provide student supports for behavioral health. This will leverage the existing workforce and the strengths of providers already doing great work in their community.

The guidance referenced in the recommendation would be a natural by-product of the work of this work group, which we anticipate having in place by November 2021.

Action Steps and Time Frame:

- ➢ HCA will convene a work group to develop strategies that support schools in accessing Medicaid-covered services, and to look for opportunities to develop partnerships that will increase access to services for all students. *By November 1, 2021*

SAO Recommendation 4: Collaborate with OSPI, service districts, managed care organizations and school district representatives to reduce administrative burdens on service districts and school districts. This includes, but is not limited to:

- Standardizing forms
- Creating boilerplate language for contracts between managed care organizations and education agencies. It should include the services and reimbursement methodology, such as setting a minimum fee schedule to establish the reimbursement to expect for services.

STATE RESPONSE: As noted above, we believe addressing this recommendation would be a natural by-product of the work group HCA is initiating. Changing forms prior to that work being completed would likely necessitate rework and would impact only a small number of districts. HCA is always available to provide assistance or guidance.

Action Steps and Time Frame:

- HCA will convene a work group to develop strategies that support schools in accessing Medicaid-covered services, and to look for opportunities to develop partnerships that will increase access to services for all students. *By November 1, 2021*

SAO Recommendation 5: Conduct a study to evaluate what would be needed to establish an 1115 waiver program for behavioral health services and request approval from the Center for Medicare and Medicaid Services, using the Family Planning Only program as a model.

STATE RESPONSE: We appreciate SAO exploring waiver options to help increase access to behavioral health services for students, and for acknowledging in the report that there are several important steps to take before seeking such a waiver. We do not agree that conducting a study as suggested is appropriate at this time. Behavioral health services are very different from family planning services, with different health and safety concerns and considerations. We are unaware of a waiver of this nature in any other state. Considering the extensive resources required to develop and seek approval of a Medicaid waiver, it would not be prudent to go down this path without knowing if the Centers for Medicare and Medicaid Services would consider approving such a waiver. HCA can develop a concept paper to present to CMS. If CMS indicates that such a waiver could be considered for approval, we could then have additional discussions to evaluate the idea.

While waivers can be an effective mechanism for expanding Medicaid-funded services, we believe there are other ways to address access, including the continuing work of the School-based Behavioral Health & Suicide Prevention Subgroup of the Children and Youth Behavioral Health Work Group. This advisory subgroup is charged with identifying strategies to create and maintain an integrated system of care in the K-12 school system that can rapidly identify students in need of care and effectively link them to appropriate services. This group has been successful in having its recommendations adopted by the Legislature.

Action Steps and Time Frame:

- HCA will prepare and submit a concept paper to the Centers for Medicare and Medicaid Services to determine if it would consider a waiver of this nature. *By December 31, 2021*

SAO Recommendation 6: To ensure Medicaid-enrolled students are receiving behavioral health screenings, as described on page 38, we recommend the Health Care Authority: Incorporate a review of children's behavioral health screenings into HCA's current monitoring process to ensure beneficiaries receive screenings to which they are entitled.

STATE RESPONSE: The audit test performed by SAO did not find that Medicaid-enrolled children are not receiving behavioral health screenings. Many of these screenings are performed as part of a well-child visit, which includes several other health and wellness screenings. As is normal and customary in health care — not just Medicaid — some types of visits, such as well-child exams, include multiple

procedures but are billed together under a single billing code. The agreements that insurers (including Medicaid) have with providers define what procedures are required during those visits.

While SAO's analysis was only able to confirm 45 percent of children received a separately identifiable behavioral health screening during well-child visits – or already had a treatment plan in place – HCA has no reason to believe the screenings are not occurring in most cases. By contractual agreement, well-child visits include behavioral health screenings.

HCA performs a wide range of program integrity activities designed to ensure services are appropriate and meet all Medicaid requirements. As mentioned in the report, one of those activities includes contracted monitoring of well-child visits. Various elements of those visits are monitored depending on identified risks, cycles and other factors, and may change as conditions change. We will assess the need to target behavioral health screenings as part of that monitoring process.

To significantly impact students' ability to connect with behavioral health supports, we will continue to work toward universal behavioral health screenings in schools for all students, not just Medicaid-enrolled students. Providing prevention and early intervention services in all school buildings would support those students screened as at-risk for behavioral health issues, where prevention and early intervention staff could assist with referrals to community-based or in-school treatment and recovery supports as available.

Action Steps and Time Frame:

- HCA will assess the level of any risk or potential value of incorporating review of behavioral health screenings into its ongoing monitoring processes. *By December 31, 2021*

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Old Capitol Building
PO Box 47200
Olympia, WA 98504-7200

k12.wa.us

June 15, 2021

The Honorable Pat McCarthy
Washington State Auditor
Insurance Building, Capital Campus
302 Sid Snyder Avenue SW
Olympia, WA 98504-0021

Dear State Auditor McCarthy:

Thank you for the opportunity to review and respond to the K–12 Student Behavioral Health in Washington: Opportunities to Improve Access to Needed Supports and Services performance audit. We appreciate the open communication and collaboration with the performance audit team as they worked to understand both historical and current K–12 student behavioral health issues and practices.

The audit report provides a succinct overview of the K–12 behavioral health challenges and opportunities faced by school districts and the behavioral health system that serves all Washington youth. The audit identifies concrete recommendations for how the Office of Superintendent of Public Instruction (OSPI) and the Health Care Authority (HCA) can improve the behavioral health system that serves the K–12 population. It also offers recommendations for the Legislature to consider for changes to Washington's behavioral health system that could improve the way students receive behavioral health supports in the K–12 setting.

We concur with the recommendation that OSPI update the district model plan for recognizing and responding to emotional and behavioral distress to follow state requirements more closely. We are currently in the process of updating the model plan to include a broader understanding of emotional or behavioral distress beyond suicidality. Once updated, we will communicate these changes to school districts.

We also support the four recommendations for HCA. Taken together, these recommendations would result in a more coordinated system, with more clearly delineated roles and responsibilities, and improved access to care. In 2015, OSPI proposed an 1115 waiver as part of Washington's Medicaid Transformation Project that is very similar to that found in

State Auditor McCarthy
June 15, 2021
Page 2

recommendation five for HCA (see attached). We believe such a waiver would remove significant administrative barriers for schools and improve access to school-based student behavioral support.

Regarding the recommendations to the Legislature, OSPI looks forward to engaging with the Legislature to explore the audit's recommendations and pursue opportunities to improve upon the state's behavioral health system to serve K–12 students in a more coordinated, wholistic and comprehensive way.

Student behavioral health is foundational to academic success. Supporting prevention, intervention, and treatment needs will require collaborative systemic response, particularly in the aftermath of the COVID-19 outbreak. OSPI stands ready to collaborate with state and local agency partners, ESDs, school districts, and students to meet student behavioral health needs.

Sincerely,

Chris Reykdal
Superintendent of
Public Instruction

TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTION

<table>
<tr><td>Contact Information</td><td>Mandy Paradise, Project AWARE Program Supervisor
Office of Superintendent of Public Instruction
360-725-6248 | Mandy.Paradise@k12.wa.us

Which organizations were involved in developing this project suggestion?
Office of Superintendent of Public Instruction (OSPI), ESD 113, ESD 112, NWESD 189, Battle Ground Public Schools, Maike & Associates, LLC</td></tr>
<tr><td>Project Title</td><td>Addressing Gaps to Increase Adolescent Access to Behavioral Health Services</td></tr>
<tr><td colspan="2">Rationale for the Project</td></tr>
<tr><td colspan="2">Problem statement –
The population of 13-18 year olds in Washington State are vulnerable to behavioral health issues. Behavioral health (including mental health and substance abuse) intersects with genetic predisposition, adverse childhood experiences, and social determinants of health. Screening for mental health is already a guaranteed benefit as defined by the Affordable Care Act and state plan amendment for Medicaid; however, issues exist in connecting people to treatment – especially among youth populations. In Washington, many youth-serving screening and service delivery models exist including school-based. Such programs report success with connecting Medicaid eligible youth to behavioral health services. However, a gap exists for non-Medicaid or privately insured youth. Although privately insured youth may have behavioral health coverage through their parent's private plans, youth may assent to services that parents will not or cannot physically, financially, or morally support. Because of this, youth cannot access insurance information or copay ability via parental plan coverage. Although youth have the right to access confidential outpatient behavioral health services starting at age 13 (RCW 71.34.530 and RCW 7096A.230), the current system puts unfair burden on youth to negotiate with parents for insurance coverage or enrollment into Apple Health, and physical and financial support despite laws that support youth access to outpatient behavioral health services without parental notification or permission.

Supporting research (evidence-based and promising practices) for the value of the proposed project:
Symptoms of behavioral health issues typically appear 2-4 years prior to the onset of a mental health disorder and subsequent diagnosis, this is the "window of opportunity" as described by the Institute on Mental Health (2005). The onset of behavioral health disorders often occurs in adolescence, and 75% of behavioral health diagnoses are identified by age 24. Therefore, early prevention, intervention and treatment of adolescent populations is vital to life-long well-being. Prevention and early intervention should take place "before costs escalate and the prospects of a happy, healthy life disintegrate" (National Council for Community Behavioral Healthcare). Washington is identified as having a high prevalence of youth mental illness and low rate of youth access to care (Parity or Disparity: The State of Mental Health in America, 2015). Washington is in the bottom ten states in the country (ranking 43rd) regarding the high numbers of children needing but not receiving mental health services. The same report identifies that Washington ranks relatively well (14th in the nation) for mental health workforce availability. Behavioral health issues intersect with social determinants of health: 1 in 4 children under age 18 lives in a home where alcohol abuse is a fact of daily life. Others are exposed to illegal drug use in their families. Children raised in chemically dependent families are at increased risk of accidents, injuries, and academic failure. Such children are more likely to suffer conduct disorders, depression, or anxiety conditions that increase the risk that children will smoke, drink, and use drugs. In Washington State 1 in 5 students, do not graduate within 5 years. Reports show that a leading barrier to graduation, as identified by districts, is the need for mental health and substance use services for students. Individuals with mental illness are four times more likely to die from treatable illnesses than those without mental illness and 58 more times likely to die before age 50. For every $1 invested in mental health treatment, $3.68 is saved in reduced criminal activity and hospitalizations. Research indicates properly diagnosing and treating mental illness saves money by treating the underlying disorders that can be at the root of medical overutilization.</td></tr>
<tr><td colspan="2">Project Description</td></tr>
</table>

Which Medicaid Transformation Goals[i] are supported by this project/intervention? Check box(es)

X Reduce avoidable use of intensive services
X Improve population health, focused on prevention
☐ Accelerate transition to value-based payment
X Ensure Medicaid per-capita growth is below national trends

Which Transformation Project Domain(s) are involved? Check box(es)

X Health Systems Capacity Building
X Care Delivery Redesign
X Population Health Improvement – prevention activities

Region(s) and sub-population(s) impacted by the project. Include a description of the target population:
All WA youth ages 13-18 seeking outpatient behavioral health care (mental health and substance use treatment), regardless of whether they meet current Medicaid edibility levels.

Relationship to Washington's Medicaid Transformation goals:
Health Systems Transformation: Building capacity outside the health system, and integrating health access points to community settings. In order for a provider of services to receive full payment from a private insurance plan they must be credentialed and paneled to bill the insurance and the insured must agree to pay for the service. This creates system barriers at the provider level and patient (youth) level. This proposal will create sustainable health-access and coverage points in non-traditional settings (such as schools) that are more accessible to adolescents in need of services. Expanding Medicaid eligibility to be inclusive of all Washington teens for outpatient behavioral health services, no matter family income or private insurance status, bolsters community-clinical linkages through the school community, and other youth-serving systems. Additionally it honors the health rights of Washington teens ages 13 and older to assent and pursue outpatient behavioral health care without notification or permission from a parent or guardian, or the familial or financial barriers associated with family-based insurance. Presently, the majority of non-Medicaid youth are served via programs with grant funding due to being under insured or to ensure confidentiality of the services they are receiving. This is where the gap begins to form. Youth may be screened and identified for behavioral health services such as mental health or substance abuse treatment; however:

A) Providers may not accept private insurance and/or be in-network provider accessible to the youth.
B) Providers do not have access to youth's private insurance information because youth themselves do not often have their insurance information and cannot make it available it to providers:
    - Youth must ask parents for insurance information and parents may deny providing insurance information if they do not want their youth to access behavioral health services (however, in Washington it is the health right of youth ages 13+ to access outpatient treatment without parental notification or consent).
    - Youth must ask parents for insurance information and parents may deny youth behavioral health care because the family cannot afford the cost of services or associated deductibles and co-pays (however, in Washington it is the health right of youth ages 13+ to access outpatient treatment without parental notification or consent).
    - The youth refuses to seek out insurance information due to having to confront parents about their need for behavioral health services, therefore the youth goes untreated

Transformation shifts include youth empowerment at individual and population levels, improved sustainability for systems and organizations currently serving Medicaid eligible youth, improve sustainability for systems and organizations committed to improving mental health promotion and substance use prevention among adolescents.
Health Care Delivery Redesign: Increased consistency in services resulting from the billability of each adolescent; coverage may incentivize providers to serve adolescents without fear of private insurance barriers or family inconsistencies. Services in schools or communities can reach more youth that were previously not serviceable.
Population Health Improvement – relating to mental illness and substance use disorders: This proposal will expand services to all youth (ages 13-18) in Washington State, preventing behavioral health issues that have significant current and future impacts on health, ability to thrive in school, employment, and family life. By providing gap funding and early intervention services, prevention of more severe and costly interventions can be avoided including in-patient treatments for substance use, potential boarding in emergency rooms and psychiatric care facilities, along with long-term/chronic need for crisis services as a response to postponed delivery of behavioral health care. Physical and chronic disease that co-occurs with behavioral health issues can affect life-long well-being

and utilization or over utilization of medical assistance.

Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.

In Washington, various schools, educational service districts and regional service networks (transitioning to behavioral health organizations) currently provide behavioral health screening, intervention, and treatment for youth. Providers and school-based programs serve a majority of Medicaid youth, and non-Medicaid (privately insured) youth face barriers to access and services due to having assumed coverage through parent insurance. Unfortunately, parent coverage often poses more barriers than it allows in terms of access to services. To close this gap, we propose providing youth the option to apply for a Medicaid-funded medical coupon that covers outpatient behavioral health services and enables all youth the option to pursue supports and treatment. This may be changing Apple Health so that youth are able to apply directly and reliance on parent initiative is no longer a barrier. This expansion of coverage will allow an entire population improved and more equitable access to care. By enabling youth to access behavioral health services through expanding Medicaid to cover their needs, health disparities unique to adolescents can be reduced. Our concept is modeled after "Take Charge", and we request a Medicaid Coupon is made available to cover outpatient behavioral health services that 13-18 year olds may apply for independently of their parents. Unlike Take Charge that is limited to serving a niche population of females who are sexually active, this proposal will serve a wide range of youth, ages 13 and older, regardless of gender or sexual activity, or other demographic indicators. Issuing a Medicaid application directly available to youth releases youth from having to confront, negotiate, or pressure parent involvement – including enrolling dependents or children in Apple Health.

Potential partners, systems, and organizations: Educational Service Districts (ESDs), Schools, behavioral health organizations, primary health care, Health Care Authority, and accountable communities of health.

Core Investment Components

Proposed activities and cost estimates for the project: Inform Medicaid providers of new protocol; analyze Take Charge system and re-create processes with behavioral health providers; issue guidance/training opportunities on signing youth up for behavioral health coupon; provide link for Behavioral Health coupon on Apple Health for Kids website (so youth can directly apply); design and implement a communications plan for both internal and external stakeholders; learn from Family Planning providers and Office of Insurance Commissioner regarding confidential services and explanation of benefits reporting; and implement evaluation tools to measure project metrics. (See Take Charge implementation costs available through DOH Family Planning.)

Best estimate (or ballpark if unknown) for:

- **How many people you expect to serve, on a monthly or annual basis, when fully implemented**
  For every six (6) existing Medicaid eligible youth age 13-18 accessing behavioral health, we anticipate serving one (1) additional, previously ineligible youth.
- **How much you expect the program to cost per person served, on a monthly or annual basis.**
  $400-$800 per client per month

How long it will take to fully implement the project within a region where you expect it will have to be phased in?:
Approximately 1-2 years

The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline:
For every $1 invested in mental health treatment, $3.68 is saved in reduced criminal activity and hospitalizations (SCOPE, Mental Health Study Group, 2003). Research indicates properly diagnosing and treating mental illness saves money by treating the underlying disorders that can be at the root of medical overutilization (Shemo, 1986)

Project Metrics

Suggested project metrics:

1) *Number of youth previously non-Medicaid eligible referred to mental health or substance treatment services*
2) *Number of youth previously non-Medicaid eligible access mental health or substance treatment services*
3) *Number of youth previously non-Medicaid eligible that complete behavioral health treatment services*

June 14, 2021

The Honorable Pat McCarthy
Washington State Auditor
Insurance Building, Capital Campus
302 Sid Snyder Avenue SW
Olympia, WA 98504-0021

Dear State Auditor McCarthy,

Thank you for the opportunity to review and respond to the *K-12 Student Behavior Health in Washington: Opportunities to Improve Access to Needed Supports and Services* performance audit. As a network, the nine Educational Service Districts (ESDs) are poised to explore ways we can support its recommendations.

United through the Association of Educational Service Districts (AESD), our ESDs have provided school-based behavioral health services through a variety of programs and funding sources for over 30 years. Together, we are a collective network in the spirit of collaboration to enhance and provide needed services with a focus on quality and impact. We have extensive experience and relationships at local, regional, state, and national levels in delivering school-based behavioral health services. Unfortunately, behavioral health supports and services that are available to students depend on what schools are able to provide at the local level leaving large gaps in service, especially in small and rural schools. Given that most children and youth are involved in some type of education program, schools are the ideal setting in which to prevent, identify, treat, and support substance use and mental illness concerns.

Statewide, there is a lack of equity and access to adolescent behavioral health services which has been amplified throughout the COVID-19 pandemic and has reinforced the need to establish an equitable statewide system for behavioral health delivery in schools. The report addresses real challenges and opportunities in state structures, policies, and funding in our state and generally, we concur with the recommendations.

Specifically, we would like to comment on **Recommendations 1, 2, and 4** from the report:

Recommendation 1 (to the Legislature): *Designate the Health Care Authority (HCA) or the Office of Superintendent of Public Instruction (OSPI) as the lead state agency tasked with ensuring student access to the continuum of behavioral health services in school settings.*

- We agree that the youth behavioral health system in our state has been reactive rather than taking a proactive approach that would include teaching health wellness and substance use prevention education, universal screening, and early intervention for emergent needs. Until such a system exits, services will continue to have minimal impact due to this fractured and uncoordinated approach as sited in the report. The behavioral health supports and services that are available to students depend on what schools are able to provide at the local level with large gaps in service for our small and rural schools.

  Regardless of which agency might be established as the “lead”, our network has long lasting positive relationships with both the HCA and OSPI to deliver high quality and responsive school-based prevention and intervention services across the state. We have (and are) working closely with both agencies to implement and coordinate the Community Prevention and Wellness Initiative (CPWI). Across the state we support over school-based 90 student assistance professionals. In addition, several ESDs have expanded their services beyond the CPWI funding and statewide we have over 100 student assistance professionals and licensed behavioral health staff serving approximately 170 sites.

  In addition, in 2019, at the start of this performance audit process, ESDs began to receive incremental funding each year to establish Regional School Safety Centers (RSSCs) as outlined in ESSHB 1216. RSSCs

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provide regional supports to school districts including threat assessment (2019), behavioral health navigation (BHN) (2020), and most recently comprehensive school safety (2021). The BHN positions assist with expanding capacity for school districts to access resources and training related to youth behavioral health.

Recommendation 2 (to the Legislature): *Allocate funding to the lead agency to…Provide flexible funding to service districts and school districts that will help them develop comprehensive behavioral health services to address the needs of their students, either directly in schools or through community partnerships. Provide upfront funding to service districts seeking to become Medicaid behavioral health providers.* (Rec. 2, bullets two and 3, p. 43)

- We believe that adjustments to the current funding system for adolescent behavioral health, similar to the Michigan Model presented in the report are necessary. The ESD network has an infrastructure in place and is poised to support this needed system evolution.

- We also agree that by providing upfront funding to ESDs to become licensed behavioral health providers will open the door for increased services through the state. This will allow ESDs to access Medicaid funding to provide comprehensive school based behavioral health services and to sustain those services. In addition, standardizing systems will help to create efficiencies and avoid duplicity throughout the various entities in the state.

Recommendation 4 (to HCA): *Collaborate with OSPI, service districts, managed care organizations and school district representative to reduce administrative burdens on service districts and school districts.*

- We support the need to take a proactive approach that addresses administrative challenges and barriers for organizations to consistently deliver proactive wrap-around behavioral health services. The current and fragmented system takes away from much needed direct student services and prevents more ESDs and school districts from providing more robust school-based services.

Ultimately, the AESD supports intentional investment in a coordinated system of services across the state, using data to drive these services to those students with the most need. We are poised as a partner and look forward to continuing to work with OSPI, HCA, and the Washington State Legislature to improve and provide more behavioral health care supports to students in the K-12 system to support overall well-being and academic success.

Sincerely,

Tim G. Merlino

Tim Merlino, Chair, AESD Superintendents,
Superintendent, ESD 112, Vancouver

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Appendix A: Initiative 900 and Auditing Standards

Initiative 900 requirements

Initiative 900, approved by Washington voters in 2005 and enacted into state law in 2006, authorized the State Auditor's Office to conduct independent, comprehensive performance audits of state and local governments.

Specifically, the law directs the Auditor's Office to "review and analyze the economy, efficiency, and effectiveness of the policies, management, fiscal affairs, and operations of state and local governments, agencies, programs, and accounts." Performance audits are to be conducted according to U.S. Government Accountability Office government auditing standards.

In addition, the law identifies nine elements that are to be considered within the scope of each performance audit. The State Auditor's Office evaluates the relevance of all nine elements to each audit. The table below indicates which elements are addressed in the audit. Specific issues are discussed in the Results and Recommendations sections of this report.

I-900 element	Addressed in the audit
1. Identify cost savings	**No.** The audit focused on the behavioral health needs of Washington K-12 students and how those needs could be better addressed. It did not identify cost savings.
2. Identify services that can be reduced or eliminated	**No.** This audit considered behavioral health supports provided to students and did not identify services that can be reduced or eliminated.
3. Identify programs or services that can be transferred to the private sector	**No.** The audit focused on identifying and connecting students to behavioral health supports in school settings.
4. Analyze gaps or overlaps in programs or services and provide recommendations to correct them	**Yes.** The audit analyzed gaps between recommended and actual practices in both the overall state approach to student behavioral health and at the local school level. The audit makes recommendations for changes to the state's approach to student behavioral health, to be made in both the short- and long-term.

I-900 element	Addressed in the audit
5. Assess feasibility of pooling information technology systems within the department	**No.** The audit did not assess the feasibility of pooling information technology systems.
6. Analyze departmental roles and functions, and provide recommendations to change or eliminate them	**Yes.** The audit analyzed the roles of the state's health and education agencies related to student behavioral health programs, and recommends changes to improve their coordination and oversight.
7. Provide recommendations for statutory or regulatory changes that may be necessary for the department to properly carry out its functions	**Yes.** The audit recommends statutory changes to improve state-level coordination and oversight of student behavioral health.
8. Analyze departmental performance data, performance measures and self-assessment systems	**No.** The audit did not identify any relevant statewide performance data, performance measures or self-assessment systems for student behavioral health. However, the audit sought to create a more complete statewide picture of student behavioral health efforts by surveying school districts and schools about their practices.
9. Identify relevant best practices	**Yes.** The audit identified national leading practices for school-based behavioral health systems. It also gathered information about promising practices from other states and Washington school districts and schools.

Compliance with generally accepted government auditing standards

We conducted this performance audit under the authority of state law (RCW 43.09.470), approved as Initiative 900 by Washington voters in 2005, and in accordance with generally accepted government auditing standards as published in *Government Auditing Standards* (July 2018 revision) issued by the U.S. Government Accountability Office. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The mission of the Office of the Washington State Auditor

To provide citizens with independent and transparent examinations of how state and local governments use public funds, and develop strategies that make government more efficient and effective. The results of our work are widely distributed through a variety of reports, which are available on our website and through our free, electronic subscription service. We take our role as partners in accountability seriously. We provide training and technical assistance to governments and have an extensive quality assurance program. For more information about the State Auditor's Office, visit www.sao.wa.gov.

Appendix B: Scope, Objectives and Methodology

Scope

This audit looked at opportunities to improve K-12 student access to prevention and early intervention activities in behavioral health. This included opportunities for health and education agencies to better identify and connect students to needed behavioral health services. The audit also examined opportunities to reduce barriers to accessing services by improving coordination between state agencies, educational service districts and school districts.

Objectives

The audit was designed to answer the following questions:

1. Are there opportunities for state agencies, educational service districts and school districts to better identify and connect Washington students to needed services?
2. Can state agencies, educational service districts and school districts reduce barriers to accessing these services and improve coordination of them?

Methodology

To answer the audit questions, we used a variety of qualitative and quantitative approaches. Each method contributed to answering one or both of the audit objectives.

Conducted interviews with state agencies and educational service districts

We interviewed managers and staff at state agencies and service districts to learn about their efforts to help schools and school districts provide behavioral health prevention and early intervention supports. We also learned what collaborative efforts they had in place to identify areas to improve coordination of service and supports. We interviewed representatives of the following agencies:

- Office of Superintendent of Public Instruction (OSPI)
- Washington's nine educational service districts
- Health Care Authority (HCA)
- Department of Health
- Liquor and Cannabis Board
- Department of Children, Youth and Families

Conducted interviews with education and county associations

We interviewed managers with education and county associations to learn more about their efforts related to student behavioral health. We asked about how schools and school districts provide behavioral health prevention and early intervention supports and the challenges they face. We interviewed representatives from the following associations:

- Association of Washington School Principals
- Washington Association of School Administrators
- Washington School-Based Health Alliance
- Washington State Association of Counties
- Washington State School Directors' Association

Reviewed state laws and tested compliance with relevant requirements

We reviewed state laws to learn the key roles and responsibilities of school districts and state agencies as they pertain to student behavioral health. We selected requirements to test for compliance with state laws for:

- RCW 28A.320.127 for school districts: We reviewed 20 school district plans that must include identification and connection to services, such as staff response to student emotional distress.
- RCW 28A.320.1271 for OSPI: We reviewed OSPI's model plan that school districts can use to implement their own district plan (described above).
- RCWs 28A.310.500 and 28A.310.510 for educational service districts: We reviewed the service districts' required training opportunities around student behavioral health, as well as their requirements as regional school safety centers (for example, that they should facilitate partnerships between schools and community providers).

Conducted a literature review to identify leading practices

We also conducted a literature review and researched best practices to learn about the roles state agencies, schools and school districts can play to implement activities around student behavioral health. We reviewed websites and studies conducted by federal agencies, national organizations, and researchers with expertise in behavioral health. A selection of these resources are listed in the Bibliography at the end of this report.

Conducted a statewide survey of Washington schools and school districts

Survey design and sample population

We first designed surveys suitable for school districts and schools. Using audit criteria, we designed questions asking for information about their prevention and early intervention activities, and schools' ability to connect students to needed services. We also designed questions around school and district barriers to providing these services.

To choose the sample of schools and districts that would receive these surveys, we reviewed the list of Washington's 295 school districts and judgmentally selected 50 school districts that represented rural and non-rural locations on both the eastern and western sides of the state (listed in **Figure 1**). We selected 30 school districts that do not have Prevention and Intervention Specialists and 20 school districts that do. We tried to make the sample as proportional as possible without applying more rigorous methods.

We also sub-sampled three of the largest districts in our sample: Seattle Public Schools (105 schools), Spokane Public Schools (52 schools), and Tacoma Public Schools (58 Schools). We did this to limit the number of responses that could be processed within the audit timeframe.

Figure 1 – School districts selected for survey

School plans also reviewed

School and district officials also interviewed

School plans also reviewed	School and district officials also interviewed	District	School plans also reviewed	School and district officials also interviewed	District
✓		Asotin-Anatone			Oroville
	✓	Bethel		✓	Othello
✓	✓	Blaine			Prescott
		Bridgeport	✓		Quilcene
		Cape Flattery	✓	✓	Renton
✓		Cheney			Republic
		Columbia (Stevens)	✓		Richland
		Davenport	✓		Rochester
✓	✓	Everett Public Schools			Seattle
✓	✓	Evergreen (Clark)		✓	Selah
	✓	Ferndale	✓		Selkirk
	✓	Hoquiam			Soap Lake
	✓	Kelso			South Bend
		La Conner			South Kitsap
		Liberty		✓	Spokane
✓		Lopez	✓		Stevenson-Carson
		Lyle			Tacoma
		Mary M. Knight	✓		Thorp
		Mary Walker	✓		Tonasket
	✓	Monroe		✓	Vancouver
		Moses Lake	✓	✓	Wahkiakum
		Mossyrock			Waitsburg
✓		Mount Vernon		✓	Wenatchee
✓		North Franklin	✓		West Valley (Yakima)
✓	✓	North Thurston Public Schools	✓	✓	Yakima

Survey response

We sent the survey to a total of 50 public school districts and 499 public schools. We received responses from 100 percent of school districts and 76 percent (379) of schools. **Figure 2** shows the response rate by key district characteristics.

Figure 2 – Survey responses

Category	School sample	School response	Response rate
Location			
East	171	138	81%
West	328	241	73%
Rural and Not rural			
Not rural	449	339	76%
Rural	50	40	80%
School type			
Elementary	250	191	76%
Middle	108	90	83%
High	141	98	70%
School size			
Large	27	23	85%
Medium	290	223	77%
Small	182	133	73%
Total	**499**	**379**	**76%**

Data limitations and extrapolating results

Because the school districts we selected are not a statistically representative sample, the results cannot be extrapolated to the entire state. However, because we selected school districts that covered the breadth of the state, a range of sizes and levels of urbanization, and a sizable portion of K-12 students, we believe the sample is representative enough to draw general conclusions about school and district practices. For example, if a large number of schools in our survey do not have a recommended practice in place, even if schools in the rest of the state use the practice at a much higher rate, the observation would still suggest a shortcoming worth addressing in our report.

Conducted group interviews with officials from schools, school districts and educational service districts

After reviewing the survey results, we selected key areas to focus in on for group interviews based upon leading practices and other practices that help connect students to needed services to answer the first objective. We then selected schools and school districts that had reported using those practices, and conducted group interviews to discuss them. The schools and districts that were part of the group interviews are marked in Figure 1.

We also met with Capitol Region Educational Service District 113 and Spokane Public Schools because they serve as Medicaid providers, and Educational Service District 189 and Educational Service District 101 because they are working toward becoming Medicaid providers.

Conducted interviews with officials from Michigan and South Carolina

We reviewed the list of states that had expanded their school-based Medicaid services to include behavioral health care. We then met with representatives from the Healthy Schools Campaign, an organization that tracks information about states that are expanding their school-based services. We selected two states to research, Michigan and South Carolina, for these reasons:

- Michigan made comprehensive behavioral health services available in school settings, from universal screening to treatment. Its educational structure is similar to Washington's educational service districts, in that it has regional school districts that provide support to school districts.
- South Carolina, like Washington, requires education agencies to contract with individual managed care organizations, rather than to bill directly to the state Medicaid agency. We wanted to know how South Carolina helped school districts with contracting and billing multiple managed care organizations.

We asked officials from Michigan and South Carolina for information about the practices, policies and strategies they used to help education agencies seeking to become Medicaid providers in order to deliver school-based behavioral health services.

Conducted data analysis of school-age children enrolled in Medicaid to determine whether they had received a behavioral health screening

We analyzed 2018 and 2019 data around well-child checkups to determine the percent of children ages 5 through 18 enrolled in Medicaid that received a separately identifiable behavioral health screening. We also took into account school-age children that had received behavioral health treatment services or medications, since this would indicate they had already been identified.

We conducted the following steps:

1. To determine the total number of children enrolled in Medicaid, created a distinct list of children who met one of these two conditions:
    - Child was enrolled in Medicaid at any period during 2018 or 2019 and had a well-child checkup
    - Child was enrolled in Medicaid with no more than one gap in enrollment of up to 45 days during the continuous enrollment period, but did not have a well-child checkup during 2018 or 2019
2. Identified whether any of the children who had received a well-child checkup received any separate behavioral health screenings, treatment services or medications in the period from 2018 through 2020.

3. Analyzed the population of children who had a well-child checkup during 2018 and 2019, and compared that to the number of children who received a separate screening during the checkup.
4. Analyzed the population of children without record of a well-child checkup during 2018 and 2019 to identify the number that had received another type of behavioral health screening outside the well-child checkups, as well as children that were already receiving behavioral health treatment.

One key limitation for this data analysis is the potential for missed screenings that were not billed during the well-child checkup for the following reasons:

- Providers receive less than $5 when they bill for each behavioral health screening during the wellness checkup. This means that some providers may not find the screening worth billing for.
- Providers may have conducted a screening through an interview, which is not separately reimbursable by Medicaid. Medicaid only reimburses for screenings conducted using a screening instrument.

Appendix C: School Survey Responses

This appendix contains selected questions from our survey of schools and school districts. We sent the survey using the online tool to a total of 50 public school districts and 499 public schools. We received responses from 100 percent of school districts and from 76 percent (379) of schools. Read more about the methodology of our survey in Appendix B.

Notes about the response numbers and percentages

1. Not all questions were posed to all respondents, because some follow-up questions were visible only if the answer to a question was 'yes.'
2. We did not calculate all percentages for all responses because answers to some questions were subsets of respondents who answered 'yes' to the previous question.

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Figure 3 – General questions about conditions in schools

On scale of 1 to 5, 5 being greatest...		Rating 4 or 5	
	Average	Number	%
What effect does each of these issues have on the ability of school staff to identify students with potential behavioral health concerns?			
Staff tend to blame a behavioral concern on poor parenting, the child's personality, laziness, or other issues rather than identifying it as a health need	2.86	122	32%
Staff don't recognize signs of behavioral health issues in students who are not disrupting the learning environment	2.75	102	27%
Staff don't report potential behavioral health concerns because there is a lack of professional behavioral health services for students and families	2.17	65	17%
Staff don't know how to identify potential behavioral health concerns	2.44	60	16%
Staff consider student behavioral health to be outside their job	2.26	57	15%
Staff-to-student ratios are too high to get to know each student	2.07	42	11%
Staff are concerned that mentioning a student behavior problem may reflect badly on their own classroom management skills	1.89	23	6%
Staff assume the issue is within the normal range of child development	2.14	24	6%
Staff don't know how to report potential behavioral health concerns	1.85	16	4%
Staff are cautious about identifying behavioral health issues due to the stigma associated with labeling	1.68	13	3%
How much of an impact do each of the following issues have on your school's ability to connect students to behavioral health services?			
Too few mental health providers (within an hour drive or without waitlist)	3.73	241	64%
Student lacks transportation to provider's location	3.49	203	54%
Parent/guardian unwilling to seek help for their child	3.34	173	46%
Too few behavioral health providers who accept Medicaid	3.26	169	45%
Parent/guardian unable to seek help for their child	3.24	162	43%
High private insurance co-pays for treatment	3.16	151	40%
Language/cultural barriers to seeking or using behavioral health services	3.04	151	40%
Student lacks health insurance	2.94	138	36%
Stigma associated with behavioral health issues	2.93	123	32%
Too few substance use disorder providers (within an hour drive or without waitlist)	2.55	122	32%

Figure 3 – General questions about conditions in schools, *continued*

On scale of 1 to 5, 5 being greatest...	Rating 4 or 5		
	Average	Number	%
How much of an impact do each of the following issues have on your school's ability to meet the educational needs of students with behavioral health issues?			
The school lacks resources to provide a Student assistance professional or Prevention-Interventionist to support these students	3.37	192	51%
Irregular student attendance due to behavioral health issues	3.28	173	46%
Educators lack knowledge on how to teach students with significant behavioral health issues in a general education classroom	3.3	170	45%
Classroom-based instructional time is interrupted for the student due to disciplinary actions	3.06	141	37%
Lost instruction time while a student receives behavioral health services	2.63	97	26%
Behavioral health providers are unable to discuss student treatment with educators	2.2	53	14%

Figure 4 – Questions about staffing dedicated to behavioral health

How many staff are allocated to your school to perform the following roles:	Average full-time equivalent (FTE)
School counselor	1.56
School psychologist	0.59
School social worker	0.11
School nurse	0.53
School resource officer	0.42
Student assistance professional / Prevention-Interventionist	0.21
Behavioral interventionist	0.17
Mental health counselor	0.16
Substance abuse counselor	0.06
Clinical psychologist	0.02

Has your school or district designated a person or team to determine how the school should respond to student emotional or behavioral health concerns?	Answering yes	
	Number	%
We have a designated person for addressing student behavioral health concerns ***at our school***	272	72%
We have a behavioral health student intervention team ***at our school***	261	69%
We have a designated person for addressing student behavioral health concerns ***at our district***	250	66%
We have a behavioral health student intervention team ***at our district***	221	58%

Figure 4 – Questions about staffing dedicated to behavioral health, *continued*

Are employees at your school trained on how to recognize and respond to student behavioral health concerns?	Answering yes	
	Number	%
Yes, some employees	270	71%
Yes, all employees	71	19%

If "Yes, some employees," who do you train to recognize and respond to student behavioral concerns? (check all that apply)	*Number of this type of employee*
Counselors	236
Administrators	235
Teachers	188
Para-educators	145
Nurses	83
Student assistance professional / Prevention-Interventionist	57
Resource officers/security	56
Secretaries	50
Therapists	49
Coaches	37
Cafeteria workers	12

What skills related to recognizing and/or responding to student behavioral health concerns are included in employee training?	Number offering this skill
Who to contact when you suspect a student might have a behavioral health concern	300
How to respond to a student in emotional or behavioral distress	292
How to identify students who might have mental health concerns	207
What information are you allowed to give the student's parent/guardian	158
How to identify students who might have substance-use concerns	124

Figure 5 – Questions about identifying student needs around behavioral health

In the last three years, has your school used a screening tool to identify individual students that might have behavioral health concerns?	Answering yes	
	Number	%
Don't know or no screening tool administered in the last three years	151	40%
Yes, only screened on an individual basis when there was a concern	108	28%
Yes, screened all students except those who declined	69	18%
Yes, screened students who have been identified as at-risk	33	9%
Yes, screened certain grade levels or another subset of the student body not based on risk	18	5%
If yes, which of the following behavioral health issues are assessed by your screening tool? (check all that apply)	*Number assessing this issue*	
Mental health	172	
Substance use	77	

Does your school routinely monitor student data indicators to identify students that might have behavioral health concerns?	Answering yes	
	Number	%
Yes, all students	203	54%
Yes, at-risk students	105	28%
If yes, which of the following data indicators do you routinely monitor? (check all that apply)	*Number monitoring this issue*	
Discipline referrals	305	
Attendance	302	
Changes in grades	178	
Changes in benchmark assessment results	170	
School nurse visits	121	

Does your school routinely monitor any of the following measures of behavioral health needs? (check all that apply)	Answering yes	
	Number	%
Measures of school climate	256	68%
Measures of student engagement with learning	212	56%
Number of students referred	198	52%
Measures of student connectedness with school	191	50%
Measures of family engagement with school	191	50%
Number of students identified	189	50%
Number of students served through the school system	176	46%
Documented academic improvement over time for students receiving interventions	168	44%
Number of students served through the healthcare system outside of school	42	11%

Figure 6 – Questions about referring students to behavioral health supports

	Answering yes	
	Number	%
Does your school have a standardized process for referring students to behavioral health services or supports within the school or at the district (school district or educational service district) level?	251	66%
If yes, is your process formalized as a written policy or procedure?	108	43%
Does your school have a standardized process for referring students to community-based behavioral health providers?	165	44%
If yes, is your process formalized as a written policy or procedure?	46	28%
Does your school or district have a list of community resources dedicated to or including organizations that address behavioral health needs?		
Yes, we use our district's community resource list	228	60%
Yes, we have developed our own community resources list	117	31%
If school has its own list, has anyone reviewed or updated your list of community behavioral health resources in the last 12 months?	78	67%

How do you tell students and families about available behavioral health resources? (check all that apply)	Number with this approach
Give students/families a physical copy of the resource list	88
School's website	33
Posted at school	28
Distributed electronically	26
District's website	21
We do not share our resource list with students/families	4

Has your school established partnerships with others for addressing student behavioral health?	Answering yes	
	Number	%
Yes	252	66%

Figure 7 – Questions about behavioral health curriculum, events, activities

In the 2019-20 academic year, did your school offer students any behavioral health-related curriculum?	**Answering yes**	
	Number	**%**
Yes	287	76%
If yes, what topics are included in your behavioral health-related curriculum? (check all that apply)	***Number including this topic***	
Social and emotional learning		
Offered to all students	240	
Offered to some students	42	
Mental health awareness		
Offered to some students	113	
Offered to all students	56	
Substance use awareness		
Offered to some students	115	
Offered to all students	67	

In the 2019-20 academic year, did your school offer events or activities that addressed behavioral health issues? (check all that apply)	**Answering yes**	
	Number	**%**
Yes, we distributed information about behavioral health issue(s) in a newsletter, on our website, during an open-house or conference week, or through social media	148	39%
Yes, we held a campaign, initiative or event that addressed a behavioral health issue (for example: a community resource fair, mental health awareness week, a student awareness or norms campaign, etc.)	57	15%
If yes or other, what topics did your events or activities address? (check all that apply)	***Number addressing this topic***	
Social and emotional skills (such as self-awareness, self-management, social awareness, relationship skills, responsible decision-making, etc.)	174	
Event or activity intended to create a positive school climate	105	
Mental health awareness (such as symptoms of mental disorders, stigma, how to get help, treatment, etc.)	88	
Substance use awareness (such as making healthy decisions, staying substance-free, risks of substance use, addiction, how to get help, treatment, etc.)	84	
Suicide awareness	73	
School club related to behavioral health awareness (such as SADD)	26	

Were these events/activities open to the entire student body?	**Number with this approach**
Yes, all students were invited	190
No, just certain students were invited	7

Figure 8 – Questions about behavioral health supports and services

In the 2019-20 academic year, how did your school support students with behavioral health concerns? Did you provide services and supports ***within your school***? (check all that apply)	Answering yes	
	Number	%
We provide low-intensity classroom supports (such as daily report card or teacher check-in)	316	83%
We provide brief individualized interventions (such as motivational interviewing or problem solving)	313	83%
We conduct small group interventions for students with similar needs	307	81%
We provide individualized student interventions (such as treatment services and supports) at school in a setting other than a school-based health clinic	177	47%
We offer a mentoring program	133	35%
We offer a Student Assistance Program	97	26%
We have a school-based health clinic offering mental health treatment	46	12%
Other services provided	21	6%
We have a school-based health clinic offering substance abuse treatment	17	4%
If yes within the school, how does your school provide school-based behavioral health services and/or supports?	***Number with this approach***	
Some services are delivered under contract and others by school or district employees	89	
School or district contracts with a behavioral health service provider(s)	76	
School or district employs provider(s) directly	75	
Educational Service District (ESD) provides services and/or supports	34	
Were school-based behavioral health services and/or supports available to the entire student body?	***Number of responses***	
Yes, all students in need can receive these services	190	
No, just certain students can receive these services	7	

In the 2019-20 academic year, how did your school support students with behavioral health concerns? Did you provide services and supports ***outside your school***? (check all that apply)	Answering yes	
	Number	%
We refer students/families to providers outside our school	328	87%
We help students navigate services outside our school	247	65%
We work with a student's behavioral health provider to coordinate educational and treatment needs	242	64%
We connect students to mentoring programs in the community	133	35%

Figure 9 – Questions about participation in the Healthy Youth Survey

Does your school participate in the state's Healthy Youth Survey (HYS)?	Answering yes	
	Number	%
Yes	221	58%
If yes, how does your school use HYS results?	***Number with this approach***	
We compare results with our school's performance over previous years	110	
We consider HYS results as part of our strategic planning process	92	
We use HYS results to evaluate the success of our efforts toward addressing students' behavioral health issues	86	
Select employees are provided with a copy of the results	62	
We conduct presentations on our results	55	
All employees are provided with a copy of the results	54	
We do not take any action when we receive our HYS results	12	

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