School-based Barriers

- **Definitions**: legal definition for screener/survey/etc is unclear, leaving it up to school specific interpretation
- **Workforce Shortages:** shortage of community behavioral health, shortage of school behavioral health personnel to meet needs of families and patients; Lack of services available to refer leads to screening hesitancy;
- **Physical Space:** lack of availability of place to send patients creates screening hesitancy
- **Time**: lack of time to provide screening and brief intervention in clinical visits and schools
- **Documentation and Data Sharing:** access to different documentation systems (between clinicians, schools and providers, etc)
- **Comfortability/Competency**: schools not comfortable screening and brief intervention or not seeing as their core function.
- **Financial - Billing:** Medical necessity required to bill for screening and brief intervention in schools, complexity of billing (bigger for schools), licensure or training required to submit to bill for SBIRT codes and broader screening and assessment codes; sustainable funding for school-based health centers.
- **Funding – Staff:** Funding for staff to implement SB SBIRT in schools.
- **Rural-specific barriers**: transportation, broadband internet, remote locations lead to less in person resources
- **Family Supports**: family capacity for involvement (time, engagement, childcare, work, medical conditions); family opt-out of screening or brief intervention.
- **Cultural and linguistic barriers:** language intervention adaptation, culturally competency trained providers

Potential Guidelines

Schools

1. **Prepare to implement screening, brief intervention and referrals to treatment or support.**
    a. **Engage community leaders**, including parents and guardians, **in the design of the screening, brief intervention and referral to treatment and support services process.** Consider resource mapping to identify community organizations to collaborate with.
    b. **Establish partnerships with community behavioral health providers** to facilitate referrals for more intensive services. Consider incorporating Mental Health Referral Service network through the state of Washington. Develop partnerships with community social service providers and public health departments to meet
    c. **Consider incorporating telehealth-based services** available on campus through partnerships with local community providers to address transportation barriers.
    d. **Develop a system to track behavioral health screening**, results and referrals with the ability to monitor follow-up and connection to care
    e. **Ensure appropriate staff are trained** in screening, providing brief intervention and referrals and youth behavioral health

    f. **Identify a dedicated space for meetings between students and staff and/or students and behavioral health professionals** to facilitate brief interventions and delivery of behavioral health services (e.g., psychotherapy)

2. **Screening. Universally screen annually for common childhood behavioral health concerns** (anxiety, depression, ADHD, trauma, substance use) according to most updated guidelines (Bright Futures, AAP, School Mental Health) using a validated instrument(s). Tools can combine core elements of other screening to ensure coverage of all concerns without the need to screen to use multiple screening tools.
    a. Choose a systematic way to screen (e.g., all 6th and 8th graders annually) and define timely process for assessing and responding to screening results.
    b. Consider diverse cultural values and attitudes as they relate to screening in your setting.
3. **Brief Intervention. For those who screen positive, assess severity of concern to determine level of support necessary** (e.g., brief intervention and follow up versus referral to mental health professionals) and provide evidence-based brief intervention as appropriate.
4. **Referral to Treatment or Support. Refer to school-based or community-based behavioral health professionals.** Track referrals to ensure timely connection to care.
5. **Monitoring and Evaluation.** Collect data on outcomes of screenings, delivery and content of brief interventions, referrals made and linkage to care.
    a. Stratify data by relevant demographics (e.g., race, ethnicity, English as a second language, sexual orientation and gender identity (SOGI), disability status, social needs) to identify and resolve inequities in access to care.

Educational Service Districts

1. Consider applying to become a behavioral health agency in Washington state?

Community Behavioral Health Providers/Clinics

2. If offering youth behavioral health services, establish partnerships for coordination and referrals with local schools, including through telehealth-based services that can be provided onsite to students.

Health Plans

3. Remove barriers to billing for screening, brief intervention and referrals in school settings (e.g., documenting medical necessity for screening in schools)
4. Evaluate provider networks for adequacy and expand when able to form robust network of mental health professionals with variety of skills and backgrounds (psychologists, psychiatrists, social workers, etc)
5. Cover services for health-related social needs (e.g., transportation to appointments, food security)

Health Care Authority

6. Support educational service districts or school districts to hire their own behavioral health staff

Washington State Legislature

7. Fund RCW.28A.320.127 to support staff for implementing school-based SBIRT
8. Designate a lead agency to support school-based SBIRT and school-based behavioral health services.