KAISER PERMANENTE®

Environmental Scan

Exploring the Landscape of Mental Health and Wellness in Washington's K-12 Education System

Summary Report

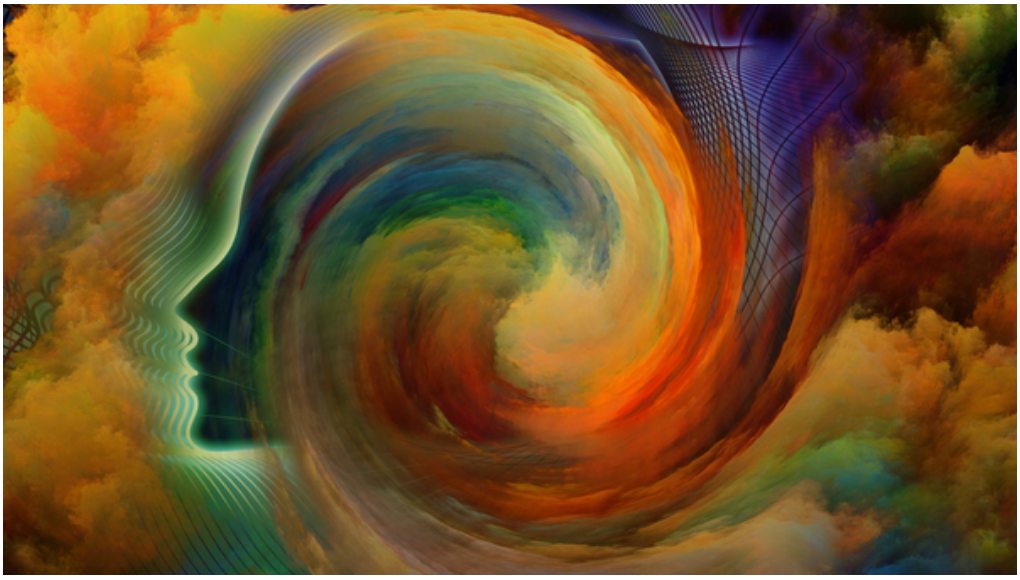
Commissioned by

Kaiser Permanente Washington Community Health

April 2018

EXECUTIVE SUMMARY:

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



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Prepared by:

Michelle M. Maike, MA
Director

Megan Osborne, MPP
Research Associate

Tasha Fox, MA
Research Associate

David Scarano
Research Assistant

maike & associates

213 Elwha Bluffs Rd
Port Angeles WA 98363
www.maikeandassociates.com

To reach Kaiser Permanente Washington Community Health, please contact Thriving Schools Manager Jill Patnode (patnode.j@ghc.org)

INTRODUCTION

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

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

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

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

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

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

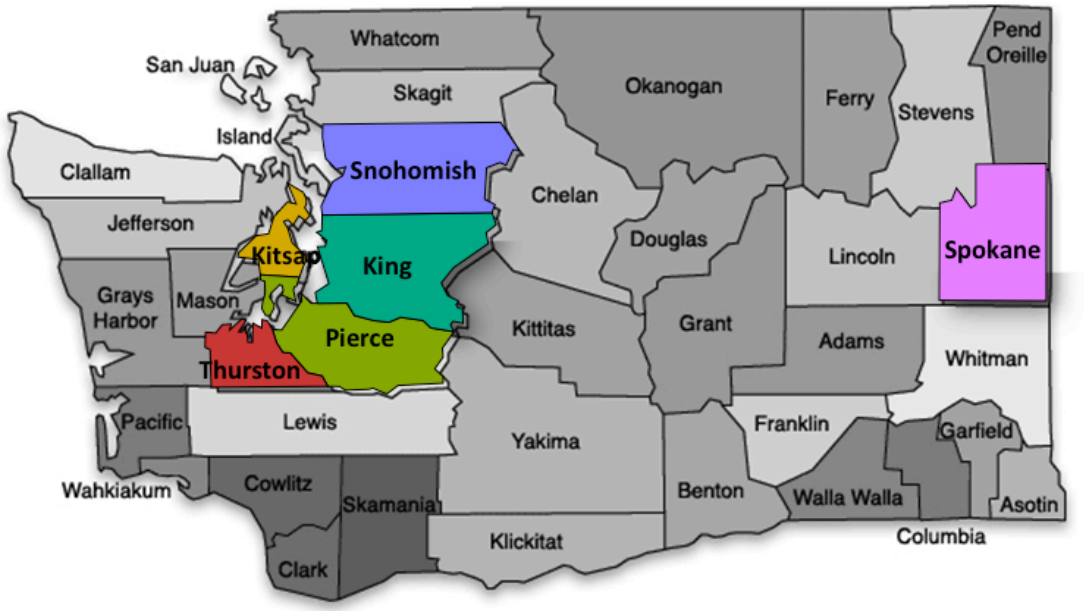
Our findings are supported by identified needs, the research base, and are echoed in the voices of our informants. This work is aligned with the two recommendations of the Educational Opportunity Gap Oversight and Accountability Committee including providing support to districts/schools to: 1) adopt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

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

EXECUTIVE SUMMARY OF NEEDS & FINDINGS

THE LANDSCAPE – SELECTED NEEDS ASSESSMENT INDICATORS

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



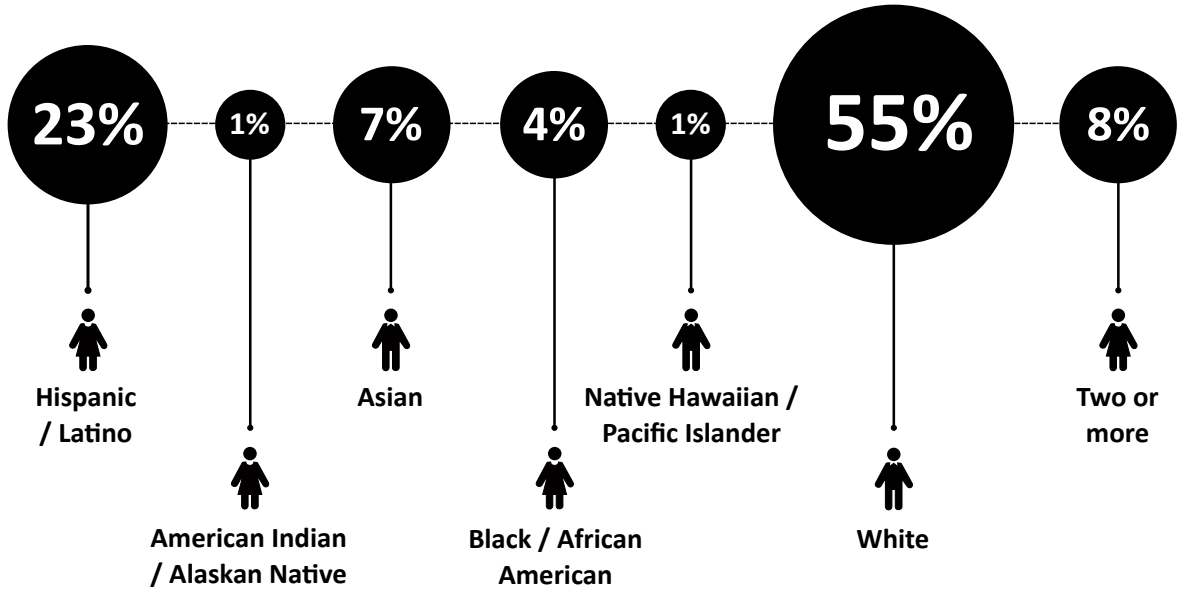
Public School Demographics

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

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

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

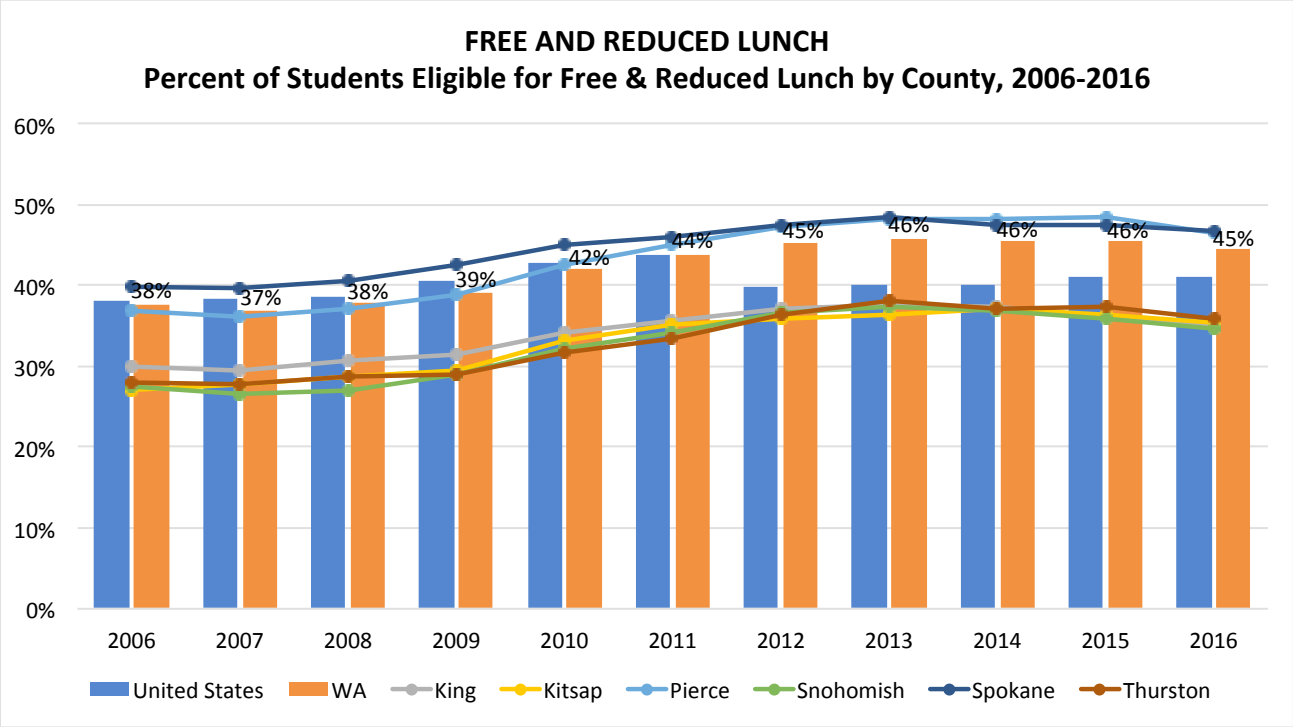
Washington State Student Enrollment Racial Demographics:



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

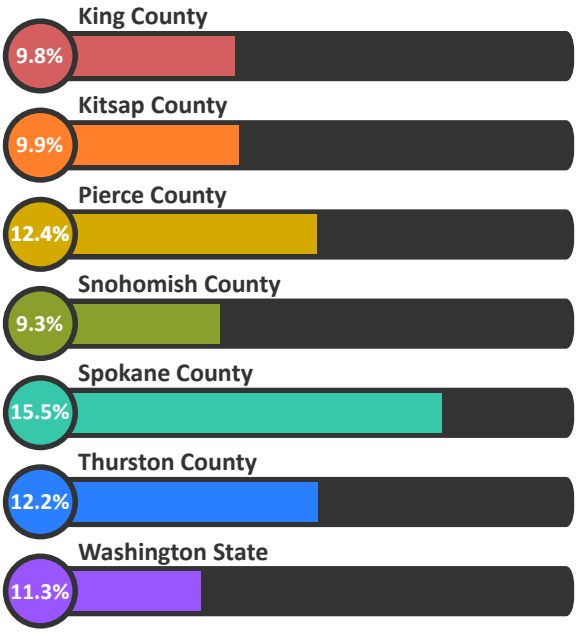
Poverty Indicators

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



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

Poverty Rate (2015):



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

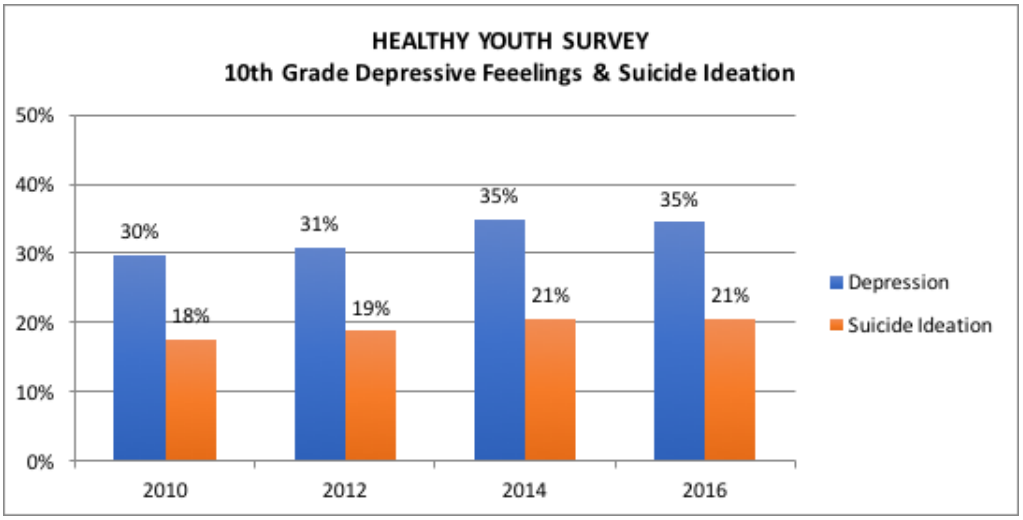
For children, poverty is also associated with poor educational achievement, and places them at higher risk of poor health and mental health challenges (Aber, Bennett, Conley, & Li, 1997; Brooks-Gunn & Duncan, 1997; National Center for Children in Poverty, n.d.).

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

Prevalence of Mental Health Disorders

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

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



School Climate

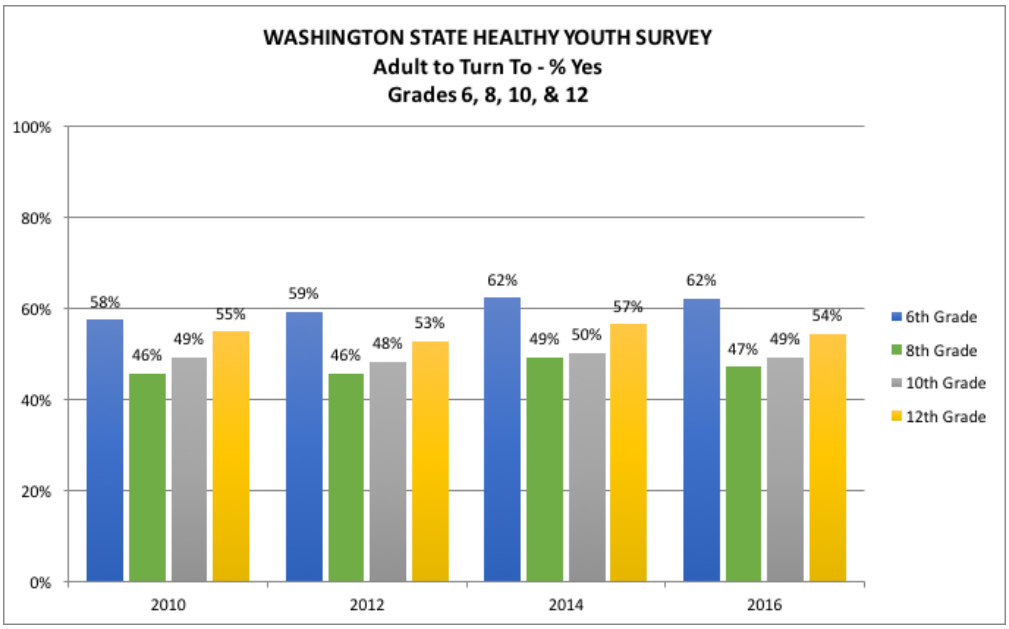
A child's future depends on the ability to overcome and move beyond the emotional and other psychological challenges associated with growing up. Being a target or victim of bullying has immediate and long-term psychological and social effects, influencing a young person's academic achievement and psychosocial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

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

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

Trauma and Resilience

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



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

KNOWLEDGE: WHAT WE KNOW

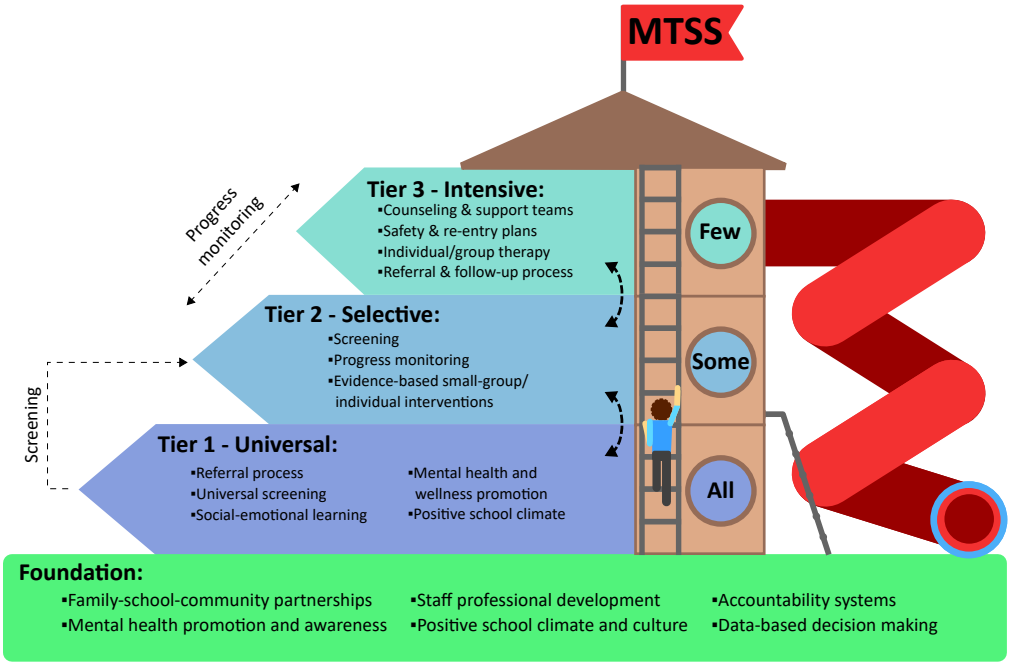
Schools play a critical role in offering youth the mental health care they need. ***With one-in-five children impacted by a diagnosable mental health or learning disorder, it is crucial that schools, communities, and families work to identify and address students' needs*** (Behrens, 2013; California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

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

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

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

These best practices work best within a multi-tiered system of supports (MTSS) framework, which enables successful prevention, early intervention, and monitoring of adolescents' mental health and wellness (Hess et al., 2017, p. 216). Trauma-sensitive practices can assist educators in recognizing students' triggers, coping mechanisms, and emotional needs. Students who have endured trauma can learn how to be resilient over time through making connections, helping others, practicing self-care, and moving toward goals, among other strategies.



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

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

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

DISCOVERY: WHAT WE FOUND

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

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

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

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

OVERALL BARRIERS AND CHALLENGES

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

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

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

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

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

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

SUMMARY OF FINDINGS

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

Concerns

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

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

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

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

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

Foundational Best Practices

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

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

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

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

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

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

Multi-Tiered System of Supports

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

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

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

Coordination and Integration

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

Impacts

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

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

NAVIGATION: BUILDING THE PATHWAY FORWARD

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

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

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

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

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

Provide sites with technical assistance/training related to:

1) School-Family-Community partnerships and sustaining engagement;
2) Social norming campaigns for mental health promotion and awareness;
3) Staff professional development opportunities, specifically related to screening and referral, signs and symptoms of mental health issues, progress monitoring, family engagement, mental health promotion and awareness, trauma-sensitive and culturally responsive schools, child and adolescent development, and staff self-care;
4) Positive school climate, including how to build teams with school and community-based providers;
5) Implementing meaningful social emotional learning accountability systems (e.g., OSPI's SEL benchmarks); and,

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

6) Using data to drive decision-making for SBMH programs, services, and supports and examine the impacts of academic and non-academic student-level outcomes.

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

Provide sites with technical assistance/training related to:

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

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

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

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

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

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

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

5. Advocate for meaningful family and youth engagement.

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

6. Reduce access barriers to care.

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

7. Integrate and coordinate care across systems.

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

8. Normalize mental health in the academic education system.

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

9. Act as a Convener.

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

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

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