WASHINGTON PROJECT AWARE

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1. INTRODUCTION

In October 2020, the Washington Office of Superintendent of Public Instruction (OSPI) was awarded a five-year Project AWARE (Advancing Wellness and Resilience in Education) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). OSPI serves as the lead agency, in collaboration with the Washington State Health Care Authority, Educational Service District 105, and a consortium of three partner school districts (LEAs) located east of the Cascade Mountain range in central Washington: Sunnyside School District, Wahluke School District and Yakima School District. Our project, *"Beyond Co-Location: Integrating and Embedding Education and Mental Health Systems"* addresses the Project AWARE initiative by building collaborative partnerships between state and local systems to promote the healthy development of school-aged youth and to prevent youth violence through an integrated multi-tiered system of support (MTSS) framework.

In addition to state level efforts to integrate mental health and MTSS initiatives, develop a sustainable regional mental health support network, and to document practices that are scalable to apply to other regions in Washington, the specific goals of the project are to:

1) Increase ***awareness*** of mental health issues among school-aged youth through the development, implementation, and sustainability of a comprehensive school-based system of mental health services and supports.
2) Train school personnel and other adults who interact with school-aged youth to detect and ***respond*** to mental health issues.
3) ***Connect*** school-aged youth who may have behavioral health issues and their families to needed services.

District Partners:

Sunnyside School District: The Sunnyside School District, located in the heart of the Yakima Valley, is on the original land of the people of the Confederate Tribes and Bands of the Yakama Nation. The district is comprised of five elementary schools (grades Pre-K-5), two middle schools (grades 6-8 grade), and one high school (grades 9-12). It serves students from the municipalities of Sunnyside and Outlook in Yakima County. At the beginning of the 2020-2021 school year, there were 6,723 students enrolled in the district (down from 6,805 in school year 2019-20). Among these students, slightly more were male (51%), and nearly all (92.7%) identified as Hispanic/Latinx of any race. Many students (86.3%) are low income, 31.6% are English Language Learners, 16.7% migrant, and 16% identify as having a disability.

"This is a small town, everyone knows each other. We are close to family, close to friends and extended family –it's a good community. Sunnyside Student

Wahluke School District: The Wahluke School District is situated on the original land of the Wanapum. The 100-acre district campus is located close to the bank of Columbia River and is backed by the Saddle Mountains to the north. The district serves Pre-K-12th grade students from the municipalities of Mattawa and Desert Aire and the surrounding region of Grant County. The

district has three elementary buildings (Pre-K-5), one junior high school (grades 6-8), a comprehensive high school (grades 9-12), and one alternative school (grades 7-12). At the beginning of the 2020-21 school year, there were 2,561 students enrolled in the district (down from 2,578 in school year 2019-2020). Among these students, slightly more were male (52.2%), and nearly all (97.1%) identified as Hispanic/Latinx. Many students (92%) are low income, with 52% English Language Learners, and 48% classified as migrant.

"If I were to say what's the most important thing to our (district's) parents, it's their family. It's their kids. This is why they came from wherever they came from, because they want a better life for their kids." School staff

Yakima School District: The Yakima School District also is located is within the boundaries of the City of Yakima, and also is situated on the original land of the people of the Confederated Tribes and Bands of the Yakama Nation. The district is the 20th largest in the state, with the second largest Latinx-majority population statewide. It serves students who primarily live within the boundaries of the City of Yakima. It is comprised of one Pre-K-12 early learning school, 13 elementary schools (grades K-5), one K-8 elementary/middle school, four middle schools (grades 6-8 grade), and six high schools, including an online school and a technical skills center (grades 9-12). At the beginning of the 2020-2021 school year, there were 15,879 students enrolled in the district (down from 16,419 in school year 2019-2020). Among these students, slightly more were male (50.6%), and most (80.1%) identified as Hispanic/Latinx of any race. Additionally, many students (82.1%) are low income, 31.1% are English Language Learners, nearly 16% have a disability, and over one-in-ten (10.9%) are migrants.

"I think families are really close knit in Yakima. They're very supportive. The large families that you know get together and care about each other and are involved in each other's lives, and so I think that's really good thing in Yakima." School staff

The first project year has been a fast-paced, planning-heavy journey to prepare for and implement activities within each of the three goals. This was further complicated by the reality of launching it in the midst of the ever-changing environment created by a global pandemic. In the sections below, we outline our progress toward the startup and implementation of key project activities and milestones accomplished.

2. STARTUP & IMPLEMENTATION ACTVITIES

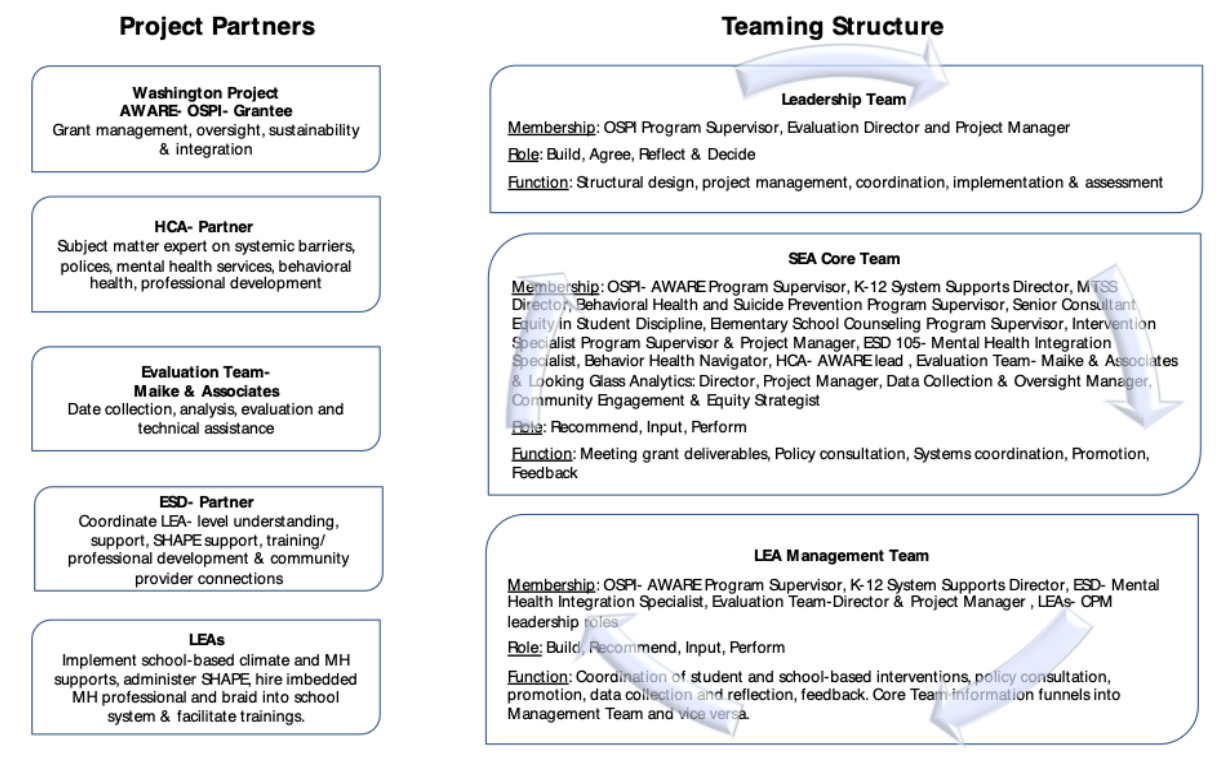
Startup Activities: The AWARE lead agency and partners developed startup activities to address the need for statewide infrastructure and the systems required for expansion of an integrated MTSS/Interconnected Systems Framework (ISF). These activities initially focused on the hiring of grant personnel and executing contracts with the LEA districts, and finalizing agreements with local mental health providers, as needed. Hiring included the OSPI/State Education Agency (SEA) Project Manager, Healthcare Authority (HCA) Project Manager, and the Educational Service District (ESD) 105 Mental Health Systems Coordinator. In addition, OSPI released a request for proposals for an external evaluator in November 2020, with applications reviewed, and the selection

process completed mid-December 2020. The contract with Maike & Associates, LLC, was executed in February 2021, with the evaluators immediately in place and working in collaboration with the SEA and LEA teams.

Teaming and Management Structure: As work began it was of the utmost importance that the team established a safe and cohesive team culture across domains, especially with the requirement of virtual meetings during the pandemic. We convened a SEA Core Team and began establishing a governance structure that operates like a feedback loop in that it both pulls from and informs our project. The Core Team includes SEA members that act as subject matter experts in the areas of behavioral health, suicide prevention, equity, student discipline, school counseling, social emotional learning, and the multi-tiered system of supports framework. The team also includes leadership positions from the Evaluation Team, the HCA, and ESD 105.

In addition to our Core Team, we have a LEA Management Team. The management team exists of key players from OSPI/SEA, HCA, ESD 105 and the three LEA-based Community Project Managers (referred to as District Leads) (Figure 1). There is continued connection between our evaluation team and LEAs and the same is true for the ESD and LEAs. Each unique team meets frequently and fosters a work force of cooperation and support.

Figure 1: Project AWARE – Teaming and Management Structure



To date, project partners have forged powerful connections across the state and beyond, including with our SAMHSA Government Project Officer, as well as with several of our national peers. We have also created connections with and receive support from the Northwest PBIS Network,

Northwest Mental Health Technology Transfer Center (MHTTC), and the University of Washington SMART (School Mental Health Assessment, Research, & Training) Center as well as other AWARE grantee states including Alaska, Colorado, Georgia, Idaho, and Montana.

Communication Plan: We developed a communication framework that is being used to disseminate information from the SEA to LEA levels statewide. To inform a wider audience, we have published a project webpage and Moodle . They are both "live." This communication framework allows us to develop and disseminate news articles, create content (such as videos or graphics), and better engage with students, families, staff, and Project AWARE partners.

We have constructed day-to-day work in a way to make room for a high-quality workflow of necessary tasks. The SEA Project Manager, as the primary project contact, facilitates local and state efforts, oversees the budget, and manages contracts as well as provides the technical assistance and support to key players to ensure the sustainability of project activities beyond the life of the SAMHSA funding.

To further clarify the roles and responsibilities of project partners to our LEAs, the following communication chart was designed and disseminated in late March 2021.

Figure 2: Project AWARE – Grant Partner Roles & Responsibilities

Project AWARE Grant Partners: Roles & Responsibilities		
Project Manager: OSPI	**Mental Health Integration Specialist: ESD 105**	**Evaluation Team: Maike & Associates**
OSPI: Responsible for day-to-day coordination of project activities; leadership and facilitation of local and state efforts, including but not limited to, assessing, and facilitating MTSS implementation, PD trainings, culturally responsive coaching, capacity development, and dissemination activities (e.g., publications, website); and work with evaluators to ensure project objectives, outcomes and GPRA performance measures are met. HCA: Co-lead the assessment and facilitation of behavioral health system alignment, liaise between SEA & LEA project staff, policy development and modification, and funding coordination.	Coordinate and integrate funding streams to sustain school-based behavioral health programming with the three LEAs and throughout the region. Engage partners in design and enhancing system of care support. Work collaboratively with OSPI and HCA. Will review policies and practices to make recommendations to reduce barriers to service delivery.	Develop project Logic Model and finalize Evaluation Plan (includes GPRA goals and project-level (SEA/LEA) Objectives, Activities, and Outcomes) Assist LEA project partners with completion of district-level SHAPE assessment tool and Resource Inventory Conduct LEA district-level community assessments Develop web-based data collection; oversee data reporting system. Prepare (monthly/quarterly) progress monitoring reports Consult with SEA and LEA program staff to problem solve issues related to project progress Produce Process and Outcome Evaluation report, annually
If you have a question related to…		
• AWARE project implementation • Grant budget: approvals & spending • State policies & practice • State-level resources (e.g., training, curriculum) • Training & Technical Assistance to support grant activities/strategies	• Training & Technical Assistance on specific behavioral health EBPs • Behavioral health referral systems • Local resources • Community-based providers • Community & family engagement strategies • Insurance billing	• Specific grant-related activities tied to achievement of goals/objectives • Data collection & reporting • Assessment Tools (e.g., SHAPE) • Fidelity & Measurement Tools (e.g., TFI) • NOMs Tool • All evaluation-related topics
Ask Bridget! Project AWARE Program Supervisor (360) 790-0527 bridget.underdahl@k12.wa.us	**Ask Hope!** Mental Health Integration Specialist (509) 895-4291 hope.baker@esd105.org	**Ask Michelle and/or Megan!** Project AWARE Evaluation Michelle: 360-460-9600/mmaike@olypen.com Megan: 541-231-9917/megan.b.osborne@gmail.com

Implementation Activities: Since grant start up through September 2021, Washington Project AWARE accomplished the following key activities and milestones.

Behavioral Health Disparity Impact Statement: In accordance with the FY 2020 Project AWARE funding opportunity announcement (FOA No. SM-20-016), we drafted an initial Behavioral Health Disparities Impact Statement within the required 60-day post-award window (See Appendix A). In collaboration with the evaluation team, this document was updated in February 2021 to reflect:

- Estimated direct service numbers
- Information about specific student subpopulations
- Quality improvement plan, and
- Adherence to the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards) in Health and Health Care.

The table below reflects the proposed number of individuals to be served during the grant period (October 1, 2020 – September 29, 2025) and all identified subpopulations in the grant service area. The disparate populations are identified in the narrative below.

Table 1: Direct Service Estimates by Project Year and Overall, 9/30/2020 – 9/29/2025

SERVICES	Year 1 (9/30/2020-9/29/2021)	Year 2 (9/30/2021-9/29/2022)	Year 3 (9/30/2022-9/29/2023)	Year 4 (9/30/2023-9/29/2024)	Year 5 (9/30/2024-9/29/2025)	Cumulative*
Advancing Wellness & Resiliency in Education	90	235	380	485	610	1,288*

Note: For the purpose of this measure, "services" are defined as those students who qualify for, and are engaged in, Tier 3 intervention/treatment, thus requiring administration of the NOMs tool. *Cumulative Goal: This is the unduplicated goal of all consumers for the total grant period. This is different than adding up all the annual goals of each grant year since that figure may contain duplicate consumers. *Assumes approximately 70% of students are unduplicated years 2-5 (e.g., 30% were previously served), and in Year 1 all are unduplicated counts.*

Table 2: Student Enrollment Demographics by LEA Site (2020-2021)

	Sunnyside	Wahluke	Yakima	AWARE Total
Student Enrollment 2020-2021	6,723	2,561	15,883	**25,167**
By Race & Ethnicity				
Black/African American	13	2	83	98
American Indian/Alaskan Native	5	11	149	165
Asian	4	0	57	61
White (Non-Hispanic)	417	56	2,475	2,948
Hispanic/Latinx	6,232	2,487	12,713	21,432
Native Hawaiian/Other Pacific Is.	0	1	12	13
Two or More Races	52	4	394	450
Total	*6,723*	*2,561*	*15,883*	*25,167*
By Gender				
Female	3,294	1,223	7,844	12,361
Male	3,429	1,338	8,038	12,805
Gender Non-Conforming	*	*	1	1
Total	*6,723*	*2,561*	*15,883*	*25,167*

* Data related to sexuality and primary language were not included in the WA OSPI Diversity Report.

Although data related to specific sub-groups is not available, throughout the project we will collect and report data to ensure a lens of equity and inclusion by disaggregating data by sub-populations, as appropriate. Disaggregated data more precisely describe the racial/ethnic makeup of communities.[1] When possible, we will also note intersectionalities, or how multiple identities together shape how a person experiences oppression or privilege. Considering intersections helps think how the multiple identities of a Latina, low-income female migrant student, for example, intensify conditions of power, privilege, or oppression in that student's life. In this manner, we can identify any disparate trends and make programmatic changes to reduce disparate impacts and improve positive outcomes for all students as outlined below.

Performance Assessment Plan: Additionally, the FOA required grantees to submit a performance assessment plan by the third month following award. The purpose of the plan is to ensure that SEA and LEA partners agree on how data are collected and reported regarding fidelity of implementation of evidence-based practices and to allow for the systematic assessment of ongoing progress or implementation of AWARE project activities aligned with overall goals and objectives (See Appendix B).

The evaluation team, in collaboration with project partners, developed the plan which outlines the data collection processes; data management, tracking, analysis, and reporting processes; performance assessment; and quality improvement. The plan also includes the required Government Performance Measures (GPRA) goals by indicator and project year. The completed plan was submitted to the SAMHSA GPO in February 2021 and was subsequently updated to include project level performance measures. During year-end interviews with project partners, LEAs provided feedback on the inclusiveness of the strategic planning process. LEA partners agreed that there was a plenty of opportunity to review and provide feedback on the plan. One LEA partner noted, *"I did feel we had a voice. The team responded and adjusted according to what our realities were during the design phase. I appreciated the changes in delaying that one measure, and how the design team recognized our needs. I don't know how it would have been better."*

Project Logic Model and Evaluation Plan: To help guide the overall project, as well as the LEA sites, the project partners, led by the evaluation team, worked collaboratively to develop a Project Logic Model (see Figure 3) that includes the three project goals, and identified outcomes. This process included the development of GRPA goals by performance measure and indicators across project years, which are included as part of the Performance Assessment Plan (referenced above).

At both the SEA and LEA levels, project partners developed activities aligned with the logic model to ensure the accomplishment of the stated goals over the project period. This more detailed document will guide both the implementation of project strategies and activities as well as the project evaluation across the 5-year project period (See Appendix C).

[1] Source: https://nces.ed.gov/pubs2017/NFES2017017.pdf

WASHINGTON PROJECT AWARE: LOGIC MODEL

Our Mission: To enhance the behavioral health of all students through an interconnected systems framework in partnership with education, mental health, and community supports which promote wellness, resilience, and tools to empower all students, families, educators, and school staff.

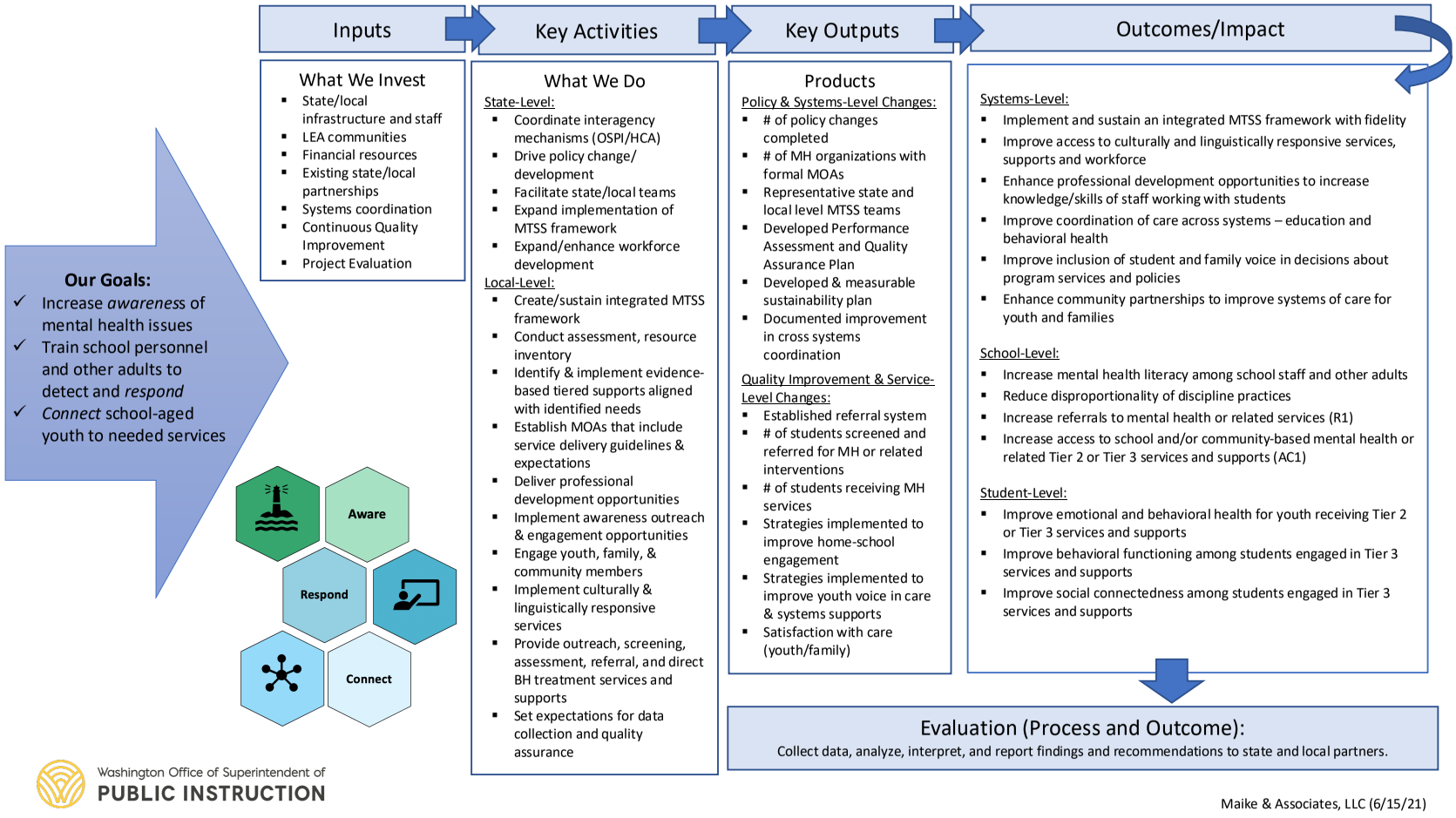
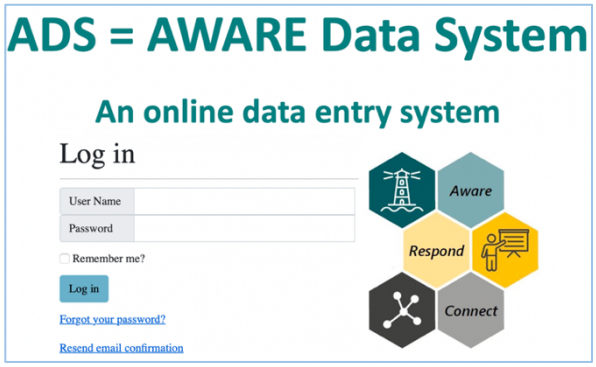
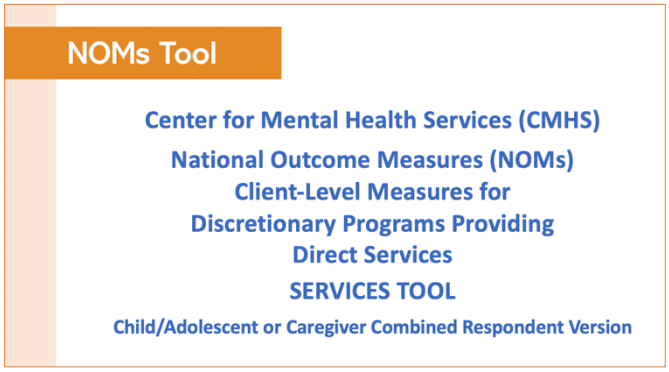


Figure 3: Washington Project AWARE: Logic Model

Data Collection System and Reporting: The evaluation team also completed the development of the initial phase of the Aware Data System (ADS), a robust data collection system that includes a web-based data portal to facilitate the entry of data (GPRA and project-level) by the SEA, LEAs, and community partners (as appropriate). ADS allows staff to enter data needed to meet SAMHSA's quarterly reporting grantee requirements as well as manage and analyze the student referral process. Beyond simply meeting reporting requirements, ADS allows schools, districts, the ESD, and state partners to quantify the work that is being done, often behind the scenes, as part of the AWARE grant. This system is customized to the needs of the project and allows users to run real-time reports enabling them to continuously monitor their own data. The system was designed with user ease and accessibility at the forefront and includes a Users' Manual. In September, project partners at both the SEA and LEA levels were trained by members of the evaluation team in the use of the online system. Further development of the ADS in Year 2 (2021-2022) will include process measure data, and further development of reporting and exporting functions.



Additionally, the evaluation team developed materials to support the collection and reporting of the required services measures linked to the National Outcomes Measures (NOMs) instrument. Materials included a training PowerPoint, and consolidated NOMs instruments and an Answer Book (both in English and Spanish). Key staff in each of the participating LEA districts were trained in the use of the NOMs tool as well as how to enter data into the SPARS system. This training provided participants with information about the AWARE project, background of the GRPA and NOMs performance measures, and expectations related to reporting of these data. Periodic review of data as well as booster training sessions will be conducted throughout the grant period as a continuous quality improvement effort.



3. INFASTRUCTURE DEVELOPMENT & SYSTEMS ACTIVITIES

As noted, the project has three broad goals, each with a set of identified objectives, activities/strategies, and process and outcome measures. These are:

1) Increase ***awareness*** of mental health issues among school-aged youth through the development, implementation, and sustainability of a comprehensive school-based system

of mental health services and supports.

2) Train school personnel and other adults who interact with school-aged youth to detect and ***respond*** to mental health issues.
3) ***Connect*** school-aged youth who may have behavioral health issues and their families to needed services.

Because the bulk of work during the startup year focused on planning and implementation, as outlined above and further delineated below, limited direct service activities (e.g., student-centered) were conducted. In the following sections, we detail services and activities conducted to date, at both the SEA and LEA levels, related to project goals.

Goal 1: Awareness – Implement a MTSS framework of mental health services and supports

Multi-Tiered System of Supports: Utilizing the MTSS framework as its base structure, project partners began to develop and implement required services and activities that would meet the needs of students, staff, and families as identified through community assessments. This process included the establishment of purposeful partnerships to ensure effective service delivery; thus, increasing the likelihood of building a seamless delivery of tiered services at increasingly intensive levels of support. This structure will allow for efficient identification, assessment, monitoring, and improvement of mental health outcomes. Levels of support across the project period will include: Tier 1 universal prevention-focused programs and supports designed to reach all students (e.g., classroom-based social emotional learning curriculum); Tier 2 selective services for students with mild or emerging behavioral issues (e.g., interventions focused on problem solving, typically in small, time-limited groups); and Tier 3 indicated interventions for students in need of more intensive evidence-based treatment (e.g., evidence-based practices (EBPs) delivered by trained mental health providers often in one-on-one sessions).

At the SEA and LEA levels, there are established MTSS teams. The core team is focused on removing silos and connecting existing systems in place within each LEA. In collaboration with LEA partners, the SEA leads and project evaluators are supporting the process of integrating existing academic and behavioral services and supports, reviewing prior trainings, and assessing gaps.

There has also been a deep connection established between the Department of Education funded School Climate Transformation Grant (SCTG) and Project AWARE, as two of the three LEAs are a part of both projects. To that end, the SEA Project Manager has been working in collaboration with the MTSS Director at OPSI to increase awareness of the project, its goals, and activities. Specifically, they are working to align and integrate these efforts at the SEA level. This has included developing a unified message that defines these two projects and how they build upon each other statewide and at the LEA levels in support of a comprehensive MTSS framework. An example of the initial integration process is illustrated in Figure 4. Additionally, the OSPI Director of MTSS is a member of the Core Team and routinely has provided technical assistance and resources to the Project AWARE team during the startup of direct services planning.

Figure 4: Example of Initial SCTG & MTSS Integration

Key Message 1: Multi-Tiered Systems of Support

School mental health programs and initiatives are always installed and aligned with core features of the Multi-Tiered System of Support (MTSS) framework. MTSS core components are screening, progress monitoring, data-based decision making at all tiers, and a multi-level prevention system (AIR, 2020). This provides a proactive, preventative framework designed to optimize student success by intentionally selecting and implementing evidence-based, culturally and linguistically responsive services and supports based on individual student strengths and needs. MTSS teams accomplish this by including multidisciplinary representation of team members from education, community partners, families and students.

School Climate Transformation Grant	Project AWARE
Training of district leadership teams on supporting MTSS capacity, aligned to District Systems Fidelity Inventory (DSFI). Ongoing coaching support to district teams in the most efficient and effective ways to collaborate across agencies.	Expansion of district team to include community providers.
Training of school teams on PBIS implementation to ensure fidelity of evidence-based practices.	School teams to include community providers at all tiers, enhanced memorandums of understanding for collaboration.
Training on screening and progress monitoring to ensure equitable identification, access, and success of student.	Data to expand beyond school-based metrics to include community data.
District capacity and Tier 1 coaching through regional implementation coordinators	District level teams in collaboration with CPMs develop and implement Tier 2 and Tier 3 services and supports (including referral management systems, screening, and problem solving)

School Health Assessment Performance and Evaluation (SHAPE) School Mental Health Quality Assessment: At the LEA level, the District Leads are actively engaged in the development and design of service level activities. They have completed the School Health Assessment Performance and Evaluation (SHAPE) School Mental Health Quality Assessment with their district-level MTSS teams, which was facilitated by the Evaluation Project Manager and the ESD Mental Health Systems Coordinator.

Table 3 shows baseline SHAPE results across the three LEAs. The composite scores show the average rating for items within each domain. In accord with SHAPE guidelines, composite scores of 1.0-2.9 are classified as "Emerging" areas, 3.0-4.9 are classified as "Progressing" areas, and 5.0-6.0 are classified as areas of "Mastery."[2]

Table 3: SHAPE Baseline Composite Scores (June 2021)

SHAPE Domain	Sunnyside	Wahluke	Yakima
Teaming	3.8	2.9	2.7
Needs Assessment/Resource Mapping	2.3	1.7	2.7
Mental Health Promotion (Tier 1)	3.8	2.3	3
Early Intervention and Treatment (Tier 2/3)	3	2.1	2.7
Funding and Sustainability	3.5	1.9	2.4
Impact	1.3	1	1.5
District Implementation Support	1.8	1.6	2.3
Impact District-Level Documenting and Reporting	1	1	1

[2] Source: https://www.theshapesystem.com/wp-content/uploads/2021/11/SMHQA_District-version.pdf

These data show that across the three AWARE LEA's levels of implementation of a comprehensive school-based mental health system of support varies. In the Sunnyside School District, scores indicate a mix of emerging and progressing implementation across the nine domains, with the areas of teaming, universal (Tier 1) mental health supports, and funding being most advanced – a reflection of the previous level of work conducted by the district. In both the Wahluke and Yakima School districts, teams assessed the respective district as emerging across all domain areas, with the exception of mental health promotion in Yakima, which is progressing.

Results from the SHAPE will be used to help prioritize project-level activities in alignment with best-practices. Such activities will include action planning; identification of tiered evidence-based practices (EBPs); set-up of referral system infrastructure; implementation of school-mental health strategies (screening, referral, services, and follow-up for youth and families); and the delivery of school-based mental health services. The LEAs will reassess implementation using the SHAPE assessment annually.

Community Health Assessments: A best practice related to the implementation of an MTSS framework is the completion of a behavioral health assessment and resource mapping to document existing school and community-based services across tiered-levels of supports. In the spring, the evaluation team completed a comprehensive community assessment for each of the LEA districts. This process incorporated both needs *and* strengths, thereby centering communities, their culture, and history; elevating community voices; and making equity and antiracism the framework (not simply a lens) in which assessments and strategic planning take place. Including assets paints a more complete picture of these communities, illustrates their resilience, and identifies opportunities for maximizing existing resources.

The purpose of this community assessment process is to:

1. Highlight community strengths and disparities and articulate how these will be addressed through the implementation of Project AWARE.
2. Ensure assessment findings inform Project AWARE's goals, activities, and outcomes.
3. Use community assessment findings to inform project partners in the design and implementation of school-based mental health services and supports.

Key data points and the latest research findings were used to assess the well-being of students and families in each AWARE district. Much of these data were pulled from public records, such census data. State, county, and school district data were also collected from the Risk and Protection Profile for Substance Abuse Prevention in Washington Communities (January 2021). Annually, the Washington State Department of Social & Health Services, Research & Data Analysis Division, produces these reports, which include technical notes on the methodological approaches used to obtain data reported at the district-level.

Additionally, data was obtained from Washington State's Healthy Youth Survey (HYS). LEA districts' 6th, 8th, 10th, and 12th grade students participate in the HYS in the fall of even numbered school years. The HYS is sponsored by the Department of Health, the Office of Superintendent

of Public Instruction, the Department of Social and Health Services, the Department of Commerce, the Family Policy Council, and the Liquor Control Board in cooperation with schools throughout the state. The survey measures health risk behaviors known to contribute to the health and safety of youth. Survey results serve two important functions: first, providing needs assessment data for program planning; and second, giving a measure of the global effectiveness of statewide prevention and health promotion.

Other major data sources used for this assessment include the County Health Rankings & Roadmaps, a program of the University of Wisconsin Population Health Institute, which provides a snapshot of a community's health using county-level data. Rankings are based on a model of population health and include data from Behavioral Risk Factor Surveillance System, Mapping Medicare Disparities Tool, American Community Survey 5-year estimates, Census Population Estimates, and other sources. For many measures, data are available by race/ethnicity within a county.

The Community Health Assessment reports provided project partners with rich qualitative and quantitative data as well as recommendations from the evaluation team to be used to guide project planning as they moved into Year 2 of the AWARE grant. In general, ideas for improvement related to services and supports across LEA sites fell into three major categories: culturally and linguistically responsive services and supports; the need to focus on equity and inclusion; and, considering the needs of priority populations. These common ideas are outlined in the graphic on the following page.

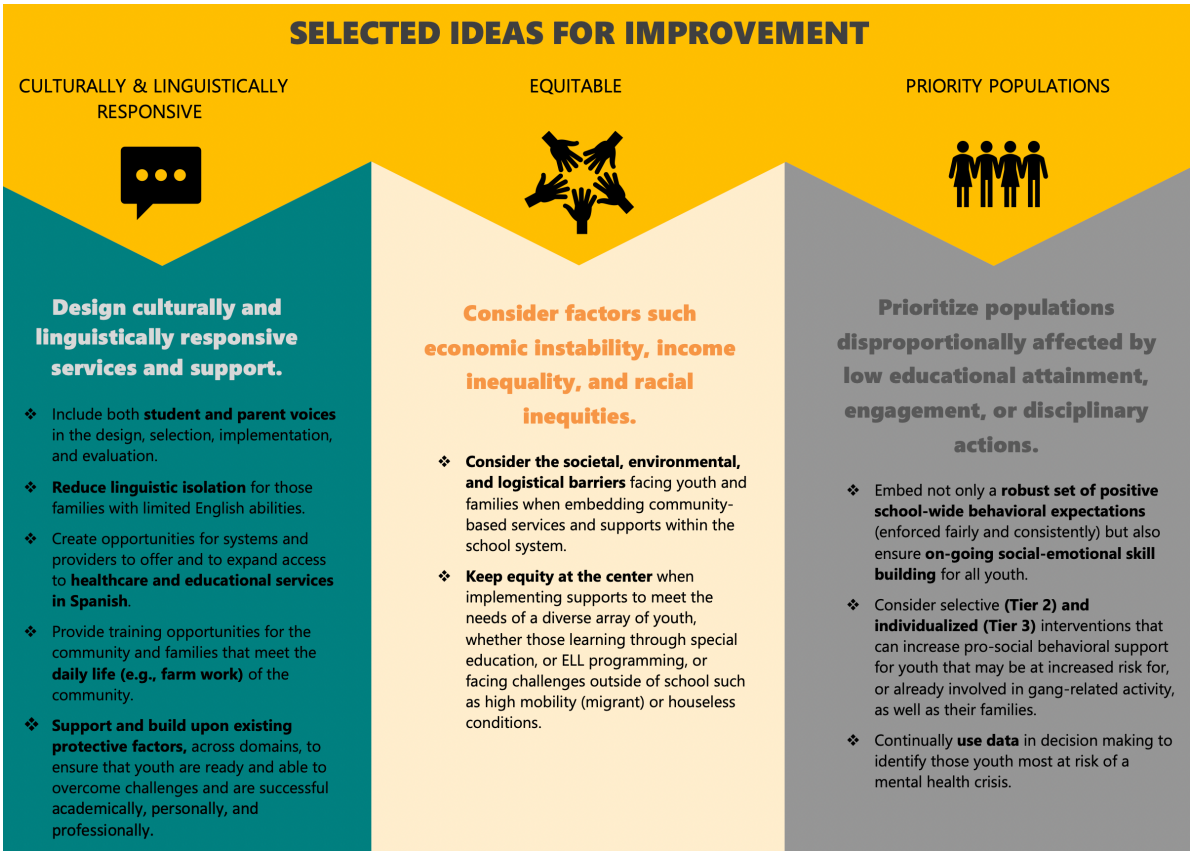
Another major component of this work was to conduct in-depth qualitative interviews and focus groups with key district informants to better understand the nature, depth, and breadth of the school-based social, emotional, and behavioral strategies currently being implemented in the LEAs. The main purpose was to ensure stakeholder voice was reflected and incorporated into this process. Participants were also asked to identify barriers or challenges that might hinder the implementation of school-based mental health services.

Participants in focus groups and interviews included staff at the elementary, middle/junior high, and high school levels. We spoke with classroom teachers, behavior interventionists, paraeducators, and school counselors, as well as parents and middle and high school students. Each LEA district lead Contact and scheduling of focus groups and interviews was coordinated by. In all, 83 individuals participated in the interviews and focus groups.

Each participant was asked to answer questions from their perspective, regarding their specific experience and expertise. As such, not all respondents answered all questions and not all questions were asked of all respondents. Individual teacher interviews were approximately 30-45

minutes, with focus groups lasting 90 minutes each. Completed interviews and focus groups were transcribed, coded for themes, analyzed, and summarized.

Figure 5: Community Assessment Findings: Selected Ideas for Improvement



Participants were asked to identify the most pressing social, emotional, and behavioral health issues facing students in their school district community. The questions asked were framed around the three goals of Project AWARE. Throughout the Community Assessment reports, we used this information to provide a snapshot of key indicators, and include trend data, as well as comparisons over time to the state and county, as appropriate, and when available.

The community assessment is an essential component of the school-based mental health systems review for the partner LEA districts. The following are a few highlights from these reports.

Mental and Behavioral Health Concerns: In large part, participants identified depression, anxiety, and stress as the most pressing mental health issues facing youth. Staff, parents, and students themselves acknowledged an increase in social anxiety due to the COVID-19 pandemic, as well as rising depression (diagnosed or not) because of the social isolation. Moreover, the pandemic and its economic, social, and health impacts were at the forefront of

"...Depression is one of the largest problems, mostly due to the isolation of COVID. It's harder for people to communicate with others..." Yakima Student

participants' minds, especially as these districts transitioned to hybrid learning model and increased social interaction.

Stigma and Mental Health Awareness: There was agreement among participants that stigma related to mental health disorders exists among Hispanic *and* white community members. Hispanic participants recognized the cultural norms in their own community about seeking services, not wanting to be seen as "crazy" as well as labeling depression as an excuse for "being lazy." Students believed that the comfort and ability to talk about mental health and wellness is very different between school and home acknowledging that stigma may be a generational issue, rather than one of race/culture. "*Closed mindedness doesn't see race,*" said one Sunnyside student.

"It is important to take into account the mental health of young people but also of parents. Moms often say, 'I'm not depressed.' Children see that and they will do the same."
Sunnyside Parent

Several participants in the focus groups raised concerns about the lack of culturally and linguistically responsive school staff and mental health supports and services available to students and families. Participants agreed that the lack of knowledge about the science of mental health and illnesses (their signs, symptoms, and treatment options), as well as the lack of school- and community-based resources were challenges.

"Sometimes we feel ashamed to express our needs and feelings. It's very difficult."
Yakima Parent

Access to Services and Supports: Participants were asked to identify additional barriers to mental health services and supports. At the top of the list were limited options to quality care, accessibility, mental health workforce issues, lack of culturally sensitive care, and a workforce that doesn't reflect the demographics of the families. Staff commended school counselors but admitted that there are few mental health support staff to meet the needs of the students that need help. The following selected comments summarize participants' perceptions:

> *"We don't have enough counselors. We don't have enough people."* – School Staff
>
> *"There has been a drastic change in the way mental health can be accessed with medical coupons. Before one could use them but now the doctor must refer to a counselor. They make an appointment for you for an evaluation, and it may take two to three months. What is the point then? That is something very wrong with the system."* — Parent
>
> *"We have the little community health mental health place but scheduling with them is very difficult because [providers] are always coming from Moses Lake or outside the area. So, they're not always here and they're not always available. I wish we had a practice here…, maybe tele-health services, some sort of services and awareness. Something that was more accessible to local people that can't always afford to travel or take time off work, because I know during harvest our families can't take time off work. That's extremely frowned upon."* — School staff
>
> *"I struggled for a long time to find quality care and I had to go outside [the community]. I had to drive an hour away and that's me taking an hour off work and taking him out of school and going an hour away and then coming back. Not a lot of people have access to [transportation] either."*— Parent

Ideas for Improvement: At the end of the interviews and focus group sessions, participants were also asked about ideas on how the schools or districts can be more supportive of staff, students, and families with regards to mental health and wellbeing. The following is a selection of their suggestions.

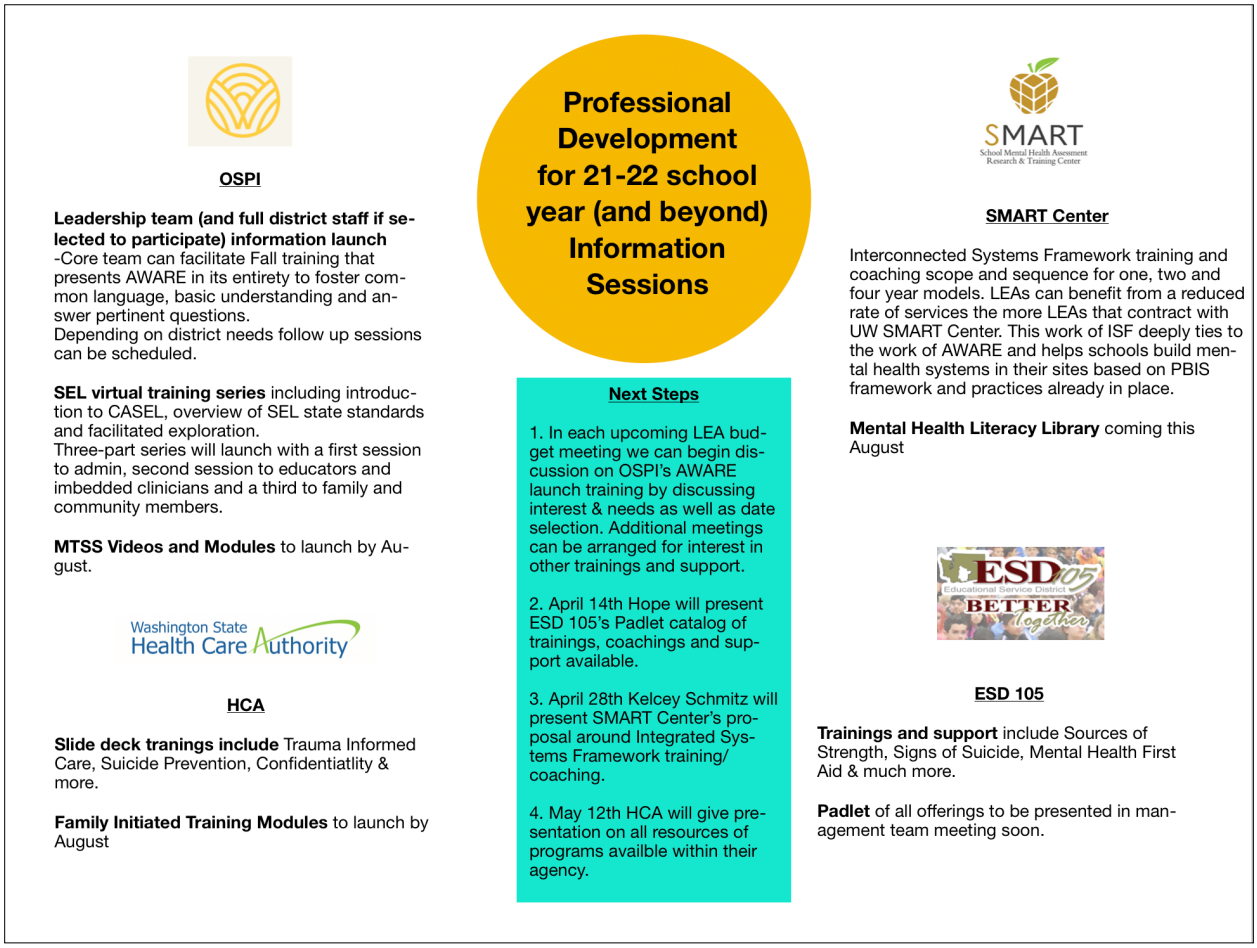
> *"A place (at the school) to be alone when I'm upset; having space to be alone and reset is empowering; to be alone and self-regulate."* – Student
>
> *"Mandatory orientation for freshman; a mental health seminar they have to attend."* – Student
>
> *Mental health (training) is not just an issue for teachers, but also for parents. If there is no concrete communication, connectivity between parents and teachers there is no follow-up. Monitoring should continue through the summer. There needs to be more patience, more plans. Instead of suspension, there should be a plan, and everyone agrees and continually reviews it.* – Parent
>
> *"Support for both kids and parents."* – Parent
>
> *"I would love to see every school be equipped with some sort of Wellness Center, whether it is just one room that's available for teachers and students to be able to gather themselves and center themselves to feel safe."* – School staff
>
> *"…there has to be balance and especially right now. Some things are going to have to be put on the backburner. If so, we can focus on getting the kids better…"* – School staff

Full Community Health Assessment reports, including a separate Voices from the Community brief, were distributed to key SEA and LEA partners in August 2021, along with a "2-page" informational snapshot designed for dissemination to the general population with this document available in English and Spanish (See Appendices D-F for the full assessments)

Goal 2: Respond – Train staff to detect and respond to mental health issues

The *LEA Training and Coaching Plan* developed, in part, to meet Goal 2, as well as the required Infrastructure Performance measures is being implemented across key players with a focus on Tier 1 supports, social, emotional learning (SEL) support and the Interconnected Systems Framework. The SEA level team has developed a system to disseminate pertinent training and coaching opportunities including several presentations to LEA partners by the SEA, HCA and ESD key players as well as from the UW SMART Center. The SEA Project Manager, in collaboration with the Core Team, designed a professional development plan for the 2021-2022 school year (and beyond) that identified next steps as well as topical areas and training facilitators (Figure 6).

Figure 6: Professional Development Plan 2021-2022



Details regarding the number and type of trainings conducted during the reporting period can be found in Section 4, *Performance Measure Progress to Date* (see page 23).

In partnership, ESD 105 and OSPI were granted the National Center for School Mental Health's Collaborative Improvement and Innovation Network (CoIIN) grant. The CoIIN is part of the School Health Services National Quality Initiative (NQI) funded by Health Resources and Services

Administration, Maternal and Child Health Bureau. A CoIIN is a learning community of multidisciplinary teams working together to address a specific, complex challenge. Quality improvement is achieved by receiving expert technical assistance and coaching, exchanging best practices and lessons learned with other state and district teams, and tracking progress toward key benchmarks and improvement goals. Quality improvements and innovations are tested locally at the district level and are intended to inform state policies and programs that promote quality, sustainability, and growth of school-based health services.

Statewide, five LEAs make up the CoIIN collaborative, including two AWARE LEAs, Wahluke and Yakima. To date, these districts have been trained on creating Plan-Do-Study-Act (PDSAs) cycles around their SHAPE results, how to complete and analyze the SHAPE, and teaming and infrastructure requirements related to grant activities. Additionally, they have received coaching about data collection cycles (including mental health screening), student functioning, chronic absenteeism, eligible students, enrolled students, and how to create and align small scale goals to encourage innovation at a rapid pace.

The involvement in this network of peers and experts has benefitted the both the AWARE SEA and LEA partners in multiple ways, including: receiving ongoing technical assistance in school-based mental health services and supports; strengthening relationships with peers and state partners to enhance school-based mental health systems; improving the visibility of this cutting edge approach to school-based mental health practices; helping shape state policies to support school-based mental health services and support efforts; improving the use of data and data-based decision-making; and receiving support around emerging topics related to the COVID-19 pandemic.

Goal 3: Connect – Connect identified students & families to needed services and supports

In using an integrated MTSS framework, it is the goal of the project to implement evidence-based programs (EBPs) across the continuum of supports. Specific to this goal is the development of Tier 2 and Tier 3 services and supports (including referral management systems, screening, progress monitoring, and problem solving) overseen by district and building-level MTSS teams.

During the reporting period, each of the three LEAs made progress towards the development of a school-based MTSS system in which contracted mental health providers and school employees collaborate to assess, refer, triage, case manage, and monitor student progress. At the school-level, school staff deliver non-treatment related SEL, classroom-based curricula designed to reduce behavioral problems, and increase SEL skills.

Figure 7 shows the general referral pathway adopted by Project AWARE sites that includes screening, referral determination and data collection (as appropriate). Figure 8 demonstrates the referral determination process.

Figure 7: AWARE Mental Health Referral Pathway

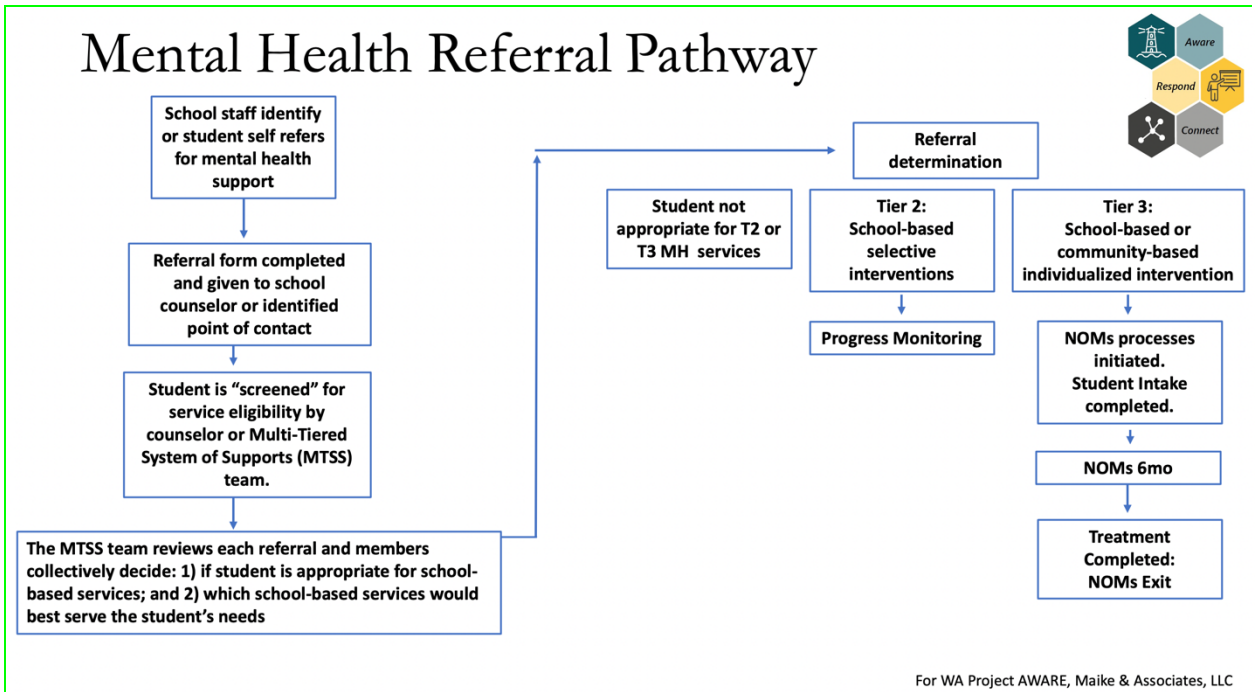
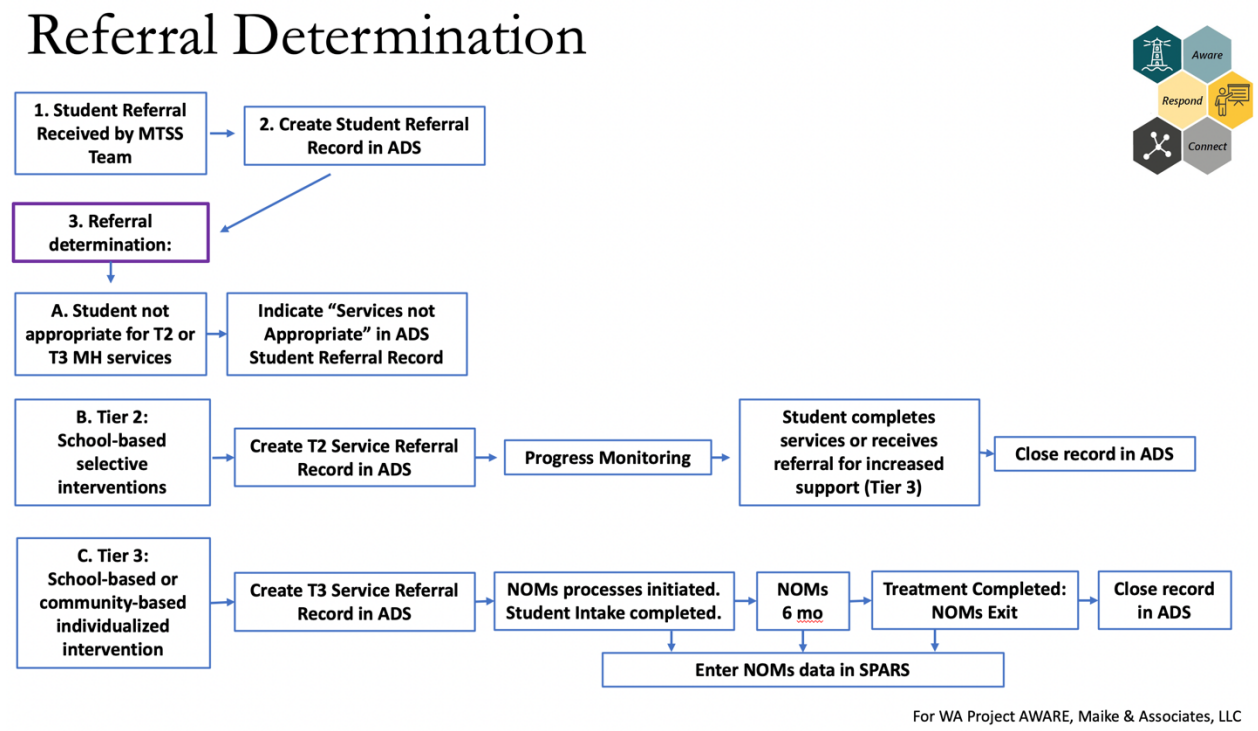
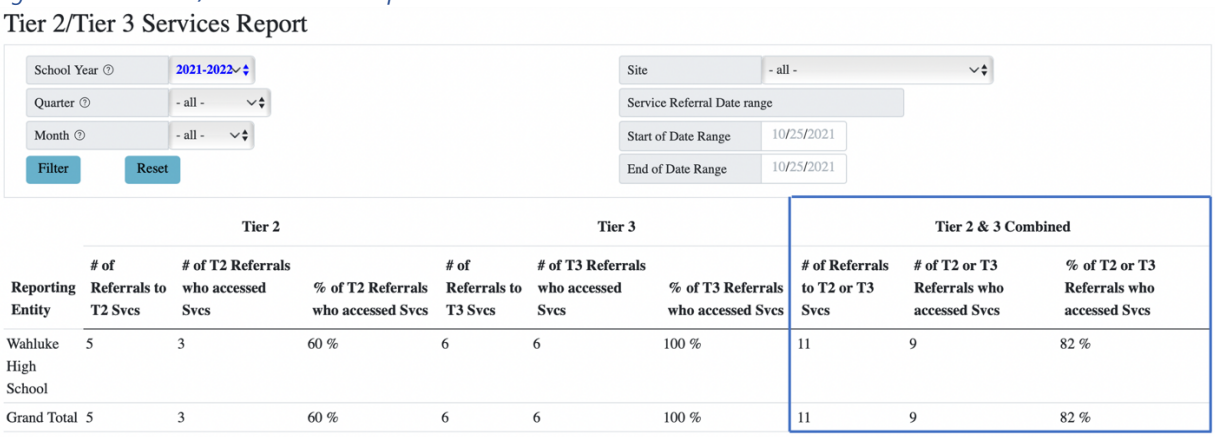


Figure 8: AWARE Mental Health Referral Determination



To support the LEAs in the tracking and progress monitoring of students referred to and engaged in mental health supports, the AWARE Data System (ADS) includes a student records component that mirrors the referral process outlined above. This platform will allow school-level MTSS teams to input data at each point in the referral process: referral to services, determination of need, referral to intervention(s), and due dates for when the NOMs must be completed based on intake date. This component of ADS will also assist the evaluation team in reporting required GPRA data during future reporting periods. Examples of these reporting features are displayed in Figures 9 and 10.

Figure 9: ADS Tier 2/Tier 3 Services Report



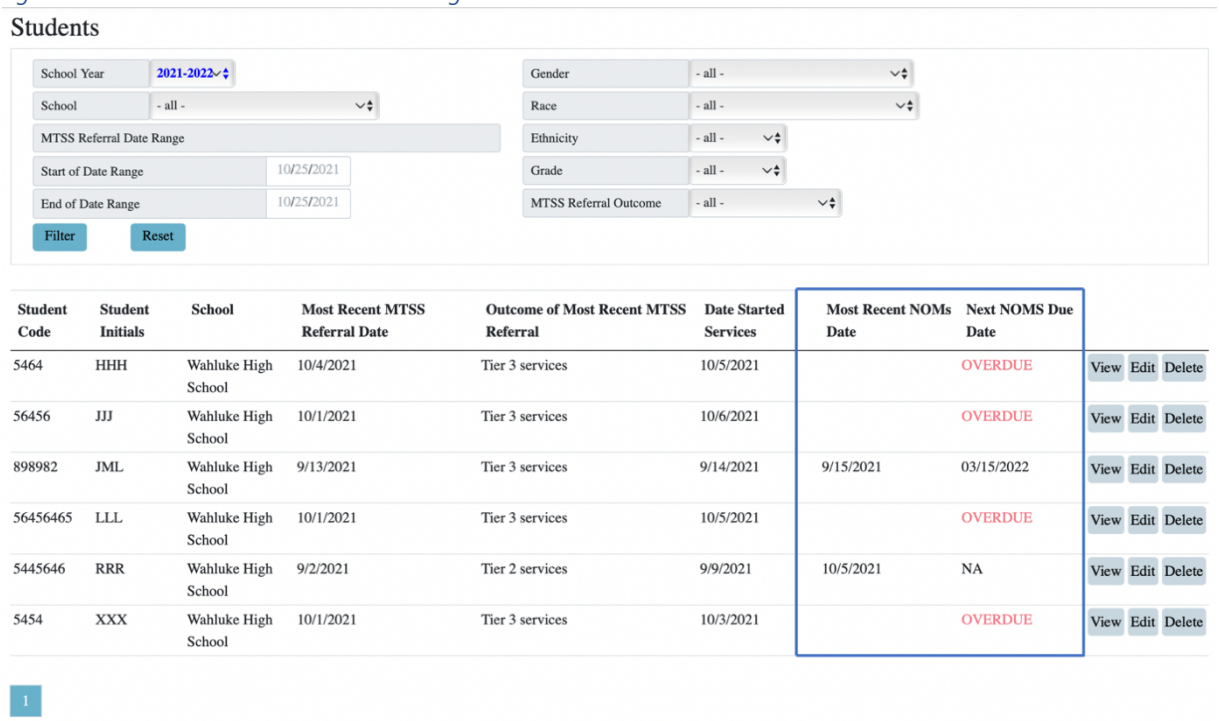
Tier 2/Tier 3 Services Report

School Year 2021-2022 | Site - all - | Quarter - all - | Service Referral Date range | Month - all - | Start of Date Range 10/25/2021 | Filter | Reset | End of Date Range 10/25/2021

	Tier 2			Tier 3			Tier 2 & 3 Combined		
Reporting Entity	# of Referrals to T2 Svcs	# of T2 Referrals who accessed Svcs	% of T2 Referrals who accessed Svcs	# of Referrals to T3 Svcs	# of T3 Referrals who accessed Svcs	% of T3 Referrals who accessed Svcs	# of Referrals to T2 or T3 Svcs	# of T2 or T3 Referrals who accessed Svcs	% of T2 or T3 Referrals who accessed Svcs
Wahluke High School	5	3	60 %	6	6	100 %	11	9	82 %
Grand Total	5	3	60 %	6	6	100 %	11	9	82 %

* Data are for display purposes only and are not reflective of actual project records.

*Figure 10: ADS Student-level NOMs Tracking**



Students

School Year 2021-2022 | Gender - all - | School - all - | Race - all - | MTSS Referral Date Range | Ethnicity - all - | Start of Date Range 10/25/2021 | Grade - all - | End of Date Range 10/25/2021 | MTSS Referral Outcome - all - | Filter | Reset

Student Code	Student Initials	School	Most Recent MTSS Referral Date	Outcome of Most Recent MTSS Referral	Date Started Services	Most Recent NOMs Date	Next NOMS Due Date	
5464	HHH	Wahluke High School	10/4/2021	Tier 3 services	10/5/2021		OVERDUE	View Edit Delete
56456	JJJ	Wahluke High School	10/1/2021	Tier 3 services	10/6/2021		OVERDUE	View Edit Delete
898982	JML	Wahluke High School	9/13/2021	Tier 3 services	9/14/2021	9/15/2021	03/15/2022	View Edit Delete
56456465	LLL	Wahluke High School	10/1/2021	Tier 3 services	10/5/2021		OVERDUE	View Edit Delete
5445646	RRR	Wahluke High School	9/2/2021	Tier 2 services	9/9/2021	10/5/2021	NA	View Edit Delete
5454	XXX	Wahluke High School	10/1/2021	Tier 3 services	10/3/2021		OVERDUE	View Edit Delete

1

* Data are for display purposes only and are not reflective of actual project records.

National Outcomes Measures (NOMs): As noted, to support data collection and reporting by LEA mental health service providers, the evaluation team developed a NOMs training aligned with the interview instrument. This training provides extensive information on how, when, and to whom the NOMs is administered as well as background information about its purpose. All LEA and project-related mental health providers have received this training, with booster sessions to be scheduled as needed.

Details regarding the number of students referred to and engaged in Tier 2 and Tier 3 mental health services during the reporting period can be found in the section: *Performance Measure Progress to Date* (see page 23).

As the LEAs continued to develop the direct-service infrastructure needed to provide school-based mental health services and supports to students, AWARE partner Educational Service District (ESD) 105 also completed the process of becoming a licensed treatment provider (see additional details in *Table 4: Policy Development, Detail* included in the next section). Through this new licensure, the ESD can directly hire licensed mental health clinicians to serve AWARE LEAs (and other districts within their region). In September 2021, the ESD partnered with the Yakima School District to onboard one new mental health provider that will be serving students in Washington and Franklin middle schools. A posting to fill this position for the other two middle schools in the district was still open at the time of this report.

As noted during the year-end interview, ESD 105 staff indicated that Project AWARE was the catalyst to licensure for the ESD as a treatment agency, which has fostered stronger partnerships and mentorships with other ESDs statewide. This funding opportunity has also prompted conversations about the current fee-for-services model and connected the ESD to regional Managed Care Organizations and the Health Care Authority to begin strategizing about a different billing model.

The Sunnyside and Wahluke school districts have also been successful in growing partnerships with community-based behavioral health agencies with the goal for these providers to be embedded in the school setting. For example, in partnership with the United Family Center, located in Grandview, WA, Sunnyside has contracted with the agency to provide four mental health professionals and two licensed substance use disorder specialists to work with students in six of their eight school buildings. The district has also revised its contract with Comprehensive Healthcare, another regional service provider, to increase the number of mental health specialists from one to three beginning in the 2021-2022 school year.

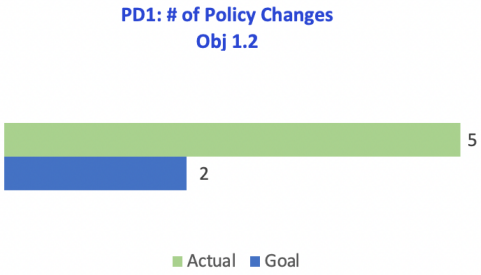
The Wahluke School district also is receiving support from the United Family Center, contracting with the agency to provide one mental health professional thus expanding support for students districtwide. The district is also in negotiations with Grant County Behavioral Health to potentially provide up to one full-time mental health professional to work directly at the school district. Currently, the agency provides services to referred students and families only in the community-setting.

4. PERFORMANCE MEASURE PROGRESS TO DATE

The following data reflect progress toward the required GRPA performance measure goals for the reporting period 10/1/20-9/30/21. The data shown represent project wide totals and include data from the three LEA sites and the SEA (inclusive of ESD 105).

Policy Development: *PD1 – The number of policy changes completed as a result of the grant. (Objective 1.2)*

Between January and September 2021, five policy changes were enacted by AWARE partners as a result of the grant, exceeding the Year One goal (two policy changes).



The details of these policy changes, by project partner and quarter, are displayed in the table below.

Table 4: Policy Development, Detail

Quarter	AWARE Site	Policy Title	Description of Policy
Q3 Mar-Jun	Sunnyside	School Board Mission & Vision	A formal presentation to the Sunnyside School Board introducing the district's newly created Vision and Mission of Project AWARE. This policy change was initiated in January 2021 and completed in April 2021.
Q4 Jul-Sep	ESD 105	Together 105 *Administrative* Policy and Procedure	Full administrative policy and procedure developed and adopted for new Together 105 Treatment Services. This policy change was initiated in May 2021 and completed in August 2021.
	ESD 105	Together 105 *Clinical* Policy and Procedure	New clinical policy and procedure developed and adopted for Together 105 Treatment Services. This policy change was initiated in May 2021 and completed in August 2021.
	ESD 105	Together 105 *Personnel* Policy and Procedure	New personnel policy and procedure developed and adopted for Together 105 Treatment Services. This policy change was initiated in May 2021 and completed in August 2021.
	ESD 105	Together 105 *Telehealth* Policy and Procedure	New telehealth policy and procedure developed and adopted for Together 105 Treatment Services. This policy change was initiated in May 2021 and completed in August 2021.
OVERALL POLICY CHANGE TOTAL: 5			

In a continuation of the Washington FY 2014 Project AWARE grant, OSPI has committed funding to enable several ESDs (101,105,112, and 189) to become licensed providers of direct-treatment mental health services. This initiative derives from the FY 2014 grant's collaboration with ESD

113 to develop a feasible model for providing mental health prevention, intervention, and treatment services. The work was further refined through a pilot project funded by AWARE and was highlighted as a promising practice. As a result, OSPI prioritized use of ESSER funds towards this model in 2021. Because of this initial work, ESD 105, with direct impact on the three LEA's associated with FY 2020 AWARE, has been supported in the licensing process as a direct result of the grant.

In 2019, the Washington State Auditor's Office initiated a comprehensive audit of K-12 student behavioral health in Washington. This audit sought to understand Washington students' access to needed supports and services, focusing on two major areas: (1) How public K-12 school districts are addressing student behavioral health via prevention and early intervention, and (2) the larger state system in place to coordinate and support these services. The findings of the audit align with Project AWARE's goals to provide a seamless continuum of supports related to mental health prevention, intervention, and treatment in educational settings. This audit reinvigorated interest in a key policy strategy proposed by OSPI as a part of FY 2014 Project AWARE: an innovative Medicaid waiver that would significantly improve access to mental health services for all students in Washington. This work continues through FY 2020 AWARE as well.

Preliminary discussions have begun concerning a possible rule change for Washington State regarding the allowance of mental health excused absences. The AWARE project manager, along with other OSPI staff, State Representatives Callan and Johnson, the Legislative Youth Advisory Council, and other youth have come to the table with an interest in allowing behavioral health issues as excused absences. The many benefits the group foresees are decreasing stigma, creating additional data collection opportunities, and establishing specific directives on what constitutes excusable absences pertaining to behavioral, emotional, and mental health needs in students. These benefits were identified by the key stakeholders in Oregon who oversaw the process of their own law change around mental health excused absences, which went into effect in 2019. Work continues in Washington for this policy change to go into effect during the grant period.

Partnership/Collaboration: *PC1 – The number of organizations that entered into formal written inter/intra-organizational agreements (e.g., MOUs/MOAs) to improve mental health-related practices/activities that are consistent with the goals of the grant. (Objective 3.4)*

Between January and September 2021, 11 partnership agreements were put into place to improve mental health-related practices among AWARE project partners as a result of the grant. This included 10 new partnership agreements and one revised agreement. Overall, the project met and exceeded the Year One goal of enacting five such agreements. The details of these agreements, by project site and quarter, are displayed in the table below.

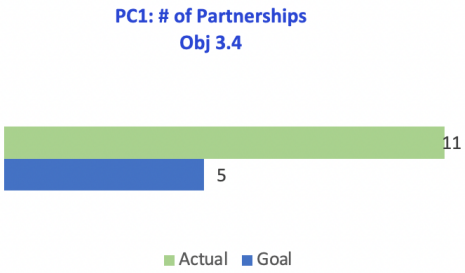
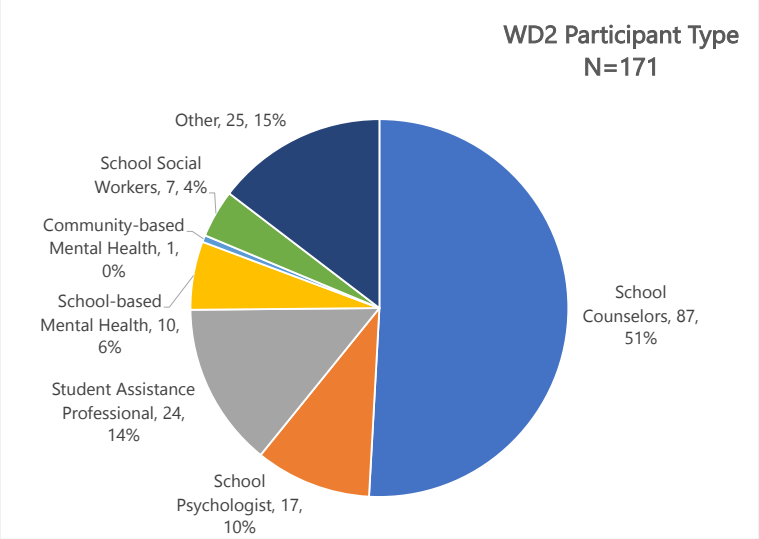


Table 5: Partnership/Collaboration, Detail

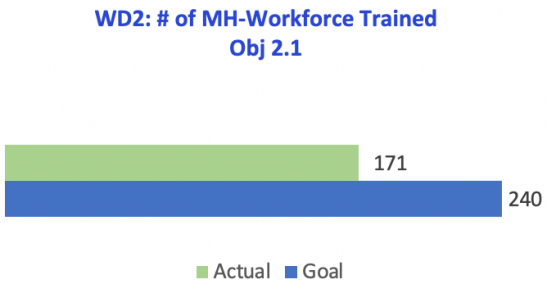
Quarter	AWARE Site	Partner Entity	Description of Agreement
Q2 Jan-Mar	Sunnyside	Comprehensive Healthcare	Increased the number of mental health providers contracted with the district from one to three
	Wahluke	Maike & Associates	Data sharing agreement with Maike & Associates
	Yakima	Maike & Associates	Data sharing agreement with Maike & Associates
	Sunnyside	Maike & Associates	Data sharing agreement with Maike & Associates
	OSPI	WA Healthcare Authority	To work in collaboration to help reduce barriers amongst the LEAs
	ESD 105	ESD 113: True North	Policy sharing and mentorship agreement established with Capital Region ESD 113: True North Student Assistance and Treatment Services for coaching and support in development of treatment policy and procedure, licensure application
Q4 Jul-Sep	Sunnyside	United Family Center	SSD has entered into an agreement to provide MHPs and Student Assistance Professionals through December 2021. At that time, we will evaluate our progress and create a new contract if needed.
	ESD 105	Yakima School District	Partnership established for placement of 2 school based mental health professionals supervised under ESD 105's licensure in middle schools in the Yakima School District
	ESD 105	Yakima Valley Farmworkers Clinic	Agreement regarding coordination of care for youth needing community-based substance use or mental health treatment services.
	ESD 105	Zoom, Inc.	Telehealth Delivery Platform: Business Associate Agreement established between Zoom and ESD 105/Together 105 to ensure HIPPA compliant platform for delivery of services on a virtual platform.
	ESD 105	Sigmund Software	Contract established with Sigmund Software for creation and maintenance of an electronic health record for all services delivered through ESD 105/Together 105.
OVERALL MOU/MOA CHANGE TOTAL: 11			

Workforce Development: *WD2 – The number of people in the mental health and related workforce trained in mental health-related practices/activities that are consistent with the goals of the grant. (Objective 2.1)*

Between January and September 2021, the project hosted 23 workforce development trainings, reaching a total of 171 individuals in the mental health workforce. The majority of those trained were school counselors (51%), followed by Student Assistance Professionals (14%) and school psychologists (10%). Other participants included mental health providers and school nurses.



Topical areas included mental health promotion (9), suicide prevention (3), treatment (1), and 8 "other" offerings such as adult self-care strategies, and selected Tier 2 and Tier 3 evidence-based practices. The details of these trainings are displayed in the table below.



Overall, the project made considerable strides toward the established Year One goal to train 240 individuals within the mental health workforce; however, fell short of meeting the objective reaching 71% of the target.

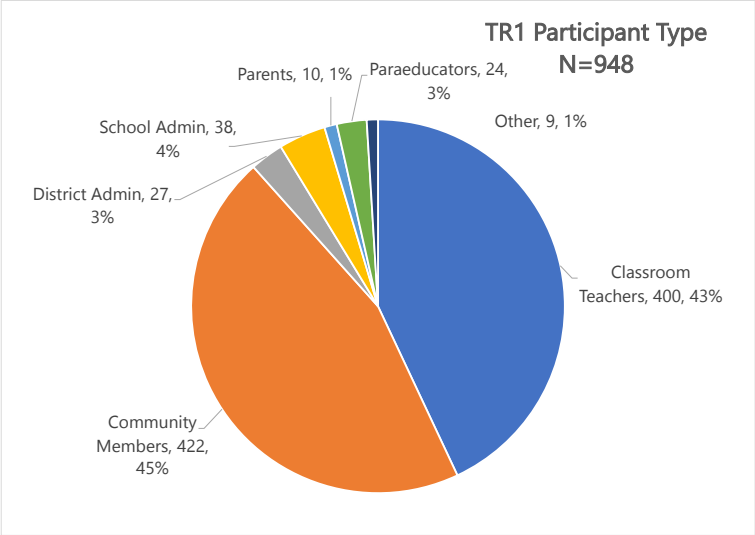
Table 6: Workforce Development Training, Detail

Quarter	AWARE Site	Training Description
Q2 Jan-Mar	Wahluke	Building PBIS teams completed Tier II training. This included training on the SRSS-IE screener and how to implement Tier 2 services from its information. A menu of Tier 2 interventions was presented that can be used to support students. Once interventions were explained, the team learned how to progress monitor them and what building-level team meetings should look like to be most effective.
	Wahluke	Two licensed individuals were trained by the Project AWARE Evaluation Team on how to administer SAMHSA's NOMs instrument for youth receiving Tier 3 services.
	Wahluke	Eight school counselors in the Wahluke School District participated in the annual WA School Counselor Association (WSCA) conference. Workshops covered multiple aspects of mental health promotion and prevention.
	Wahluke	Eight school counselors in the Wahluke School District participated in an 8-hour Youth Mental Health First Aid Training.

Quarter	AWARE Site	Training Description
	Yakima	28 individuals in the Yakima School District were trained in the mental health promotion/suicide prevention program, QPR - Question. Persuade. Refer.
Q3 Mar-Jun	Sunnyside	The evaluation team provided training on SAMHSA's NOMs instrument to one newly hired mental health professional and two support staff in the Sunnyside School District.
	Wahluke	12 school counselors were trained in the NowPow system for mental health referrals and screening. NowPow is a closed-loop community referral platform.
	Wahluke	One district counselor participated in a Suicide Risk for Hispanic Youth training on identifying suicide risk among young people, recognizing trends in suicide, and highlighting culturally specific risks.
Q4 Jul-Sep	SEA -ESD 105 CoIIN	Initial meeting to engage Ellensburg Care Corps team in CoIIN grant participation to develop mental health capacity in the Ellensburg School District.
	SEA - ESD 105 CoIIN	Training Ellensburg Care Corps team about confidentiality laws, how they apply to school based services, and successful teaming.
	SEA - OSPI CoIIN	Training CoIIN participating districts on goals of the CoIIN grant, how it supports school based mental health capacity building, grant expectations and deliverables.
	ESD 105	Question Persuade Refer suicide prevention training delivered to all Student Assistance Professionals and School Based Mental Health Professionals in the ESD 105 Service Region.
	ESD 105	ESD 105 staff trained to deliver Question. Persuade. Refer. Gatekeeper training
	ESD 105	ESD 105 staff trained to deliver Youth Mental Health First Aid training
	Sunnyside	Basic information offered to school staff including definition of terms, use of person first language, current Sunnyside data, most common disorders in young people, and a brief explanation of trauma informed schools. Provided by ESD 105. **(3 trainings)**
	Yakima	Refilling Our Cup: Beyond Self Care to Supportive Systems. Training about staff wellness from an MTSS framework that integrates systems level supports for staff wellness along with individual level wellness promotion activities and external resources.
	Yakima	Training Student Assistance professionals and school based mental health providers placed in the Yakima School District in the use of TRAILS, an evidence based mental health promotion education series.
	Yakima	Youth Mental Health First Aid training. Provided by ESD 105 **(4 trainings)**
OVERALL WORKFORCE DEVELOPMENT TRAININGS TOTAL: 23		

Training: *TR1 – The number of individuals who have received training in prevention or mental health. (Objective 2.2)*

Between January and September 2021, the project hosted 20 non-workforce development trainings, reaching a total of 945 individuals. The two largest groups of participants were community members (45%) and classroom teachers (43%).



Topical areas included mental health promotion (9), prevention (7), suicide prevention (2), and screening and assessment tools for building administrators (2). The details of these trainings, by quarter and project site, are displayed in the table below.

Findings indicate that the project met and exceeded the overall Year One goal to train 295 non-workforce related individuals in prevention and mental health.

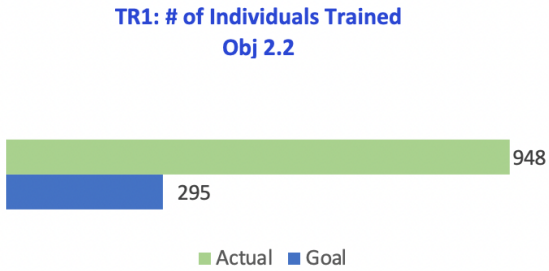


Table 7: Prevention and Mental Health Training, Detail

Quarter	AWARE Site	Training Description
Q2 Jan-Mar	Wahluke	Building PBIS teams completed Tier 2 training to understand how a student became in need of Tier 2 services. This included training on the SRSS-IE screener and how to implement Tier 2 services from its information. Once interventions were explained, the team learned how to progress monitor them and what building-level team meetings should look like to be most effective. These teams included 18 non-MH workforce staff, including PBIS specialists, school admins and other school staff.
	Sunnyside	Online prevention training focused on social, emotional leaning and *empathy*. 121 community members participated.
	Sunnyside	Online prevention training focused on social-emotional leaning and *self-awareness*. 92 community members participated in this training.
	Sunnyside	Online prevention training focused on social-emotional leaning and *self-management*. 56 community members participated in this training.
	Sunnyside	Online prevention training focused on social-emotional leaning and *social awareness*. 50 community members participated in this training.
Q3 Apr-Jun	Sunnyside	Online prevention training focused on social-emotional learning and *responsible decision-making*. 40 community members participated in this training.
	Sunnyside	Online prevention training focused on social emotional learning and *relationship skills*. 60 community members participated in this training.
	Sunnyside	ESD 105 provided a Youth Mental Health First Aid training to 8 district administrators.

Quarter	AWARE Site	Training Description
	Wahluke	Wahluke School District provided a Spanish language Question. Persuade. Refer. (QPR) (Entrenamieno Para Adultos- Preguntar Persuadir Referir) training for three parents in the school district.
	Yakima	ESD 105 provided a Spanish language Question. Persuade Refer. (QPR) training in the Yakima School District. 2 parents, 2 community members, and one other non-MH related school staff member participated.
Q4 Jul-Sep	Sunnyside	School Administrators learned how to construct a Social-Emotional Screener Survey in the Panorama tool and why and how it will be important data for our work.
	Sunnyside	Basic information offered to school staff including definition of terms, use of person first language, current Sunnyside data, most common disorders in young people, and a brief explanation of trauma informed schools. Provided by ESD 105. **(3 trainings)**
	SEA - OSPI CoIIN Learning Session	Ellensburg, Highland, Wahluke and Yakima took part in training around data support. This included: creating PDSAs around their SHAPE results, how to complete and analyze the SHAPE, and teaming and infrastructure requirements. It also included: monthly data collection cycles including mental health screening, student functioning, chronic absence, eligible students, enrolled students and how to create and align small scale goals to encourage innovation at a rapid pace for the year.
	Yakima	ESD 105 provided English Language QPR Training for Yakima Parents
	Yakima	ESD 105 provided YMHFA Training for staff in Yakima **(4 trainings)**
OVERALL NON-WORKFORCE RELATED PREVENTION & MENTAL HEALTH TRAININGS TOTAL: 20		

Referral: *R1 – The number of individuals referred to mental health or related services. (Objective 3.5)*

Between March 1 – June 30, 2021, 346 students were referred to Tier 2 or Tier 3 services, including 265 (77%) from Sunnyside School district, 21 (6%) from Wahluke School district, and 60 (17%) from the Yakima School district.

Table 8: Number of Youth Referred to Tier 2 or Tier 3 Services, Jan 2021 – Sep 2021

District	Q1 Oct-Dec	Q2 Jan-Mar	Q3-Apr-Jun	Q4 – Jul-Sep	Total
Sunnyside	N/A	213	0	52	**265**
Wahluke	N/A	3	7	11	**21**
Yakima	N/A	0	0	60	**60**
Total	**N/A**	**216**	**7**	**123**	**346**

Overall, the project fell short of reaching its year-one target to refer 1,265 students, project wide, to Tier 2 or Tier 3 services.

Access: AC1 – *The number and percentage of individuals receiving mental health or related services after referral. (Objective 3.6)*

Of the 346 youth referred to services, nearly all (341 or 99%) were reported as engaging in services.

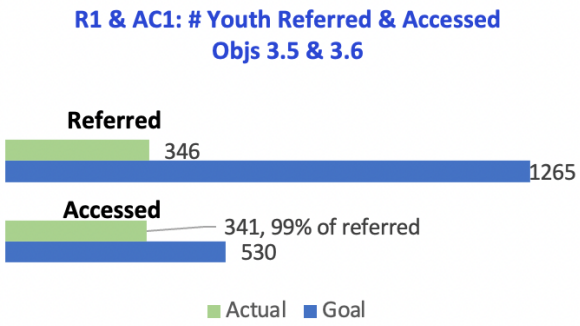


Table 9: Number of Youth Engaged in Tier 2 or Tier 3 Services, Oct 2020 – Sep 2021

District	Q1 Oct-Dec	Q2 Jan-Mar	Q3-Apr-Jun	Q4 Jul-Sep	Total
Sunnyside	N/A	213	0	52	**265**
Wahluke	N/A	0	5	11	**16**
Yakima	N/A	0	0	60	**60**
Total	**N/A**	**213**	**5**	**123**	**341**

Although the project fell short of reaching its year one target of 530 students accessing Tier 2 or Tier 3 services, the percentage of those youth who engaged in services exceeded the targeted expectation of 42%.

Due to the delay in the startup of direct services only limited student-level supports were provided during the initial project period. It is anticipated that the project will meet referral and access targets in the upcoming year as the direct service components are fully in place.

5. PROJECT CHANGES

The most significant change during the reporting period was the finalization of project level objectives associated with the three broad project goals, thus replacing those identified in the submitted grant narrative. As noted in Section 2. Startup & Implementation Activities, the development of the performance assessment plan, project logic model and review of behavioral health assessment data provided project partners with a better understanding of project needs and were driving factors in the development of the final project objectives.

Below are the project goals, each with a set of updated SMART objectives.

Goal 1) Increase awareness of mental health issues among school-aged youth through the development, implementation, and sustainability of a comprehensive school-based system of mental health services and supports.

1.1 Implement and sustain an integrated multi-tiered system of support framework with fidelity across all three LEA districts, in 80% of targeted schools by the end of the grant period (September 2025).

1.2 Implement two (2) policy changes as a result of the grant by the end of Year 1; implement three (3) policy changes annually in Years 2-5 for a total of 14 policy changes by the end of the grant period (September 2025). ***(PD1)***

1.3 Improve inclusion of student and family voice in decisions about program services and policies by project end (September 2025) as compared to baseline (Spring 2021).

Goal 2: Train school personnel and other adults who interact with school-aged youth to detect and respond to mental health issues.

2.1 Enhance professional development opportunities to increase knowledge/skills of staff working with students by training 240 people in the mental health and related workforce in mental health-related practices/activities that are consistent with the goals of the grant by the end of year 1; and training 335 people annually in years 2-5 for a total of 1,580 people trained by September 29, 2025. ***(WD2)***

2.2 Train 295 individuals (*not* in the mental health and related workforce) in prevention or mental health promotion by the end of year 1; train between 530 and 680 people in years 2-5 for a total of 2,715 individuals trained by the end of the grant period (September 2025) ***(TR1)***

2.3 Increase mental health literacy among school staff and other adults as reported by 75% of training participants by the end of Year 3 as compared to baseline (Spring 2021).

2.4 Reduce disproportionality of discipline practices among LEA sites as compared to baseline (Spring 2021) by project end.

Goal 3: Connect school-aged youth who may have behavioral health issues and their families to needed services.

3.1 Improve coordination of care across systems – education and behavioral health – by 75% as compared to baseline (Spring 2021) by project end (September 2025) as reported of key partners.

3.2 Improve access to culturally and linguistically responsive services, supports, and workforce by 50% by project end (September 2025) as compared to baseline (Spring 2021).

3.3 Enhance community partnerships to improve systems of care for youth and families by Year 3 (September 2023), and thereafter, as compared to baseline (Spring 2021).

3.4 Execute formal written inter/intra-organizational agreements (e.g., MOUs/MOAs) to improve mental health-related practices/activities that are consistent with the goals of the grant with 8 unique organizations by the end of Year 2. ***(PC1)***

3.5 Increase referrals to school-based mental health services, with approximately 5% of students in the schools of focus referred to mental health or related services (Tier 2 and 3) by the end of Year 1; refer approximately 10% annually in years 2 & 3 and approximately 15% annually in years 4 & 5. ***(R1)***

3.6 In Year 1, 42% of students who were referred to mental health or related services (Tier 2 or 3, 3.5 above) will receive those services; Year 2: 55%, Year 3: 63%, Year 4: 70%, Year 5: 78%. ***(AC1)***

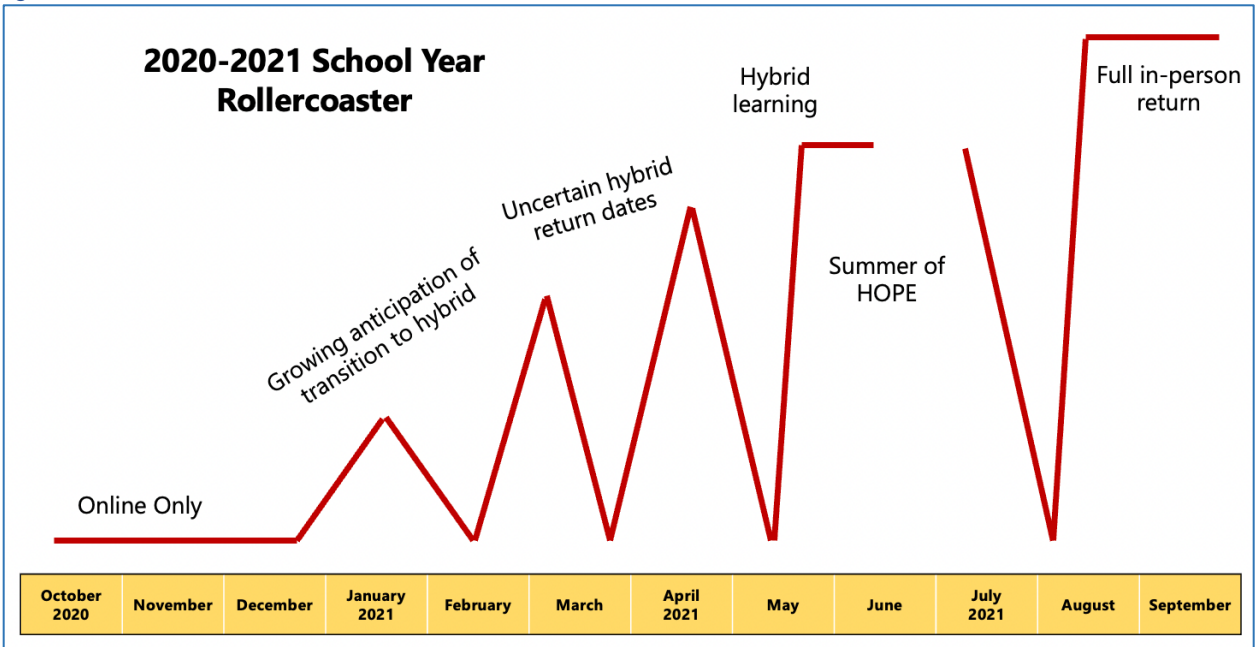
~~3.7 Annually, improve behavioral functioning among 50% of students engaged in Tier 3 services and supports as compared to baseline.~~ Note: Project partners voted to delay action on this objective until the start of the 2022-2023 school year.

3.8 Annually, improve social connectedness among 50% of students engaged in Tier 3 services and supports as compared to baseline.

6. PROJECT BARRIERS AND ACTIONS TAKEN

Not surprisingly, the largest barriers to navigate for all project partners have been those associated with the ongoing COVID-19 pandemic. During initial project launch, all Washington school districts were operating virtually. Throughout the spring, some districts began to phase into a hybrid learning model, and by the start of the 2021-2022 school year, all had returned to a full-time in-person teaching and learning model. Needless to say, districts, schools, and their staff continue to experience immense challenges. Districts and schools are constantly transitioning to adapt to the health and safety requirements brought on by the pandemic while also focused on meeting the social-emotional and academic needs of their students.

Figure 11: 2020-2021 School Year Rollercoaster - Visualization



Designed by Maike & Associates, LLC

Activities and strategies that may have been smoother or more quickly adopted in a more personal setting and with structures that were familiar to key players were not available to us during this launch. As a result, we had to learn new systems and different ways of being present and engaging partners. We had to build cooperative systems that didn't leave room for silos.

The deep stress all key players were subjected to while also staying connected to the important work of AWARE was something we had to acknowledge and hold space and empathy for as we developed the foundation of AWARE. This stress left capacity gaps at the LEA level key players needed to adjust to.

However, considering the scope of struggles nationally, we deem these slight offsets of goals as reasonable and are proud of the adjustments and good work individuals have done in face of their hardships.

The following are brief excerpts from year-end interviews with project partners as they reflected on the impact of the pandemic during year end interviews:

> *"The pandemic continues to create roadblocks for work that we want and need to do in person."*
>
> *"Our schools are in crisis. I am continuing to navigate how AWARE can be the most beneficial impact to schools in distress rather than deliverables that need to be checked off and therefore do not remain sustainable."*
>
> *"COVID made it slower and harder to figure out. Having this grant and all the other changes in the district has been hard. It takes so long to lay the groundwork. As leaders, having to learn how to do this – how to lead. It was hard to align everyone on where we're at. There is not enough time in the day to do all the work. A big challenge has been being clear and concise about all of the different initiatives, how they are different, and how they work together (e.g., AWARE, SCT, CoIIN)."*

Another challenge the project is facing is high staff and leadership turnover at both the building and district levels, as well as a limited mental health workforce pool. While transition and staff shortages may very well be exacerbated by the ongoing turmoil of the pandemic, Washington State has long faced a shortage of qualified mental health staff, particularly those willing to work within the school-system or in rural areas of the state. While the project was recently successful in partnering with a local behavioral health provider to support two of the grant LEAs, the broader shortage remains, as noted by this LEA partner:

"Our district has quite the staff shortage."

> *"A challenge has been placement of a mental health professional in two of our middle schools. We have interviewed four people, and processed many more applications than this, but we have not had a candidate that has the experience and skills that these schools would like to see."*

The SEA Core team continues to collaborate with other statewide partners to find potential long-term solutions to the workforce issues. These have included conversations around shifting billing options, increasing wages for those in the field, and modifying training requirements to allow staff to provide some level of services as they work toward full licensure.

7. THE PATH FORWARD – NEXT STEPS

This last section provides a brief synopsis of work AWARE partners are most looking forward to in the 2021-2022 project period, as reported during year-end interviews.

SEA Lead: *Short-term* – As schools add many new beneficial mental health implementations, AWARE must support these individual endeavors in being unified into a genuine school- based mental health system, rather than leaving them fragmented and disjointed. How can schools be better supported to share their mental health supports with the community, as well as results and next steps from the community assessment? How can Hispanic and Latinx students be

made to feel more comfortable reaching out for and receiving mental health services? How do you support a tiered structure when so many students have so many needs therefore making Tier 1 very important, and very heavy?

Long term - Educator and staff wellness and burnout is top of mind. Well-being, secondary trauma and burn-out are being discussed to *"make it systemic rather than one time pizza party or meditation."* Would like to see LEAs take on Interconnected Systems Framework (ISF) work so the positions and changes are sustainable after the AWARE grant ends.

Sunnyside Lead: *Short-term* – In October, the district will launch the SEL community series; analyze and share our Panorama data in order to determine needs in schools; create the ongoing training plan for school employees; provide crisis response and confidentiality training to school counseling staff; provide mental health awareness training to our para-educators.

Long term – All 8 schools have articulated tiers of supports, with MTSS teams up and running. *"We want to see teaming structures in place with the MH Specialists involved. Looking forward to the ability to track referrals and use data for decision-making."*

Wahluke Lead: *Short-term* – Parent surveys will be given at conferences in September plática events (parent information livestreams) to improve inclusion of parent voice. Teams will write mission and vision statements and goals for the year.

Long term- Tier 3 services. Having a referral process that is in place to track students. *"Having a replicable referral process – if we left tomorrow, the system would still carry-on. That's the goal. We really want to see the system in place."*

Yakima Lead: *Short-term* - Organizing Tier 2 menu of interventions with clearly articulated entry and exit criteria.

Long term- Tying AWARE to the current system and having a strong universal design. *"Defining our advanced tiered support system and clearly know what it looks like, and how it operates."*

ESD 105 Lead: *Short-term:* To change the system in the state and continue those conversations that started this year to build a model with the Managed Care Organizations (MCOs) at the region-level. *"Fee-for-service is a recipe for burnout. The desire to partner is there within our region and we should be able to create change across the state – not just for kids but for everyone."* (Note: staff recognize this will take more than a year to accomplish).

Long term: The ESD is a licensed behavioral health provided that has contracts in place with MCOs, and the three AWARE LEA sites are fully staffed with behavioral health professionals.

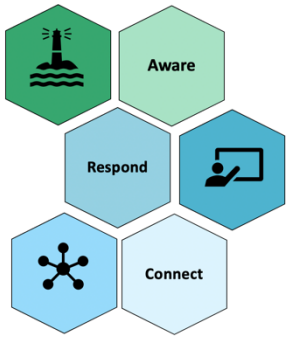
APPENDICES (attached)

Appendix A: Behavioral health Disparities Impact Statement

Appendix B: Performance Assessment Plan

Appendix C: Final AWARE Project Logic Model

Appendix D-F: LEA Community Assessments



WASHINGTON STATE PROJECT AWARE

GRANT NUMBER 1H79SM083653

BEHAVIORAL HEALTH

DISPARITY IMPACT STATEMENT

INTRODUCTION

In the 2021 Mental Health America report, Washington ranks among the lowest states regarding access to care for youth mental health.[1] Statewide data show that accessibility for mental health, and over all behavioral health services, are disproportionally limited among people of color, people living in poverty, and people living in rural locations in Washington. The population of Washington is 69.3% White, 12.4% Hispanic, 3.7% African American and 8.11% Asian. Almost one in five Washingtonians (19.3%) speak a language other than English. [2]

In contrast, the local educational agencies (LEAs) that the Washington Office of Superintendent of Public Instruction (OSPI) selected for Project AWARE FY-2020, are more diverse than the state as a whole and demonstrate our intent to serve communities of color (specifically Hispanic/Latinx), low income, and rural populations. These three LEAs have high vulnerability to barriers in accessing mental health supports. Moreover, the LEAs reflect significant need and readiness to benefit from implementation of Project AWARE services and supports. These districts are located in the central region of Washington known as the Yakima Valley and include Sunnyside School District, Wahluke School District and Yakima School District.

Below we provide a brief summary of these districts at time of project implementation.

Location 1: Sunnyside School District

Sunnyside School District is in Sunnyside, Washington. The district is comprised of five elementary schools (grades Pre-K-5), two middle schools (grades 6-8 grade), and one high school (grades 9-12). At the beginning of the school year 2020-2021, there were 6,723 students enrolled in the district (down from 6,805 in school year 2019-20). Of the student body, 49% identified as female and 92.7% identified as Hispanic/Latinx of any race, while 72% of teachers are female, 62.3% identify as white, and 35.4% identify as Hispanic/Latinx of any race. Over two-thirds of students (68% or 4,564 individuals) identified as low income, 29.4% as English Language Learners, and 14% as having disabilities.

[1] Source: https://www.mhanational.org/issues/2021/mental-health-america-youth-data
[2] Source: https://www.cha.wa.gov/demographics

During the 2018-19 school year,[3] 686 or 9.7% of the 7,073 students enrolled in Sunnyside School District received a short-term suspension, long-term suspension, emergency expulsion, or expulsion for a discipline related incident (up from 6.5% in the 2017-2018 school year). The discipline rate is highest among 7th (19.4%), 8th (18.4%), 9th (19.2%) and 10th (18.9%) grade students. Based on student characteristics, those who are English Language Learners, in foster care, homeless, low income, migrant or who have disabilities are excluded for behavioral violations at higher rates than those who do not meet these characteristics.

In addition to regular school staff positions, the district has supported several behavioral health focused Student Assistance Professionals (SAP) that provide prevention and intervention services at the Tier 1 and Tier 2 levels specific to identified or suspected behavioral health issues. One SAP is shared between the two middle schools (Harrison Middle School, population 946 and Sierra Vista Middle School, population 749). The district has one locally funded SAP who works with youth at risk of or involved with gangs. Additionally, there is one SAP at Sunnyside High School (grades 9-12, population 2,129).

We highlight these district-level positions as evidence of the Sunnyside School District's commitment to improving the behavioral health supports to students, and that tiered and integrated systems are beginning to take shape. Project AWARE will grow upon this system by blending Tier 3 direct services, and by strengthening universal (Tier 1) supports.

Location 2: Wahluke School District

Wahluke School District is in Mattawa, Washington. In the 2020-2021 school year, the district enrollment is 2,561students. Of these students, 48% identify as female. The majority of the student body at Wahluke identify as Hispanic/Latinx (97%) and as low income (94.5%). Slightly half of the students are English Learners (49.4%) while just over half are migrant (51%). Overall, 12.4% identify as students with disabilities. The majority of teachers identify as female (69%) and white 76%.

During the 2018-19 school year, 149 students or 5.8% of the 2,578 students enrolled in the district received a suspension or expulsion for a discipline related incident. Data indicate that students with disabilities are suspended at a higher rate than those without disabilities (10.7% vs. 5.0%). The rate of students suspended or excluded vary just slightly between Non-English Learners (6.4%) and English Learners (5.3%), housed (5.8%) and houseless (5.5%), non-low income (7%) and low income (5.6%), and non-migrant (6.3%) and migrant (5.2%).

[3] Due to the impact on discipline data for the 2019-20 school year as a result of the close of all in-person instruction in Washington State schools because of COVID-19 mid-March 2020, we are using the complete dataset from the 2018-19 school year as our baseline for these districts. More information related to COVID-19 data impact is available at https://washingtonstatereportcard.ospi.k12.wa.us/.

The district serves Pre-K-12th grade students in three elementary buildings (PK-6th), one junior high school (grades 6-8), a comprehensive high school (grades 9-12), and one alternative school (grades 7-12). Presently, the district has one SAP to support the implementation of Tier 2 Prevention-Intervention services at the junior high (population 466), the high school (population 510) and the alternative school, Sentinel Tech (population 35). The SAP serves three (3) days a week at the junior high and two (2) days a week at the high school unless there is an emerging situation that must be attended to at one of the other buildings. This position integrates the school and community efforts by participating in both the community coalition and the youth coalition.

Location 3: Yakima School District

Yakima county's population in 2019 was 250,873 and the Hispanic/Latinx population of any race was just above half, at 50.2%, according to the U.S. Census Bureau. The City of Yakima is the county seat and Yakima School District is among the largest districts in the region serving 15,883 students K-12 in the 2020-2021 school year. Nearly half of the student body identifies as female (49.4%) and 80% of students identify as Hispanic/Latinx of any race. Among students, 78.6% identify as low income and 30% as English Learners. Furthermore, 13.9% of students identify as having disabilities and 9.0% as migrant. The majority of teachers identify as female (70%) and white (72%).

During the 2018-19 school year, 7.8% of students districtwide were excluded in response to a behavioral violation. Across ethnic/racial groups, 18.6% of the Black/African American, 15.2% of the American Indian/Alaskan Native, 7.3% of the Hispanic/Latinx and 8.5% of white students enrolled in Yakima School District received a suspension or expulsion for a discipline related incident. Of the youth on foster care, 21.3% were excluded in response to a behavioral violation (compared to 7.6% of those not in foster care); while 18.5% of students in section 504 (compared to 7.4% of those not in section 504) were suspended or excluded. Disciplinary sanctions are also higher for students who are houseless vs. housed (12.8% vs. 7.6%), low income vs. not low income (8.6% vs. 4.4%), and with disabilities vs. not (11.6% vs. 7.2%).

The district is comprised of 13 elementary schools, four middle schools and two comprehensive high schools. The district also serves students at the Juvenile Detention Center, the Yakima Adult Jail, one alternative school, and an online school. Presently, Yakima has one SAP that serves youth at A.C. Davis High School (grades 9-12, population 2,206). The Student Assistance Professional delivers the Prevention Ed series to the 9th grade health classes and provides Spanish-language Strengthening Families. Additional connections exist with the Safe Yakima YOUTH coalition and the A.C. Davis CCAN (Caring, Compassionate, Aspiring Navigators) Prevention club.

In the following section, we outline our response for how best to ensure that Project AWARE services meet the needs of the diverse population and sub-groups within these LEA sites.

1. **Proposed number of individuals to be served in the grant service area, with information also provided about specific by subpopulations.**

The table below reflects the proposed number of individuals to be served during the grant period (October 1, 2020 – September 29, 2025) and all identified subpopulations in the grant service area. The disparate populations are identified in the narrative below.

Table 1: Direct Service Estimates by Project Year and Overall

SERVICES	Year 1 (9/30/2020-9/29/2021)	Year 2 (9/30/2021-9/29/2022)	Year 3 (9/30/2022-9/29/2023)	Year 4 (9/30/2023-9/29/2024)	Year 5 (9/30/2024-9/29/2025)	Cumulative*
Advancing Wellness and Resiliency in Education (9/30/2020-9/29/2025)	90	235	380	485	610	1,288*

Note: For the purpose of this measure, "services" are defined as those students who qualify for, and are engaged in, Tier 3 intervention/treatment, thus requiring administration of the NOMs tool. *Cumulative Goal: This is the unduplicated goal of all consumers for the total grant period. This is different than adding up all the annual goals of each grant year since that figure may contain duplicate consumers. *Assumes approximately 70% of students are unduplicated years 2-5 (e.g., 30% were previously served), and in Year 1 all are unduplicated counts.*

Table 2: Student Enrollment Demographics by LEA Site (2020-2021)

	Sunnyside	Wahluke	Yakima	AWARE Total
Student Enrollment 2020-2021	6,723	2,561	15,883	**25,167**
By Race & Ethnicity				
Black/African American	13	2	83	98
American Indian/Alaskan Native	5	11	149	165
Asian	4	0	57	61
White (Non-Hispanic)	417	56	2,475	2,948
Hispanic/Latinx	6,232	2,487	12,713	21,432
Native Hawaiian/Other Pacific Is.	0	1	12	13
Two or More Races	52	4	394	450
Total	*6,723*	*2,561*	*15,883*	*25,167*
By Gender				
Female	3,294	1,223	7,844	12,361
Male	3,429	1,338	8,038	12,805
Gender Non-Conforming	*	*	1	1
Total	*6,723*	*2,561*	*15,883*	*25,167*

* Data related to sexuality and primary language were not included in the WA OSPI Diversity Report.

Although data related to specific sub-groups is not available, throughout the project we will collect and report data to ensure a lens of equity and inclusion by disaggregating data by sub-populations, as appropriate. Disaggregated data more precisely describe the racial/ethnic makeup of communities.[4] When possible, we will also note intersectionalities, or how multiple

[4] Source: https://nces.ed.gov/pubs2017/NFES2017017.pdf

identities together shape how a person experiences oppression or privilege. Considering intersections helps think how the multiple identities of a Latina, low-income female migrant student, for example, intensify conditions of power, privilege or oppression in that student's life. In this manner, we can identify any disparate trends and make programmatic changes to reduce disparate impacts and improve positive outcomes for all students as outlined below.

2. Quality Improvement Plan Using Our Data

Services and activities will be designed and implemented in accordance with the cultural and linguistic needs of individuals and families in the identified communities. The project team will collaborate with the regional behavioral health navigator, district leadership and community coalition leaders in planning the design and implementation of program activities to ensure the cultural and linguistic needs of grant participants are effectively addressed, particularly the priority population. A continuous quality improvement approach will be used to analyze, assess, and monitor key GPRA and project-level performance indicators as a mechanism to ensure high-quality and effective program operations. These data will be used to monitor and manage program outcomes by gender, race, ethnicity, disability, housing, foster care, and LGBTQ+ status, as data are available, within a quality improvement process.

Programmatic adjustments will be made as indicated to address identified issues, including behavioral health disparities, across program domains. A primary objective of the data collection and reporting will be to monitor/measure project activities in a manner that optimizes the usefulness of data for project staff and consumers; evaluation findings will be integrated into program planning and management on an ongoing basis (a "self-correcting" model of evaluation). For example, referral to enrollment, treatment completion and discharge data will be reported to staff on an ongoing basis, including analyses and discussions of who may be likely to enroll and complete the program (and possible interventions).

The evaluation team will meet on a monthly basis with regional and district level staff, providing an opportunity for staff to identify successes and barriers encountered in the process of project implementation. These meetings will be a forum for discussion of evaluation findings, allowing staff to adjust or modify project services to maximize project success. Outcomes for all services and supports will be monitored across race, ethnicity, language spoken at home, and other factors to determine the grant's impact on behavioral health disparities. (Additional details regarding performance assessment and quality improvement can be found in the project's Data Collection, Performance Assessment, and Quality Improvement Plan).

3. Adherence to the CLAS Standards

Our quality improvement plan will ensure adherence to the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards) in Health and Health Care. This will include attention to:

a. Diverse cultural health beliefs and practices
   Training and hiring protocols will be implemented to support the culture and language of all subpopulations, with a focus on the Hispanic and Native American subpopulation.

b. Preferred languages
   Interpreters and translated materials will be used for monolingual Spanish speakers and other non-English speaking clients as well as those who speak English but prefer materials in their primary language. Key documents will be translated into Spanish.

c. Health literacy and other communication needs of all sub-populations identified in the project proposal.

All supports, services, and programs will be tailored to include individuals and families who have low literacy in English, Spanish or their primary language. Staff will receive training to ensure capacity to provide supports that are culturally and linguistically appropriate.

Sources:

Sunnyside School District:
https://washingtonstatereportcard.ospi.k12.wa.us/ReportCard/ViewSchoolOrDistrict/100260

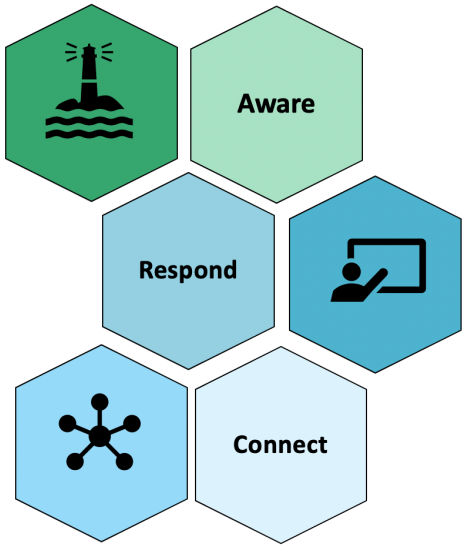
Wahluke School District:
https://washingtonstatereportcard.ospi.k12.wa.us/ReportCard/ViewSchoolOrDistrict/100281

Yakima School District:
https://washingtonstatereportcard.ospi.k12.wa.us/ReportCard/ViewSchoolOrDistrict/100303

US Census Data:
https://www.census.gov/quickfacts/fact/table/yakimacountywashington,yakimacitywashington/PST045219

WASHINGTON PROJECT AWARE

DATA COLLECTION, PERFORMANCE ASSESSMENT, AND QUALITY IMPROVEMENT PLAN



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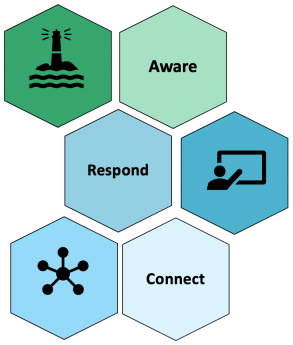
WASHINGTON PROJECT AWARE
DATA COLLECTION, PERFORMANCE ASSESSMENT, AND QUALITY IMPROVEMENT PLAN

INTRODUCTION

The Project AWARE evaluation is designed around the three project goals:



1) *Increase awareness of mental health issues among school-aged youth through the development, implementation, and sustainability of a comprehensive school-based system of mental health services and supports*
2) *Train school personnel and other adults who interact with school-aged youth to detect and respond to mental health issue*
3) *Connect school-aged youth who may have behavioral health issues and their families to needed services*

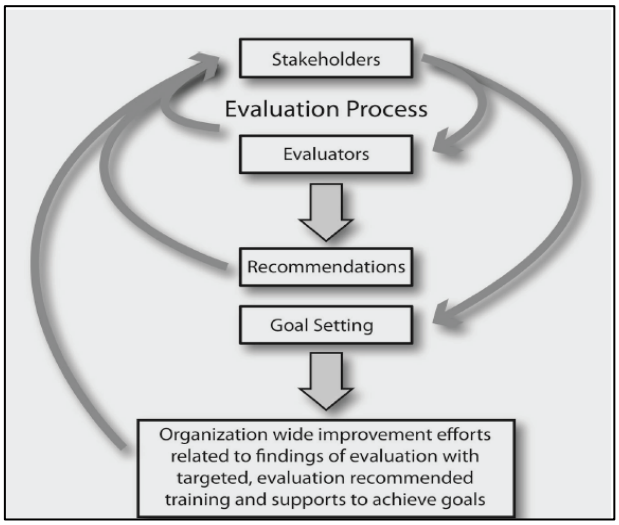
The purpose of the evaluation is to systematically assess the ongoing status of Project AWARE by providing timely information for creating strategic plans, measuring progress, and keeping the project focused on the overall objectives and aligned with the project's Logic Model (Appendix A). As such, the proposed evaluation design will take a two-pronged approach:

1) To assess progress toward stated goals and objectives (outcome evaluation); and

2) To assess the implementation of, and fidelity to, the overall project design at the SEA and LEA levels (process evaluation).

The strength of this design allows us to: a) deliver an outcome evaluation that supports clear statements regarding the effectiveness of the overall project; and b) closely monitor fidelity of the implementation of project services including fidelity of evidence-based programs.

Figure 1: Participatory Evaluation Process



The evaluation team will implement a data-gathering and reporting infrastructure in a manner that incorporates contributions of youth and families and will do so within the context of culturally responsive evaluation practices. Our design and protocols will aim to produce evaluation questions capable of teasing out nuances that are often overlooked by common evaluation processes. Interview and survey instruments will be developed with participants' culture in mind. For example, we will move beyond the "what" and "who" of evaluation models and emphasize the "why" and the "how", which acknowledge cultural differences, and any

unstated assumptions about the priority population benefitting from the Project AWARE initiative. By incorporating equity into the evaluation, we can better understand the underlying causes of mental health outcomes.

In utilizing a collaborative and participatory evaluation process (Figure 1), we approach our work through a personable lens, focused on the cultivation of relationships and building trust with project partners through clear, linguistically- and culturally responsive and timely communication. This strategy allows for adaptability and flexibility by meeting project partners where they are (in terms of time/resources/capacity) versus a one-size-fits-all data collection and engagement strategy.

SECTION 1: DATA COLLECTION

Data Collection:

Government Performance Measures (GPRA): As required, performance measure data will be collected monthly and reported quarterly throughout the five-year project including GRPA (Infrastructure and Services) and project-level objectives. Analysis of GPRA measures will include collecting information about culturally and linguistically responsive organizations as well as the number of training participants and referred individuals that are bilingual and/or bicultural. Table 1 outlines the required measures and includes analysis methods, data sources, data collection schedule, and responsible parties.

Table 1: Required GPRA Performance Measures

GPRA: Infrastructure Performance Measure	Analysis Method/ Data Source	Frequency	Responsible Staff
1) The number of state and local policy changes completed as a result of the grant. (GPRA, PD1)	Data analysis; web-based tracking form; program records	Monthly	BHSN; CPMs; SEA PM; SMHA PM
2) The number of people in mental health and related workforce trained in mental health-related practices/activities that are consistent with the goals of the grant. (GPRA, WD2)	As above	Monthly	BHSN; CPMs; SEA PM; SMHA PM
3) The number of organizations that entered into a formal written inter/intra-organizational agreement (e.g., MOUs/MOAs) to improve mental health-related practices/activities that are consistent with the goals of the grant. (GPRA, PC1)	Data analysis; web-based tracking form; document review	Monthly	BHSN; CPMs; SEA PM; SMHA PM
4) The number of individuals who have received training in prevention or mental health promotion. (GPRA, TR1)	As above	Monthly	CPMs; SEA PM; SMHA PM
5) The number of individuals referred to mental health or related services. (GPRA, R1)	As above	Monthly	CPMs; MHPs; MTSS teams

GPRA: Infrastructure Performance Measure	Analysis Method/ Data Source	Frequency	Responsible Staff
6) The number and percentage of individuals receiving mental health or related services after referral. (GPRA, AC1)	As above	Monthly	CPMs; MHP; MTSS teams
GPRA: Services Performance Measures	**Analysis Method/ Data Source**	**Frequency**	**Responsible Staff**
7) The number of consumers to be served, and the unduplicated cumulative goal of consumers to be served during the grant performance period (Tier 3, only). (9/30/20 – 9/29/25)	Data analysis; web-based tracking form; program records Interviews; NOMS Tool	Monthly Intake; every 6-Months; & Discharge	CPMs; MHP; MTSS teams

* BHSN = Behavioral Health Systems Manager; CPMs = Community Project Managers; MHP = Mental Health Professional; SEA PM = OSPI Project Manager; SMHA PM = State Mental Health Agency Project Manager.
** Disaggregated by race/ethnicity, zip code, gender, and sexual orientation, Free or Reduced Lunch, annual income, language spoken at home, parent/caregiver education level (if data are available)

The table below outlines the targeted goals, by project year, for the direct services performance measures and the six infrastructure measures as required by the funder.

Table 2: Performance Measure Goals by Indicator and Project Year

SERVICES	Year 1 (9/30/2020-9/29/2021)	Year 2 (9/30/2021-9/29/2022)	Year 3 (9/30/2022-9/29/2023)	Year 4 (9/30/2023-9/29/2024)	Year 5 (9/30/2024-9/29/2025)	Cumulative*
Advancing Wellness and Resiliency in Education (9/30/2020-9/29/2025)	90	235	380	485	610	1,288*

Note: For the purpose of this measure, "services" are defined as those students who qualify for, and are engaged in, Tier 3 intervention/treatment, thus requiring administration of the NOMs tool. *Cumulative Goal: This is the unduplicated goal of all consumers for the total grant period. This is different than adding up all the annual goals of each grant year since that figure may contain duplicate consumers. *Assumes approximately 70% of students are unduplicated years 2-5 (e.g., 30% were previously served), and in Year 1 all are unduplicated counts.*

Infrastructure Indicators					
Policy Development	**Year 1 (9/30/2020-9/29/2021)**	**Year 2 (9/30/2021-9/29/2022)**	**Year 3 (9/30/2022-9/29/2023)**	**Year 4 (9/30/2023-9/29/2024)**	**Year 5 (9/30/2024-9/29/2025)**
PD1–The number of policy changes completed as a result of the grant.	2	3	3	3	3
Workforce Development					
WD2–The number of people in the mental health and related workforce trained in mental health-related practices/activities that are consistent with the goals of the grant.	240	335	335	335	335

Partnership/Collaboration	Year 1 (9/30/2020-9/29/2021)	Year 2 (9/30/2021-9/29/2022)	Year 3 (9/30/2022-9/29/2023)	Year 4 (9/30/2023-9/29/2024)	Year 5 (9/30/2024-9/29/2025)
PC1–The number of organizations that entered into formal written inter/intra-organizational agreements (e.g., MOUs/MOAs) to improve mental health-related practices/activities that are consistent with the goals of the grant.	5	8	6	6	6
Training					
TR1–The number of individuals who have received training in prevention or mental health promotion.	295	530	580	630	680
Prevention and Mental Health Indicators					
Referral					
R1–The number of individuals referred to mental health or related services.	1,265	2,535	2,535	3,800	3,800
Access					
AC1–The number and percentage of individuals receiving mental health or related services after referral.	530 (42%)	1,400 (55%)	1,590 (63%)	2,660 (70%)	2,950 (78%)

RI estimates are based on the anticipated number of youths that will be referred to Tier 2 *and* Tier 3 services during any given school year. Estimates include anticipated percentage of student population based on best-practice (e.g., no more than 20% of the student population for any given year).

Table 3: Project-Level Measures (See Appendix A)

Additionally, the evaluation team developed and launched a robust web-based data collection system to facilitate the entry of data (GPRA and project-level) by the SEA, LEAs, and community partners throughout the project. The AWARE Data System (ADS) is customized to exact needs of the project and allows users to run real-time reports enabling them to continuously monitor their own data. The system is designed with user ease and accessibility at the forefront. A copy of the ADS manual is attached in Appendix B.

SECTION 2: DATA MANAGEMENT, TRACKING, ANALYSIS, AND REPORTING

Data Management:

Confidential and de-identified data are stored on Maike & Associates' password protected computers. Only authorized Research staff will have access to these data. Additionally, at time of hire, all Research staff and sub-contractors sign an Agreement of Nondisclosure of Confidentiality, with this updated annually.

While collecting, analyzing, and storing data, the evaluators will comply with the provisions of FERPA and Federal Policy for the Protection of Human Subjects by adhering to the following policies:

1. Use the data shared during this project for no purpose other than fulfilling the project. Data received during this project will not be shared with any other entity.

2. Maintain all data obtained during this project in a secure computer environment and not copy, reproduce, or transmit data obtained pursuant to this agreement except as necessary to fulfill the purpose of this project.

3. Ensure that transmission or transfer of data is done via secured methods by and between Educational Agencies, other institutions authorized to provide data for purposes of this project, and the evaluators for purposes of fulfilling the project. This includes password protecting electronic data files with confidential information and providing password in a separate communication.

4. Not to disclose any data obtained under this agreement in a manner that could identify an individual student, except as authorized by FERPA, to any other entity. The evaluators may report information obtained, but specifically agrees to abide by the "small numbers" policy of excluding all data items that include any group of students less than ten (10), and to report data only in aggregate form only with no identifying information.

5. Not to provide any data obtained under this agreement to any party ineligible to receive data protected by FERPA or prohibited from receiving data from any entity by virtue of a finding under Section 99.31(6)(iii) of Title 34, Code of Federal Regulations.

6. Destroy all data obtained during this project when it is no longer needed for the purpose for which it was obtained.

7. If applicable, maintain the confidentiality of alcohol and drug abuse client records according to the provisions of Title 42 of the Code of Federal Regulations, Part II.

a. Applying these guidelines to the proposed data collection activities, the following procedures will be used:
    - For youth surveys, as long as they are voluntary, items related to the eight protected areas can be included (e.g., items on mental health or delinquency-related behaviors); however, it will be necessary to provide direct written notification to parents along with passive parental consent (e.g., providing them with the opportunity to opt out) when asking questions related to these areas (Note: this is the current procedure employed with the Healthy Youth Survey);
    - Informed consent will be obtained from all interview participants via verbal consent by the interviewer, and they will be asked questions to be sure that they understand the consent form;
    - For existing data or sharing of data across service providers, if there is any identifiable information (including IDs, names, etc.), then active parental consent (e.g., release forms) will be obtained by provider.

- Consents for treatment among minors under the age of 13 will require active parental consent and will be requested by the provider (Youth age 13-17 can access behavioral health services without parental consent in the state of Washington)[1]; and
- Participants will be provided copies of what they sign.

b. In addition, the data collection tools are designed to protect participants' privacy. For example, students will not put their names on survey(s). Additionally, evaluators will obtain the raw data with no identifiers or in aggregate form. During site visits and training sessions, staff will be counted, and all satisfaction surveys will be anonymous. No school, staff member, or student will ever be mentioned by name in a report of the results, without explicit consent.

c. With respect to service provision, clinicians providing services will follow LEA safety/security policies and procedures to reduce the risk to the individuals. Contractors will sign confidentiality agreements as part of providing services to abide by all confidentially laws. There will be an MOU between entities who may be working together for service provision that will clearly document how confidentiality and privacy will be maintained. Data on referrals and service provision will be reported in aggregate form only (# of students served) to maintain client confidentiality. All client records will be placed in drawers with locks and keys, and all clinicians will be bound by licensing standards by the state of Washington.

Data Tracking:

In order to reduce the burden of the evaluation on service recipients and stakeholders, the project will make use of existing data sources whenever possible. Data for SEA and LEA performance measurements and reporting will be obtained through a variety of mechanisms involving core evaluation team staff, state, and local program staff who will be trained and supported to guide evaluation activities. These data will be entered into a web-based portal designed for this project for analysis by the evaluation team. Both the Evaluation Project Manager and the Evaluation Data Manager will be responsible for the oversight and monitoring of data. Members of the evaluation team will establish data collection checks to ensure that the SEA, LEAs, and their community partners successfully collect and report GPRA and project-level data throughout the five project years. Evaluators will monitor data collection deadlines as well as enter data into the SPARS system within the required reporting timelines and adhere to federal guidelines for data collection.

Data Analysis:

The evaluation team, under the direction of the Evaluation Director, will be responsible for conducting all data analysis. Process and outcomes data will be analyzed as they are collected and routinely communicated to program staff, governing and advisory bodies, pilot

[1] Refer to: https://www.hca.wa.gov/assets/program/fact-sheet-age-consent-behavioral-health-treatment.pdf

communities, and stakeholders to create a results-based feedback loop (See Section 3, Performance Assessment for additional details).

The evaluation team will use a combination of descriptive and inferential statistics to analyze grant outcomes. Descriptive statistics (e.g., frequency, minimum, maximum, mean) will be reported on all data at baseline and at follow-up. Outcomes measuring change over time (e.g., reduced severity of mental health symptoms in students referred to treatment) will be analyzed using the appropriate statistical method (e.g., chi-square, paired-sample t-test) and attrition analysis will be conducted to ensure there is not attrition bias in the data. Qualitative data derived from interviews, open ended survey questions, and monthly reporting forms, will be categorized thematically for analysis and interpretation of findings.

Data Reporting:
The evaluation team will, in collaboration with the SEA-Project Coordinator, be responsible for the completion of all federally required reports. Additionally, the evaluation team will routinely develop at least monthly reports to assess progress toward identified performance measures as data become available.

SECTION 3: PERFORMANCE ASSESSMENT

As required, performance measure data will be collected and reported to SAMHSA at least quarterly throughout the five-year project. However, the evaluation team, under the direction of the Evaluation Director, will conduct performance assessment activities on a continuous basis. Data will be used to understand the impacts of the project strategies and activities at both the system and project level, with course corrections made as needed. Fidelity monitoring of evidence-based practices will be embedded into the evaluation design. Formative and summative data will be analyzed routinely and communicated to stakeholders to create a results-based feedback loop. Problem resolution will be transparent and dynamic; identified problems will be addressed to ensure that the project is successful in reaching its goals and objectives. In addition to semi-annual data summaries, evaluators will write an annual report providing analysis of the project and congruence with objectives. Reports will summarize data in a manner meaningful to project stakeholders and to meet accountability requirements.

Outcome Evaluation: The outcomes component of the evaluation will address questions related to the effects of the strategic planning process and implementation of evidence-based programs (EBPs) on outcomes. Specifically, the Outcome Evaluation will yield information to answer the following questions:

1) What was the effect of the strategic planning process and implementation of selected intervention(s) on the key outcome goals identified by the SEA and three LEAs?
    a. Was the strategic planning process designed and developed with equity in mind?
    b. Did the process routinely engage community stakeholders, including those experiencing health inequities?

2) What program/contextual factors were associated with SEA, LEA, and local community outcomes?
3) What factors and underlying causes were associated with outcomes, including race/ethnicity, gender, sexual orientation, income levels, and literacy (providing data are available)?
    a. Were there key variables missing in those we used to track the influence of project efforts on populations experiencing health inequities?
4) How effectively did the project reach populations at high risk for mental, emotional, and behavioral-health disorders and violence?
    a. What worked? For whom? Under what conditions? Is there any differential impact? Have inequities decreased, increased, or remained the same?
    b. What were the systemwide changes that ultimately resulted from this project?
    c. Did the project affect race or intergroup relations, institutional changes, equity, socioeconomic status, or disparities in outcomes in the priority communities? Is there evidence that more changes are likely in the future?
5) What were the barriers to interagency collaboration, partnership development, and shared decision-making and how were they addressed?

Process Evaluation: The process evaluation will assess adherence to identified project tasks and timelines, the projected number and characteristics of participants, and other process measures and objectives to be outlined in the Evaluation Logic Model. Process data will be formally reviewed at monthly Project Lead meetings (as they become available) to ensure adherence to timelines, fidelity to the project and evidence-based models, and progress on objectives. The local evaluation will address *process questions* related to the extent to which implementation matched the comprehensive plan, deviations from the implementation plan, their causes, and their effects. Specific questions to be addressed through the process evaluation are:

1) How closely did program implementation match the comprehensive plan at the state and local levels?
2) As the project progressed, what types of changes were made to the plan? What led to these changes?
3) What factor(s) facilitated or hindered the development and implementation of the plan?
4) Were the screening policies and procedures, trainings, services, and supports appropriate to participants' cultures?
5) What processes were in place to determine when culturally responsive tools or methodologies were needed?
6) What types of policy changes were made to address disparities?
7) What policies at the state and local level facilitated or hindered implementation of the plan?
8) How did the project partners share efforts with diverse stakeholders?
9) How did the project engage families and youth?

Another major component of the process evaluation will focus on fidelity to evidence-based practices (EBPs). Because a clear link has been established between fidelity, intervention quality, and system and client-level outcomes (Henggeler et al, 1999), local evaluation efforts focusing on fidelity will enrich the understanding of the relationship between EBPs and performance indicators. Fidelity tracking coupled with outcome data will contribute to a more complete understanding of these questions. Validated fidelity measures may include:

1. *School Health Assessment Performance Evaluation (SHAPE) System* - School Mental Health Quality Assessment. The SHAPE School Mental Health Quality Assessment is designed for teams to assess the comprehensiveness of their school mental health system and to identify priority areas for improvement. The Quality Assessment comprises seven domains: Teaming, Needs Assessment/Resource Mapping, Screening, Mental Health Promotion, Early Intervention and Treatment, Funding and Sustainability, Impact.

2. *School Health Assessment Performance Evaluation (SHAPE) System - The Trauma Responsive Schools Implementation Assessment (TRS-IA).* The TRS-IA is a quality improvement tool developed by the NCTSN Treatment and Services Adaptation Center for Resilience, Hope, and Wellness in Schools and the National Center for School Mental Health. The TRS-IA is an evidence-informed self-assessment that comprises the eight key domains: Safety Planning, Prevention Planning, Trauma Programming, Classroom Strategies, Prevention/Intervention Trauma Programming, Targeted Trauma-Informed Programming, Staff Self Care, and Family and Community Engagement.

3. *Tiered Fidelity Inventory (TFI)* (Recently adapted to be conducted remotely, September 2020) (Algozzine, Barrett, Horner, Lewis, Putnam, Swain-Bradway, McIntosh, & Sugia 2014). The purpose of the TFI is to provide a valid, reliable, and efficient measure of the extent to which school personnel are applying the core features of Positive Behavioral Interventions and Supports (PBIS). The tool is divided into three sections (Tier I: Universal Features; Tier II: Targeted Features; and Tier III: Intensive Features) that can be used separately or in combination to assess the extent to which core features are in place.

4. Program of Intervention Specific *Fidelity Tools* (e.g., Second Step Fidelity Checklist, PAX Good-Behavior Games Fidelity Checklist).

SECTION 4: QUALITY IMPROVEMENT

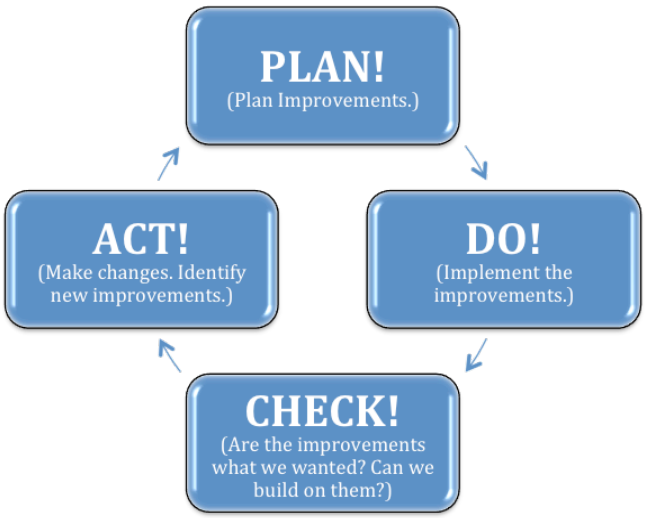
Research demonstrates that implementation of practices and strategies often fall short of their intended objectives when sufficient quality assurance techniques are not implemented from the start. To ensure that the project is on target to complete its stated goals and objectives and deliver services as designed we will adopt the Continuous Quality Improvement (CQI) approach. Continuous quality improvement is a tool for improving the quality of services provided. CQI is a systematic approach to collecting and reviewing data or information in order to identify opportunities to improve program performance with the end result of reaching better

outcomes. An effective CQI process will enable the project to achieve the objectives outlined in the Coordination and Integration Plan. CQI emphasizes an ongoing or continual process of improvement and evaluation. The process involves:

- Identifying improvements
- Implementing the improvements
- Evaluating the effect of improvements, and
- Going back to identify more improvements.

A common approach is to see CQI as an ongoing cycle involving planning, doing, checking, and acting and then starting again (Figure 2).

Figure 2: Plan, Do, Check, Act Cycle



Plan:

- ✓ Clarify issues or problems
- ✓ Collect and review data or other information related to the issues or problems
- ✓ Identify the causes of the issue or problem
- ✓ Clearly identify improvements that can be made
- ✓ Clarify the outcomes for improvements
- ✓ Develop strategies to implement improvements—consider stakeholders—consider strategies to get management support
- ✓ Identify how you will measure the success of the improvement and identify how you will collect the data
- ✓ Identify key tasks

Do:

- ✓ Gain approval for improvements
- ✓ Implement the improvements— assign key tasks
- ✓ Monitor the implementation—make sure key tasks are completed
- ✓ Collect data on improvements

Check:

- ✓ Did the improvement work? If not, why not?
- ✓ Were there any unintended consequences?
- ✓ Collect ongoing data on the performance of the project, e.g., client feedback, staff feedback, outcomes data, etc.—what does this tell us about the improvements?

Act:

- ✓ Consider improvements—do they suggest other improvements—e.g., staff training, review of procedures, changes to service delivery or EBPs?
- ✓ If improvements did not work what do we need to do?
- ✓ If there were unintended consequences to improvements—do we need to do anything about them?
- ✓ Consider new data—e.g., client feedback, staff feedback, outcomes data, etc. —does it suggest improvements?
- ✓ Look for things to improve—look at problems and consider solutions.

Through this process we will:

- Ensure staff are effectively trained in the delivery of EBPs, use of screening tools, and in data collection processes;
- Establish internal quality assurance (QA) processes; and
- Modify approaches based upon results of the CQI processes.

At the SEA and LEA-levels, process and outcomes data will be analyzed as they are collected and routinely communicated to state and LEA program staff, and other stakeholders to create a results-based feedback loop. Regular feedback on project performance is critical to identifying areas of weakness and allowing for adjustments to plans to compensate for any digressions and keeping the project focused. As a result, problem resolution will be transparent and dynamic – that is, identified problems will be addressed in a real-time framework to ensure that the project is successful in reaching its targeted goals and objectives.

The Core Leadership Team, including the Evaluation Director or Evaluation Project Manager, will conduct monthly check-ins as well as more extensive quarterly meetings with project staff on progress toward meeting targeted process and outcomes objectives. Quarterly meetings will include review of project progress and allow for identified problems to be addressed, thus, permitting program staff to adjust plans to ensure that the project is successful in reaching its targeted goals and objectives.

At the LEA level, program staff will be adequately prepared and trained in the delivery of EBPs and monitored to ensure these are implemented with a high level of fidelity. Staff will receive follow up training, as well as ongoing encouragement, feedback, and coaching designed to improve knowledge, skills, confidence, and competency, needed, to ensure consistent delivery of program services/strategies. Project Leads will create training and supervisory models to enhance the local leadership and capacity to deliver services beyond the scope of this project

e.g., trainer of trainer, coaching and mentoring.

Key process and output as well as outcome data as it become available will be compiled in monthly summary reports. Data reviews will include suggestions for steps to remedy shortcomings, with recommendations and actions taken in response to them incorporated, in turn, into semi-annual and annual data summaries. In addition to the semi-annual data summaries, the Evaluation Team will provide an annual report providing analysis of program data and congruence with grant objectives. Reports will summarize data in a manner meaningful to project stakeholders and appropriate to meet accountability requirements.

APPENDICES:

Appendix A: AWARE Project Logic Model (under separate cover)

Appendix B: AWARE Data System User Manual

WASHINGTON PROJECT AWARE LOGIC MODEL (JUNE 2021)

Goal 1) Increase awareness of mental health issues among school-aged youth through the development, implementation, and sustainability of a comprehensive school-based system of mental health services and supports.			
Objectives	*Activities*	*Process/Outputs*	*Outcomes*
1.1 Implement and sustain an integrated multi-tiered system of support (MTSS) framework with fidelity across all three LEA districts, in 80% of targeted schools by the end of the grant period (September 2025). (Systems-Level)	SEA Activity Summary: Expand implementation of an integrated MTSS/Interconnected Systems Framework (ISF) statewide; State-level coordinators develop a **plan of action** to promote wide-scale adoption of the MTSS model including successful strategies, programs, and policies developed under the auspices of this proposal. This plan will strengthen the collaboration and commitment of organizational leadership across LEA and community partners, ensure that local projects coordinate with and build on each other and leverage and work alongside other community initiatives. Specific SEA Activities: ▪ Develop MTSS/ISF Plan of Action in collaboration with project partners; review/update as needed ▪ Develop Behavioral Health Disparities Impact Statement ▪ Develop and submit Performance Assessment Plan in collaboration with Project Evaluators ▪ Conduct State Capacity Assessment/State Systems Fidelity Inventory/other similar tool (aligned w/SCTG) ▪ Facilitate state/local teams ▪ Offer MTSS video and modules series for support LEA/District Activity Summary: Implement comprehensive SMH policies, practices, and services across the tiers of the MTSS/ISF framework, these will be culturally and linguistically competent across the developmental spectrum, with the ultimate goal of a sustained and integrated MTSS. Specific LEA Activities: ▪ Community Project Managers (CPM) establish and lead district and building level MTSS Teams ▪ Establish district level MTSS Team ▪ CPMs lead data driven teams in the conduct of the SHAPE	*SEA: Process/Outputs* Established state-level (SEA) team (Core & Management) # of SEA team meetings # and type of team members Developed/Implemented MTSS/ISF Plan of Action; review/update annually Completed Behavioral Health Disparities Impact Statement; review/update annually Completed Performance Assessment Plan; review/update Completed State Capacity Assessment; update annually Developed MTSS/ISF Sustainability and Scalability Plan *LEA: Process/Outputs* Established district-level MTSS teams # of district-level MTSS team meetings # and type of district-level MTSS team members Completed district-level SHAPE	1.1 Implement and sustain an integrated multi-tiered system of support framework with fidelity across all three LEA districts, in 80% of targeted schools by the end of the grant period (September 2025) as measured by the SHAPE School Mental Health Quality Assessment (SMHQA) and project records (inclusive of the TFI and/or a district capacity assessment).

Goal 1) Increase awareness of mental health issues among school-aged youth through the development, implementation, and sustainability of a comprehensive school-based system of mental health services and supports.			
Objectives	*Activities*	*Process/Outputs*	*Outcomes*
	System ▪ Conduct resource inventory/mapping; document mental health (MH) services available across tiered levels of support ▪ Select EBPs ▪ Adopt universal screening policies and procedures by the end of year 2 ▪ Conduct quality improvement ▪ Develop sustainability plan <u>Building Level:</u> ▪ Establish building level MTSS Teams ▪ Conduct SHAPE Assessment; analyze results ▪ Conduct resource inventory/mapping; document mental health (MH) services available across tiers of support ▪ Assess and/or develop universal screening practices for early identification of students with behavioral health concerns ▪ Adopt Universal Screening Tool (YR2, Grades 9–12; YR3, Grades 6–12; YR4, Grades 4–12; YR5 K–12)	assessment; update annually Completed resource inventory; review annually # and type of EBPs Adopted/implemented universal screening policies Developed sustainability plan MTSS/ISF model fidelity Adherence to CLAS standards <u>*Building: Process/Outputs*</u> Established building-level MTSS teams # of building-level team mtgs # and type of building-level MTSS team members Completed school SHAPE assessment; update annually Completed resource inventory; review annually Adopt/implement universal screening practices	

Goal 1) Increase awareness of mental health issues among school-aged youth through the development, implementation, and sustainability of a comprehensive school-based system of mental health services and supports.			
Objectives	*Activities*	*Process/Outputs*	*Outcomes*
1.2 Implement two (2) policy changes as a result of the grant by the end of Year 1; implement three (3) policy changes annually in Years 2-5 for a total of 14 policy changes by the end of the grant period (September 2025). (PD1) (Systems-Level) (GPRA PM)	SEA Activity Summary: See 1.1 Specific SEA Activities: ▪ Drive policy change/development ▪ Establish state and local level partnerships ▪ State-level coordinators, CPMs, and the BHSN review policies and practices at state and local levels, make recommendations to revise as needed ▪ Review/update state-level policies and practices, as needed, to ensure communication and information sharing across systems reduces barriers (e.g., access to service delivery) LEA/District Activities: ▪ Drive policy change/development to support implementation of MTSS/ISF as identified through the SHAPE-SMHQA Building Level: ▪ Adopt district-led MTSS/ISF policy/practice changes ▪ Formalize and/or enhance referral procedures, annually ▪ Establish, implement, and sustain procedures for universal screening (e.g., Panorama)	*SEA: Process/Outputs* # and type of policy changes completed *LEA: Process/Outputs* As SEA measures above *Building: Process/Outputs* Adopted/implemented MTSS/ISF policy/practices Formalized referral/screening procedures	1.2 Implement two (2) policy changes as a result of the grant by the end of Year 1; implement three (3) policy changes annually in Years 2-5 for a total of 14 policy changes by the end of the grant period (September 2025) as measured by the SHAPE (district-specific policy indicators) and project records. (PD1)

Goal 1) Increase awareness of mental health issues among school-aged youth through the development, implementation, and sustainability of a comprehensive school-based system of mental health services and supports.			
Objectives	*Activities*	*Process/Outputs*	*Outcomes*
1.3 Improve inclusion of student and family voice in decisions about program services and policies by project end (September 2025) as compared to baseline (Spring 2021). (Systems-Level)	<u>SEA Activities</u>: ▪ Develop a needs assessment tool in Spanish/English to assess community knowledge relative to mental health policies and services in the local region. ▪ Provide culturally and linguistically relevant family engagement opportunities to support a clear understanding of project goals and anticipated outcomes. ▪ Secure resources from OSPI Migrant education department for distribution across region, in support of equitable access of services. These resources are available in Spanish. ▪ Develop a tool in Spanish to assess student understanding of available resources and services. <u>ESD 105 Activities:</u> ▪ Solicit parent and youth participation on policy development committees (similar to soliciting parent and youth participation in community coalitions). <u>LEA/District Activities:</u> ▪ Survey students and families to indicate future SEL/Mental Health seminar topics (SSD) ▪ Assess community needs that can be addressed by services rendered through the project. Adapt to meet identified needs as services are developed (WSD) ▪ Develop and implement a process for including student and family voice in policy decisions (WSD) <u>Building Level:</u> ▪ As district-level	*<u>SEA: Process/Outputs</u>* # and type of strategies/activities implemented to improve student/family voice # and type of youth, family and community members engaged *<u>ESD: Process/Outputs</u>* # and type of parents and youth involved *<u>LEA: Process/Outputs</u>* Developed and implemented student/family voice policy/practices at district and building-levels *<u>Building: Process/Outputs</u>* As LEA measures above	1.3 Improve inclusion of student and family voice in decisions about program services and policies by project end (September 2025) as compared to baseline (Spring 2021) as measured by project records, interviews, focus groups, and locally designed retrospective post-partner survey.

Goal 2) Train school personnel and other adults who interact with school-aged youth to detect and respond to mental health issues.			
Objectives	*Activities*	*Process/Outputs*	*Outcomes*
2.1 Enhance professional development (PD) opportunities to increase knowledge/skills of staff working with students by training 240 people **in the mental health and related workforce** in mental health-related practices/activities that are consistent with the goals of the grant by the end of year 1; and training 335 people annually in years 2-5 for a total of 1,580 people trained by September 29, 2025. (WD2) (Systems-Level & GPRA PM) NOTE from GPO: "*For this particular indicator, please count school personnel that are in the mental health or related workforce such as school psychologist, social workers, counselors etc.*"	<u>SEA Activity Summary:</u> SEA partners, in collaboration with CPMs, ESD 105 BHSN, and district and school-building teams, develop formalized **professional development (PD) plans** for school staff in the mental health and related workforce (e.g., school psychologies, social workers) to enhance knowledge and skills to detect and respond to mental health issues. <u>Specific SEA Activities:</u> ▪ Coordinate promotional offerings in collaboration with other key partners such as the OSPI Behavioral Health and Suicide Prevention Coordinator, National Alliance on Mental Illness, Jordan Binion Project, Chad's Legacy, and the UW SMART Center. ▪ Annually, deliver training and booster sessions in topical areas such as staff wellness, social emotional learning, child and adolescent mental health literacy, adverse childhood experiences, and trauma-sensitive and culturally responsive classrooms, etc., to school personnel ▪ Review local action plans and develop and implement *workforce development/training plan* to improve MH awareness and literacy, school climate, and policies. ▪ Expand/enhance workforce development at state and local levels <u>LEA/District Activity Summary</u>: CPMs coordinate training, outreach, and engagement strategies with school and other community partners to increase knowledge and awareness of mental, emotional, and behavioral health issues. <u>Specific LEA Activities:</u> ▪ Deliver professional development opportunities; provide booster session, annually <u>Building Level:</u> ▪ Lead and participate in professional development offerings, annually ▪ Provide training on confidentiality to school counselors and administration staff (and others as needed according the MTSS team membership)	<u>*SEA: Process/Outputs*</u> Developed/implemented PD plan for mental health and related workforce # and topic of PD trainings offered # and type of staff engaged in trainings <u>*LEA: Process/Outputs*</u> Completed/implemented district-level PD plan # and topic of PD trainings offered # and type of staff engaged in trainings <u>*Building: Process/Outputs*</u> N/A	2.1 Enhance professional development (PD) opportunities to increase knowledge/skills of staff working with students by training 240 people in the mental health and related workforce in mental health-related practices/activities that are consistent with the goals of the grant by the end of year 1; train 335 people annually in years 2-5 for a total of 1,580 people trained by September 29, 2025, as measured by program records. (WD2)

Goal 2) Train school personnel and other adults who interact with school-aged youth to detect and respond to mental health issues.			
Objectives	*Activities*	*Process/Outputs*	*Outcomes*
	▪ Continue suicide prevention training updates to counseling and support staff, annually ▪ Train, or provide booster sessions to counseling, support staff, and administrators in the use of universal screening instrument (e.g., Panorama), annually		
2.2 Train 295 individuals (*not* in the mental health and related workforce) in prevention or mental health promotion by the end of year 1; train between 530 and 680 people in years 2-5 for a total of 2,715 individuals trained by the end of the grant period (September 2025) (TR1) (Systems-Level GPRA PM) NOTE from GPO: *"TR1 is where you would count teachers, administrators and other school staff that are not in the mental health workforce."*	SEA Activity Summary: SEA partners, in collaboration with CPMs and district and school-building teams, develop formalized **professional development and training plans** for school staff and other community partners) to enhance knowledge and skills to detect and respond to mental health issues. Specific SEA Activities: ▪ Coordinate the delivery of Youth Mental Health First Aid and/or Sources of Strength trainings; trainings focus on staff NOT in the MH and related work force including school administrators, classroom teachers, other school staff (e.g., bus drivers, para-educators), parents, and the community. ▪ Conduct ToT training for BHSN in the delivery of a comprehensive classroom-based suicide prevention curriculum (e.g., Lifelines Trilogy). LEA/District Activities: ▪ CPMs coordinate training, outreach, and engagement strategies with school and other community partners to increase knowledge and awareness of mental, emotional, and behavioral health issues ▪ Deliver professional development opportunities; provide booster session, annually Building Level: ▪ Participate in professional development offerings ▪ Provide training in Youth Mental Health First Aid (or similar curriculum) to all Certified and Classified staff	*SEA: Process/Outputs* Developed/implemented PD and training plan for staff and other adults **NOT in the MH or related workforce** # and topic of PD trainings offered and/or facilitated # and type of **non-workforce** related staff engaged in trainings *LEA: Process/Outputs* # and topic of PD trainings offered and/or facilitated # and type of staff engaged in trainings *Building: Process/Outputs* As LEA measures above	2.2 Train 295 individuals (*not* in the mental health and related workforce) in prevention or mental health promotion by the end of year 1; train between 530 and 680 people in years 2-5 for a total of 2,715 individuals trained by the end of the grant period (September 2025) as measured by project records (TR1).

Goal 2) Train school personnel and other adults who interact with school-aged youth to detect and respond to mental health issues.			
Objectives	*Activities*	*Process/Outputs*	*Outcomes*
2.3 Increase mental health literacy among school staff and other adults as reported by 75% of training participants by the end of Year 3 as compared to baseline (Spring 2021). (School-Level) *Mental health literacy is defined as:* 1. *Understanding how to foster and maintain good mental health* 2. *Understanding mental disorders and their treatments* 3. *Decreasing Stigma* 4. *Understanding how to seek help effectively*	<u>SEA Activities:</u> ▪ Project coordinators work with LEAs and community stakeholders to identify training and technical assistance needs to increase mental health literacy and broaden awareness to support and sustain SMH services <u>LEA/District Activity Summary:</u> Assist school and district level teams to design and implement awareness campaigns in collaboration with students, school staff, parents, and community partners aimed at reducing stigma and normalizing mental illness and treatment. These activities will be developmentally, linguistically, and culturally appropriate. <u>LEA Activities (from SHAPE, Tier 1 Q#9):</u> ▪ Develop a clear plan for assessing current mental health literacy of school staff and other adults, as baseline data and to inform your team's plan for further improvement ▪ Work with school staff and other adults to determine the most meaningful, feasible ways to promote mental health literacy ▪ Deliver and evaluate professional learning opportunities to 1) understand how to optimize and maintain good mental health for themselves and others 2) understand mental disorders and their treatment 3) reduce stigma about mental health needs and supports and 4) increase skills to link students to mental health prevention or intervention supports when needed ▪ Ensure mental health literacy activities are ongoing throughout the school year (i.e., activities go beyond a one-time training or educational materials posted in the building) ▪ Reassess mental health literacy on a routine basis to monitor progress and inform team planning for ongoing activities <u>Building Level:</u> ▪ School staff and parents participate in mental health literacy offerings at least annually. ▪ Conduct building-wide (Tier 1) mental health campaigns focused on literacy promotion and de-stigmatization of mental health issues. ▪ School staff and parents participate in trainings on the de-stigmatization of mental health issues at least annually.	<u>*SEA: Process/Outputs*</u> See 2.1 & 2.2 above <u>*LEA: Process/Outputs*</u> # and topic of MH literacy awareness campaigns/offerings provided # and type of participants engaged in MH literacy offerings Satisfaction with MH literacy offerings <u>*Building: Process/Outputs*</u> As LEA measures above	2.3 Increase mental health literacy among school staff and other adults as reported by 75% of training participants by the end of Year 3 as compared to baseline (Spring 2021) as measured by locally designed retrospective post-survey.

Goal 2) Train school personnel and other adults who interact with school-aged youth to detect and respond to mental health issues.			
Objectives	*Activities*	*Process/Outputs*	*Outcomes*
2.4 Reduce disproportionality of discipline practices among LEA sites as compared to baseline (Spring 2021) by project end (September 2025). (School-Level)	<u>LEA Activities (from SHAPE, Tier 1 Q#8):</u> ▪ Establish consistent expectations, rules, and schoolwide positive reinforcement systems to promote positive behaviors ▪ Train and support school staff in emotional and behavioral health ▪ Train and support school staff in evidence-informed, culturally responsive crisis de-escalation strategies and techniques ▪ Develop a multi-tiered system of emotional and behavioral health services and supports for students at risk for disruptive behavior related to mental health concerns ▪ Examine number of suspensions/expulsions by demographic group to better understand any differences in policies or practices ▪ Use restorative justice practices that encourage student disciplinary practices that focus on repairing the harm caused by an incident and allowing the people most affected by the incident to participate in its resolution	*<u>LEA: Process/Outputs</u>* # of policy/practice changes implemented Development and implementation of Tier 2 and Tier 3 supports. # of suspensions/expulsions annually Evidence of restorative justice practices implemented	2.4 Reduce disproportionality of discipline practices among LEA sites as compared to baseline (Spring 2021) by project end (September 2025) as measure by the SHAPE SMHQA – Mental Health Promotion (Tier 1) domain and official school records (i.e., suspension/expulsion).

Goal 3) Connect school-aged youth who may have behavioral health issues and their families to needed services.			
Objective	*Activities*	*Process/Outputs*	*Outcomes*
3.1 Improve coordination of care across systems – education and behavioral health – by 75% as compared to baseline (Spring 2021) by project end (September 2025) as reported of key partners. (Systems-Level)	SEA Activity Summary: SEA and HCA Program Managers work collaboratively with LEAs and community-based providers to de-silo education and behavioral health systems to improve coordination of care for students and families. Specific SEA Activities: ▪ Identify existing barriers to service integration to ensure community-based providers are fully integrated into school-based teams. ▪ Work with districts and community-based providers to overcome systems-level barriers. ▪ Problem solve issues related to integration such as confidentiality e.g., FERPA/HIPPA, funding, and other policy implications. ▪ In collaboration with ESD 105 MH Integration Specialist, BHSN, districts and BH providers, identify evidence-based interventions that meet the cultural and linguistic needs of the districts/communities. ▪ Conduct trainings and/or provide technical assistance related to the selection and implementation of Tier 3 behavioral health interventions. ▪ Provide training or technical assistance related to building school-community-family partnerships ESD 105 Activity Summary: Act as primary link between the K–12 education system and the publicly funded behavioral health system. Specific Activities: ▪ Support improvements in youth and family-serving systems through the coordination and integration of funding streams to sustain this and similar programs ▪ Assess and/or strengthen LEA partnerships with MH providers to ensure services meet student cultural and developmental needs, are not duplicative, and complement existing efforts	*SEA: Process/Outputs* See also 1.1 # and topic of cross-systems meetings held # and type of meeting participants # and topic of trainings/TA sessions held re: Tier 3 and school-community-family partnerships # and type of training/session participants *ESD 105: Process/Outputs* # and topic of cross-systems meetings held # and type of meeting participants	3.1 Improve coordination of care across systems – education and behavioral health –by 75% as compared to baseline (Spring 2021) by project end (September 2025) as measured by locally designed retrospective post-survey of key partners.

Goal 3) Connect school-aged youth who may have behavioral health issues and their families to needed services.			
Objective	*Activities*	*Process/Outputs*	*Outcomes*
	LEA/District Activity Summary: Oversee the development of an integrated MTSS framework, implement evidence-based programs (EBPs) across the continuum of supports. Specific LEA Activities: ▪ Facilitate the development and implementation of Tier 2 and Tier 3 services and supports (including referral management systems, screening, and problem solving) ▪ Document school-and community-employed MH staffing ▪ Develop and implement systems for mental health referrals ▪ Implement culturally and linguistically responsive services ▪ Monitor fidelity Building Level: ▪ Implement MTSS Tier 2/Tier 3 teams in schools of focus by the end of Year 2 ▪ Building level teams in collaboration with CPMs and District teams develop and implement Tier 2 and Tier 3 services and supports (including referral management systems, screening, and problem solving) ▪ Through school-based MTSS teaming processes, contracted MH providers and school employees will function collaboratively to assess, refer, triage, case manage, and monitor student progress	*LEA: Process/Outputs* See 1.1 *Building: Process/Outputs* See 1.1	

Goal 3) Connect school-aged youth who may have behavioral health issues and their families to needed services.			
Objective	*Activities*	*Process/Outputs*	*Outcomes*
3.2 Improve access to culturally and linguistically responsive services, supports, and workforce by 50% by project end (September 2025) as compared to baseline (Spring 2021). (Systems-Level)	SEA Activities: ▪ Collaborate with agency partners (HCA, DOH, DCYF, OSPI) to further recruitment efforts across the region in hiring/retention of providers with knowledge/expertise in regional cultural and language. ▪ Determine a process for active recruitment of providers with culturally responsive background in MH services. ESD 105 Activities: ▪ Offer training, partner with providers, implement Familia Adelante Cohorts. ▪ Offer training to existing workforce to improve cultural literacy. ▪ Partner with providers to recruit and retain culturally diverse staffing. ▪ Incentivize attainment of fluency in languages represented in district populations. ▪ Implement at least 2 Familia Adelante Cohorts within a year of Familia Adelante training. LEA/District Activities: ▪ Work to hire/contract bilingual service providers ▪ Examine curricula and programs adopted under project for cultural responsiveness Building Level: ▪ Incorporate services and curricula adopted by district into building activities	*SEA: Process/Outputs* # and topic of workforce related meetings # and type of participants Evidence of process for improving recruitment of culturally responsive workforce Adherence to CLAS standards *ESD 105: Process/Outputs* # and topic of partner trainings # and type of training participants Evidence of process for improving recruitment of culturally responsive workforce Adherence to CLAS standards *LEA & Building: Process/Outputs* Evidence of process for improving recruitment of culturally responsive workforce Evidence of curricula/program review and adoption Adherence to CLAS standards	3.2 Improve access to culturally and linguistically responsive services, supports, and workforce by 50% by project end (September 2025) as compared to baseline (Spring 2021) as measured by locally designed retrospective key partner survey and project records.

Goal 3) Connect school-aged youth who may have behavioral health issues and their families to needed services.			
Objective	*Activities*	*Process/Outputs*	*Outcomes*
3.3 Enhance community partnerships to improve systems of care for youth and families by Year 3 (September 2023), and thereafter, as compared to baseline (Spring 2021). (Systems-Level)	SEA Activities: ▪ Revise policies and procedures as needed to ensure enhanced communication and information sharing across school and community MH service systems. ▪ Core Team members address barriers to service delivery through review of policies and practices and formulate plans to increase access through cross agencies collaboration LEA/District Activities: From the SHAPE (Teaming/Q#3): ▪ Establish communication mechanisms (e.g., team meetings, email communications, conference calls) to ensure ongoing and effective communication between school leadership/staff and community partners ▪ Use memorandums of understanding or other agreements to detail the terms of the partnership (e.g., by whom, what, when, where, and how will services/supports be provided) ▪ Support a full continuum of care within a multi-tiered system of support by school and community partners working together and maximizing their respective knowledge and resources ▪ Use data sharing agreements to allow for accessing and sharing data to inform needed services and supports and the impact of partnership activities	*SEA: Process/Outputs* See 1.2 and 3.1 *LEA: Process/Outputs* See 1.1 and 3.1 Evidence of progress monitoring for T2/T3 supports by building level MTSS teams	3.3. Enhance community partnerships to improve systems of care for youth and families by Year 3 (September 2023), and thereafter, as compared to baseline (Spring 2021) as measured by a retrospective post-key partner survey.
3.4 Execute formal written inter/intra-organizational agreements (e.g., MOUs/MOAs) to improve mental health-related practices/activities that are consistent with the goals of the grant with 8 unique organizations by the end of Year 2. (PC1) (GPRA PM)	SEA Activities: ▪ Coordinate interagency mechanisms (OSPI/HCA) LEA/District Activities: ▪ Establish/Enhance local level provider-partnerships ▪ Establish MOU/MOAs with community based BH providers to deliver T2/T3 services Building Level: N/A	*SEA: Process/Outputs* Executed MOUs/MOAs with state-level partners *LEA: Process/Outputs* Executed/enhanced MOUs/MOAs with community-based BH partners	3.4 Execute formal written inter/intra-organizational agreements (e.g., MOUs/MOAs) to improve mental health-related practices/activities that are consistent with the goals of the grant with 8 unique organizations by the end of Year 2 as measured by project records.

Goal 3) Connect school-aged youth who may have behavioral health issues and their families to needed services.			
Objective	*Activities*	*Process/Outputs*	*Outcomes*
3.5 Increase the number of individuals referred to mental health or related services, with approximately 5% of students in the schools of focus referred to mental health or related services (Tier 2 and 3) by the end of Year 1; refer approximately 10% annually in years 2 & 3 and approximately 15% annually in years 4 & 5. (R1) (School-Level & GPRA PM)	LEA/District Activities: ▪ Develop and implement systems for mental health referrals ▪ Provide outreach, screening, assessment, referral, and direct BH treatment services and supports ▪ Standardize school-community mental health partnerships ▪ Develop and implement systems for mental health referrals ▪ Provide outreach, screening, assessment, referral, and direct BH treatment services and supports ▪ Standardize school-community mental health partnerships Building Level: ▪ Implement integrated, aligned referral system to be used in each building ▪ Utilize supports organized through district efforts to support students and families	*LEA & Building: Process/Outputs* Established/implemented screening and referral systems/practices # and type of students screened for T2/T3 MH or related services through MTSS teaming process # and type of T2/T3 students referred for MH or related services # and type of students referred to T2/T3 interventions # and type of T2/T3 interventions # and type of students engaged in T2/T3 interventions Dosage of T2/T3 interventions Level of student satisfaction	3.5 Increase the number of individuals referred to mental health or related services, with approximately 5% of students in the schools of focus referred to mental health or related services (Tier 2 and 3) by the end of Year 1; refer approximately 10% annually in years 2 & 3 and approximately 15% annually in years 4 & 5 as measured by project records. (R1)
3.6 In Year 1, 42% of students who were referred to mental health or related services (Tier 2 or 3, 3.5 above) will receive those services; Year 2: 55%, Year 3: 63%, Year 4: 70%, Year 5: 78%. (AC1) (GPRA PM)	SEA Activities: ▪ Identify and inform policy issues and barriers related to mental health awareness, promotion, and access BHSN Activities: ▪ In collaboration with district, school, and community-level partners engage regional and state level partners (e.g., Accountable Communities of Health, MCOs, etc.), to assess schools' reinvestment of Medicaid funds (SBHS and MAC) ▪ Design/enhance building level billing systems ▪ Conduct outreach/education to make eligible families aware of and knowledgeable about the Medicaid system and how to access it ▪ Address capacity barriers through recruitment and incentives for rural communities (similar to practice transformation work at HCA)	*SEA: Process/Outputs* See 1.2 *ESD 105: Process/Outputs* Evidence of collaborative processes to engage cross-system partners	3.6 In Year 1, 42% of students who were referred to mental health or related services (Tier 2 or 3, 3.5 above) will receive those services; Year 2: 55%, Year 3: 63%, Year 4: 70%, Year 5: 78% as measured by project records. (AC1)

Goal 3) Connect school-aged youth who may have behavioral health issues and their families to needed services.			
Objective	*Activities*	*Process/Outputs*	*Outcomes*
	LEA/District Activities: ▪ Develop relationships with other agencies, broaden link to available resources, coordinate/integrate funding Building Level: ▪ Monitor number of referrals in relationship to data targets ▪ Utilize supports organized through district efforts to support students and families	*LEA: Process/Outputs* See also 3.5 Evidence of collaborative processes to engage cross-system partners and braid/integrate funding sources *Building: Process/Outputs* See 3.5	
~~3.7 Annually, improve emotional and behavioral health among 50% of youth receiving Tier 2 services and supports as compared to baseline.~~ ~~(Student-Level)~~ Revisit at end of Year 2 – activities moved to Objective 3.5.	~~SEA Activities:~~ ~~▪ Facilitate trainings among district-and school-based MTSS teams to implement a system of function-based supports for students with persistent challenging behavior. The primary goal of the Basic FBA to BIP series is to train school-based personnel to conduct "Basic" functional behavioral assessments (FBA) and design, implement, and evaluate function-based behavior intervention plans (BIP).~~ ~~▪ See 3.6 above~~ ~~LEA/District Activities:~~ ~~▪ Identify & implement evidence-based tiered supports aligned with identified needs~~ ~~Building Level:~~ ~~▪ MTSS building level team identify culturally and developmentally appropriate EBPs for implementation across the tiered continuum of services and supports. Classroom-based and/or small group/individual sessions will help school-aged youth develop skills that promote resilience; avert development of mental and behavioral health disorders; increase MH literacy; improve school climate; and prevent youth violence.~~	~~*SEA: Process/Outputs*~~ ~~See 2.1-2.3~~ ~~*LEA: Process/Outputs*~~ ~~See 3.5~~ ~~*Building: Process/Outputs*~~ ~~See 3.5~~	~~3.7 Annually, improve emotional and behavioral health among 50% of youth receiving Tier 2 services and supports as compared to baseline as measured by project records.~~

Goal 3) Connect school-aged youth who may have behavioral health issues and their families to needed services.			
Objective	*Activities*	*Process/Outputs*	*Outcomes*
3.8 Annually, improve behavioral functioning among 50% of students engaged in Tier 3 services and supports as compared to baseline. *The number of participants who engage in school-based mental health services (Tier 3)* *100% of T3 participants complete the NOMs Intake instrument.* *80% of those completing the NOMsS Intake complete a 6-month follow NOMs (as appropriate)* *80% of those completing the NOMSs intake, complete the NOMs discharge tool at program completion/exit.* *The number and percentage of participants who show changes in behavioral health indicators e.g., substance use, mental health functioning, criminal justice involvement and other identified measures* *GPRA PM* (Student-Level)	SEA Activities: ▪ See 3.5 - 3.7 above ESD 105: ▪ In collaboration with Evaluation Team, partner with community providers for support in completing required measures (NOMs) LEA/District Activities: ▪ For Tier 3 services, community-based MH providers will be embedded into the school system to deliver SMH services that are culturally and developmentally appropriate and evidence-based (e.g., CBT). These evidenced-based Tier 3 services will include individual, group, and family treatment; consultation; and progress monitoring for students with symptoms consistent with a mental or social emotional disorder(s). Building Level: ▪ By the end of Year 2, have 5 embedded mental health providers: 1 at HS, 2 at MS, 2 at ES (SSD) ▪ By the end of Year 2, have 4 embedded mental health providers: 1 at HS, and 3 serving other buildings. (WSD) ▪ By the end of Year 3, have 4 mental health providers at each of the middle schools (YSD)	*SEA: Process/Outputs* See 2.1-2.3 *LEA: Process/Outputs* # of MH providers embedded in school system See 3.5 (T3 students) *Building: Process/Outputs* # of MH providers embedded in school-level MTSS teams Incorporation of FBA into Tier 3 services and supports See 3.5 (Tier 3 students)	3.8 Annually, improve behavioral functioning among 50% of students engaged in Tier 3 services and supports as compared to baseline as measured by the NOMs Intake and Discharge instruments.
3.9 Annually, improve social connectedness among 50% of students engaged in Tier 3 services and supports as compared to baseline. *GPRA PM – See above.* (Student-Level)	SEA Activities: ▪ See 3.5-3.8 above LEA/District Activities: ▪ See 3.5-3.8 above Building Level: ▪ See 3.5-3.8 above	*SEA: Process/Outputs* As SEA measures in 3.8 *LEA & Building: Process/Outputs* As LEA measures in 3.8	3.9 Annually, improve social connectedness among 50% of students engaged in Tier 3 services and supports as compared to baseline as measured by the NOMs Intake and Discharge instruments.

WASHINGTON PROJECT AWARE FY 2020

Sunnyside School District Community Health Assessment

"All students will be successful." **– District vision**

June 2021

Prepared for:
Washington State Office of Superintendent for Public Instruction

Washington Office of Superintendent of
PUBLIC INSTRUCTION

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In collaboration with:
Contacto Consulting and
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Introduction

In October 2020, the Washington Office of Superintendent of Public Instruction (OSPI) was awarded a five-year Project AWARE (Advancing Wellness and Resilience in Education) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). OSPI serves as the lead agency for a consortium of three partner school districts, or Local Education Agencies (LEAs): Sunnyside School District, Wahluke School District and Yakima School District. This project, *"Beyond Co-Location: Integrating and Embedding Education and Mental Health Systems"* addresses the national Project Aware initiative. The building of collaborative partnerships between state and local systems specifically education and mental health strengthens the system's capacity to promote the healthy development of school-aged youth and to prevent youth violence through an integrated multi-tiered system of support (MTSS) framework.

In addition to efforts at the state level to integrate education and mental health, strengthen MTSS initiatives, develop sustainable regional mental health support networks, and document practices that are scalable to other regions in Washington, the specific goals of the AWARE project are to:

1) Increase ***awareness*** of mental health issues among school-aged youth through the development, implementation, and sustainability of a comprehensive school-based system of mental health services and supports.
2) Train school personnel and other adults who interact with school-aged youth to detect and ***respond*** to mental health issues.
3) ***Connect*** school-aged youth who may have behavioral health issues and their families to needed services.

A best practice related to the implementation of an MTSS framework is the conduct of a behavioral health assessment and resource mapping to document existing school and community-based services across tiered-levels of supports. Through this process, both needs *and* strengths are incorporated, thereby centering communities, their culture, and history; elevating community voices; and making equity and antiracism the framework (not simply a lens) in which assessments and strategic planning take place. By including assets, we can paint a more complete picture of communities, illustrate their resilience, and identify opportunities for maximizing existing resources.

The purpose of this assessment process is to:

1. Highlight community strengths and disparities and articulate how these will be addressed through the implementation of Project AWARE.
2. Ensure assessment findings inform Project AWARE's goals, activities, and outcomes.
3. Use community assessment findings to inform project partners in the design and implementation of school-based mental health services and supports.

This report contains the findings for the Sunnyside School District Regional Community Health Assessment conducted by Maike & Associates in the spring of 2021.

Methodology

Key data points and the latest research findings were used to assess the well-being of Sunnyside students and families. Much of the data comes from public records, such as national and state census data. State, county, and school district data were also collected from the Risk and Protection Profile for Substance Abuse Prevention in Washington Communities (January 2021). Annually, the Washington State Department of Social & Health Services, Research & Data Analysis Division, produces these reports, which include technical notes on the methodological approaches used to obtain data reported at the district-level.

Additionally, Sunnyside School District 6th, 8th, 10th, and 12th grade students participate in the Washington State Healthy Youth Survey (HYS) in the fall of even numbered school years. The HYS is sponsored by the Department of Health, the Office of Superintendent of Public Instruction, the Department of Social and Health Services, the Department of Commerce, the Family Policy Council, and the Liquor Control Board in cooperation with schools throughout the state. The survey measures health risk behaviors known to contribute to the health and safety of youth. Survey results serve two important functions: first, providing needs assessment data for program planning; and second, giving a measure of the global effectiveness of statewide prevention and health promotion. The regular collection of HYS data is crucial for tracking progress toward improved outcomes. (Survey response rates, by grade and survey year, can be found in Appendix A).

Other major data sources used for this assessment include the County Health Rankings & Roadmaps, a program of the University of Wisconsin Population Health Institute, which provides a snapshot of a community's health using county-level data. Rankings are based on a model of population health and include data from Behavioral Risk Factor Surveillance System, Mapping Medicare Disparities Tool, American Community Survey 5-year estimates, Census Population Estimates, and other sources. For many measures, data are available by race/ethnicity within a county.

Another major component of this work was to conduct in-depth qualitative interviews and focus groups with key district informants to better understand the nature, depth, and breadth of current school-based social, emotional, and behavioral strategies being implemented. The main purpose of the interview was to obtain a deeper understanding of the scope of resources, services, or programs available to students and staff within each respondent or group of respondents' roles. We also sought to identify barriers or challenges that could hinder the implementation of school-based mental health services.

Participants included staff at the elementary, middle, and high school levels, including buildings administrators and school counselors. Other key informants included parents, students, and community members. Contact and scheduling of focus groups and interviews was coordinated by the LEA district. In all, 36 individuals participated in the interview and focus group process.

Each participant was asked to answer questions from their perspective, with regard to their specific experience and expertise. As such, not all respondents answered all questions and not all questions were asked of all respondents. Individual teacher interviews were approximately 30-45 minutes, with

focus groups lasting 90 minutes each. Completed interviews were transcribed, coded for themes, analyzed, and are summarized in the following sections. (See Appendix B for focus and interview questions by group).

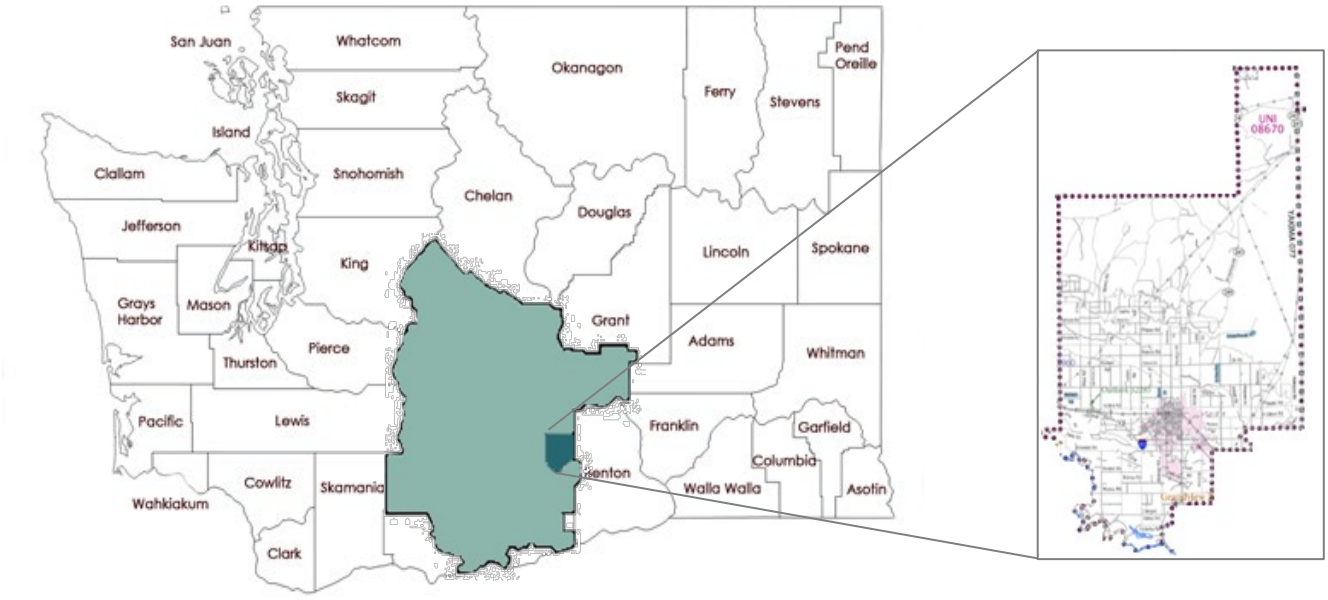
Participants were asked to identify the most pressing social, emotional, behavioral health issues facing students in their school district community. These questions asked were framed around the three goals of Project AWARE outlined previously. Throughout this report, we use this information to provide a snapshot of key indicators, and include trend data, as well as comparisons over time to the state, and county, as appropriate, and when available. This process is an essential component of the school-based mental health systems review for the Sunnyside School District.

District and Community Demographics

Geographic Description

The Sunnyside School District is located in Washington state, on the eastern side of the Cascade Mountain range in the heart of the Yakima Valley. The Sunnyside School District is comprised of five elementary schools (grades Pre-K-5), two middle schools (grades 6-8 grade), and one high school (grades 9-12). It serves students from the municipalities of Sunnyside and Outlook in Yakima County.

Educational Service District (ESD) 105, one of nine regional ESDs across the state, provides services and supports to the district, along with 24 other public-school districts and more than 20 state-approved private and tribal schools located in the south-central region of the state.



Sunnyside School District is located within the service boundaries of ESD 105 in Washington State.

Covering 4,293.4 square miles, Yakima County is the second-largest county in Washington by land area, and ninth-largest by population. The county is situated on the original land of the people of the Confederated Tribes and Bands of the Yakama Nation that extended in all directions along the Cascade Mountain Range to the Columbia River and beyond (https://www.yakama.com/about/). Today, the Yakama Nation Reservation, covers over 1.3 million acres, and is located within the county (U.S. Census). The county's economy is agriculture-based, with vineyards, pastures, orchards, and hops the main crops. The Yakima River provides irrigation for the farmlands throughout the valley.

The city of Sunnyside is situated in the middle of the Yakima Valley at 745 feet, with a total area of 6.63 square miles. The city center is accessed off State Highway 82, nearly equidistant between the City of Yakima (to the North) and the Tri-Cities area (to the Southeast). Outlook is an unincorporated community located 4 miles west of Sunnyside.

Population

The population in Yakima County is estimated at 249,697, with a density of 58.2 persons per square mile, considerably less than the Washington state average (101.2 persons/square mi). The city of Sunnyside has an estimated population of 16,559, and the town Outlook's population is 48 persons. The Sunnyside School District region is comprised of an estimated 26,189 residents (not just enrolled students).

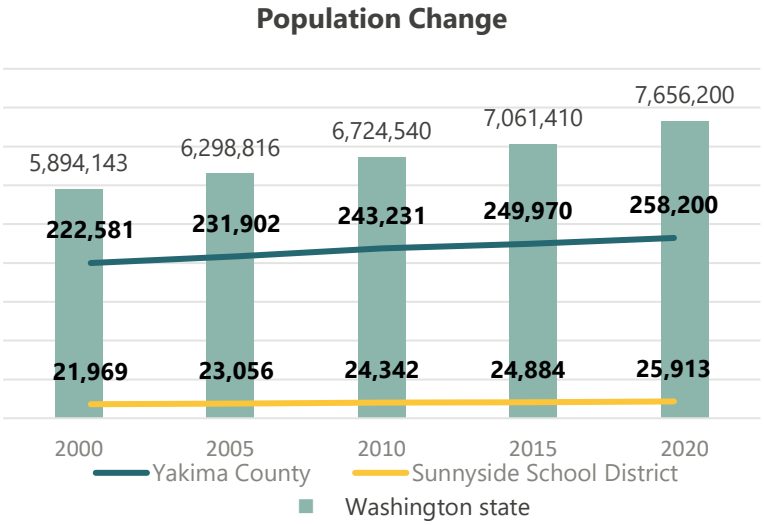


	Washington State	Yakima County	Sunnyside School District*
Total population	7,404,107	249,697	26,189

*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

Population Change

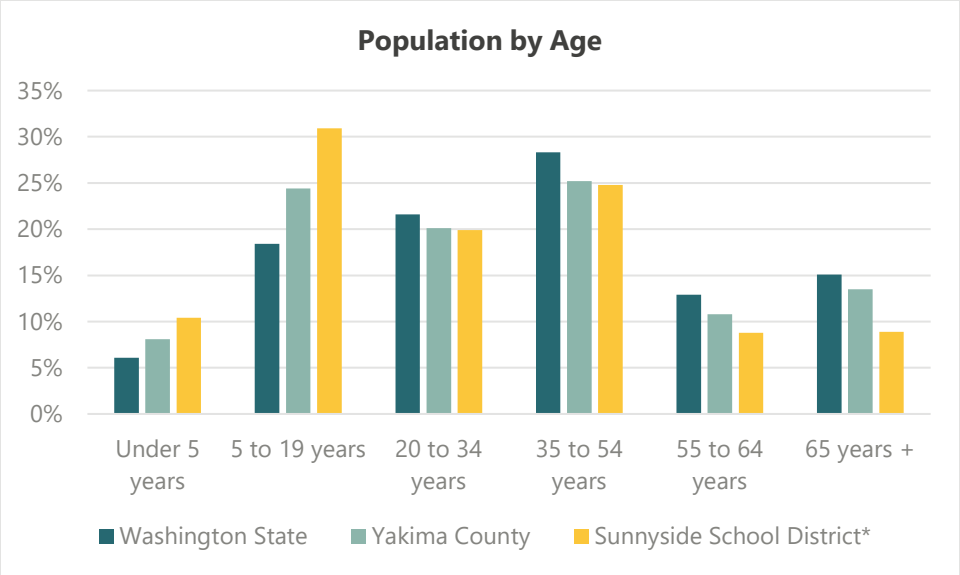
Washington state's population grew by 109,800 persons, or 1.5%, between 2019 and 2020. Migration was the primary driver behind the state's population growth (OFM, 2021). Over the past decade, Yakima County had an annual average population growth rate of less than 1 percent, slightly below the growth experienced at the state level (1.5%). Growth within the Sunnyside School District area also lagged the state average.



Source: WA State Office of Financial Management, Decennial Census Population Counts, 1890 – 2010 and 2010-2020

Age and Sex Distribution

While one quarter (24.5%) of Washington's population is 19 years or younger, nearly 30% of people living in Yakima County, and 39% of the district's residents fall within that age distribution.



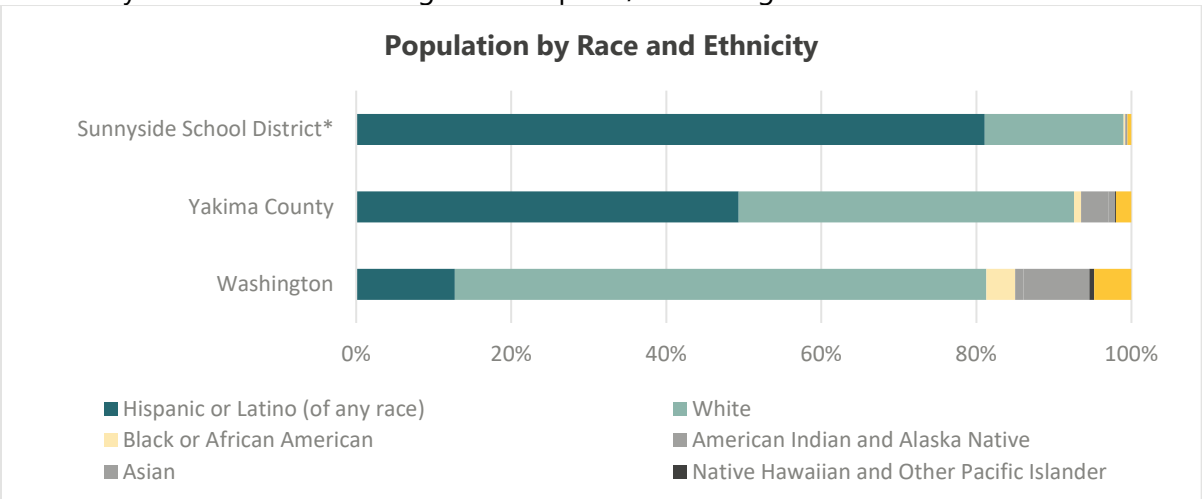
*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

Census data indicate that females comprise half the population in the state (50.3%) and the county (50.4%), with slightly more females (53%) in the Sunnyside School District region.

District Population: At the beginning of the 2020-2021 school year, there were 6,723 students enrolled in the district (down from 6,805 in school year 2019-20). Among these students, slightly more were male (51%) than female (49%).

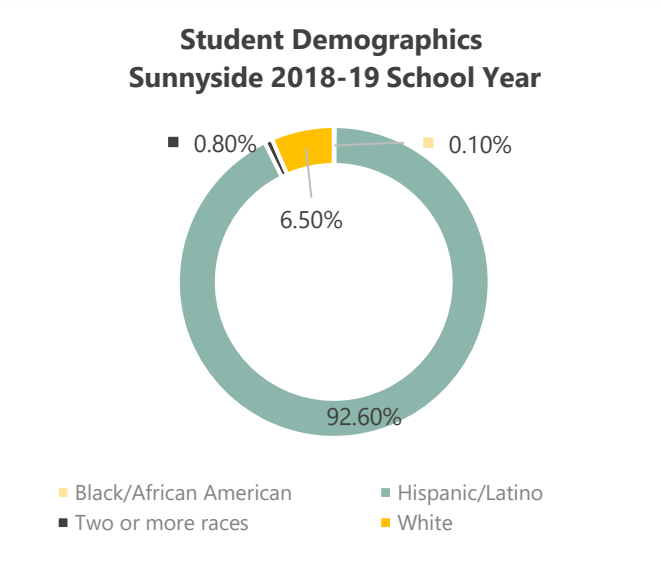
Race and Ethnicity

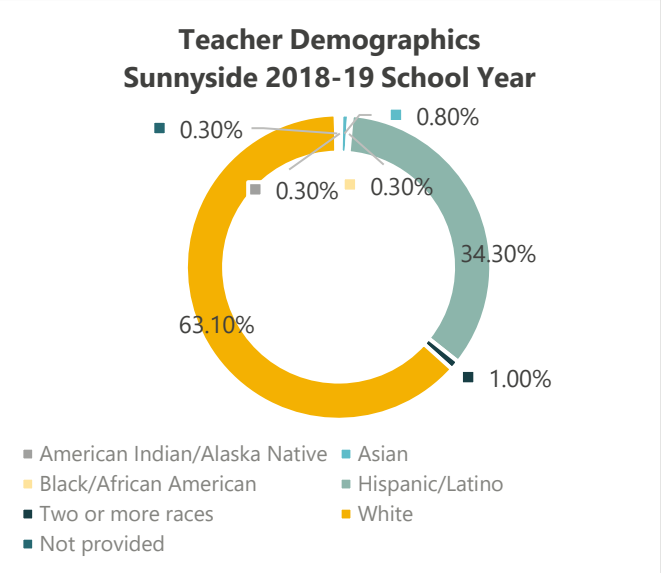
The percentage of people who are Hispanic/Latinx in Yakima County is higher than Washington State and the United States (49.3% compared to 12.7% and 18%, respectively). The percentage of people living the Sunnyside School District region of Hispanic/Latinx origin is 81%.



*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

District Population: In the 2018-19 school year, 48% of students and 72% of classroom teachers in the Sunnyside School District identified as female. Among racial/ethnic groups, nearly all students (92.6%) identified as Hispanic/Latinx of any race, compared to 34.3% of classroom teachers. Statewide, 74% of the classroom teachers identify as female and 87% as white.



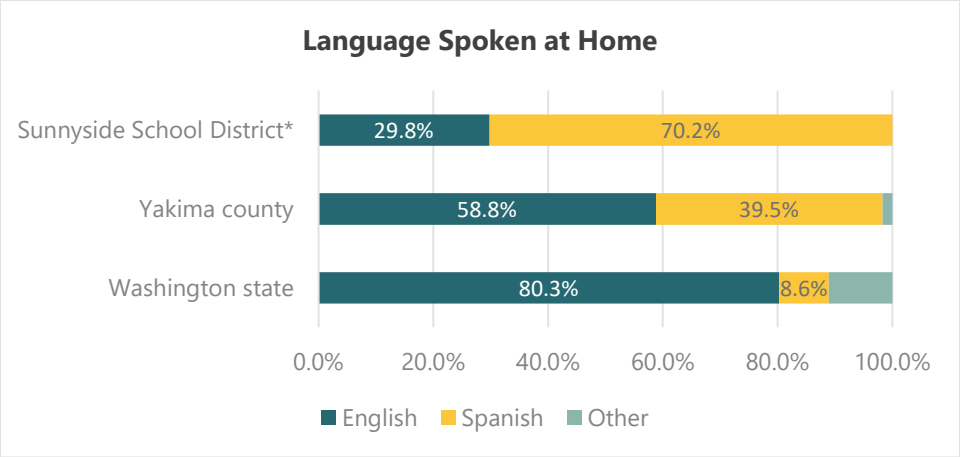


Source: OSPI Report Card, 2018-19

Additionally, many students (86.3% or 5,914 individuals) identified as low income, 31.6% as English Language Learners, 16.7% as migrant, and 16% as having disabilities.

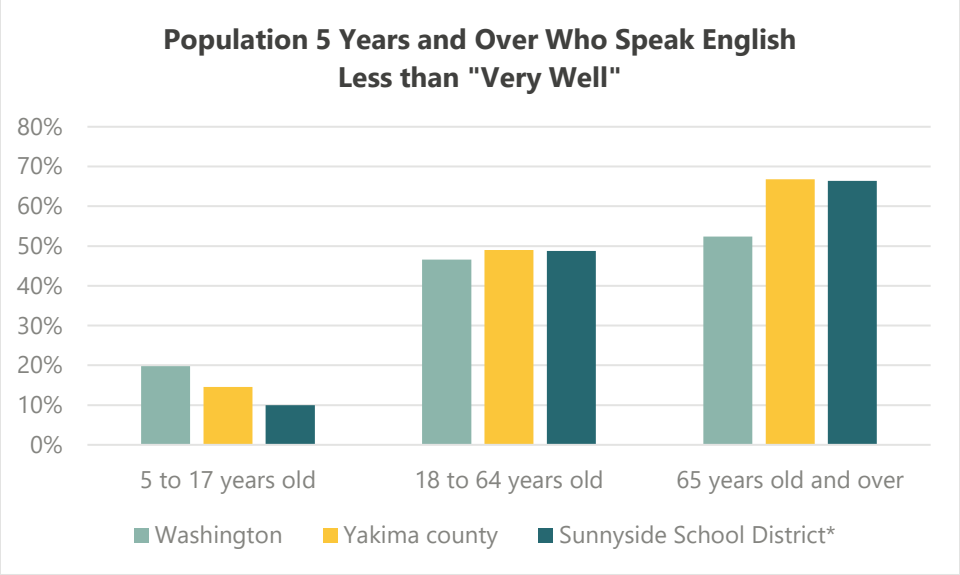
Language Spoken at Home and English-speaking Ability

Over two-thirds of residents within the Sunnyside School District community speak a language other than English, with Spanish being the predominant language spoken at home. This compares to approximately 40% of families in the county, and 9% of the population statewide.



*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

Almost half of adults 18 to 64 and nearly two thirds of adults 65 and older in the Sunnyside School District region speak English less than "very well." That suggests that while many students (90%) speak both English and Spanish, most of their parents and caregivers communicate better in Spanish.



*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

Summary and Implications

Although the Sunnyside School District's regional population has lagged behind both the county and state growth rates over the past two decades, the district and its surrounding communities are comprised of a relatively young population. In fact, nearly 40% of the regional population is 19 years of age or younger. The demographic make-up indicates a highly diverse population as compared to the state, with most residents of Hispanic/Latinx origin who are predominantly Spanish speaking. School-level enrollment data also reflect a student population that is comprised of nearly all Hispanic/Latinx youth.

Community connectedness and family were at the top of the list for all respondents in terms of assets and strengths of the Sunnyside School District.

> *"This is a small town, everyone knows each other. We are close to family, close to friends and extended family –it's a good community."* —Student

> *"It's a very tight knit community in the way of support for people. When someone is struggling, the community steps up and helps, whether it's a sickness or a death or a house fire."* —School staff member

At the same time, participants raised concerns about implicit biases and a lack of culturally and linguistically responsive school staff and mental health support available to students and families.

> *"The other big piece is having staff that can speak the languages of the parents that we serve. A lot is lost in translation; between trying to translate to the mental health worker and asking the child questions, there's interruption."* —School staff member

Parents feel that schools must gain the families' trust and build relationships. "It has to be personal."

> *"Our people are ashamed to ask for help. Create time to establish trust."*

Staff agree:

> *"I found that it's trust. We work with a lot of people that (are) Hispanic, and Black and brown people are like 'I'm not gonna trust a lot of people that don't look like me'. Once you break down those barriers of 'hey, we're here to help you. I'm not here to call CPS on you; you're not in trouble', parents start realizing that, 'gosh, these guys are really legit."*

> *"I think it matters how you present it to them, how it comes across will make a big difference as to how they will open up to those services."*

These findings indicate a strong need to ensure Project AWARE services and supports are culturally and linguistically responsive and relevant to the population of students, families, and community members served. Moreover, given the higher-than-average percentage of young people and families who make up the region it is likely that the district will see even more growth in the enrollment population in the coming years. As the district plans for service implementation the following areas of focus are suggested (as appropriate):

- Ensure inclusion of family voice to reduce linguistic isolation for those families with limited English abilities.
- Provide training opportunities for community and families that meet the linguistic and daily life (e.g., agricultural work) considerations of the community, both in transportation to/from services, and access to services that have the capacity to serve a primarily Spanish speaking population.
- Create opportunities for systems and providers to offer and to expand access to healthcare and educational services in Spanish.

Upstream Determinants of Health and Educational Opportunities

Health and education are both influenced by many factors, and they also influence each other. Good health—both physical and mental—is critical to children's success in school. At the same time, education is one of the conditions that impacts health outcomes. Health is more than healthcare. In fact, only 20% of someone's overall health is affected by access and quality of healthcare (Schroeder, 2007). Although Washington generally performs better than other states in terms of health indicators, health disparities do exist in the state, and not all communities show consistent good quality health.

Because Project AWARE's goals are centered around the interconnectedness of the education and behavioral healthcare systems, it is important to consider the numerous social and environmental factors that affect the whole person, and thus the whole community. The following section describes some of the upstream determinants of health (and education), their connection with health equity, and the degree to which these factors are present in the Sunnyside School District region.

Definitions

There are many factors that influence the health of a community. Assuring that positive social factors are present in people's lives is a key approach to achieving **health equity**. Health equity is "giving special attention to the needs of those at greatest risk of poor health, based on social conditions" (Seattle Children's Hospital, 2019). That doesn't mean "sameness" or equality, since some populations need more or different access and services to achieve health. Ultimately, healthy equity occurs "when everyone has the opportunity to 'attain their full health potential' and no one is 'disadvantaged from achieving this potential because of their social position or other socially determined circumstance'" (Brennan Ramirez LK, 2008).

Health inequities cause health disparities, defined as health differences that are closely linked with economic, social, or environmental disadvantage. "**Health disparities** adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic-status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion" (Healthy People 2020).

On the educational side, the ways in which race, ethnicity, ZIP code, socioeconomic status, English proficiency, and other factors impact students' educational aspirations, achievement, and attainment (Great Schools Partnership, 2014) is known as the **opportunity gap.** While the opportunity gap looks at the inputs of the system, the **achievement gap** refers to significant disparities in academic outcomes between different groups of students, such as white and BIPOC (black, indigenous, people of color) students. These results are grounded in the **structural racism** of the education system, which is historically centered in whiteness, and are amplified by government-mandated reporting metrics such as standardized test scores, grades, and graduation rates (National Network of State Teachers of the Year, 2018). Unlike individual racism, structural racism encompasses larger systems that work to create and maintain dominant white culture to the detriment of people of color.

The conditions in which people are born, grow, live, and age shape both health and educational opportunity. These are known as **social determinants of health (and education)** and are grouped into five domains according to Healthy People 2030 (US Department of Health).

Health care access and quality Influenced by health insurance, services and medication affordability and access, health literacy, among other issues	**Economic stability/ wellness** Refers to people's access to jobs and their ability to keep steady employment.	**Education access and quality** Which is impacted by family's income, disability, discrimination and other interrelated factors.	**Neighborhood and built environment** Including transportation systems, affordable and quality housing, access to safe air and water, and access to public lands and services	**Social and community context** Takes into consideration safe and positive family relations, community support, and a sense of belonging.

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion

Below, we describe findings for the Sunnyside School District region aligned with these five areas of social determinants of health and education.

Health Care Access and Quality

Access to quality health care that is affordable, close to home, with the services that people need, and that is culturally sensitive, contribute to the overall wellbeing of individuals and communities.

Access to Care

Access to health care, which includes primary, specialty, emergency, dental and mental health care, encompasses the ability of an individual or family to visit a healthcare provider when needed, as well as the quality and accessibility of the interaction with the healthcare system. Family education, health insurance coverage, health literacy, supports to navigating healthcare services, in-language services, access to interpreters and translated information are all elements of health care access. At the same time, barriers to navigating the healthcare system, such as insurance eligibility requirements, lack of insurance coverage, lack of care coordination, long wait times, and the challenges of travelling to appointments impact access to care.

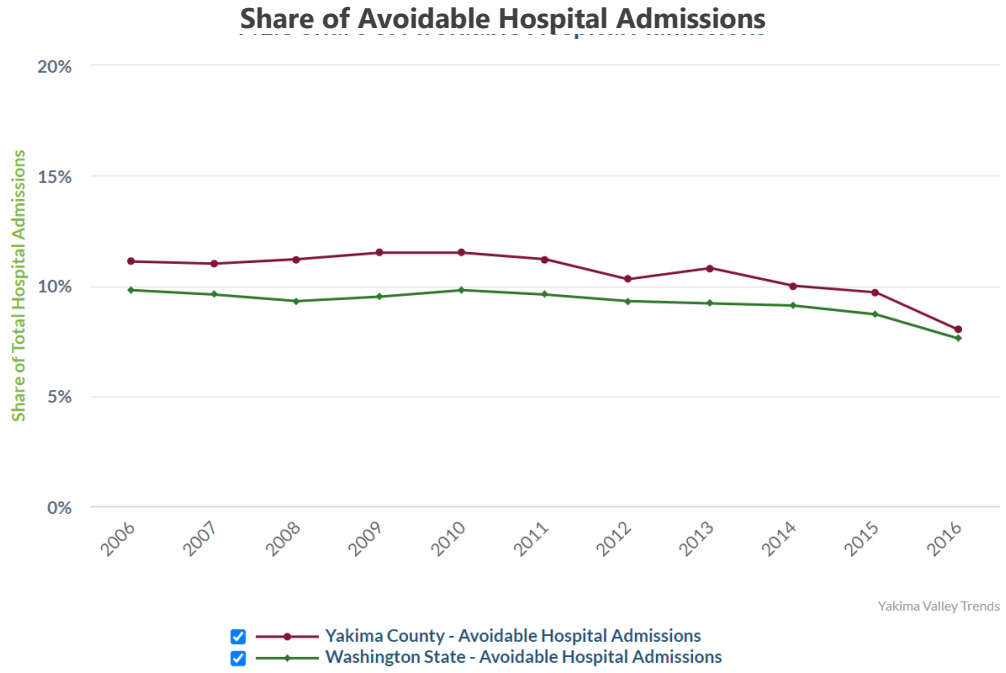
In Yakima County, the ratio of residents to primary and dental care providers is above state and national norms (County Health Rankings, 2021), meaning the public has access to fewer providers. During 2016, the

share of avoidable hospital admissions in Yakima County was 8.0%, decreasing from 11.1% in 2006 and above the Washington State share (7.6%).

Ratio of Healthcare Providers to Residents

Clinical Care Setting	Yakima County	Washington
Primary care physicians	1,500:1	1,180:1
Dentists	1,490:1	1,230:1

Source: County Health Rankings 2020 (using 2019 data)

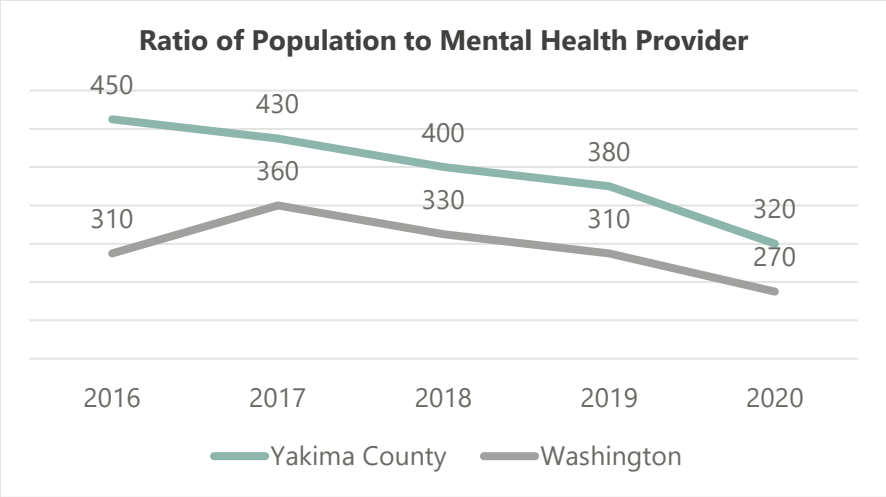


Source: Eastern Washington University Institute for Public Policy and Economic Analysis, http://yakimavalleytrends.org/

Shortage of Mental Health Workforce

According to Seattle Children's Hospital (2019), Washingtonians are concerned about the lack of community resources that make it challenging to access mental and behavioral health care. Further, findings indicate that community members statewide stress the importance of having providers that reflect the community's diversity; urge the need to address geographical disparities in access to care for more rural areas; and residents note that specialty care is especially difficult to access.

While access to care has improved, the rate of mental health providers (including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists and advanced practice nurses specializing in mental health care) per population, if the population were equally distributed across providers, has gotten better overtime. Data indicate that access to mental health providers in Yakima County is improving. In fact, in 2020, the ratio of persons to providers in Yakima County was 320:1 – a considerable improvement from 2016 (450:1). In Washington, ratios range from 2,250:1 to 220:1, with an overall ratio of 270:1.

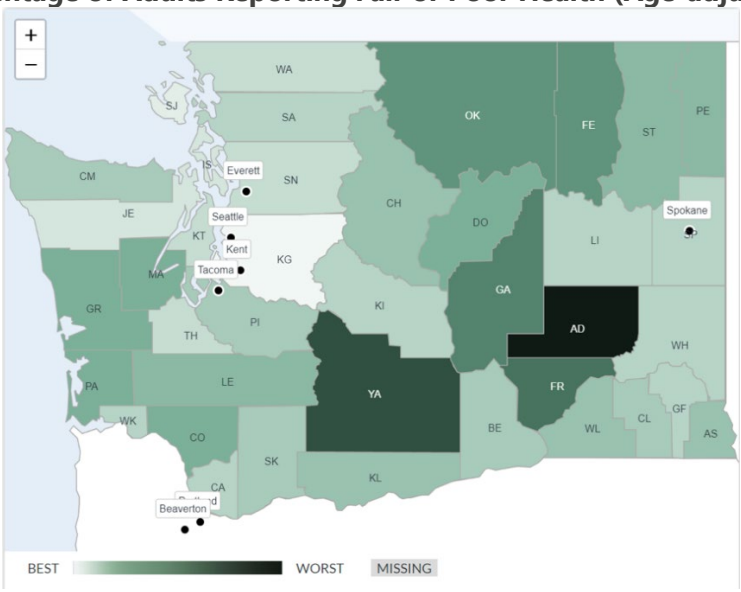


Source: *County Health Rankings 2021*. Note: Higher number is worse.

Quality of Life

Quality of life refers to how healthy people feel while they are alive. "It represents the well-being of a community, and underscores the importance of physical, mental, social, and emotional health from birth to adulthood" (County Health Rankings & Roadmaps).

Percentage of Adults Reporting Fair or Poor Health (Age-adjusted)



Source: 2021 County Health Rankings using data from 2018

In general, more people in Yakima County consider themselves to be in poor or fair health as compared to others in the state.

COVID-19 Pandemic

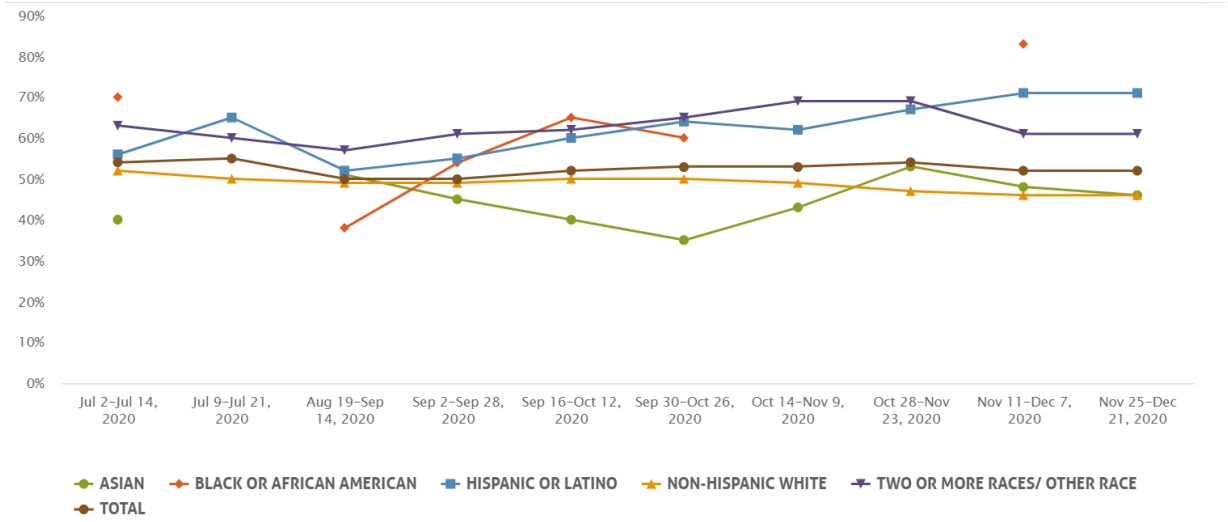
On March 13, 2020, the United States government declared a national emergency concerning the novel coronavirus disease, COVID-19; thus, officially marking the start of the pandemic in the U.S. Since then, the U.S. Census Bureau, along with other federal and state agencies, have collected and tracked data to measure household experiences resulting from the COVID-19 pandemic.

In Washington state, socio-economic consequences of the pandemic include:

- Since March 13, 2020, half of Washingtonians living in households with children have lost employment. The percentage is higher for Hispanic/Latinx households (71%) and households of two or more races (61%) (see graph).
- The percentage of adults ages 18 to 24 who reported that they or a household member lost employment income steadily increased from 47% in June-July 2020 to 63% in Nov-Dec 2020.
- One in six adults (16%) living in households with children have little or no confidence in their ability to pay their next rent or mortgage payment on time.

While everyone has experienced the effects of the COVID-19 global pandemic in one way or another, the health, social, and economic consequences for BIPOC families and communities have been more severe. The pandemic exacerbated long-standing systemic racism. Racism is *the* reason why BIPOC communities have been disproportionately impacted by COVID-19 (CDC, 2021; Mental Health America, 2020; and others). In fact, women, Black, Hispanic, and mixed-race respondents reported a higher prevalence of adverse behavioral health outcomes due to worry and stress related to the pandemic as compared to men, White, and Asian participants (Panchal, Kamal, Orgera, Cox, Garfield, Hamel, Munana, & Chidambaram, 2020).

Adults Living in Households with Children Who Lost Employment Income since March 13, 2020, in Washington by Race/Ethnicity



Source: Population Reference Bureau analysis of the U.S. Census Bureau, Household Pulse Survey, 2021.
Graphic: KIDS COUNT Data Center, datacenter.kidscount.org – A project of the Annie E. Casey Foundation

BIPOC communities have also been hit harder by infection rates. For example, public health data in October 2020 showed that 31% of Washington state cases were Hispanic/Latinx, even though they comprise only 13% of the state population.

Other pandemic-related disparities facing the Hispanic/Latinx population in the state include:

- Lack of insurance - Approximately 20% of Hispanic/Latinx people are uninsured. In comparison, Washington's uninsured rate went from just over 6% pre-Covid, to 13% in May 2020 (Office of Financial Management, 2021).
- Working conditions – The most common occupations held by Hispanic/Latinx people in the U.S. (cleaning, construction, agriculture, and service industries) were considered "essential" at the beginning of the pandemic and workers continued working on-site, increasing their risk of becoming infected (Baquero et. al., 2020).
- Housing conditions – many Hipanic/Latinx families live in multigenerational households, which contributes to social cohesion. It also increases the risk of infection. In June 2020, Yakima County saw an increase in COVID cases among Hispanic/Latinx individuals, attributed to lack of personal protective equipment (PPE), lack of physical distancing guidelines, crowded housing conditions, and poor sanitation in work (Baquero et. al., 2020).
- Language barriers - Limited access to information, lower levels of health literacy, and wide-spread misinformation across media and social media have been a big challenge to preventing the spread of COVID (Baquero et. al., 2020).
- BIPOC populations have received fewer doses of the COVID-19 vaccine compared to non-Hispanic white people. While Latinx/Hispanic account for approximately 32% of cases, only 4.7% of Washington residents who have received the vaccine (as of February 2021) were Hispanic (Washington DOH, 2021).

Summary and Implications

Access to healthcare in the county has gotten increasingly worse over time, with a shortage of both primary care physicians and mental health providers. Identified health inequities are further evidenced by poorer and worsening quality of life among residents in part as a result of the COIVD-19 pandemic. Among BIPOC communities these challenges are even more dire, with higher rates of infection, and increased likelihood of unemployment as compared to white residents.

For participants of interviews and focus groups, the limited access to local, accessible, culturally sensitive care was at the top of the list of factors related to quality healthcare.

> *Having enough providers is a major gap in our community. (We don't know) where we're at with community mental health partners as far as local enough for some of our lower income families to be able to obtain. And so, we want to be able to refer and we do refer, but there are times that we don't get a lot of follow through from families because it's just too hard.*
>
> —School staff member

Providers that accept insurance that is available to families is another barrier. So are long wait times.

> *There has been a drastic change in the way mental health can be accessed with medical coupons. Before one could use them but now the doctor must refer to a counselor. They make an appointment for you for an evaluation and it may take two to three months. What is the point then? That is something very wrong with the system.* —Parent

An overarching goal of Project AWARE is to *connect school-aged youth who may have behavioral health issues and their families to needed services*. Research and data reported in this section demonstrate that health inequities and consequences of systemic racism faced by BIPOC populations impact access to quality healthcare. Although much of these data are focused on the state and county levels, the healthcare disadvantages facing the Hispanic/Latinx communities are clear. As such, it is important to consider the ways in which grant-funded services and supports can increase the number of behavioral health services available to students and families in the Sunnyside School District, but also how these systems can improve equitable access to quality healthcare services.

Community Assets and Resources

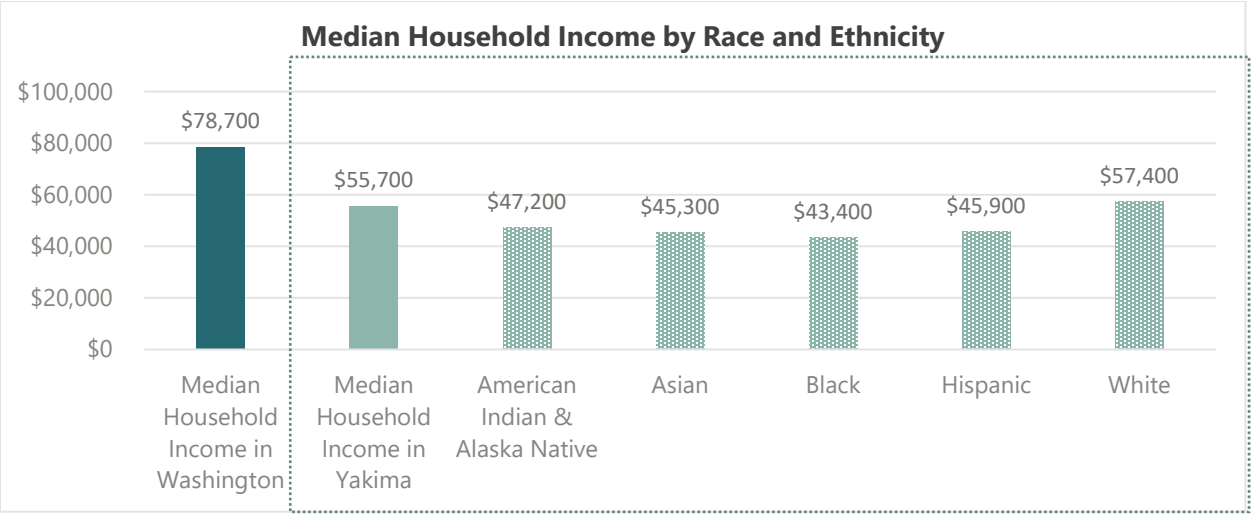
Some of the valuable organizations that contribute to the health and well-being of young people and families in the Sunnyside School District area include:

- The Yakima Health District improves Yakima County's public health by providing communicable disease prevention, adult immunizations, injury prevention, and promotion of healthy eating and physical activity.
- Children's Village provides services to children with special health care needs and their families, including medical specialty clinics, developmental screening, and mental health counseling.
- Yakima Valley Farm Workers Clinic is a healthcare system of over 40 clinics across Washington Oregon, offering pregnancy to behavioral to dental care.
- Astria Health is the parent non-profit owner of Astria Sunnyside Hospital, a 25-bed facility, and Astria Regional Medical Center, a 214-bed facility located in Yakima.
- Yakima Valley Memorial, a 226-bed non-profit community hospital that has served the Yakima valley for more than 70 years.
- Yakima Neighborhood Health Services has community clinics in Yakima, Sunnyside, and Granger that provide medical, dental, maternity, and pharmacy services to patients regardless of ability to pay. They also offer services to unhoused individuals.

Economic Stability and Well-Being

There have been increasing concerns about the relevance of traditional economic indicators to measure well-being, including poverty (Organisation for Economic Co-operation and Development, 2013). Current metrics often look at individual or household outcomes, rather than the collective well-being. For example, the number of people living below the poverty line does little to show a community's

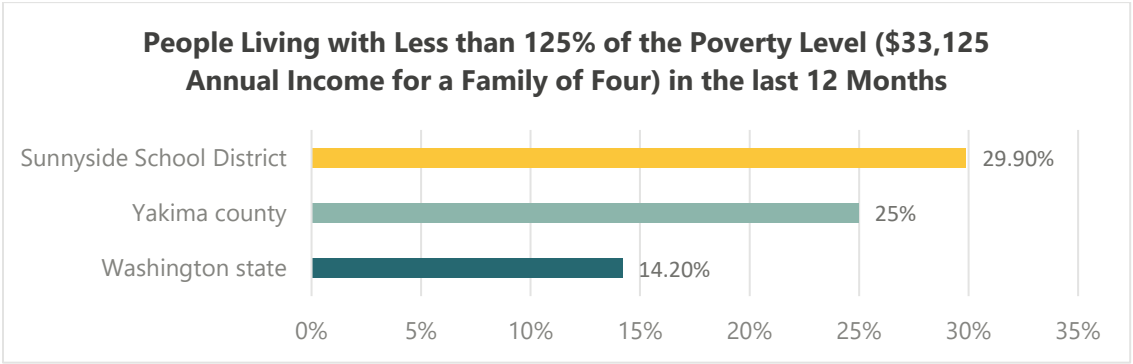
overall well-being (The New Economy Washington Report, 2019). Economic well-being can be understood as having present and future economic security, including the ability for people to meet their daily basic needs and to make choices that give them a sense of security, satisfaction, and fulfillment over time (Council on Social Work Education, 2016).



Source: 2021 County Health Rankings using 2019 US Census Bureau data

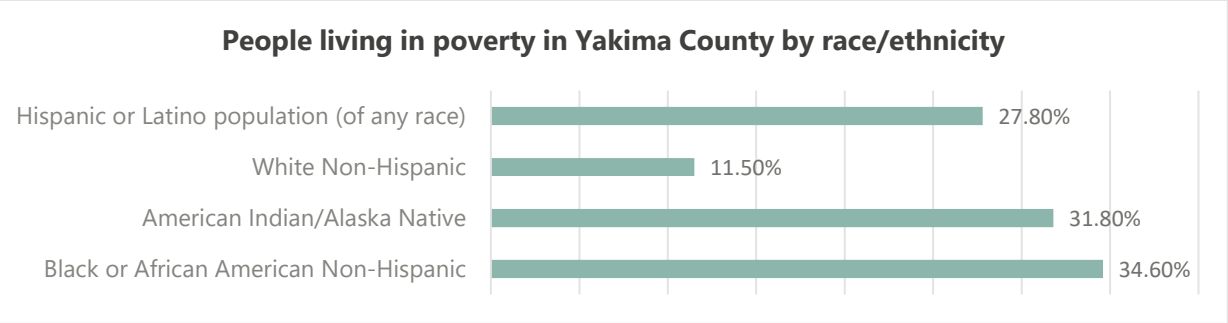
In Yakima County, the median household income in 2019 was estimated at $55,700 – well below the Washington estimate of $78,700. Data show disparities in income by race and ethnicity, with white individuals averaging $1,700 above the county average, and lower household incomes among BIPOC individuals.

In the Sunnyside School District, nearly one third of families live below the federal poverty level (less than $33,125 annual income).



Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

Findings further demonstrate the disparate rates of poverty across race/ethnicity among county residents. In fact, 34.6% of Black/African Americans, 31.8% of American Indian/Alaska Natives, and 27.8% of Hispanic/Latinx residents live in poverty as compared to just 11.5% of white residents (Astria Health Community Health Needs Assessment, 2018).

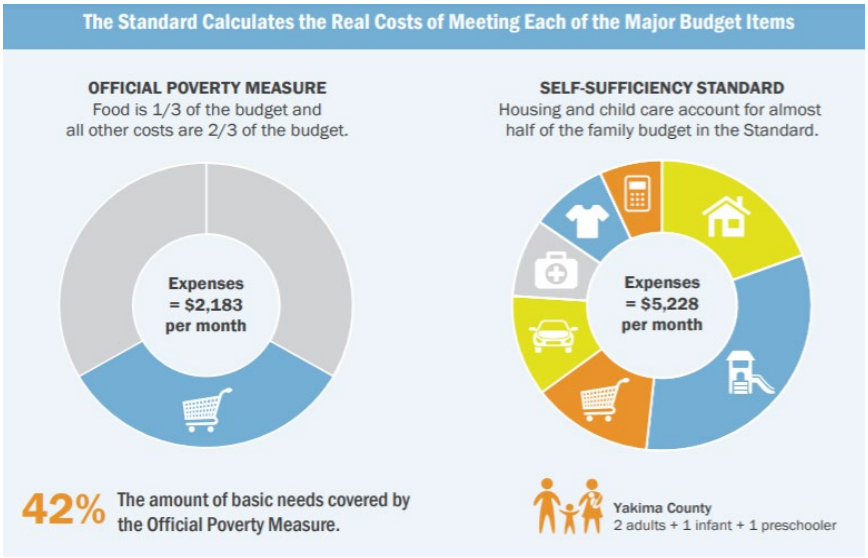


Source: Astria Health Community Health Needs Assessment, 2018

Self-Sufficiency Standard by County

Another measure of economic well-being is the Self-Sufficiency Standard. The standard calculates how much income a family must earn to meet basic needs (including taxes) without public subsidies (e.g., public housing, food stamps, Medicaid, or childcare) and without private/informal assistance (e.g., free babysitting by a relative or friend, food provided by churches or local food banks, or shared housing). The calculation takes into account family composition as well as where a family resides in Washington state.[1]

The self-sufficiency standard is different from the official poverty measure in that it calculates the real costs of meeting all basic needs – housing, childcare, food, transportation, etc. – while the latter is based only on the cost of food. Specifically, the federal poverty guidelines establish household expenses for a family of four living in Yakima County at $,2183 per month ($26,200 annually). Conversely, the self-sufficiency standard estimates expenses for this same family at $5,228 ($56,765 annually) or 217% of the federal poverty guidelines.



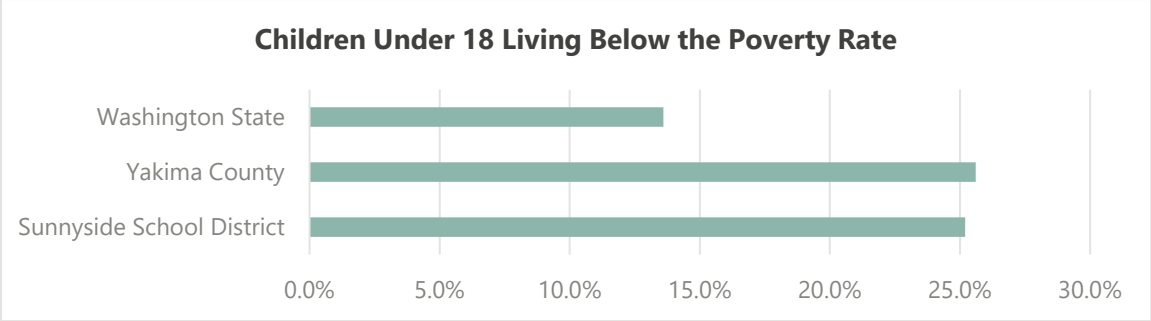
Source: Pearce, Diana M., PhD, The Self-Sufficiency Standard for Washington State, 2020

Children (age 18 and under) in Low-income Families

Poverty can negatively impact children's educational achievements, health, and earnings as adults. Income-related health disparities appear to be growing over time. As such, policies that promote economic equity may have broad health effects (Seattle Children's Hospital, 2019). In Yakima County, 25.6% of youth under age 18 lived in poverty in 2019, nearly twice the state average; however, the

[1] See http://www.selfsufficiencystandard.org/the-standard

percentage of youth living in poverty has decreased in recent years. The percentage of children that live in low-income families in the Sunnyside School District (25.2%) is comparable to the county rate (25.6%).



Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

Income Inequality

Income inequality is the gap in income between richer and poorer households. Income inequality can have broad health impacts, including increased risk of mortality, poor health, and loss of social connectedness, because inequalities can accentuate differences in social class and status and serve as a social stressor (County Health Rankings).

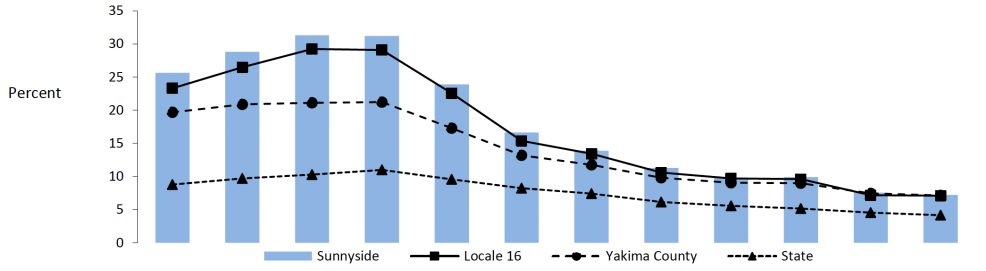
Specifically, income inequality is the ratio of household income at the 80th percentile to that at the 20th percentile, i.e., when the incomes of all households in a county are listed from highest to lowest, the 80th percentile is the level of income at which only 20% of households have higher incomes, and the 20th percentile is the level of income at which only 20% of households have lower incomes. A higher inequality ratio indicates greater division between the top and bottom ends of the income spectrum. Yakima county has a slightly lower income inequality ratio than Washington (4.0 vs. 4.4, state).

Temporary Assistance to Needy Families

Temporary Assistance for Needy Families or TANF assists families with children when the parents or caregivers cannot provide for the family's basic needs. The program provides temporary cash to families. Although Washington state's budget for TANF has decreased significantly in the last few years, the number of TANF recipients has increased considerably – up by nearly 30% – since 2019 from 53,513 total recipients in October 2019 to 68,748 in September 2020, with this likely due to the economic impact of the pandemic (Administration for Children and Families, 2021). In general, children account for about 70% of total TANF recipients.

The following graph shows the decline in the percentage of children aged 0-17 receiving TANF benefits. These data illustrate that the number of families eligible for services has decreased over time with this due to time limits (a person can receive TANF benefits for up to five years) and other post-recession policy restrictions imposed on the program in 2011. Most recently, however, due to the COVID-19 pandemic emergency, families who have exhausted the 60-month time limit will not be denied benefits. In the Sunnyside School District, the percentage of child recipients in 2019 was nearly double the state average.

Temporary Assistance to Needy Families (TANF), Child Recipients



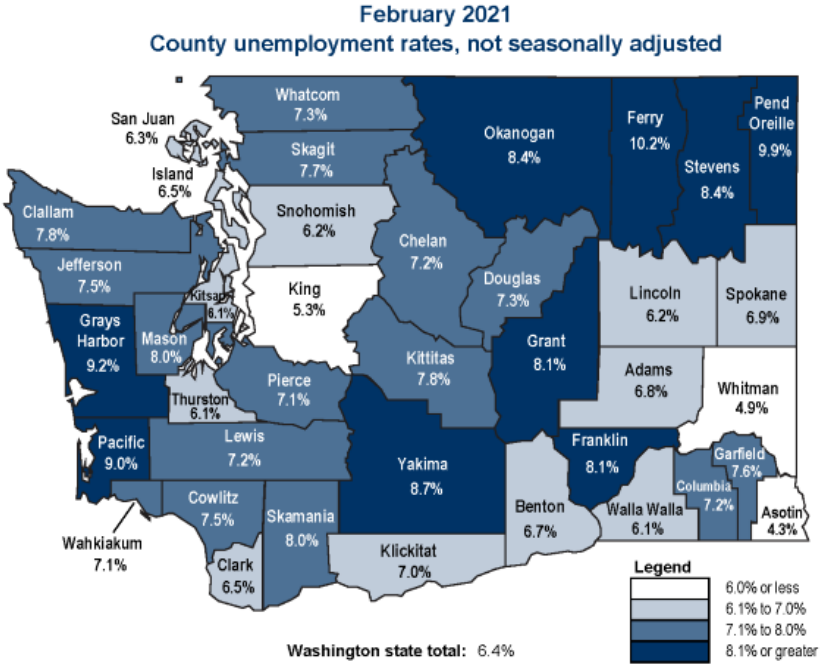
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
State	8.78	9.72	10.28	10.99	9.58	8.25	7.41	6.15	5.58	5.16	4.56	4.16
Yakima County	19.68	20.86	21.12	21.22	17.28	13.19	11.76	9.82	9.07	8.99	7.46	7.14
Locale 16	23.31	26.49	29.23	29.06	22.54	15.37	13.42	10.61	9.71	9.61	7.19	7.10
Sunnyside	25.64	28.82	31.31	31.21	23.87	16.65	13.86	11.29	9.78	9.91	7.55	7.22
TANF Children	2,236	2,540	2,732	2,793	2,145	1,504	1,261	1,040	922	926	708	677
Children, birth-17	8,720	8,813	8,727	8,949	8,988	9,035	9,097	9,210	9,432	9,342	9,379	9,383

Note: "A locale covers an area large enough to provide a stable population for rates and minimize the choppiness caused by small number issues." Locale 16 includes Sunnyside and Grandview School Districts.

Source: Washington State Department of Social & Health Services, 2021

Employment

Many aspects of employment including job security, working conditions, and financial compensation influence health. Unemployment has been linked to heart conditions, arthritis, depression and other mental health illnesses, and unhealthy coping behaviors such as substance abuse (Virginia Mason Memorial, 2019).



Source: Washington State Employment Security Department, 2021

Agriculture, health services and local government provide the most jobs in Yakima County. The unemployment rate (not seasonally adjusted) of 8.7% in February 2021 was one of the higher rates in the state, above the state rate of 6.4% (Washington State Employment Security Department, 2021).

Summary and Implications

Findings in this section demonstrate that the Sunnyside School District's regional community is impacted by several economic disadvantages, including economic instability, income inequality, and higher rates of poverty and social service utilization as compared to the county and the state. In designing services and supports for students, families, staff, and community members it is imperative that these factors are considered for a multitude of reasons. For example, we know that poverty and economic insecurity are underlying issues that are closely linked to embedded racial inequities. Black, Indigenous, and people of color are disproportionately poor as a result of oppression, historical disadvantages and discriminatory practices that have been institutionalized (Delgado, R and Stefanic, J. in Critical Race Theory, cited by Seattle Children's Hospital, 2019). This creates and/or perpetuates barriers to services, resources, and opportunities (Seattle Children's Hospital, 2019).

Many students and families experience lack of financial resources. Interviewees called out how the financial instability leads to other community problems, including gang activity. They also highlighted mutual aid to support one another in the community, and applauded the district for their contributions.

> *"When the pandemic hit, we put together backpacks with paper and pencils and crayons and all those things because we know that a lot of our families can't afford all of that, especially when you've got five and six siblings in the home. At the district, we gave out several hotspots for Wi-Fi connections and things like that."* —School staff member

For low-income youth affected by poverty, access to treatment for mental health issues can be challenging. In fact, one study found that more than 90% of low-income adolescents went untreated (Behrens et al., 2013; California Health Interview Survey, 2005). Moreover, schools in high poverty areas tend to experience higher levels of teacher burnout, turnover, and general changes in school leadership – all of which negatively impact the school climate (Beteille et al., 2011; Greenberg et al., 2016).

Community Assets and Resources

Some of the available resources that could contribute to people's economic stability and well-being and are located within Yakima County and the Sunnyside District region include:

- Opportunities Industrialization Center (OIC) of Washington works to eliminate unemployment, poverty, illiteracy, and racism so all people can live with greater human dignity. It offers trainings, workshops, food and resource distribution, career training, housing repair assistance, financial education, and more.
- Yakima County Development Association works to retain, expand, and recruit new businesses and industry.
- People for People offers employment and training opportunities through the Community Jobs, WorkFirst, and Workforce Innovation & Opportunity Act Adult programs, among others.
- Yakima Valley Technical Skills Center provides 23 free academic and hands-on technical career programs to high school students.

Education Access and Quality

Education is associated with better health. Higher education also has implications for access to better jobs and increased income. Several indicators are associated with better quality education, including kindergarten readiness and high school completion (Washington State Health Assessment, 2018).

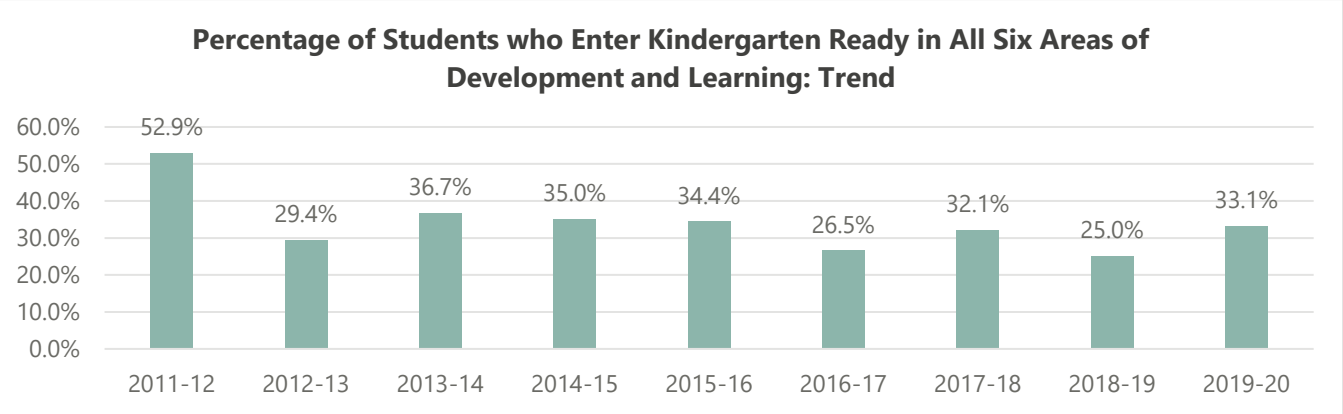
There is increased interest in tracking equity in education. In fact, the Monitoring Educational Equity report calls for a national system *to not simply track progress toward educational goals but to also identify disparities in outcomes and opportunity* (National Academies of Sciences, Engineering, and Medicine, 2019). The report proposes two sets of indicators to track disparities:

- *Disparities in students' educational outcomes*, including kindergarten readiness; K-12 learning and engagement; and educational attainment.
- *Disparities in students' access to resources and opportunities* including extent of racial, ethnic, and economic segregation; equitable access to early childhood education, high-quality curricula, and instruction; and access to supportive environments.

In the next section, we cover some of these educational equity indicators (as data allow).

Kindergarten Readiness

WaKIDS, the Washington Kindergarten Inventory of Developing Skills, includes an assessment that is administered during the first two months of kindergarten. Teachers observe students across six areas of development and learning: Social-Emotional, Physical, Language, Cognitive, Literacy, and Math. Although the only requirement for kindergarten in Washington is to be five years old by August 31, children who demonstrate readiness in all six areas have a greater likelihood of success in kindergarten and beyond.



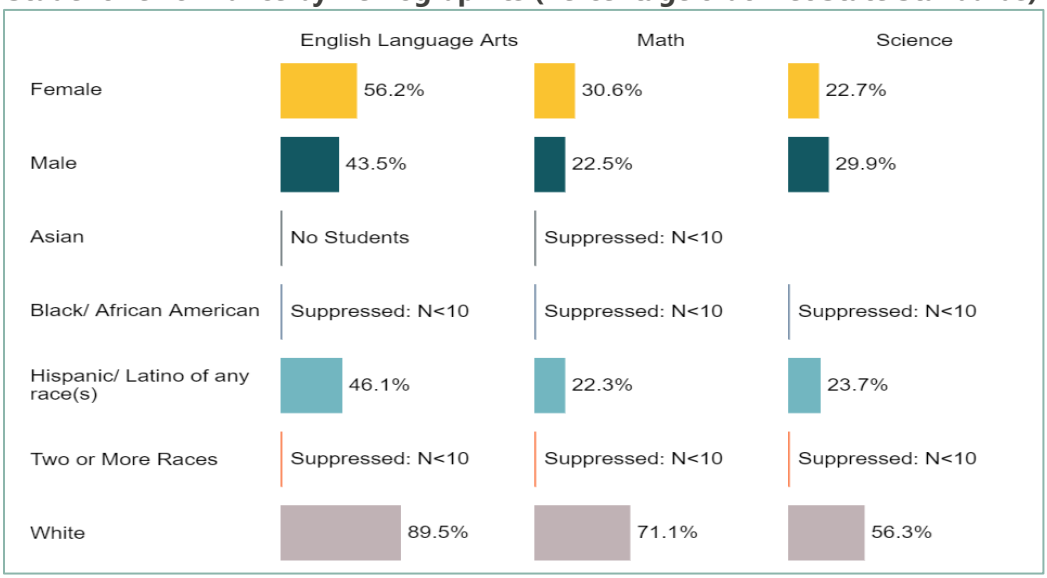
Source: OSPI Report Card, Sunnyside School District

Kindergarten readiness in the Sunnyside School District is trending downward from the 2011-12 school year, and the percentage of students ready for kindergarten has varied across years. However, between the 2018-19 and 2019-20 school years, more children demonstrated readiness across the six skill areas. During the 2019-2020 school year, 33.1% of Sunnyside kindergartens were assessed as meeting all six skill areas, compared to 51.5% of children statewide.

K-12 Learning and Engagement

Every spring, students in specific grades are assessed in Math, English Language Arts and Science. In the 2018-19 school year, few Sunnyside School District students met the standards for math and science. Over half of female students (56.2%) and 43.5% of male students met the state standard for English Language Arts. In general, students who identify as white performed better in all three subjects as compared to their Hispanic/Latinx counterparts. Additionally, findings indicate that students who are English language learners, not housed, low income, migrant, and with disabilities under performed in state assessments compared to their peers who do not meet these characteristics.

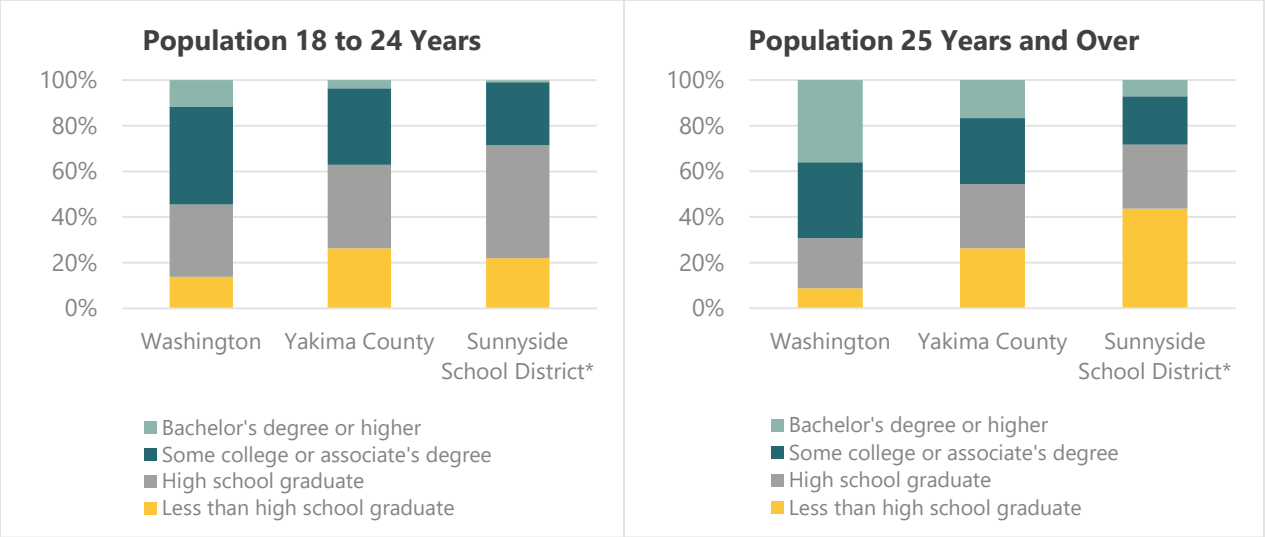
Student Performance by Demographics (Percentage that Met State Standards)



Source: Sunnyside Report Card, OSPI, 2018-19

Educational Attainment

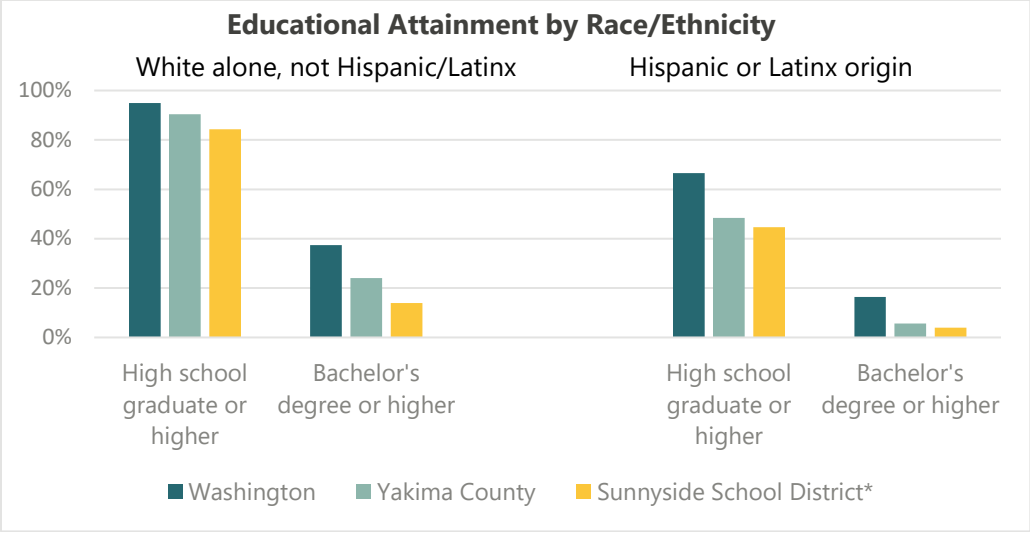
We know that graduating from high school is a critical step towards a successful adulthood. Significant disparities exist between the Sunnyside School District region and the rest of the state regarding graduation rates.



*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates

Age: Regardless of age, more residents within the Sunnyside School District region have not completed high school compared to the state. Additionally, while just 8.7% of Washingtonians over the age of 25 did not graduate from high school, nearly half (47.5%) of people who live in the district's region has less than a high school degree.

Race/Ethnicity: There are also disparities in educational attainment regarding race and ethnicity as demonstrated in the below chart. While 84.3% of the residents from the Sunnyside School District region who identify as white have completed high school and 13.9% have earned a bachelor's degree, just 44.7% of people who identify as Hispanic/Latinx have a high school diploma and 4.0% have a bachelor's degree or higher.



"Overall, more Washingtonians are completing high school, but disparities remain particularly for the Hispanic community" (Department of Health, 2018).

*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates

Gender: Countywide, males ages 18 to 24 are more likely to have not completed high school as compared to females. In the district region, nearly one third of males 18 to 24 years did not graduate from high school compared to 14.0% of their female peers. Additionally, only 5.3% of males and 8.7% females 25 years and over have earned a bachelor's degree or higher – well below the state average.

	Washington		Yakima County		Sunnyside District*	
	Male	Female	Male	Female	Male	Female
Population 18 to 24 years						
Less than high school graduate	15.3%	12.2%	29.7%	22.7%	30.3%	14.0%
High school graduate	35.3%	27.9%	36.9%	36.2%	44.0%	54.6%
Some college or associate's degree	39.9%	46.2%	30.3%	36.9%	25.7%	29.7%
Bachelor's degree or higher	9.6%	13.7%	3.1%	4.2%	0.0%	1.6%
Population 25 years and over						
Less than high school graduate	9.1%	8.3%	28.5%	24.2%	44.8%	42.8%
High school graduate	22.8%	21.2%	29.4%	26.9%	29.7%	26.4%
Some college or associate's degree	32.1	34.5	26.4	31.3	20.2	22.1
Bachelor's degree or higher	36.0%	36.1%	15.7%	17.7%	5.3%	8.7%

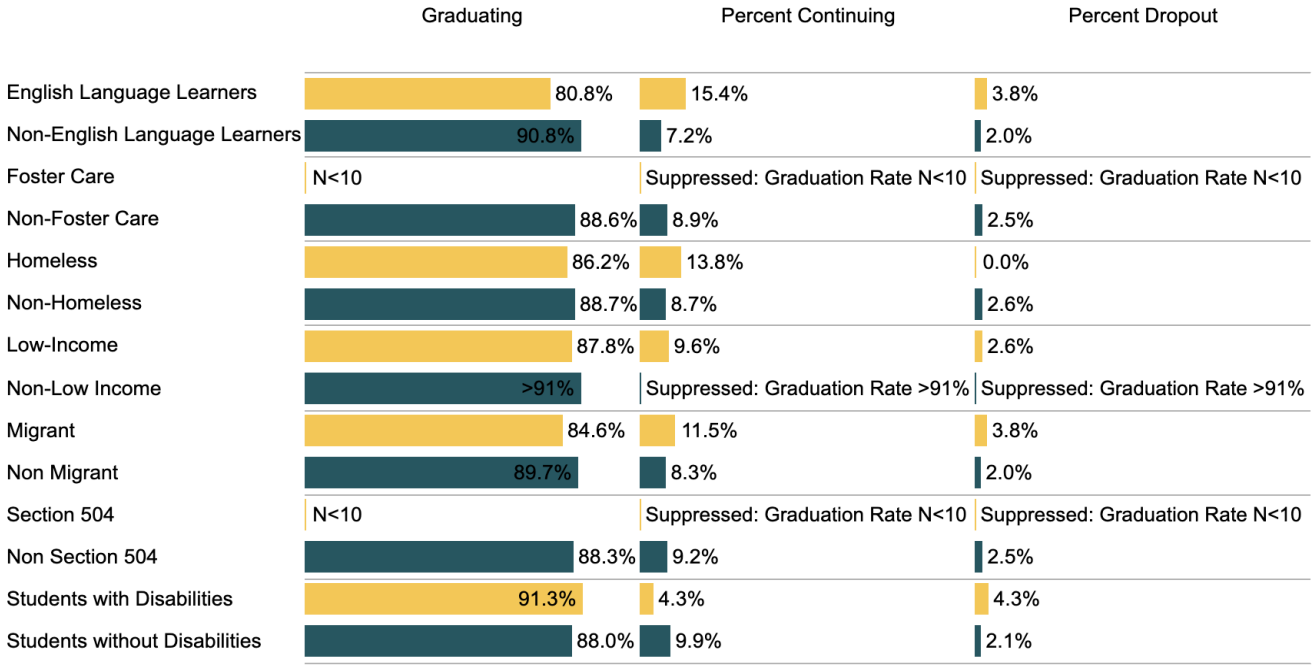
*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

On-Time Graduation

Since 2013, the percentage of Sunnyside School District students who have graduated from high school within four years has increased from 85.1% (Class of 2015) to 88.5% (Class of 2020), above the state average (82.9%). This upward trend in graduation rates is also demonstrated among both female and male students and across racial groups.

However, opportunity gaps do exist. For example, a higher percentage of females graduate in four years as compared to their male peers, with 91.3% of females and 85.4% of male students graduating on-time in 2020–a 5.9-percentage point gap. Among students who identify as Hispanic/Latinx, there has also been an increase in on-time graduation rates overtime, from 85.4% (Class of 2013) to 88.6% (Class of 2020) meeting graduation requirements. For the Class of 2020, data show disproportionality in reaching this academic milestone among two student groups. In fact, on-time graduation rates for students identified as an English language learner or migrant are lower, with these students slightly more likely to drop out of school than their peers. It should be noted, however, that across student characteristics and programs, few students drop out of school.

Percentage of Students Graduating within 4 years, by Student Program and Characteristics (2020)



Source: Washington State Report Card Sunnyside School District, 2020. Note: "Section 504" is a federal law that protects students from discrimination based on disability.

Racial, Ethnic and Economic Segregation

Residential segregation has been linked to negative health consequences, poor-quality housing, violence, reduced educational and employment opportunities, and other adverse conditions (County Health Rankings, 2021). The County Health Rankings define racial/ethnic residential segregation as the degree to which two or more groups live separately from one another in a geographic area. "The index of dissimilarity is a demographic measure of the evenness with which two groups (non-White and White residents, in this case) are distributed across the component geographic areas (census tracts, in this case) that make up a larger area (counties, in this case)" (ibid). According to the Monitoring Educational Equity report (2019), despite integration efforts, racial and economic segregation have continued to increase in recent decades.

> *"School segregation—both racial and economic—poses one of the most formidable barriers to educational equity"* (National Academies of Sciences, Engineering, and Medicine, 2019).

The 2021 County Health Rankings use the index of dissimilarity where higher values indicate greater residential segregation between non-white and white county residents, with scores ranging from 0 (complete integration) to 100 (complete segregation). The score represents the percentage of either non-white or white residents that would have to move to different geographic areas in order to produce a distribution that matches that of the larger area. For Yakima County, the index score is 31 while for Washington it is 38.

Access to Early Childhood Education

The Educational Service District (ESD) 105, which serves the Sunnyside School District, offers the state-funded Early Childhood Education and Assistance Program (ECEAP) to many communities in its region. ECEAP provides free preschool, family support, and child health coordination to eligible children and their families. ESD 105 offers ECEAP in Yakima, Toppenish, Union Gap, and Cle Elum/Roslyn, while providing support to local providers in the surrounding Sunnyside communities. The ESD also offers Head Start and Migrant/Seasonal Head Start services at different locations in the area (see ESD 105), with these offered within the Sunnyside community by a local provider. In partnership with Insight, a community-based agency, early childhood services are provided at the Pioneer Elementary school facility. Additionally, the district offers Developmental Pre-School serving students identified for Special Education at two sites: Pioneer Elementary School and Sun Valley Elementary School.

Access to High-Quality Curricula and Instruction

The National Academies of Sciences, Engineering, and Medicine (2019) highlights the interaction between students and teachers, students' access to a rich coursework, and the teachers' qualifications, experience, and diversity as indicators of quality learning. Several measures that OSPI tracks and reports annually illustrate students' access to curricula and instruction. The data below show disparities between the district and statewide averages. For example, the district falls below the state average for funds expended per-pupil, with fewer master's-level (or higher) teachers as compared to the state.

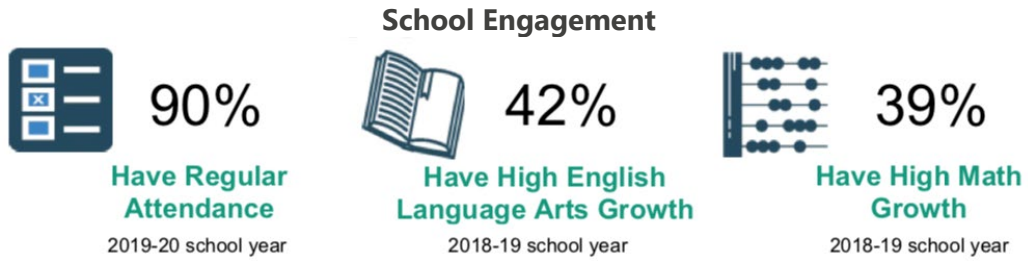
						
Per-pupil expenditure	Average class size	Years of teaching experience	Held full certificates	Teachers with a master's degree or higher	Teachers considered "experienced"	Years of experience as principal/ leader
$12,964 Sunnyside **$14,213 WA**	**21 pupils Sunnyside** **18 WA**	**12.4 years Sunnyside** **12.8 WA**	**87% Sunnyside** **92% WA**	**56% Sunnyside** **61% WA**	**63% Sunnyside** **72% WA**	**8.6 years Sunnyside** **6.8 WA**

Source: Office of the Superintendent of Public Instruction

Access to computers and Internet is a growing need for students and has been particularly critical during the COVID-19 pandemic when students accessed education remotely or in a "hybrid" model. While the majority of households (86%) in the Sunnyside School District region have internet connection, 854 households still do not have access. In comparison, 91.3% of Washington households and 84% of Yakima County households have internet access (Census 2019: ACS 5-Year Estimates).

Academic Engagement

Findings on school engagement demonstrate a high level of participation by Sunnyside students with nearly all (90%) attending regularly during the 2019-20 school year. Further, during the 2018-19 academic year, 42% of students illustrated high growth in ELA, above the state norm (33.6%), with 39% exhibiting high growth in Math, again, exceeding the state average (33.7%).



Graphic: Office of the Superintendent of Public Instruction

Discipline Practices

During the 2018-19 school year, 686 or 9.7% of the 7,073 students enrolled in Sunnyside School District received a short-or long-term suspension, emergency expulsion, or expulsion for a discipline related incident (up from 6.5% in the 2017-2018 school year). Statewide the discipline rate was 4.0%. In reviewing data by student group, disparate application of disciplinary actions is apparent. Particularly, findings show:

- Male students were nearly twice as likely as their female peers to be disciplined (12.4% vs. 6.8%).
- Hispanic/Latinx students were sanctioned more often as compared to white youth (9.9% vs. 6.6%, respectively).
- Section 504 students were more likely to be disciplined as compared to and non-Section 504 youth (15.6% vs. 9.6%, respectively).
- Students with disabilities were twice as likely to be disciplined compared to those without disabilities (15.1% vs. 8.7%, respectively).
- Higher rates were noted for non-highly capable than highly capable students (9.8% vs. 2.6%, respectively).

Summary and Implications

The Sunnyside School District is showing modest improvements in kindergarten readiness, student engagement, and graduation rates over time.

Some participants of interviews and focus groups were proud of the academic improvements achieved at Sunnyside School District.

"We've taken our kids from a 49% graduation rate up into the 90s over the last 7-8 years. That was huge and it was a complete turnaround. We have a very strong intentional focus. (At the elementary schools) we have a banner outside that says 'Graduation starts here'. And so, we firmly believe that we're setting that foundation. At an early learning school, the things that we do that are pretty much similar to what they're doing at the high school in terms of reaching our kids."
—School staff member

However, inequities in reaching these educational milestones exist. For the Class of 2020, data show disproportionality among two student groups. In fact, on-time graduation rates for students identified as an English language learner, or migrant are lower, with these students slightly more likely to drop out of school than their peers. Further, findings indicate a considerable gap in the racial and ethnic diversity between the student population and classroom teachers. Results also show disparate application of disciplinary actions among student groups.

We know that graduating from high school is a critical step towards a successful adulthood. In fact, youths that dropout are more likely to have difficulties with employment and earning a satisfactory living. These deficits contribute to a greater likelihood of other social and personal problems including mental, emotional, and behavioral disorders (Annie E. Casey Foundation 2014). We also know that engaged students are more likely to earn better grades, perform well on standardized tests, and stay in school (Fredricks, Blumenfeld, & Paris 2004), and less likely to engage in health-risk behaviors, including substance use, violence-related behaviors, and risky sexual behaviors (United Way Worldwide, 2011).

A report conducted in Washington state found that exclusionary discipline practices disproportionally impacted BIPOC youth, and students of low socioeconomic status (Mosehauer, McGrath, Nist, Pillar, 2012). At the institutional level, the use of exclusionary discipline practices and policies that are disproportionately applied to students of color marginalize these youth, and limits opportunities for social, emotional, and academic development. Additionally, at the individual level, school staffs' implicit biases produce low expectations and set up students of color and marginalized youth to disengage from the school environment (Simmons, Brackett & Adler 2018).

Project AWARE focuses specifically on increasing universal behavioral health supports for youth, including youth's social-emotional skills. Social and emotional learning (SEL) provides students with competencies necessary to lead productive and healthy lives. SEL refers to life skills that support students (and adults) to experience, manage, and express emotions, fosters sound decision making, and build interpersonal relationships. These skills protect children and youth against adverse risk-taking behaviors, emotional distress, and conduct problems, thus, contribute to health, academic achievement, and success later in life.

When considering AWARE programming, implementation efforts should identify populations disproportionally affected by low educational attainment, engagement, or disciplinary actions and ensure supports are implemented equitably to meet the needs of a diverse array of youth, whether those learning though special education, or ELL programming, or facing challenges outside of school such as high mobility (migrant) or houseless living conditions. In the development of the supports,

efforts should ensure both student and parent voices are included in the process from selection to implementation.

Community Assets and Resources

Some of the available resources related to education access and quality available in Yakima County and the Sunnyside School District area are:

- Educational Service District 105 is the multi-resource support site for the schools and education partners in south central Washington, including Yakima County. ESD 105 provides cost-effective ways related to school and student success, health, and safety, and professional development, administrative, business, and financial support, and new technology.
- Sunnyside School District offers K-12 education to students residing in Sunnyside and Outlook. The district emphasizes the social, emotional, physical, and intellectual development of each youth.
- Inspire Development Centers is a community-based nonprofit organization that provides culturally responsive services to families and children through programs such as Migrant and Seasonal Head Start Program, Migrant and Seasonal Early Head Start, and Early Childhood Assistance (ECAP). It has locations in eight Washington counties including Yakima and Grant.

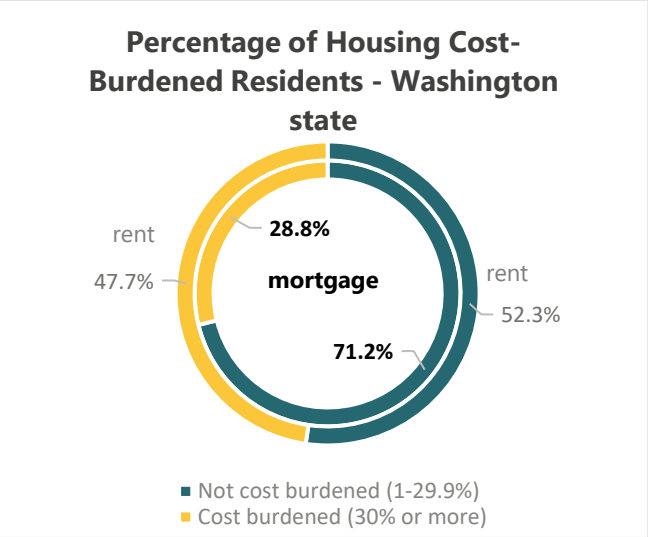
Neighborhood and Built Environment

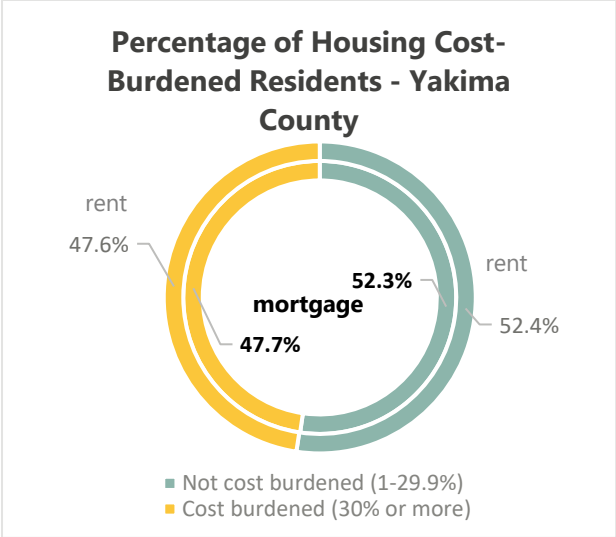
Place matters. Where people live has a significant impact on their health and well-being. Oftentimes, there are persistent disparities among people living just a few blocks apart, in part because of their neighborhood and surrounding environment such as having grocery stores that offer a variety of food options, especially healthy ones, or access to parks or other green spaces. Living in places with limited availability of grocery stores and lack of access to fresh fruits and vegetables – often referred to as "food deserts" – is correlated with premature death and high prevalence of obesity (Washington State Department of Health. Food Insecurity and Hunger, 2018). Ensuring access to healthy food, affordable housing, parks and recreation, and reliable transportation for everyone improves health in communities (Robert Wood-Johnson Foundation, 2021).

Housing

Quality, safe, and affordable housing is critical for the well-being of kids and families. Families who pay more than they can afford for housing may not have enough left to cover other basic needs such as food, healthcare, and childcare. A widely used measure to assess housing affordability is known as the "30-percent rule" or housing cost burden.

In Washington, nearly half of renters (47.7%) and 28.8% of homeowners are considered cost burdened. Conversely, in Yakima County homeowners and renters face similar levels of financial challenge, with 47.6% of mortgage holders, and 47.7% of renters cost burdened.





Source: U.S. Census Bureau, 2019 American Community Survey 1-Year Estimates

Houselessness/Housing Instability

Houselessness is the lack of stable, safe, permanent, and adequate housing. People experiencing houselessness may be unsheltered or staying in emergency shelters or transitional housing. At the same time, houselessness can result in illness due to exposure to communicable disease, violence, and poor nutrition.

> *"Homelessness is often caused by a complex combination of interwoven social and health factors. Poor physical and mental health can both cause and result in homelessness. Illness or injury can lead to lost income, the loss of a job and health insurance leading to a downward spiral in health"* (Washington Department of Health, 2018).

Annually, communities across the country complete the Point-in-Time (PIT) count which determines the number of individuals who are unhoused, either experiencing houselessness or housing instability. In January 2019, the PIT in Yakima County found there were 636 people who were unhoused. Of the total number of houseless persons counted, about 175 were unsheltered and 367 were in emergency shelters. "For the second year in a row, there is a large increase in unsheltered community members from the previous 8 years of data collected" (Yakima County Homeless Point-in-Time Count, 2019). Of the total PIT survey participants, 8% were 18 to 24 years old and 1% was under 18.

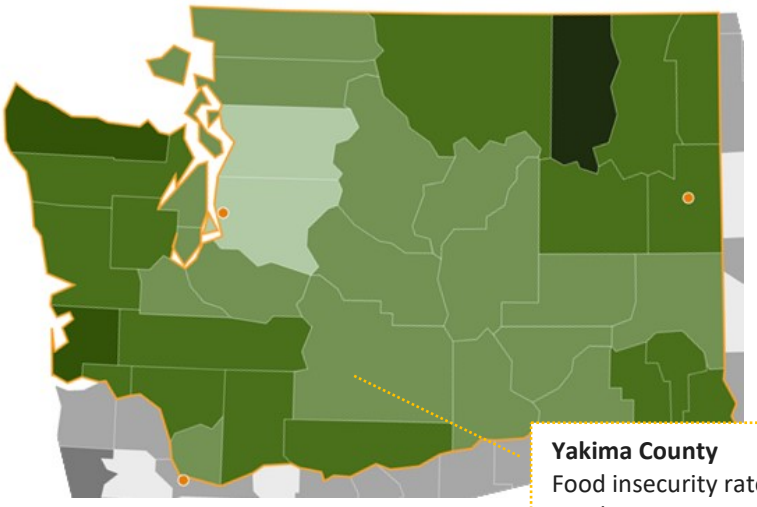
Additionally, each fall school districts report the number of students living in unstable housing circumstances to OSPI. OSPI uses a broader definition of "houseless" that includes students who are living "doubled up" and "couch surfing" as such the number of children reported by OSPI as houseless are historically higher than those of the PIT. During the 2020-21 school year, there were 209 students identified as houselessness in the Sunnyside district, representing 4.3% of the student population (OSPI Report Card).

Food Security

Definition: Food insecurity is the limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in a socially acceptable way. (DOH, 2018)

Hunger and food insecurity in children are associated with psychosocial problems, frequent colds, anemia, asthma, headaches, impaired cognitive functions, and poorer academic achievement (Washington State Department of Health. Food Insecurity and Hunger, 2018). A recent study of people that experienced frequent hunger in childhood found a correlation to low self-control, and interpersonal violence later in life (Piquero, 2016).

Food security means a person has access to enough food to have a healthy life. Food insecure households are not always food insecure at all times and vice versa. Food security is measured by the food environment index, which combines the percentage of the population that is low-income and do not live close to a grocery store, and the percentage of the population that are food insecure. The index scale ranges from 0 (worst) to 10 (best). The food environment index in Yakima County is worse than Washington state (7.9 vs. 8.2, state) (County Health Rankings, 2020). According to a recent report, nearly one-in-five (19.3%) children in Yakima County (before COVID-19) experienced food insecurity, with over one-in-ten persons (12.4%), countywide, food insecure (Feeding America, 2018).



Source: Feeding America, 2018

Government assistance programs have been shown to reduce child food insecurity rates and lessen the impacts of food insecurity among children (Seattle Children's Hospital, 2019). These programs include the Supplemental Nutrition Assistance Program (SNAP), national school meal programs, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) – all indicators of extreme family economic deprivation.

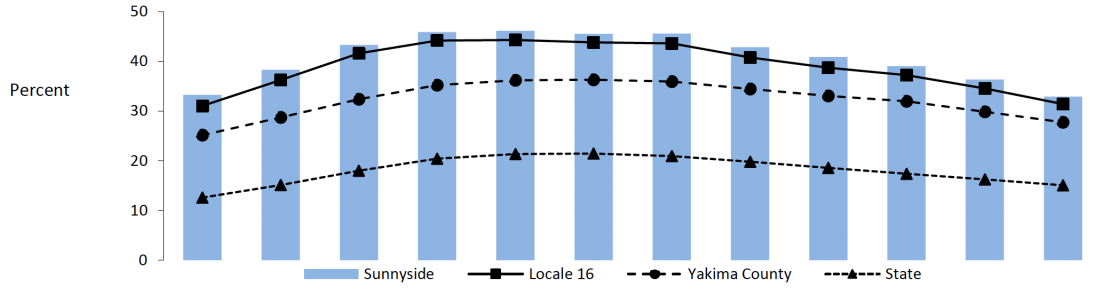
Supplemental Nutritional Assistance Program (SNAP)

The federally funded Supplemental Nutrition Assistance Program (SNAP), formerly known as the food stamp program, helps children and families with low incomes afford food. SNAP is the nation's largest

nutrition assistance program, with more than 35 million children and families participating. An estimated 72.9% of households with children under the age of 18 in the Sunnyside School District receive SNAP, compared to 63.4% in Yakima county and 44.3% in Washington state (Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates).

The figure below demonstrates that the rate of persons (not households) receiving SNAP services has declined since peaking in 2013 at the state, county, and school-district levels. However, usage rates for Yakima County and the district region have consistently exceeded state averages across all reporting years. In 2019, the percentage of Sunnyside School District recipients participating in SNAP was twice the state average.

Supplemental Nutritional Assistance Program (SNAP)



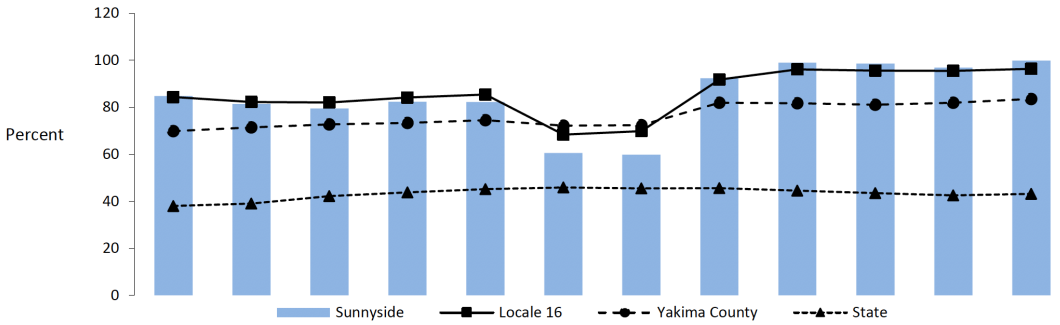
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
State	12.60	15.11	18.00	20.44	21.35	21.45	20.95	19.80	18.58	17.38	16.26	15.09
Yakima County	25.15	28.70	32.36	35.23	36.19	36.30	35.91	34.43	33.07	31.97	29.85	27.76
Locale 16	31.04	36.22	41.60	44.17	44.29	43.83	43.61	40.75	38.70	37.21	34.55	31.41
Sunnyside	33.23	38.32	43.28	45.89	46.14	45.53	45.56	42.82	40.88	39.02	36.32	32.89
Recipients	7,915	9,240	10,318	11,262	11,379	11,267	11,304	10,650	10,248	9,840	9,240	8,436
All Persons	23,821	24,115	23,840	24,543	24,661	24,748	24,810	24,871	25,067	25,219	25,443	25,652

Source: Washington State Department of Social & Health Services, 2021

Free or Reduced-Price Meals Program

The national school meals program provides breakfast, lunch, afterschool snack, meals during the summer months, and afterschool meals to children with low incomes attending public, private, and charter schools, as well as residential childcare institutions (RCCIs). In 2019, 84% of children in Yakima County and 43% in Washington state were eligible for free or reduced-price lunch. In comparison, of the 6,732 students enrolled in the Sunnyside School District, nearly all (99.8%) were eligible to participate in the free and reduced meal program, significantly above the state average.

Students Eligible for Free or Reduced Price Lunch



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
State	38.01	39.04	42.22	43.75	45.17	45.87	45.50	45.60	44.51	43.49	42.50	43.16
Yakima County	69.85	71.40	72.67	73.35	74.56	72.16	72.38	81.89	81.71	81.03	81.90	83.55
Locale 16	84.32	82.23	82.06	84.16	85.43	68.36	69.87	91.73	96.15	95.56	95.50	96.35
Sunnyside	84.79	81.41	79.53	82.38	82.22	60.56	59.80	92.31	98.94	98.52	96.82	99.88
Eligible Students	4,840	4,759	4,783	5,045	5,179	3,915	3,847	6,106	6,632	6,653	6,586	6,724
Enrolled Students	5,708	5,846	6,014	6,124	6,299	6,465	6,433	6,615	6,703	6,753	6,802	6,732

Source: Washington State Department of Social & Health Services, 2021

Transportation

Transportation, including active transportation (walking, biking), access to transportation, and income spent on transportation, is another social determinant of health. Access to childcare, health care, and education can be difficult for people with low incomes, individuals with mental illnesses, or those without a car. In a regional survey conducted for the Astria Health's 2018 Community Health Assessment, residents identified the burden of travel as a barrier to accessing healthcare and other services. Participants listed *transportation* as one of the top five barriers to improving health, in addition to housing, employment, education, and emotional/mental health (Astria Health, 2018).

Summary and Implications

Data presented in this section show that there are a number of environmental factors that may create increased barriers to services and supports for the Sunnyside community. For example, nearly half of both homeowners and renters face a financial burden to meeting housing costs, with an increasing number of unhoused individuals in the region. Rates of food insecurity in the region are higher than state averages, with utilization of food assistance (both through SNAP and the free and reduced priced meals program) well above state rates, and nearly all (99.8%) students eligible for reduce priced school meals.

Research has shown that food insecurity is associated with a wide range of adolescent mental health disorders, such as past-year mood, anxiety, behavior, and substance disorders, even when controlling for other aspects of socio-economic status (McLaughlin, et. al, 2012). Other research has found that children from chronically food insecure homes were approximately one-and-a-half times more likely to have internalizing problems and two times more likely to have externalizing problems, when compared to children in food secure homes (Slopen et.al, 2010).

For youth and other interviewees, sports are a strong community asset. They also highlighted other public facilities such as the swimming pool, the basketball courts, and the parks. At the same time, participants expressed discontent about how the City of Sunnyside provides insufficient investments for the youth. As an example, they mentioned how the Parks and Recreation department used to provide sports and other classes at low cost.

> *"There is a disconnect from the city council and the school district. There is not a partnership there…"* —Parent

Considering the societal, environmental, and logistical barriers facing youth and families, it is critical to embed community-based services and supports within the school system to increase access while reducing barriers.

Community Assets and Strengths

Some of the community resources that contribute to ensuring access to healthy food, affordable housing, and transportation in the Sunnyside District area include:

- Several food banks operate in Sunnyside, including the bank at the Mosaic Church Friday and the Sunnyside Food Bank.
- The Yakima County Homeless Coalition (YHC) is the primary body that has been planning and coordinating to address houselessness activities in the Yakima Valley. The coalition includes over 40 local service providers and community members.
- People for People offers a variety of services including Meals on Wheels, basic food outreach, and a few transportation routes that connect seniors, individuals with disabilities, and the general public in the city of Sunnyside with surrounding communities.

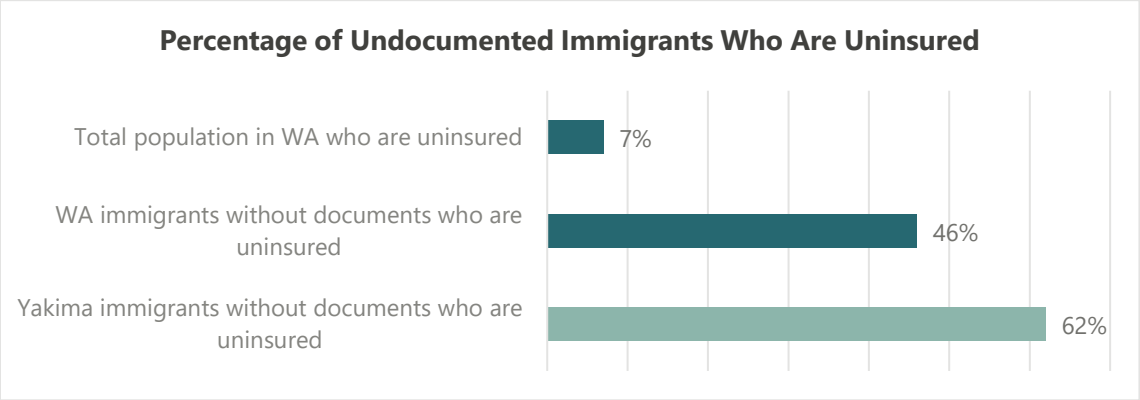
Social and Community Context

Relationships are important for physical and mental health and well-being. The social and community context domain includes issues related to social cohesion, safety, civic participation, discrimination, and incarceration, among others.

Immigration Status

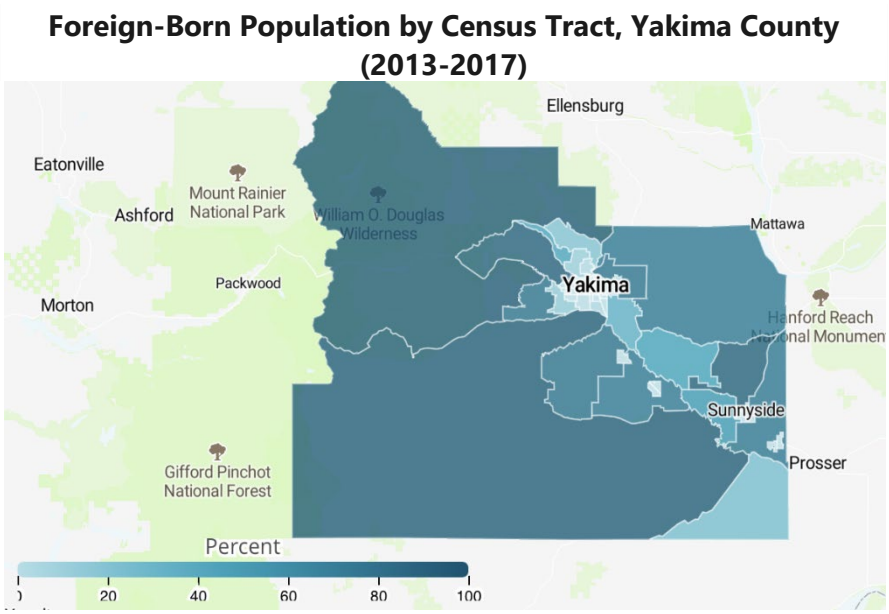
Immigration is a consequence of social determinants of health such as poverty, educational opportunities, and political persecution. Immigration itself is also a social determinant of health (Castañeda et. al. 2014). "Heightened immigration enforcement in recent years, including historic levels of deportation, has resulted in negative impacts on health and well-being" (ibid). Fear of deportation and actual deportation have many social, economic and health impacts on individuals, and on the families (Langhout et. al., 2018).

While the number of undocumented immigrants is difficult to measure, in 2018 an estimated 11 million undocumented people lived in the U.S. including 240,000 in Washington state, representing approximately 5.2% of the total state population. Among the implications of immigration status on health and well-being are the restrictions to accessing programs that offer public health coverage (Washington State Health Equity for Immigrants Report 2020). Undocumented immigrants, including DACA (Deferred Action for Childhood Arrivals) holders, are ineligible to receive most federal public benefits, including SNAP and TANF. They may, however, be eligible for a handful of benefits to protect life or guarantee safety in emergency situations, such as access to healthcare and nutrition under the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) (National Immigration Forum, 2018).



Source: 2018 data result from Migration Policy Institute (MPI) analysis of U.S. Census Bureau data from the pooled 2014–18 American Community Survey (ACS) and the 2008 Survey of Income and Program Participation (SIPP), weighted to 2018 unauthorized immigrant population estimates provided by Jennifer Van Hook of The Pennsylvania State University.

In 2018, 62% of undocumented immigrants in Yakima were uninsured, well above the 46% reported as such statewide, and significantly above the 7% of the overall population of the state.



Source: Hunger in Washington

Most persons living within the Sunnyside School District region (Census track 21.02) and surrounding communities are foreign-born residents. In fact, an estimated 54.6% of the population living in the designated census tract (21.02) was born outside of the US as compared to 23.5% countywide (Hunger in Washington with Census tract data, 2013-2017).

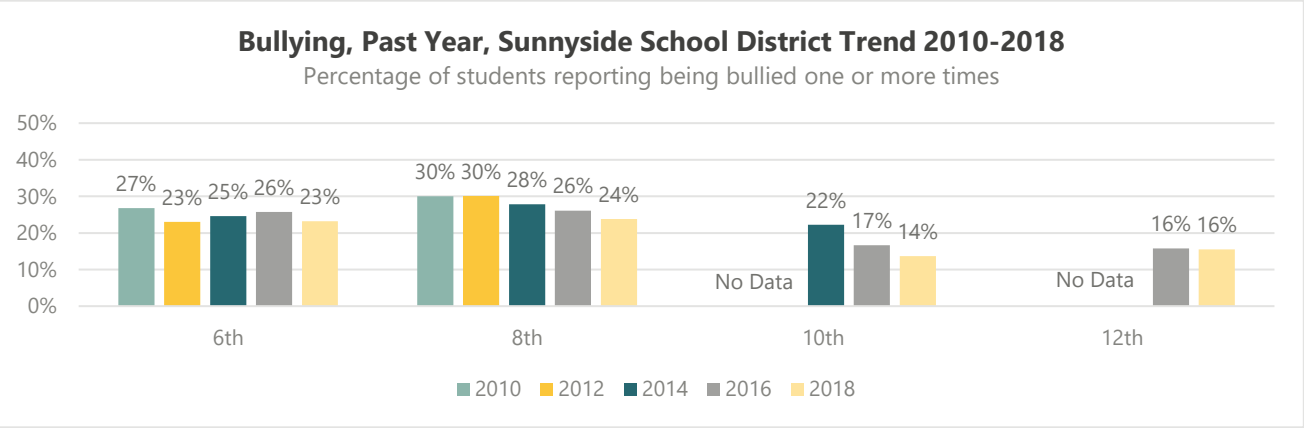
School Climate and Safety

As noted, since 2002, the Healthy Youth Survey has been administered every other year in the fall to students in grades 6, 8, 10, and 12 across the state. The survey measures health risk behaviors known to contribute to the health and safety of youth.

Bullying

Healthy Youth Survey data from the past three survey administrations on the percentage of youth in Sunnyside School District reporting being a victim of bullying show that, overall, reports of bullying are trending downward. Victimization rates are somewhat higher among middle school-aged youth, a trend seen statewide. Findings further indicate that, in 2018, bullying declined across grade levels to historically low rates as compared to previous years.

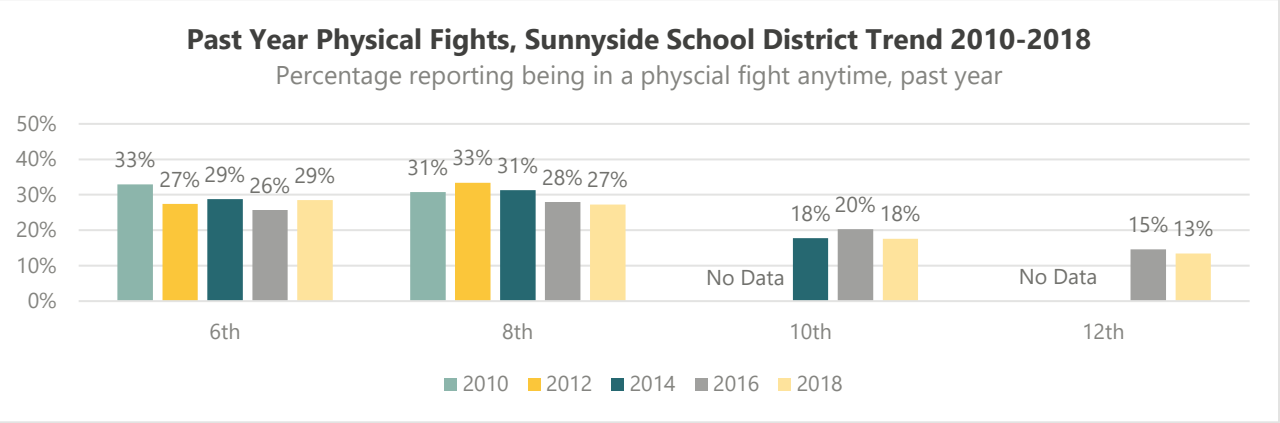
A recent study released by the University of Michigan (2020) found that *"Bully victimization damages how people view themselves in adolescence and that negative view can linger into adulthood, contributing to poor mental health."*



Source: Healthy Youth Survey (2010-2018 at askhys.net

Physical Fighting and Weapon Carrying

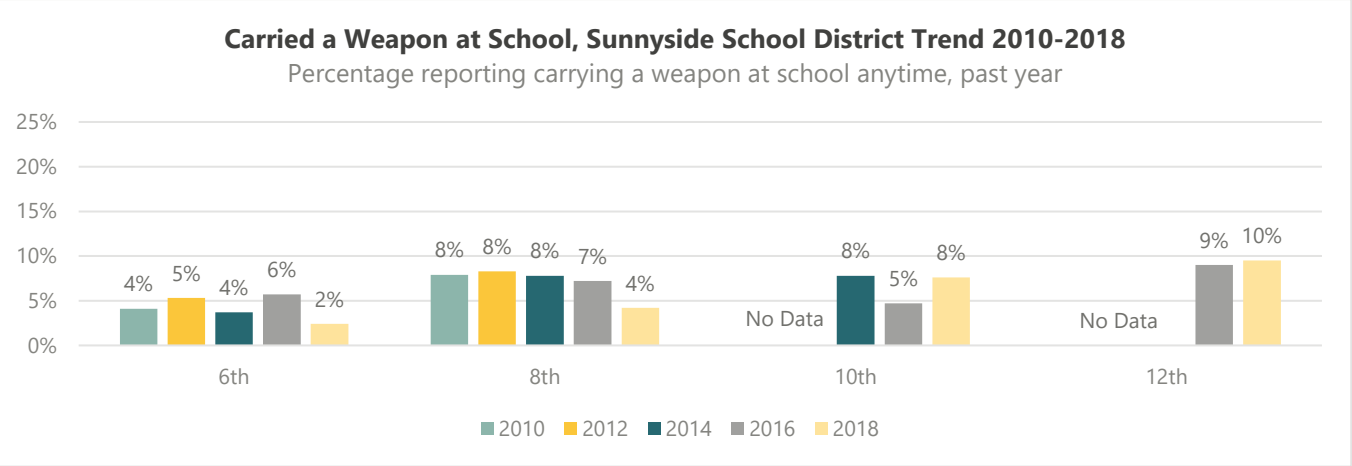
The following figures show the percentage of youth that reported engaging in behaviors related to intentional injury of others.



Source: Healthy Youth Survey (2010-2018 at askhys.net

The percentage of youth reporting being in at least one physical fight in the past year varies greatly among grade groups and across survey periods, with more middle school-aged youth engaging in this type of behavior. In 2018, 29% of 6th graders and 27% of 8th graders reported being in a physical fight. Among high school students, a higher percentage of 10th grade students reported fighting than 12th grade youth (18% vs. 13%, respectively).

The graph below shows the percentage of HYS respondents that reported carrying a weapon at school during the previous school year.

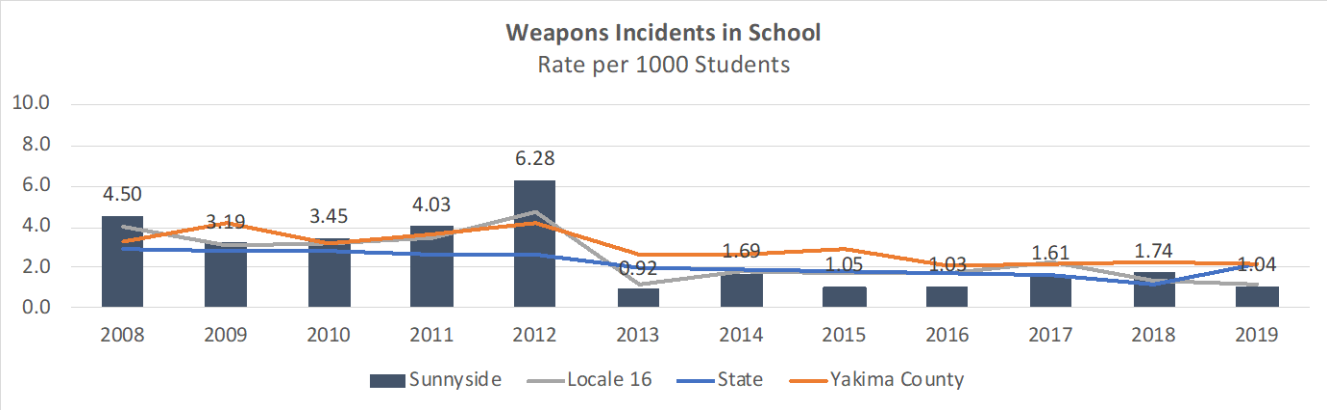


Source: Healthy Youth Survey (2010-2018 at askhys.net

These data show that the percentage of 6th grade youth that report carrying a weapon at school has fluctuated over the survey periods and most recently declined from 6% to 2% between 2016 and 2018. Similarly, weapons carrying among 8th graders dropped by nearly half during the same period. Among older youth, however, rates increased slightly in 2018, with an average of nearly one-in-ten high-school-aged students taking a weapon to school during the year.

The below figure shows the rate of weapons incidents reported in schools between 2008-2019.[2] In general, incidents of guns and other weapons on school property are rare events both locally and statewide. Since peaking in 2012, the frequency of weapons incidents in the Sunnyside School District has declined substantially to at or below state and regional rates.

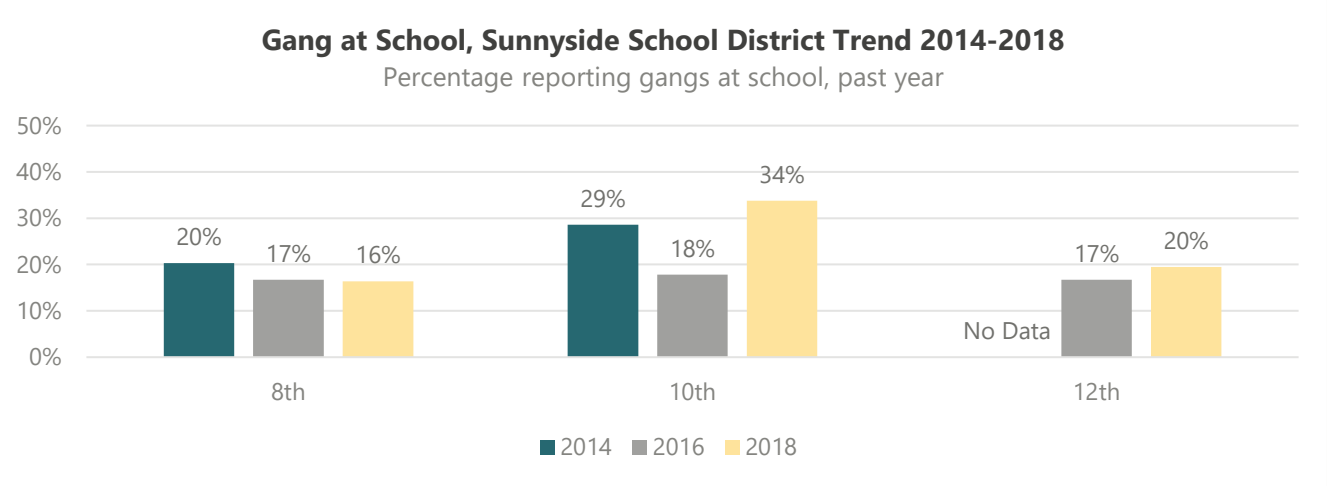
[2] The reported incidents involving guns and other weapons at any grade level per 1000 students enrolled in October of all grades.



Source: Office of Superintendent of Public Instruction, Information Services, Safe and Drug-free Schools: Report to the Legislature on Weapons in Schools RCW 28A.320.130

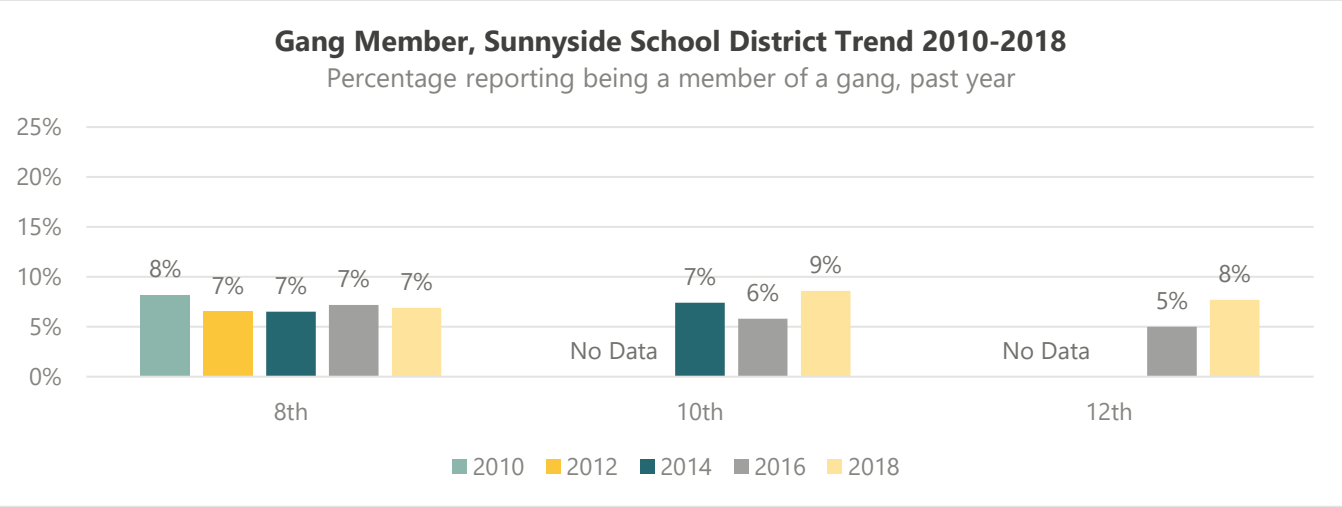
Gangs in Schools

In response to the question, "Are there gangs at your school?" between 16%–34% of students in 2018 responded in the affirmative. Among high-school-aged youth the presence of gangs in schools increased from 2016 levels, with one-in-three 10th graders and one-in-five 12th graders reporting gangs in their schools in 2018. Perceptions of gang activity have declined across years for 8th grade youth.



Source: Healthy Youth Survey (2010-2018 at askhys.net

The HYS also asks students if they had been a member of a gang during the past 12 months. Gangs are defined as "a group of people with a leader who act together often for violent or illegal activities" (HYS, 2018). Although few students, across grade levels, acknowledged gang membership, rates have remained stable across survey years. Between 7%-9% of students claimed such behavior in 2018.



Source: Healthy Youth Survey (2010-2018 at askhys.net

Summary and Implications

In the school environment, results demonstrate that bullying victimization, physical fighting, and weapon incident rates have declined or remained stable. However, student perception of gang activity in their schools has increased among 10th and 12th graders between 2016 and 2018. Although few students, in general, acknowledge gang membership, 2018 rates have increased slightly among 10th and 12th graders.

Participants of interviews and focus groups raised concerns about the growing gang activity in Sunnyside:

> *"There is a gang problem in Sunnyside…interconnected with drugs, violence, and homelessness (couch surfing). During COVID jails did a lot of early release. This meant incarcerated gang members were released, they have been actively recruiting during COVID."* —Parent

> *"We do have a lot of gang activity. Sunnyside got it under control a couple years back and it's my understanding, unfortunately, several of those people that were put away were released and we started seeing the activity pick up again and just that in itself, you know in years ago we used to have the Gang Awareness come in (to schools). We had police officers that would come in and talk to kids about staying away from gangs and things like that. It's unfortunate though because we even have it in our five-year-olds. They'll come in wearing blue or red. I don't know, it's the eagerness I think to jump into a gang type environment and kids are being born and raised in that environment a lot.* —School staff member

Not surprisingly, there are numerous consequences of gang membership. Research findings show that youth involved with gangs engage in higher levels of delinquency than their peers who are not involved with gangs are more than twice as likely to carry a gun, and three times as likely to sell drugs as compared to youth who are not gang involved (Bjerragaard and Lizotte 1995; Cahill and Hayeslip 2010;

Hill, Lui, Hawkins 2001; Spergel 1995; Thornberry 1998). Moreover, gang involved youth are considerably more likely to be victims of violence than other individuals (Howell 2013).
Gang problems disproportionately occur in schools that serve areas of concentrated poverty and social disorganization, where many families experience economic hardship and the unemployment rate is high (National Criminal Justice Reference Service, 2013). As demonstrated in previous sections of this assessment, the Sunnyside community faces a number of these social and environmental factors.

Research on school related protective factors indicates that when students are provided with meaningful opportunities to participate and are recognized and rewarded for their contributions, they are less likely to engage in delinquent or risky health behaviors. In addition, Arthur et al. (2005) found that reduction of risk factors and substance use and increased protective factors among school populations are linked to improved student academic outcomes.

Research has also demonstrated that a positive school climate is a crucial component of violence prevention that can influence behavioral outcomes (e.g., lower rates of aggression, victimization, and dropout), and may enhance youth's resilience factors (National School Climate Center, 2012). As such, it is essential to embed not only a robust set of positive school-wide behavioral expectations (enforced fairly and consistently) but also to ensure on-going social-emotional (SEL) skill building for all youth. In addition, as part of the build out of a multi-tiered system of supports, the district should also consider selective (Tier 2) and individualized (Tier 3) interventions that can provide further pro-social behavioral support for youth that may be at increased risk for, or already involved in gang-related activity as well as ensuring that family members are engaged in intervention services across all levels.

Community Assets and Strengths

Below are available assets and resources supporting Yakima County and the Sunnyside School District region:

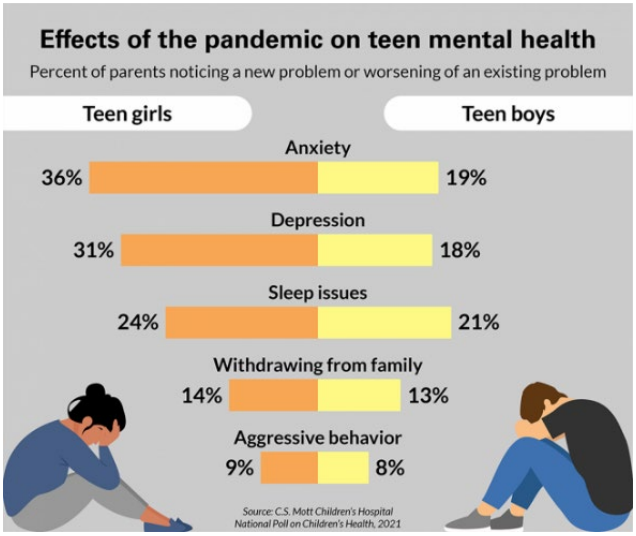
- The Washington Office of Refugee and Immigrant Assistance (ORIA) partners with organizations across the state to offer services that are culturally respectful and in the preferred language of immigrants and refugees.
- Washington Immigrant Solidarity Network (WAISN) is the largest immigrant-led coalition in Washington state, composed of immigrant and refugee-rights organizations and individuals. It strives to protect, serve, and strengthen communities across the state. Its hotline (1-844-724-3737) serves as an avenue for immigrant and refugee communities to report Immigration Custom and Enforcement (ICE)/Custom Border Patrol (CBP) activity in their community, report the detention of a group or individual, and obtain information or referral assistance.
- Washington COVID-19 Immigrant Relief Fund is a pool of funding created during the coronavirus pandemic by and for immigrants to support people ineligible for federal stimulus money or unemployment benefits due to their immigration status.
- Sunnyside United-Unidos began as a coalition of volunteers and leaders who strive for a community where youth can thrive and grow. They focus on reducing youth substance use, depression, suicide, and gang violence.

Mental and Behavioral Health and Well-Being

Mental health disorders are prevalent among school-aged children (aged 13-16) with approximately one-in-five impacted by a diagnosable mental health or learning disorder (Center for Disease Control and Prevention, May 2013). Despite growing knowledge and awareness of mental health issues among school-aged children, there remains a persistent gap between the number of children needing mental health supports and those that receive it. In fact, the average delay (nationally) between the onset of mental health symptoms and intervention is 8 to 10 years, with many children never receiving services (Behrens, 2013; Gall et al., 2000; Kataoka et al., 2002).

In Washington state, young people face major barriers to getting mental health care. In fact, the 2021 Mental Health America report ranks Washington among the lowest states regarding access to care for youth mental health (Mental Health America, 2021). Experts agree that because schools offer unparalleled access to youth, the education system is key to providing children with the needed behavioral health care. Yet historically Washington's education system has failed to adequately address issues related to students' mental health and well-being. For example, public schools employ, on average, one psychologist for every 1,000 students, far below the national standard of one psychologist for every 500-700 students (The Seattle Times, April 4, 2021).

In addition to the existing needs and traditional barriers that students and families face when accessing behavioral health care, including racism, these are likely exacerbated by the ongoing uncertainty and distress of the COVID-19 pandemic. "Nationally, emergency visits for mental health issues jumped by 31% among 12- to 17-year-olds during the pandemic" (The Seattle Times, April 4, 2021 citing the Centers for Disease Control). The need in our state has grown exponentially, prompting Governor Jay Inslee to declare a youth mental health crisis in March 2021.



Teachers and other adults in schools have important health and wellness needs, too. Findings from a poll conducted by the Kaiser Family Foundation in mid-July 2020 found that 53% of adults surveyed reported that their mental health had been negatively impacted as a result of worry and anxiety over the COVID-19 pandemic – up significantly from the 32% of adults reporting such in March (Panchal, Kamal, Orgera, Cox, Garfield, Hamel, Munana, & Chidambaram, 2020).

Stress among teachers has also been linked to poor job performance and decreased student outcomes. Indeed, students of highly stressed teachers demonstrated lower levels of academic performance and social adjustment (Jennings & Greenberg, 2009). When high job demands and stress are combined with low social-emotional competence, teacher performance and classroom management deteriorate (Montgomery & Rupp, 2005).

Participants of focus groups and interviews identified a range of pressing mental health issues facing youth in the Sunnyside School District. They span from stress and anxiety due to school and family pressures; to grief, death, and suicide; to self-harm, self-medication; and eating disorders, particularly among female students.

"For the last several years, there's been an increase in students self-harming. It's almost like an epidemic." —School staff member

"It's easier and cheaper to self-medicate than get therapy and ask for help." —Student

Staff, parents, and students identified increased social anxiety due to COVID, as well as depression (diagnosed or not) because of isolation. The COVID pandemic and its economic, social, and health impacts were on everybody's mind, even as the community transitions to hybrid school models and more social interaction.

"COVID elevated the issues and created barriers." —Parent

These areas of concern are not new, however. Participants acknowledged that there have been ongoing behavioral challenges related to home and life instability, Adverse Childhood Experiences (including poverty, domestic violence, divorce, and separation), and intergenerational trauma.

"Domestic violence is common and women are taught that we have to endure. Many girls are living it." —Parent

"It's just having the time and the resources to support these kids. Some kiddos are struggling with anxiety and fear. We've seen quite a few suicides in our surrounding area through this last year." —School staff member

Participants highlighted that they have all seen the Sunnyside School District making efforts to contribute to the mental health of youth and also teachers and staff. Students expressed that there are many teachers and caring adults at the school they can talk to, who make a point to "check on them and see if things are OK", and that "will be allies/back up students when needed." At the high school, "leadership is working on a room where kids can go to chill when they need to."

"Teachers talk a lot about mental health at school during advisory and leadership. Every Wednesday there is a "Preparing for the Future" talk about a different topic each week."

"Teachers have lists of resources they share."

"Some students have a rough home life. Teachers understand that."

There was agreement that stigma related to mental health exists among both Hispanic/Latinx *and* white community members. Hispanic/Latinx participants recognized the cultural norms in their own

community about seeing depression as "being lazy". Students said that the comfort and ability to talk about mental health is very different between school and home.

> *"In Hispanic communities there is machismo. If you go to the counselor, it is because you are crazy. Problem starts with more counseling."* —Parent

> *"At home there is a mentality to "'be strong'".* —Student

> *"Some families they keep (the idea to) get over it, move on, take an aspirin. (Some families think that) their kids were faking. They were lazy. Once we started engaging, 'you do have a problem and it's not just with your child', then they start to realize that yeah, maybe this is real."*
>
> —School staff member

Some students wondered if the stigma was more a generational issue, than one of race ("close mindness doesn't see race," said one of the students).

> *"There is still a little bit of stigma around mental health. It would help if more adults talked about mental health, it would make it easier for the kids to talk about it."* —Student

Parents, students say, don't believe in mental health, and sharing issues with others (including mental health professionals) may be frowned upon. The parent participants agreed. One shared that "we do not want things to be known outside the house."

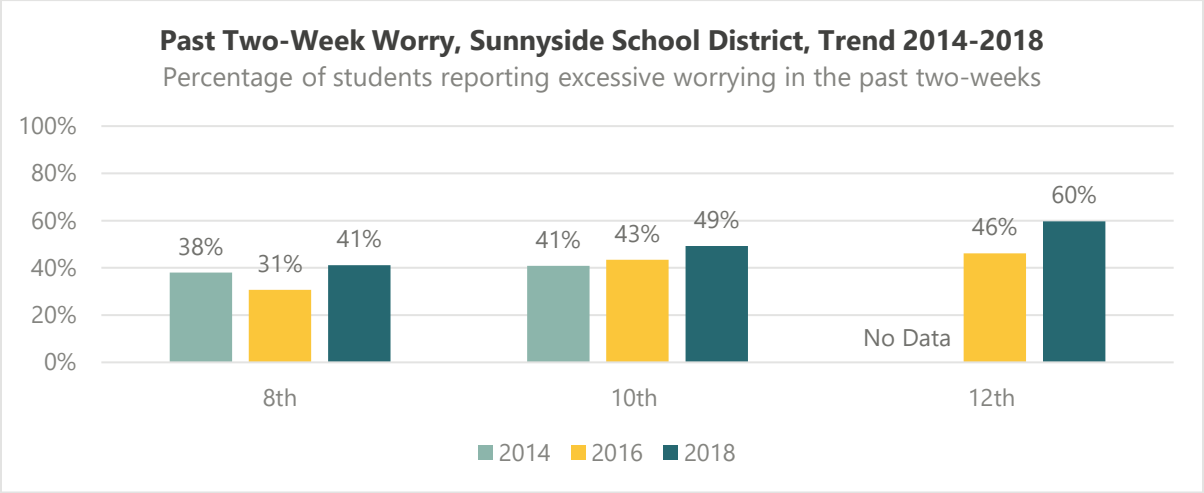
> *"Mental health in the Hispanic culture 'is not real'. If you just ignore it, 'it will go away. 'Immerse yourself in other things'. I bump heads with my parents (about it). These are hard conversations to have."*
>
> *"Don't want to talk to parents about it because it feels like a guilt trip. The parents think it's their fault and feel bad, which makes the kid feel bad, so they don't talk about it at home."*
>
> *"Sometimes we just want someone to listen."*
>
> —Selected comments by students

Emotional Well-being

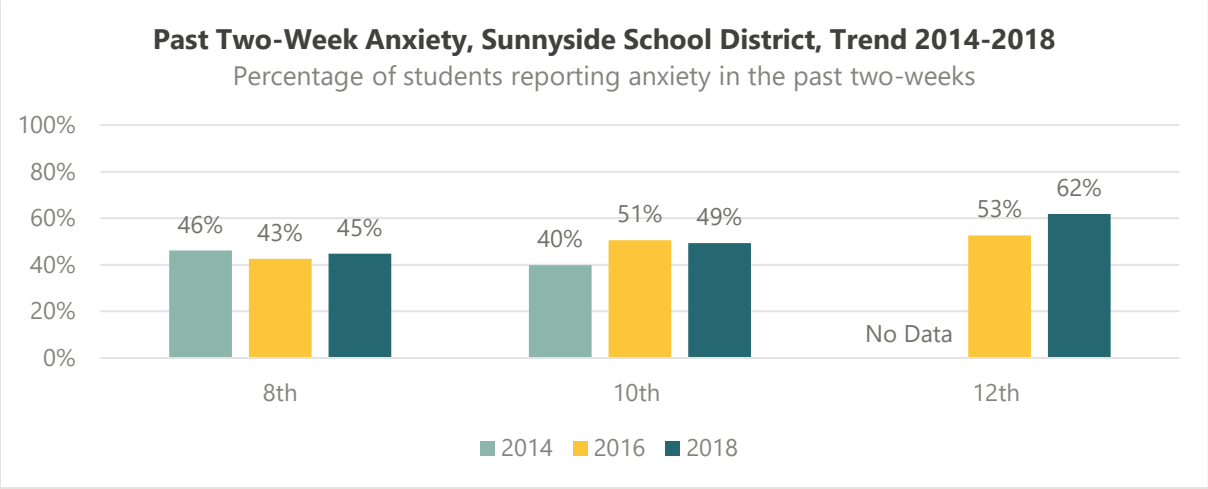
Emotional well-being refers to the emotional quality an individual experiences, and can be influenced by a variety of demographic, economic, and situational factors. The implications of decreased emotional well-being are related to some of the most common mental disorders in school-aged youth, including depression, anxiety, attention-deficit hyperactivity disorder (ADHD), and behavioral or conduct problems (Perou, R., Bitsko, R, Blumberg, S, et al., 2013), all of which can negatively affect their ability to function in the school, home, and community settings.

Worrying and Anxiety: In 2014, two mental health related questions were added to the HYS for 8th, 10th, and 12th grade youth: "*How often over the past 2 weeks were you bothered by not being able to stop or control worrying?*" and, *"How often over the last 2 weeks, were you bothered by feeling nervous, anxious, or on edge?*"

The following figures show rates of reported past two-week excessive worrying and anxiety among Sunnyside's 8th, 10th, and 12th grade youth. In 2018, 41% to 60% of students reported excessive worrying during the previous two weeks, with rates increasing across all grade levels from 2016. Findings further show in 2018 that from 45% to 62% of students reported feeling anxious, with rates rising among 12th grade youth between 2016 and 2018, while mostly unchanged among 8th and 10th graders.



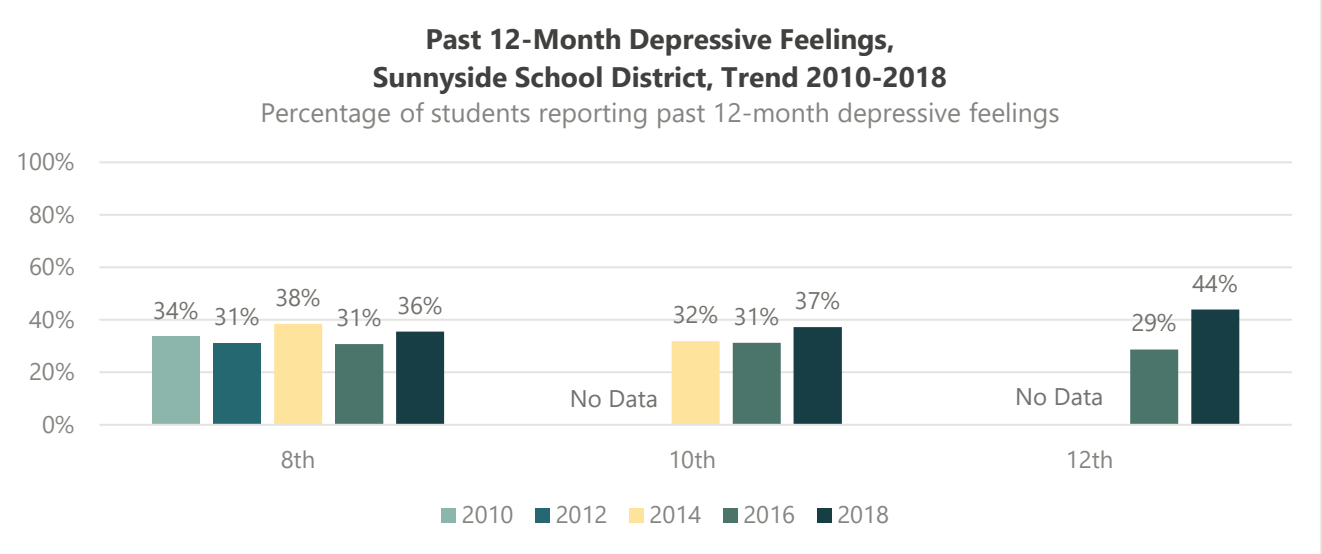
Source: Healthy Youth Survey (2014-2018) at askhys.net



Source: Healthy Youth Survey (2014-2018) at askhys.net

The HYS also asks youth about the frequency of feelings of depression, asking students, *"During the past 12 months, did you ever feel so sad or hopeless almost every day for two or more weeks in a row that you stopped doing some usual activities?"* Findings show that rates of past year depression among 8th, 10th, and 12th grade youth increased between 2016 and 2018, with this considerable for 12th graders. In 2018, 36% of 8th graders, 37% of 10th graders, and 44% of 12th grade youth reported feeling sad or

hopeless. Putting these data into perspective, **an estimated 202 8th graders and 189 10th grade youth reporting symptoms of depression** in the past year.[3]



Source: Healthy Youth Survey (2010-2018) at askhys.net

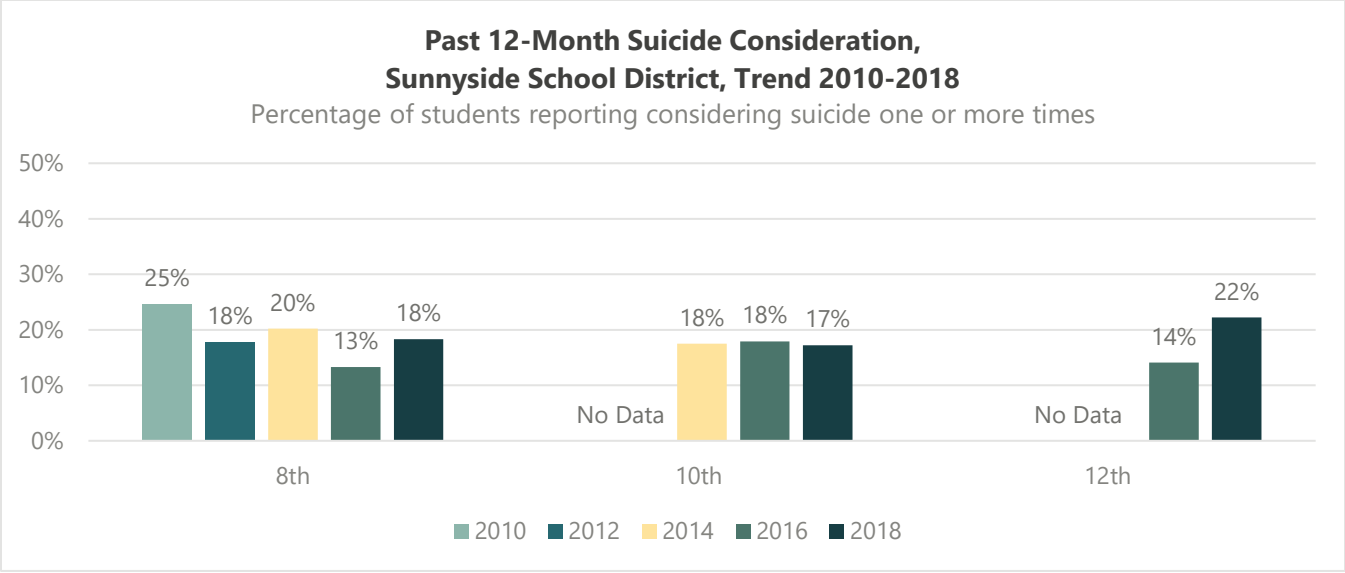
Suicide

Nationally, rates of suicide were rising, even before the pandemic. For teens between the ages of 15 and 19 suicide rates increased by 76% between 2007 and 2017, with the suicide rate for 10-to 14-year-olds nearly tripling over that same time period (US Center for Disease Control, 2019).[4] Since the pandemic, the Centers for Disease Control and Prevention (CDC) estimates that nationally, one in four people under age 18 have struggled with suicidal thoughts. Rates were particularly high among certain other populations, including young adult respondents aged 18–24 (25.5%), Hispanic respondents (18.6%), Black respondents (15.1%), and essential workers (21.7%) (WA State DOH, December 2020)

Since inception, the HYS has asked a series of questions about suicide. The following figures show responses to the following three questions, by grade level: "*During the past 12 months did you ever seriously consider attempting suicide?*", *"During the past 12 months did you make a plan about how you would attempt suicide?",* and *"During the past 12 months, how many times did you actually attempt suicide (any)?"*

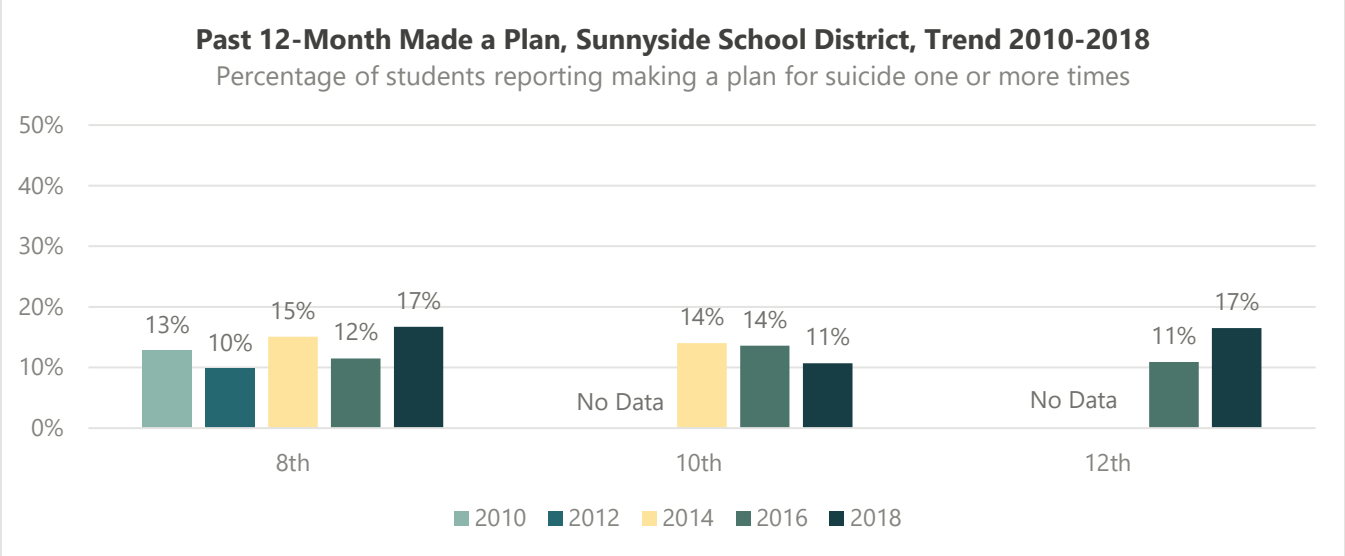
In the first figure below, data show the percentage of 8th, 10th, and 12th grade Sunnyside youth who reported past year suicide ideation.

[3] Extrapolations figures are based on the enrollment for 8th and 10th grade students in 2018 and assume a representative sample of students responded. Response rates (2018) 8th Grade: 74%, 10th Grade: 69%
Death Rates Due to Suicide and Homicide Among Persons Aged 10–24: United States, 2000–2017, see https://www.cdc.gov/nchs/products/databriefs/db352.htm



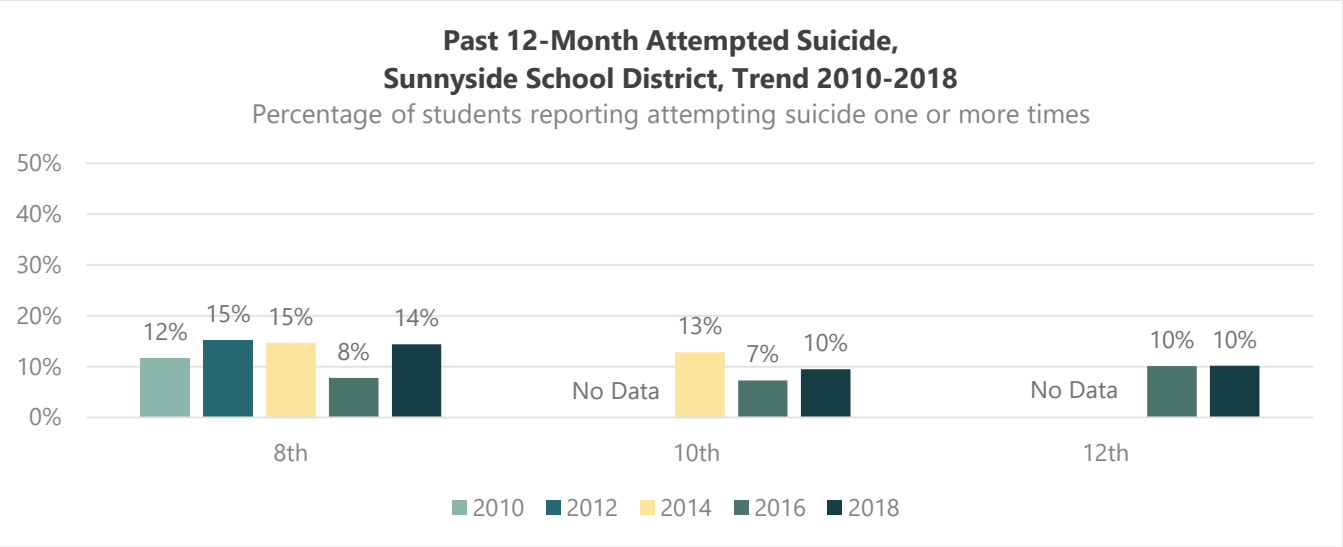
Source: Healthy Youth Survey (2010-2018) at askhys.net

These data indicate that rates of suicidal ideation have fluctuated, though trended downward, among 8th grade youth since 2010, with nearly one-in-five considering suicide in 2018. Rates among 10th grade youth have remained stable, while data for 12th grade students shows rates of ideation nearly doubling between 2016 and 2018, from 14% to 22%. According to these data, approximately **101 8th grade youth and 87 10th graders considered suicide** in 2018.



Source: Healthy Youth Survey (2010-2018) at askhys.net

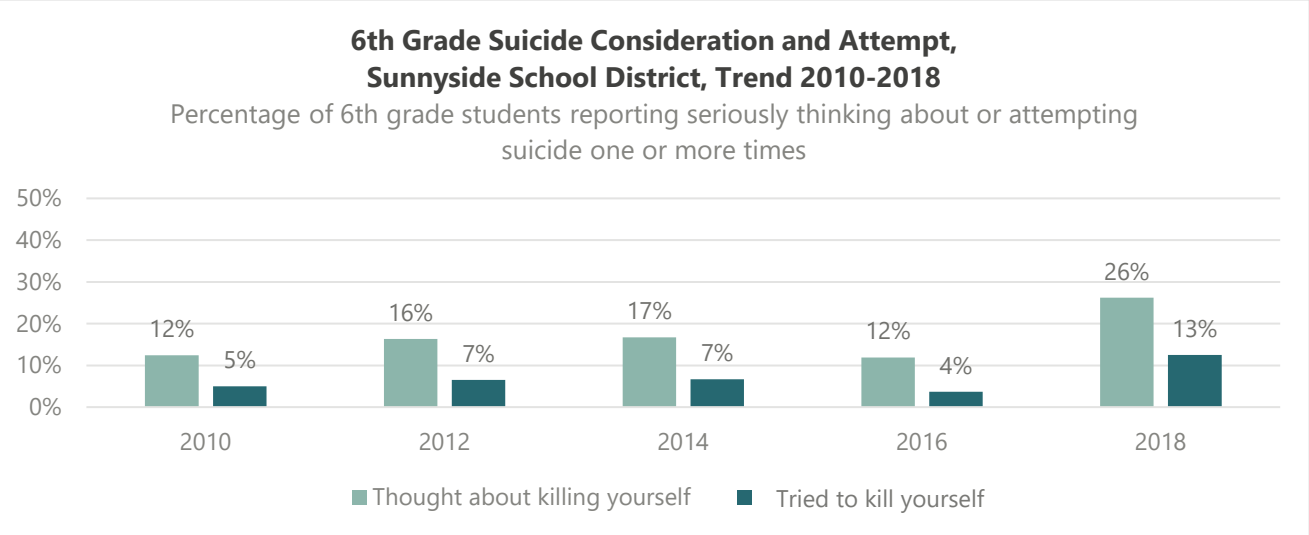
Rates of reported plan making for suicide show that these types of actions have increased among 8th and 12th grade youth but decreased slightly for 10th grade respondents. In 2018, nearly one-in-five 8th and 12th graders, and one-in-ten 10th grade youth made a plan to commit suicide on at least one occasion.



Source: Healthy Youth Survey (2010-2018) at askhys.net

The above figure illustrates the percentage of 8th, 10th, and 12th grade students that reported attempting suicide on one or more occasions in the past year. In 2018, 14% of 8th graders, 10% of 10th graders, and 10% of 12th grade students attempted suicide. For 8th grade students these findings demonstrate an alarming upward trend with rates nearly twice that reported in 2016. According to these data, **over 125 8th (78) and 10th (51) grade students attempted suicide** at least once in the previous year.

The HYS also asks 6th grade youth the following two questions about suicide: *Have you ever seriously thought about killing yourself? Have you ever tried to kill yourself?*

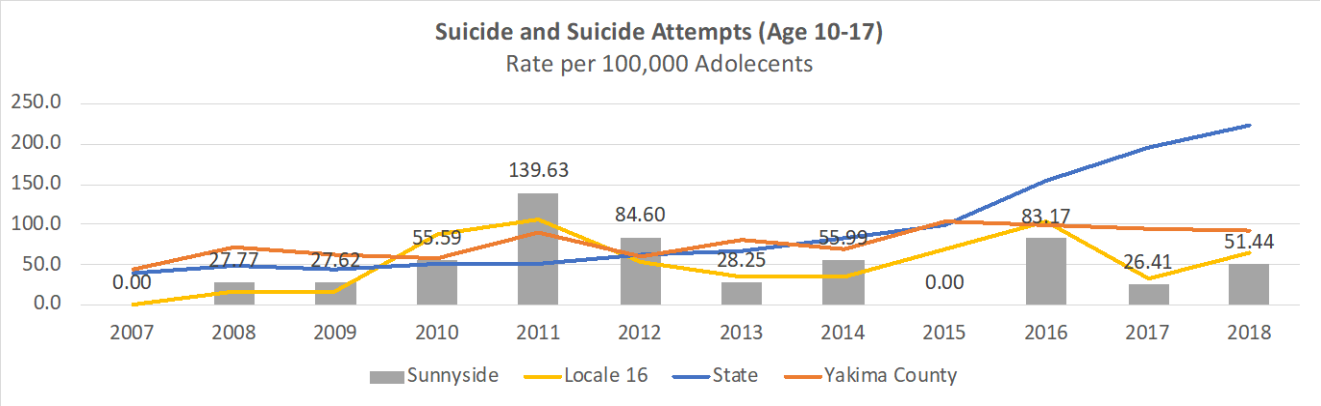


Source: Healthy Youth Survey (2010-2018) at askhys.net

Among Sunnyside 6th graders lifetime suicide ideation has increased considerably since 2010, with one-in-four students reporting these thoughts in 2018 – a rate that exceeds their older peers. Suicide attempts have also risen dramatically since 2010, with a threefold increase between 2016 and 2018 (4%

vs. 13%, respectively). In 2018, approximately **78 6th grade students reported attempting suicide** at least once in their lifetimes.

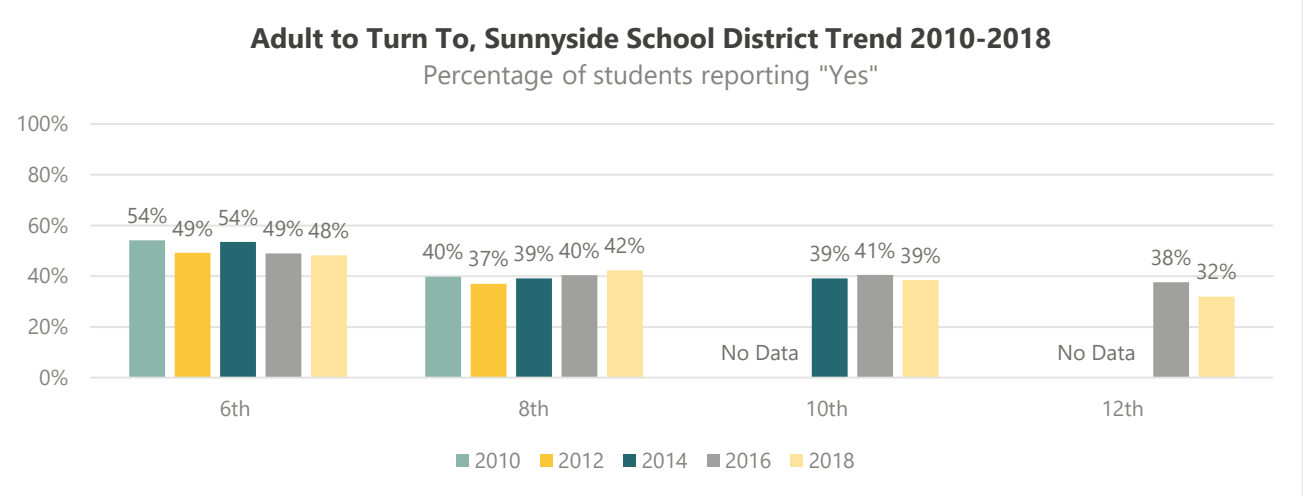
The following graph shows the rate of adolescent suicide and suicide attempts among youth aged 10-17 comparing Sunnyside School District to Locale 16, county, and statewide trends between 2007-2018. These data these demonstrate the high and increasing rate of suicidal ideation and suicide among school-aged youth statewide in recent years, with the rate per 100,00 rising dramatically since 2007. In 2018, among the Sunnyside youth population this rate doubled as compared to the previous year; however, is well below the state rate (51.44 vs. 224.2, state).



Source: Department of Health, Office of Hospital and Patient Data Systems, Comprehensive Hospital Abstract Reporting System (CHARS) and Department of Health, Center for Health Statistics Death Certificate Data

Help Seeking

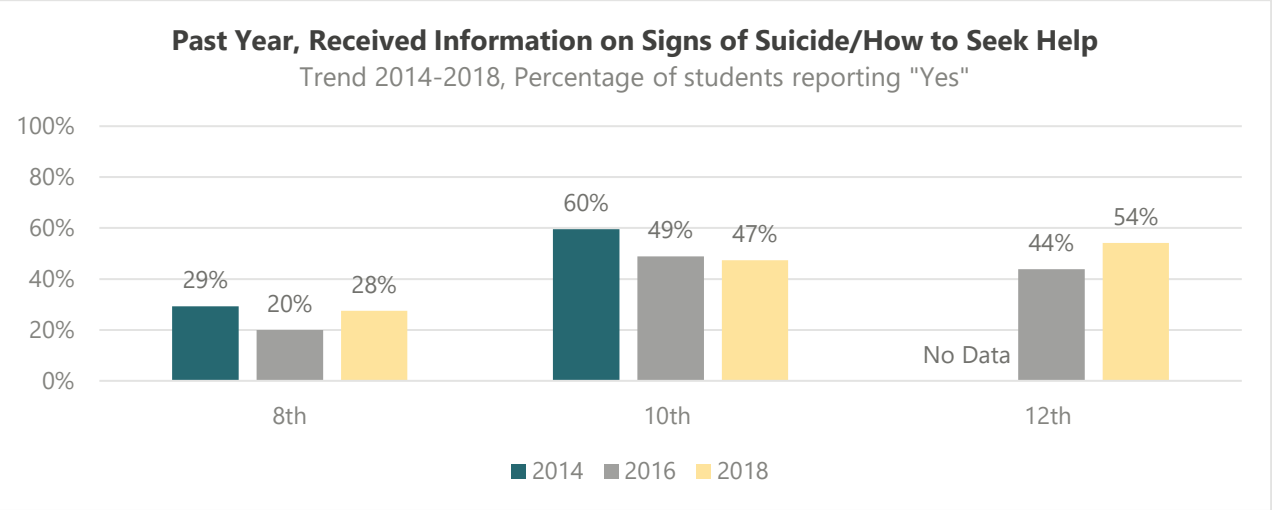
The HYS asked students, "When you feel sad or hopeless, are there adults that you can turn to for help?"



Source: Healthy Youth Survey (2010-2018) at askhys.net

These data show the percentage of students that reported having an adult to turn to if/when they feel sad or hopeless. In general, rates have remained mostly stable across survey years and grade levels. Although, for both 6th and 12th graders, in 2018, fewer students reported having an adult to turn to as compared to previous years.

The final figure shows the percentage of students who recalled receiving information regarding the signs of suicide and how to seek help (for themselves and others). These data illustrate that in 2018, nearly half or more of 10th and 12th grade students reported receiving these types of information. In contrast, among 8th grade youth just over one-quarter were aware of this information.



Source: Healthy Youth Survey (2014-2018) at askhys.net

Staff who participated in the assessment interviews mentioned different resources that had been available in the past and others that are offered to students now. Parents and youth (primarily high school students) shared a general lack of awareness about available resources and "where to go for help". At the same time, there is uncertainty that follow-through occurs and that care is actually offered and provided at home, at school or in the community. There was a call for bringing back home visits.

> *"We got to see families in their own environment, which was totally different. Visiting parents in their own home, they share and open up a lot more. You learn so much more about them, and I think that's an important piece, especially when they're not big on seeking mental health services. They have more time to ask all those questions and (we can) find out about family dynamics."*
>
> —School staff member

> *"Involve the family. Have a social worker come talk to the family. There is domestic violence (...) Maybe someone died in the house, there may be sick people, divorce. I know families who live in a small room and they are 6-7 people. Some come home from work late and go to sleep late. That is not reasonable housing for young people who have to get up early to go to school."*
>
> —Parent

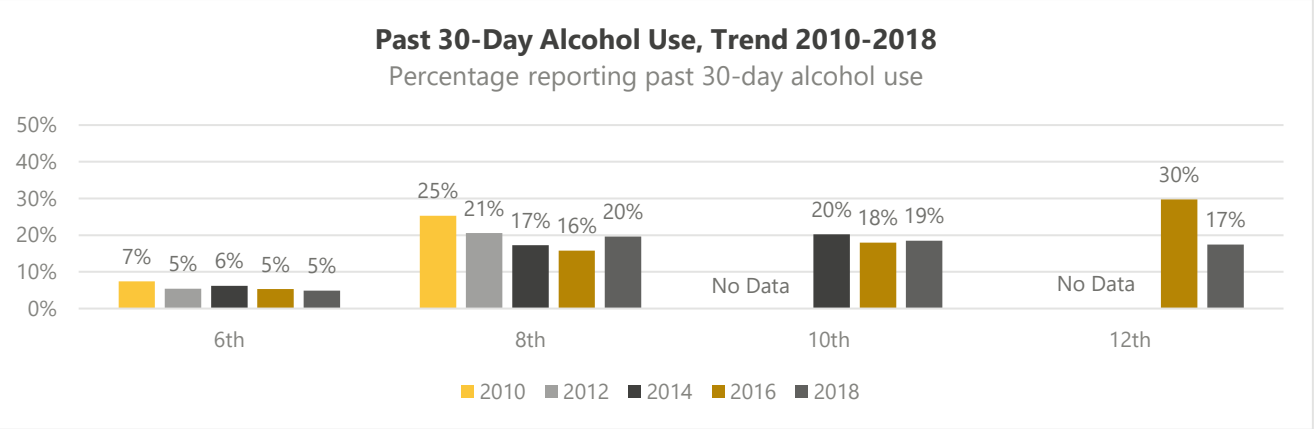
Adolescent Substance Use

Alcohol use

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

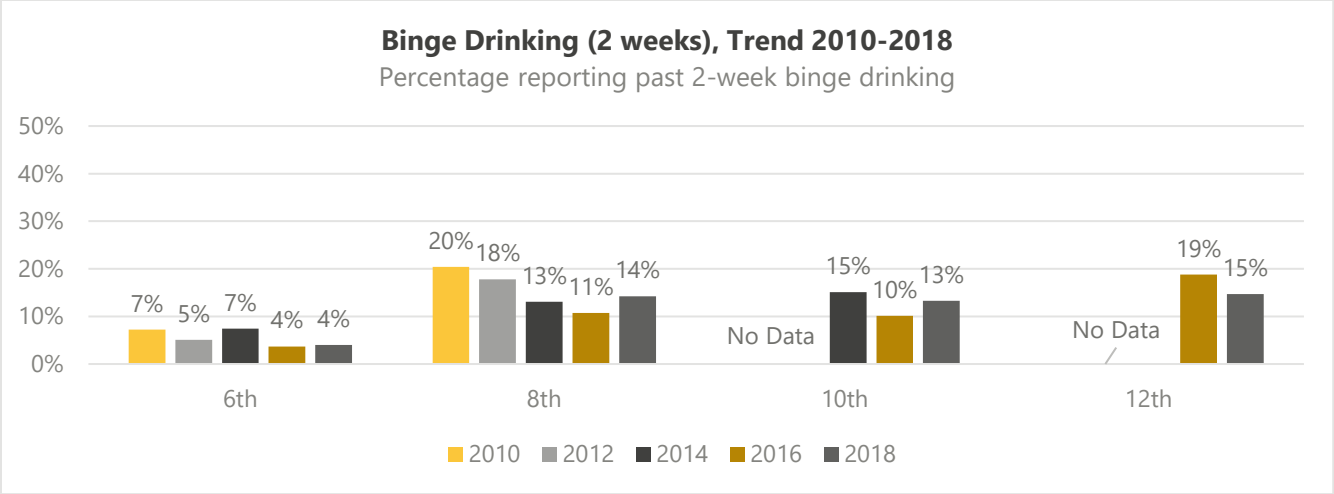
"While multiple factors influence suicidal behaviors, substance use—especially alcohol use—is a significant factor that is linked to a substantial number of suicides and suicide attempts. This "nexus" between substance use and suicide provides an opportunity for behavioral health leaders to develop a cohesive strategy within a public health framework to reduce suicidal behaviors and suicide rates." – SAMSHA Brief (2016)

The following figures illustrate past-30 day and binge drinking rates among survey participants. Rates of recent alcohol use (past 30-day) among Sunnyside students, in general, is declining from 2010 levels – a trend seen statewide. However, data show a significant increase in alcohol use between 6th and 8th grades, with a four-fold rise in use rates. Additionally, use increased in 2018, among 8th graders, with one-in-five reporting recent alcohol use. Among high school-aged youth, rates were stable for 10th graders, while declining substantially at the 12th grade level.



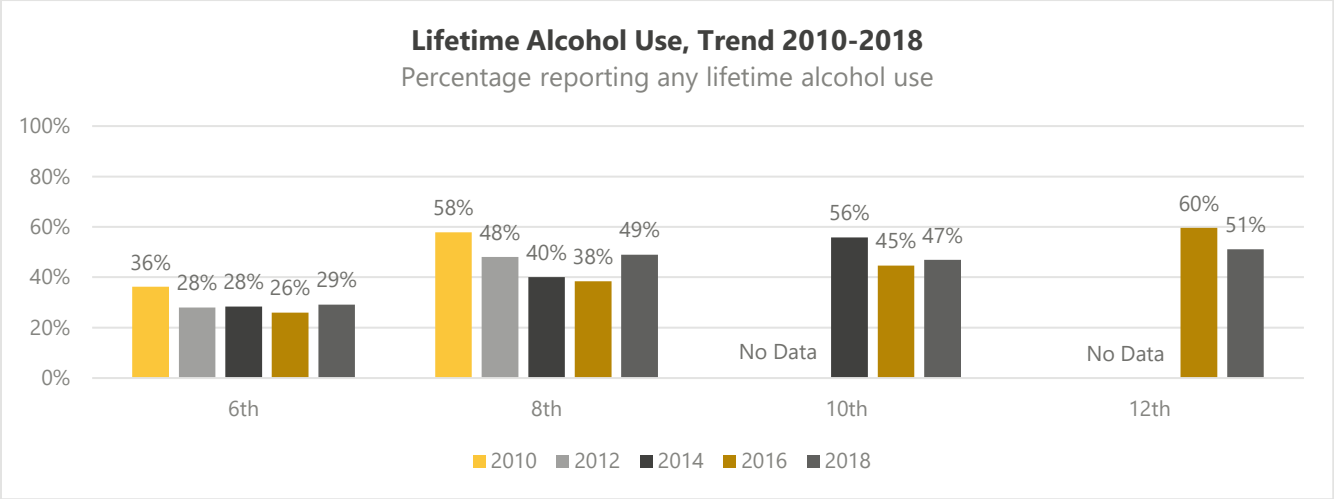
Source: Healthy Youth Survey (2010-2018) at askhys.net

Although binge drinking rates among students across grades has declined from peak use levels, data show increased binge drinking among 8th, and 10th graders between 2016 and 2018. In contrast, among 12th grade respondents, fewer reported heavy use in 2018 compared to 2016.



Source: Healthy Youth Survey (2010-2018) at askhys.net

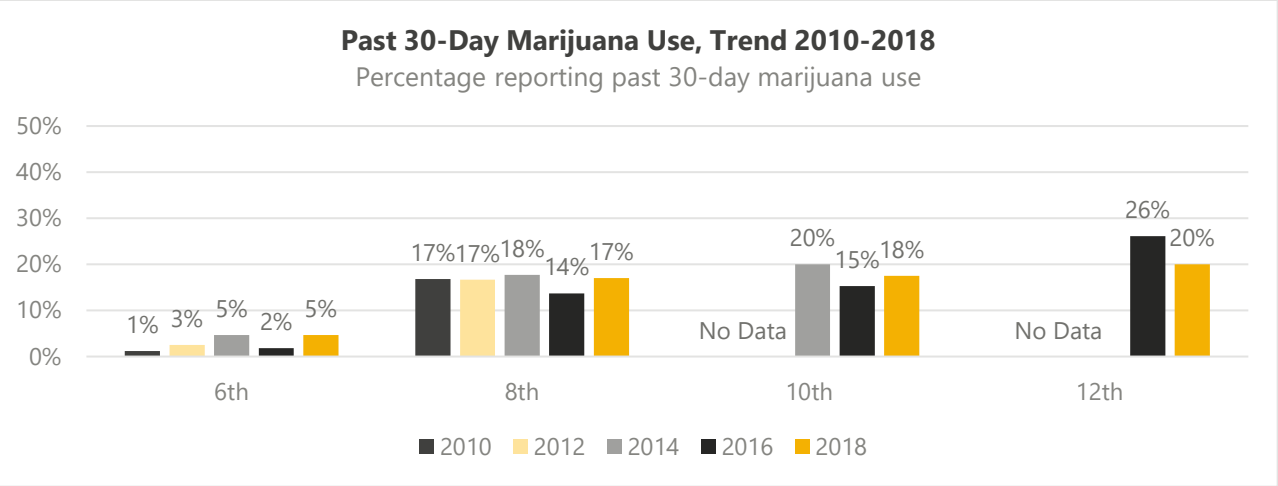
Lifetime alcohol use among Sunnyside students indicate that although rates have declined overtime among 6th graders, slightly more reported use in 2018 as compared to 2016. Among 8th grade respondents, rates declined steadily between 2010 and 2016, but show a marked increase between 2016 and 2018. Among high school-aged respondents, nearly half or more reported lifetime alcohol use in 2018, representing an uptick for 10th graders, and a decrease in the percentage of 12th graders with lifetime alcohol use as compared to 2016 rates.



Source: Healthy Youth Survey (2010-2018) at askhys.net

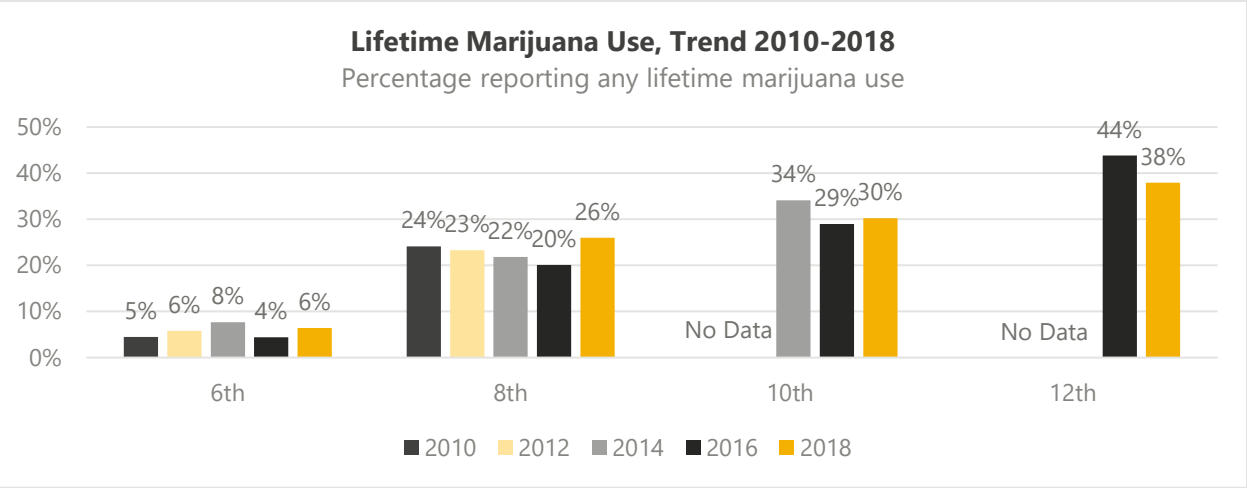
Marijuana Use

Past 30-day marijuana use among 6th grade youth fluctuated over the survey periods, with use increasing between 2016 and 2018. For 8th grade respondents, nearly one-in-five reported recent use in 2018, reflecting an increase as compared to 2016. At the high school-level, approximately one-in-five 10th and 12th graders reported past 30-day marijuana use in 2018, with use increasing slightly among 10th graders while declining for 12th graders from 2016 rates.



Source: Healthy Youth Survey (2010-2018) at askhys.net

The final figure shows lifetime use rates for Sunnyside students. Among 6th and 8th graders, the percentage reporting lifetime marijuana use increased between 2016 and 2018. In contrast, fewer 12th grade participants reported lifetime marijuana use in 2018 than in the previous survey period. Among Sunnyside youth, 6% of 6th graders, 26% of 8th graders, 30% of 10th graders, and 38% of 12th grade students reported any lifetime marijuana use in 2018



Source: Healthy Youth Survey (2010-2018) at askhys.net

Summary and Implications

Findings show a disturbing trend of increased mental and emotional stress among Sunnyside School District students in 2018, including a rise in excessive worrying and increasing levels of anxiety across grade levels. Even more troubling is the percentage of youth who acknowledge symptoms of depression – from 36% to 44%– as well as increased or unchanged levels of suicidal ideation across grade groups. Further, one-in-ten or more 6th, 8th, 10th, and 12th grade students reported attempting suicide in 2018, with rates of ideation and attempts nearly doubling across the district's region between

2017 and 2018. In 2018, 28% of 8th graders, 47% of 10th graders, and 54% of 12th grade you reported receiving information on signs of suicide or help seeking during the school year. Additionally, these results indicate increased or sustained levels of alcohol and marijuana use in 2018 among 6th, 8th, and 10th grade students, while use declined among 12th grade respondents.

Adolescents may begin using alcohol and other drugs to deal with the impacts of depression or anxiety; on the other hand, frequent drug use by teens may also cause or precipitate those disorders. The research related to substance use by adolescent youth is clear. In fact, drug use in adolescents frequently overlaps with other mental health problems. For example, a teen with a substance use disorder is more likely to have a mood, anxiety, learning, or behavioral disorder, too (NIDA, 2014). Further, adolescent substance use can impact physical, cognitive, and neurological development, leading to lifelong health and wellness issues.

Research also suggests a strong link between early substance using behaviors and mental health. For example, estimated rates of co-occurring mental illness among adolescents with substance use disorders range from 60 to 75 percent (youth.gov). Among adolescents with no prior substance use, the rates of first-time use of drugs and alcohol in the previous year are higher in those who have had a major depressive episode than in those who did not (SAMHSA, 2010). Without a means to counteract the negative effects of early substance use, these issues can affect youth well into adulthood.

Everyone who spoke with us shared that in the Sunnyside School District area, young people face barriers to getting mental health care. They acknowledge that teachers and parents face severe health and wellness needs, too, and that the issues impacting everyone have many layers to it.

> *"I think that some of the systems that we have in place here are strong systems, but we just don't have maybe the knowledge or expertise or manpower to kind of serve the kids the best we can. And I also think we have a lot of staff members, not only just our families and our kids - we have staff members that are also having their own mental issues too, so when you're not in the most optimal place, it's hard to provide optimal support for your kids too."* —School staff member

> *"It is important to take into account the mental health of young people but also of parents. Moms often say, "I'm not depressed." Children see that and they will do the same."*
>
> —Parent

The main issues include lack of awareness, access to care, gaps in coordination, absence of a multi-tier systems of support, focusing on punitive measures rather than prevention, and need for training across all groups (students, parents, and staff).

Awareness

It seems that for some families COVID has made talking about mental health more acceptable.

> *"Maybe coming in off this pandemic, there's a new awareness of mental health, and there's some new different kinds of mental health that have risen because of what people have been through. A lot of people lost loved ones, you know, and are struggling to get through that and just not being able to see people."* —School staff member

According to interview participants, there have been some efforts (both before and during the pandemic) to reduce stigma and increase awareness about mental health at the schools. Initiatives have included posting the crisis line number around the schools, placing posters, and having an anonymous automated hotline where people can call into if they are concerned about something or someone.

Yet, all participants asked for an increase in mental health education and awareness activities directed to parents and caregivers. There is widespread lack of knowledge about the science of mental health and illnesses, as well as school- and community-based resources.

Specifically, they suggested talks and family nights about the signs, symptoms, and treatment options for mental health issues; mandatory reporting; age of consent for behavioral health treatment; and overall wellbeing. To increase participation, they suggested wider promotion through the district messenger system, social media, and word-of-mouth, as well as offering incentives such food box distribution at the meeting. The call to action from students is clear:

> *"We want to be able to change the narrative around mental health and being able to talk about issues."*

Lack of school-based mental health providers

There was overwhelming agreement among interview participants that there is a need to have more therapists and highly-qualified mental health professionals in schools. Staff commended the school counselors and admitted there is a limited number of mental health supports to work with the many students that need it.

> *"I know that our counselors are consistently saying they don't have the expertise to work with some of the trauma that some of our kids are faced with and then they don't have the skillset, I guess. It's different, I guess what they've been trained in."* —School staff member

> *"There is only one counselor for the entire high school. Even in kindergarten there should be a counselor. One that builds trust and that young people feel that can talk to them. Have someone to talk to, who is nonjudgmental."* —Parent

> *"We do try to refer them out as much as possible and we do try to provide the support here at school as much as we can as well, but I feel like it's not at the level of what the families need (…) We are limited in what we can do here."* —School staff member

There is also the need to increase and improve the pipeline of future mental health candidates by expanding the offer of mental and behavioral health related programs, potentially through partnerships with colleges and universities.

> *"It's kind of like the trickle-down effect. In our community, they've dropped that program in several (colleges) like at Heritage, WSU Tri Cities. So, my other concern is that there's going to be a lack of good candidates for many positions."* —School staff member

Suspension vs. prevention

Participants from all groups—from students to parents to staff—expressed concern about the lack of concerted and coordinated efforts to prevent issues before they escalate.

"Identification of need usually happens through the discipline pathway, not prevention and intervention." —School staff member

"Suspension is not the way to discipline them. They must know what is happening with the youth. If they are on the defensive, it is because something is happening. Teachers need to understand better and find a solution." —Parent

"Ask questions before punishment." —Student

Coordination

According to staff, there has been broad-minded work done in the district to address mental health needs of students.

"We try the very best we can to meet the needs of these kids. We have parent meetings. We do refer to outside agencies. We meet once a week; it's called our Resource Management Team. Teachers will refer a student to us. We have conversations and then we set out an action plan to try to address these issues. We put support systems in place: small group meetings, buddy groups or friendship groups (for students)."

Yet it still appears that for many, it is more a reactive system than a proactive one. It feels like hit and miss on referral pathways, and on the ability for youth to engage in services. Generally, issues are not addressed comprehensively. Participants perceive that coordination with outside providers is a gap in the current system. It appears that it was present in past systems.

"I thought years ago we had a better system of linking lots of resources together. And it was lots of agencies that would come to the table at the same time for specific crisis instances for families, but that hasn't happened for over 10 years probably so I just think in the past (…) we would sit down for some resource management like meetings, we would have someone from Comprehensive (Health) there. We would have someone from CPS sitting at the end, we have multiple agencies working together towards us. It was very specific to a family and how can we provide wrap-around services to the family."

Both students and teachers/school staff praised the use of the "SOS form" or a student support team referral which, they explained, is a checklist of Tier 1, Tier 2, Tier 3 interventions: counselors and teachers talk about the interventions they want to try and they can check back on the form to see what else they could try.

Communication between parents, teachers, and students appears to be a significant issue. Parents would like to see a protocol for a feedback loop to parents regarding mental health services and supports; students feel that issues shared with counselors or teachers shouldn't be shared with parents and guardians.

"Teachers could do a little more to be aware. There is the need for them to have the ability and the knowledge of how to close the loop on communication and interactions." —Parent

Staff training

Participants were asked if they felt staff received enough training to detect and respond to students' mental health concerns. Responses were unanimously, "No." There was also agreement that some training has been offered (the ACEs training was mentioned a few times), but it's been inconsistent and because the schools receive new teachers on an ongoing basis, offering recurrent trainings is necessary.

> *"Mental health isn't something that teachers receive in their college prep classes. That is not anything that they really cover in depth at all. So, I think that that when we get teachers, we (need to) provide training here."* —School staff member

> *"(Teachers) look at things as 'it's just the behavior, we need to correct the behavior', and I'm like no, no, no, this child doesn't know how to self-regulate. We have to help co-regulate. So, there's not enough education about trauma. There's not enough education about co-regulation and what that looks like."* —School staff member

Ideas for improvement

All participants were also asked to give their ideas for how the school/district can be more supportive of staff, students, and families with regards to mental health. This is a summary of their suggestions.

> *"The school needs to share out what resources are available. We get email about available scholarships/academic opportunities all the time. Why not send out the same level of information for mental health?"*

> *"Mandatory orientation for freshman; a mental health seminar they have to attend."*

> *"De-stigmatization campaign focused at males"*

> *"More learning around how to create safe space for peers going through mental health issues."*

> *"A Health class that teaches that being sad or happy is OK! That all bodies are normal and OK! It needs to address the body dysmorphia for female students."* —Students

> *"A counseling Center PLUS ability for treatment (T3) "The community needs help: more recreational things, more activities, leagues for the children, classes."*

> *"Mental health (training) is not just an issue for teachers, but also for parents. If there is no concrete communication, connectivity between parents and teachers there is no follow-up. Monitoring should continue through the summer. There needs to be more patience, more plans. Instead of suspension, there should be a plan and everyone agrees and continually reviews it."* —Parents

> *"I would love to see every school be equipped with some sort of Wellness Center, whether it is just one room that's available for teachers and students to be able to gather themselves and center themselves to feel safe."*

"I would love to have somebody on site that could provide more Intense regular counseling for our kiddos. Some of the things our kids have gone through are life changing events and we're not able to provide the kind of support that they need (…) We have kids who have some pretty extreme behaviors and it would be really nice to have somebody who had the expertise to look at triggers and reinforcements."

"(Having) somebody who's available for parents, because some of our parents need as much therapy and stuff like that as their kids do. I think a lot of the things that our kids are dealing with are sometimes reflective of their parent's issues who aren't getting support or aren't thriving and getting resources either." —School staff members

Project AWARE's overarching goals are tied specifically to increasing the mental and behavioral health supports available to youth and families in each of the participating districts. Services aligned with increasing identification and referral of students to Tier 2 (Selective) and Tier 3 (Intensive) services are key components to this project. These supports should be based on the needs identified from these findings, as well as the continual use of data-based decision making to identify those youth most at risk of a mental health crisis.

Community Assets and Resources

Community resources to improve the mental and behavioral health and well-being of people in Yakima County and the Sunnyside District region include:

- Mental Health Crisis Lines are available for all people in Washington regardless of income or insurance: Washington Recovery Help Line: **1-866-789-1511** (open all day, every day) and Yakima County Line: **1-888-544-9986**
- Comprehensive Healthcare offers a number of services in Sunnyside including outpatient therapy for adults and children, substance use disorder treatment services including suboxone, medication management, school-based counseling, and 24-hour crisis intervention services.

Protective Factors & Resilience

The research literature is rich with information related to how risk factors can serve as predictors of student problem behaviors. Students with multiple risk factors, or few protective factors are much more likely than their peers to engage in delinquent behaviors including violence; alcohol, tobacco, or other drug use; and are more likely to drop out of school. Elevated risk factors may be balanced and offset by the presence of protective factors. Protective factors are conditions or attributes in individuals, families, communities, or the larger society that mitigate or eliminate risk in families and communities, thereby increasing the health and well-being of children and families (Hawkins, et 1994; Hawkins, Catalano, Miller, 1992). Moreover, strengths, or protective factors, present in BIPOC communities, such as strong family ties and cultural identity, help to overcome the negative influences risks, challenges, and the effects of trauma.

Resilience, the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress can further counter the impacts of risks (American Psychological Association, 2020). Because Black, Indigenous, and other People of Color (BIPOC) face multigenerational trauma, systemic racism, and cultural barriers, resilience looks different for them as compared to the rest of society. For example, Hispanics/Latinx living in the United States may face stresses due to immigration and acculturation, poor educational opportunities, poverty, discrimination, and inadequate access to health care. Therefore, for BIPOC individuals "being resilient is an act of resistance and survival, while [also celebrating] the joys across and within each community" (Molinar, 2020).

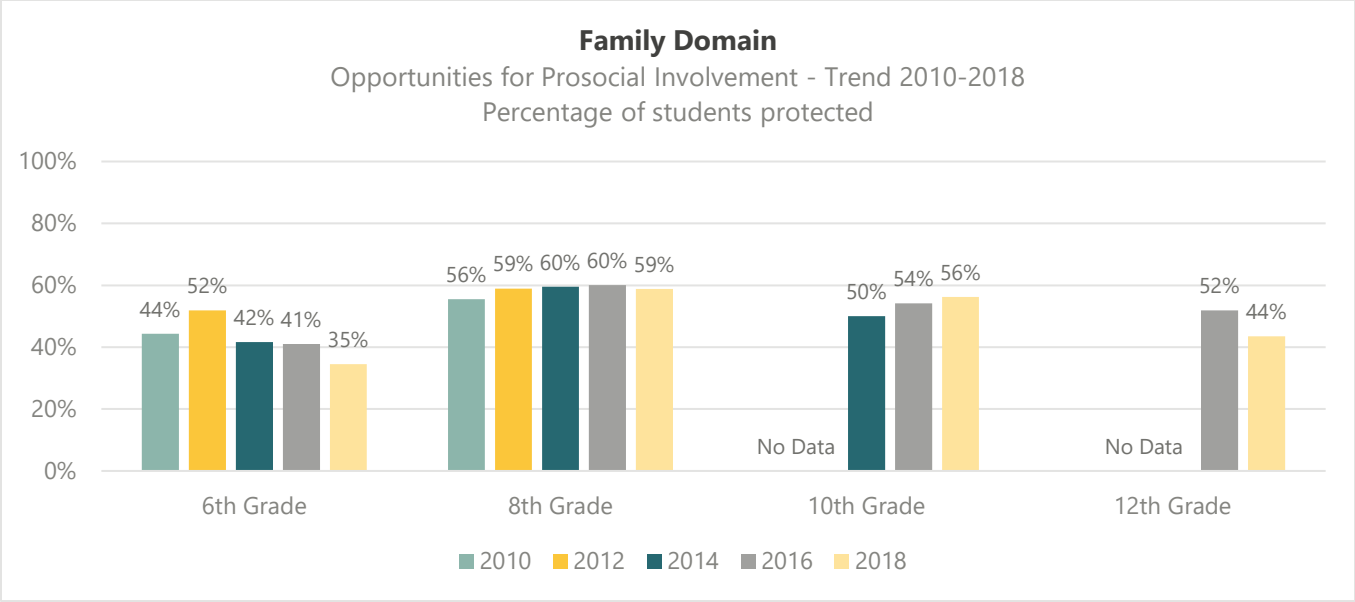
This section of the report highlights identified strengths within the Sunnyside School District community that mitigate adversities and provide opportunities to thrive. It also includes data about the disproportionate distribution of protective factors and highlights how the conditions for mitigation of risks is dependent upon an individual's race, ethnicity, sex, gender, income, or other characteristics.

Composite Protective Factors

The following Information is from the Healthy Youth Survey Risk and Protective Factor Scale results. These composite scales are comprised of multiple survey questions that assess students' views on the presence of protective factors across multiple domains: family, school, peer-individual, and community. For each Protective Factor scale, the percentage of students who are resilient is reported; higher percentages indicate that fewer students are likely to engage in problem behaviors. The following figures show trend results of these composite scales for 8th, 10th, and 12th grade students for the 2010 – 2018 surveys periods (as available).

Family Domain

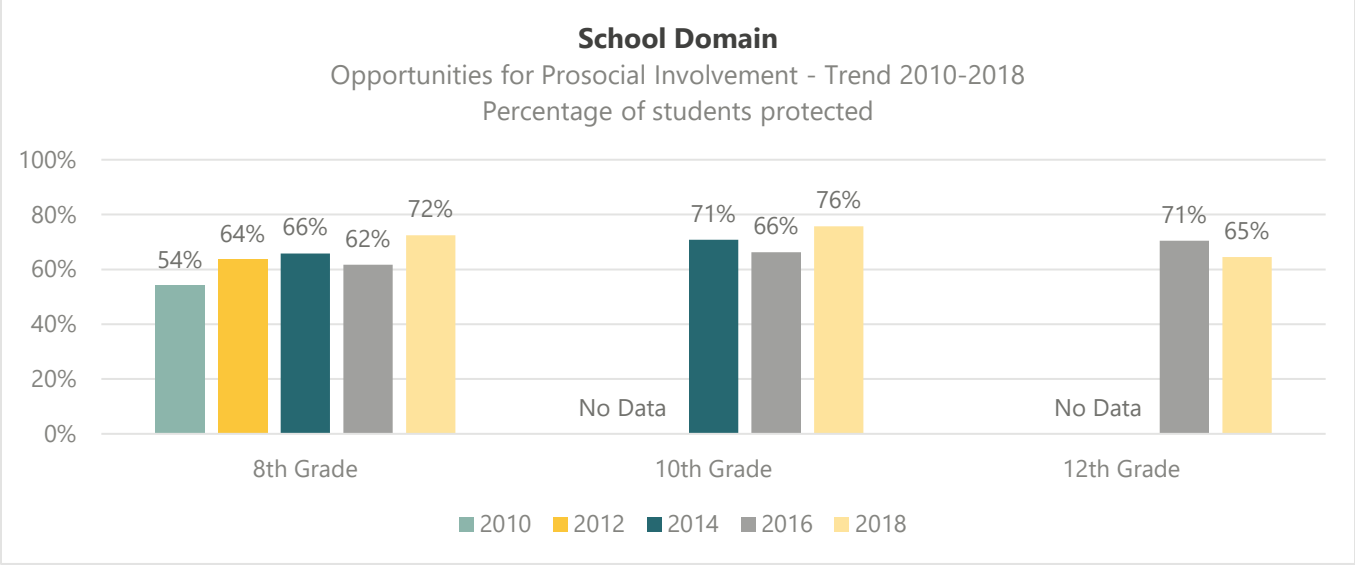
The family protective factor domain assesses students' perception of opportunities and rewards for prosocial involvement and include questions such as "*My parents give me lots of chances to do fun things with them*", and "*If I had a personal problem, I could ask my mom or dad for help.*"



Source: Healthy Youth Survey (2010-2018) at askhys.net

School Domain

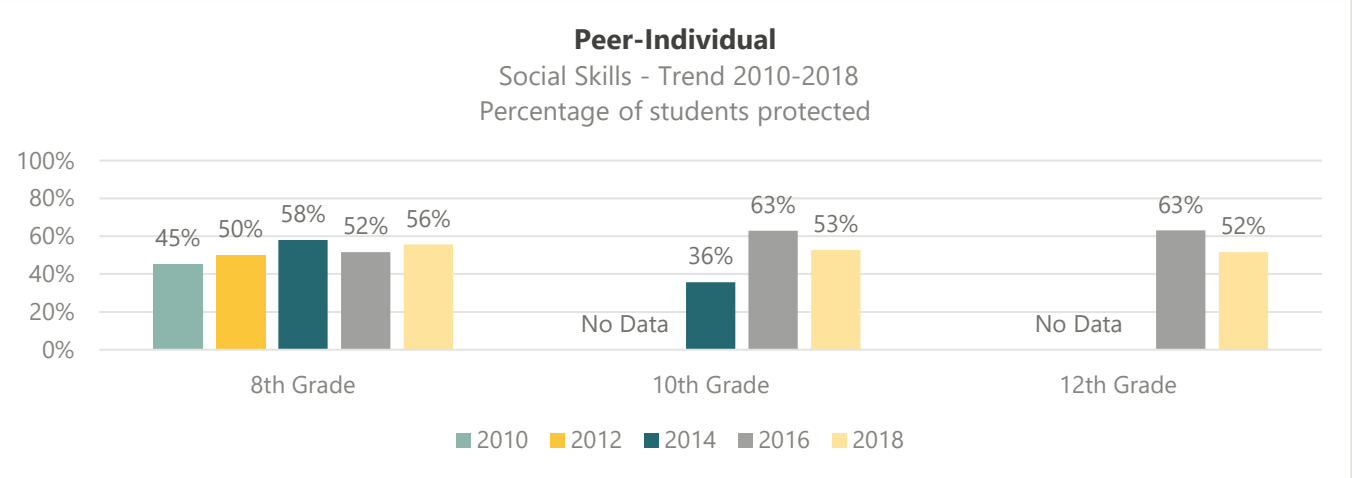
Factors assessed in the school protective factor domain include opportunities for prosocial involvement. Questions include: "*There are lots of chances for students in my school to talk with a teacher one-on-one*" and, "*There are lots of chances for students in my school to get involved in sports, clubs, and other school activities outside of class.*"



Source: Healthy Youth Survey (2010-2018) at askhys.net

Peer-Individual Domain

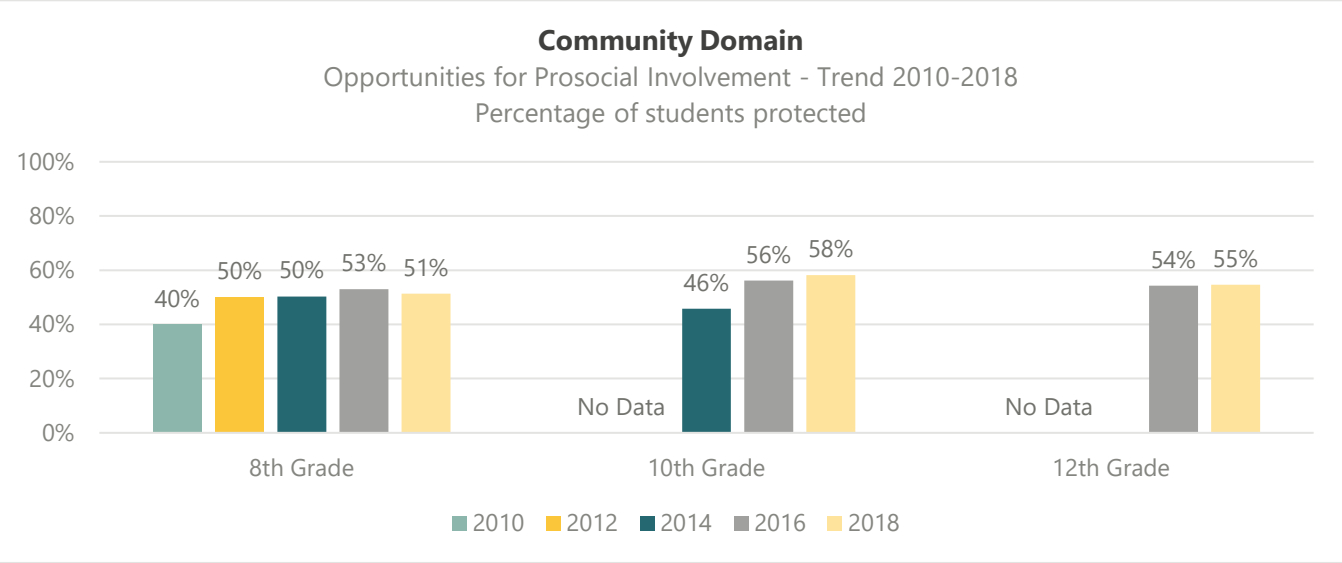
Protective factors assessed here are linked to the presence of social skills. For example, students are asked: "*You are at a party at someone's house and one of your friends offers you a drink containing alcohol. What would you say or do?*"



Source: Healthy Youth Survey (2010-2018) at askhys.net

Community Domain

Protective factors within the community domain also include opportunities and rewards for prosocial involvement. These include opportunities for youth to engage with pro-social adults (e.g., "*There are adults in my neighborhood or community I could talk to about something important.*") and pro-social activities such as sports teams, and recreation e.g., Boys & Girls Clubs, YMCA, or other youth-centered clubs.



Source: Healthy Youth Survey (2010-2018) at askhys.net

Findings

In general, these data show that in 2018 most Sunnyside 8th, 10th, and 12th grade students reported resiliency across multiple domains. These protections were highest, across grade levels and survey years, in the school domain. In fact, students reported multiple opportunities for prosocial involvement including engagement in decision making related to classroom rules and class discussions, high-levels of student-to-teacher interaction, and involvement in school-based clubs, sports, or other extracurricular school activities. However, the perception of protection declined somewhat among 12th graders between 2016 and 2018. At the peer-individual level, the majority of 8th, 10th, and 12th graders acknowledged protective factors specifically related to social skills that reduce their risks for delinquent and substance using behaviors. Although, among 10th and 12th graders, protection declined from 2016.

Perceptions of the presence of family protective factors show variability across grade levels in 2018, with 8th and 10th grade students reporting higher involvement in family-based prosocial opportunities such as decision-making, family outings, and talking to parents about personal problems. The presence of these factors was considerably lower among 6th and 12th grade youth. In contrast, across grade levels, most youth identified community protective factors. On average over half of these students reported pro-social opportunities in and around their communities, such as access to positive adult role models in their neighborhood as well as recreational activities, and youth-focused service clubs and organizations.

Children's Hope Scale

We end this report on a note of hope. Hope reflects a future orientated mindset and motivational process by which an individual has an expectation toward attaining a desirable goal. Research has linked hope with overall physical, psychological, and social well-being (Hellman, Worley, and Munoz, 2016). Further, if youth do not perceive themselves to have the capacity to pursue their goals, they may be less likely to make changes in their behaviors, or in the ways that they think and feel about themselves (Jiang, Otis, Weber, and Scott, 2018).

In 2018, a version of the Children's Hope Scale (Snyder et al. 1997) was added to the Healthy Youth Survey. Computed from four questions,[5] the scale is "based on the premise that children are goal directed and that their goal-related thoughts can be understood according to two components (Snyder et al., 1997, p. 400). These are: agency – one's ability to initiate and sustain action towards goals; and pathways – one's capacity to find a means to carry out goals.

[5] Questions include: I can think of many ways to get the things in life that are important to me; I am doing just as well as other kids my age; When I have a problem, I can come up with lots of ways to solve it; and, I think the things I have done in the past will help me in the future. Response format is a 6-point Likert scale (1= None of the time, 2= A little of the time, 3= Some of the time, 4 = A lot of the time, 5 = Most of the time, 6 = All of the time).

The data in the table show responses by grade level. Findings indicate that among Sunnyside youth, most students (approximately 75%) were at least moderately hopeful for the future, with these rates similar across grade groups. Findings indicate that older students were more likely to report no or very little hope, with one-in-ten or more 10th and 12th graders reporting such responses.

Healthy Youth Survey Hope Scale (2018)	8th Grade	10th Grade	12th Grade
No or Very Little Hope	5%	10%	12%
Slightly Hopeful	20%	18%	15%
Moderately Hopeful	28%	21%	26%
Highly Hopeful	47%	51%	48%

Source: Healthy Youth Survey (2018) at askhys.net

Summary and Implications

Results indicate that most Sunnyside 8th, 10th, and 12th grade students reported resiliency across multiple domains in 2018, with these highest, across grade levels and survey years, in the school domain. These findings suggest that students identified opportunities for prosocial involvement in the school setting as well as high-levels of student-to-teacher interaction, and engagement in school-based activities. Other areas of strengths included peer-individual, family, and community protective factors. However, among 6th graders level of family protective factors have declined in recent years. Findings also demonstrate that many Sunnyside youth were at least moderately hopeful about their future, including nearly half or more who were "highly" hopeful.

Protective factors are conditions or attributes in individuals, families, communities, or the larger society that mitigate or eliminate risk in families and communities, thereby increasing the health and well-being of children and families. Elevated risk factors may be balanced and offset by the presence of protective factors. Research has found that students with higher levels of protective factors may be more resilient to the effects of the negative influences of risk factors. Resilience, the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress can counter these impacts.

Strong families and healthy communities are key parts of this process, and together with schools, can help a child transition into adulthood. A large body of research shows that family engagement in schools improves student achievement, reduces absenteeism, and restores parents' confidence in their children's education. Parental involvement also facilitates children's cognitive, social, and emotional functioning and has been linked to increased self- esteem, improved behavior, and more positive attitudes toward school (Christenson & Havsy, 2004; Patrikakou, Weissberg, Redding, & Walberg, 2005).

All assessment participants were asked to name the people, places, and things that make the Sunnyside School District community healthy, safe, and strong. In other words, to list some of the protective factors that could help to increase the health and well-being of children and families and mitigate or eliminate risk in families and communities. The following summarizes some of the comments from students, staff, and parent participants.

"Comprehensive Healthcare is an asset. We have a hospital in our district town."

"The Strengthening Families program here in Sunnyside is very good."

"Diversity in the community is an asset. Hard working (in agriculture), dedicated community members."

"Not a lot of assets in Sunnyside, but we have a lot of talent and businesses interested in helping and supporting the district. (There are) lots of potential for a stronger family-school-community partnership."

"I believe we're a pretty progressive district in regards to supporting mental, social, emotional health, and it's something that the district I believe has been talking about for a while, and we've seen a shift."

"The people that work here, for the most part, they choose to work here. What I appreciate most about our families is that they are very trusting of us as educators and being the ones that are providing services for their kids. I feel like there's very little pushback. It's always 100% respectful and appreciative of what we're doing here at this school. We have amazing families at our school. Most fantastic."

With the overarching goals of Project AWARE to increase awareness of mental health issues, and to detect, connect, and respond to student mental health needs, the Sunnyside School District has the opportunity to not only increase access to behavioral health care for students and families, but also to support systems-level changes to enhance family-school-community partnerships and family engagement. As such, it is imperative that Project AWARE services and supports are designed in a manner that supports and builds upon existing protective factors, across domains, to ensure that youth are ready and able to overcome challenges and are successful academically, personally, and professionally.

References

ACR Business Consulting (2019), Yakima County Homeless Point-in-time Count. Available at: https://yakimacounty.us/DocumentCenter/View/22119/2019-Yakima-County-Point-in-Time-Report?bidId

Administration for Children and Families, U.S. Department of Health & Human Services (2021), Temporary Assistance for Needy Families (TANF). Available at: https://www.acf.hhs.gov/sites/default/files/documents/ofa/fy2020_tanf_caseload_1.pdf

American Psychological Association (2012), Building your resilience. Available at: https://www.apa.org/topics/resilience

Annie E. Casey Foundation. Kids Count Data Book (2014). Retrieved from, http://www.aecf.org/m/resourcedoc/aecf-2014kidscountdatabook-2014.pdf

Astria Health (2018), Community Health Needs Assessment and Improvement Plan. Available at: https://www.astria.health/site/files/file_manager/page/shared/2018-astria-chna-action-plan-final-03012019.pdf

Baquero, B., Gonzalez, C., Ramirez, M., Chavez Santos, E., & Ornelas, I. J. (2020). Understanding and Addressing Latinx COVID-19 Disparities in Washington State. *Health education & behavior: the official publication of the Society for Public Health Education*, *47*(6), 845–849. https://doi.org/10.1177/1090198120963099

Behrens, D., Lear, J.G., & Price, O.A. (2013). Improving access to children's mental health care: Lessons from a study of eleven states. The George Washington University: Washington, D.C. http://www.healthinschools.org/wp-content/uploads/2016/10/March2013-StatePrograms_d5_color_FINAL.pdf

Beteille, T., Kalogrides, D., & Loeb, S. (2011). Stepping Stones: Principal Career Paths and School Outcomes. NBER Working Paper No. w17243.

Bjerragaard and Lizotte (1995). Gun Ownership and Gang Membership. *Journal of Criminal Law and Criminology* Volume: 86 Issue: 1 Dated: (Fall 1995) Pages: 37-58. Office of Justice Programs, U.S. Department of Justice. https://www.ojp.gov/ncjrs/virtual-library/abstracts/gun-ownership-and-gang-membership

Brennan Ramirez LK, B.E., Metzler M., (2008), Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health, Centers for Disease Control and Prevention, Editor. Department of Health and Human Services: Atlanta, GA

Cahill and Hayeslip (2010). Findings From the Evaluation of OJJDP's Gang Reduction Program. Office of Juvenile Justice and Delinquency Prevention. Office of Justice Programs, U.S. Department of Justice https://www.ojp.gov/pdffiles1/ojjdp/230106.pdf

California Health Interview Survey. (2005). Los Angeles, CA: UCLA Center for Health Policy Research, 2007.

Castañeda, H, Holmes, S.M., Madrigal, D.S., DeTrinidad Young, M-E., Beyeler, N., Quesada, J. (2014), Immigration as a Social Determinant of Health. *Annual Review of Public Health,* 36:1, 375-392

Center for Disease Control and Prevention (May 2013), Mental health symptoms in school-aged children in four communities. Available at: https://www.cdc.gov/childrensmentalhealth/features/school-aged-mental-health-in-communities.html

Christenson, S. L., & Havsy, L. H. (2004). Family-school-peer relationships: Significance for social, emotional, and academic learning. In J. E. Zins, R. P. Weissberg, M. C. Wang, & H. J. Walberg (Eds.), *Building academic success on social and emotional learning: What does the research say?* (p. 59–75). Teachers College Press.

Commission on Social Determinants of Health (CSDH), (2008), Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health, World Health Organization: Geneva

Conway, Swendsen, Husky, He, & Merikangas (2016). Association of Lifetime Mental Disorders and Subsequent Alcohol and Illicit Drug Use: Results From the National Comorbidity Survey–Adolescent Supplement: https://www.jaacap.org/article/S0890-8567(16)00070-8/fulltext

Council on Social Work Education *(2016),* Working Definition of Economic Well-Being. Available at: https://www.cswe.org/Centers-Initiatives/Initiatives/Clearinghouse-for-Economic-Well-Being/Working-Definition-of-Economic-Well-Being

Espelage & DeLaRue (2012). School Bullying: Its Nature and Ecology. *International Journal of Adolescent Medicine and Health, 24(1), 3-10.*

Furfaro, Hanna (April 4, 2021). Washington students are facing a mental health crisis. Here's why schools are on the front lines. *The Seattle Times.* Available at: https://www.seattletimes.com/education-lab/washington-students-are-facing-a-mental-health-crisis-heres-why-schools-are-on-the-front-lines/

Gall, G., Pagano, M.E., Desmond, M.S., Perrin, J.M., & Murphy, J.M. (2000). Utility of psychosocial screening at a school-based health center. *The Journal of School Health 70*(7), 292-298.

Great Schools Partnership (2014). The Glossary of Education Reform. Available at: https://www.edglossary.org/

Greenberg, M.T., Brown, J.L., & Avenavoli, R.M. (2016). Teacher stress and health: Effects on teachers, students, and schools. Robert Wood Johnson Foundation. http://www.rwjf.org/en/library/research/2016/07/teacher-stress-and-health.html

Hawkins, J.D., et al. (1992). Risk and protective factor framework: Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin,* 112(1), 64-105.

Healthy Youth Survey, 2010-2018. Retrieved from AskHYS.net

Hellman, C. H. Worley, J. A., & Munoz R. T. (2016) A Primer On Hope As A Theory of Change for Human Service Providers. Available at https://thurstonthrives.org/wp-content/uploads/2016/05/Hope-White-Paper.pdf

Hill, Lui, Hawkins (2001). Early Precursors of Gang Membership: A Study of Seattle Youth. Office of Juvenile Justice and Delinquency Prevention. Office of Justice Programs, U.S. Department of Justice. https://www.ojp.gov/pdffiles1/ojjdp/190106.pdf

Howell, James C. (2013). *Chapter One: Why Is Gang-Membership Prevention Important?* Changing Course: Preventing Gang Membership. National Institute of Justice, National Center for Injury and Prevention Control. https://storage.googleapis.com/edcompass/quantum/materials/1216_Gang-Membership-Updated.pdf#page=9

Jennings, P. A., & Greenberg, M. T. (2009). The prosocial classroom: Teacher social and emotional competence in relation to student and classroom outcomes. *Review of Educational Research, 79*, 491–525.

Jiang, X., Otis, K. L., Weber, M., & Huebner, E. S. (2018). *Hope and adolescent mental health.* In M. W. Gallagher & S. J. Lopez (Eds.), *Oxford library of psychology. The Oxford handbook of hope* (p. 299–312). Oxford University Press.

Kataoka, S.H., Zhang, L., & Wells, K.B. (2002). Unmet need for mental health care among U.S. children: variation by ethnicity and insurance status. *American Journal of Psychiatry, 159*(9), 1548-55.

KIDS COUNT Data Center, A project of the Annie E. Casey Foundation (2021). Available at: datacenter.kidscount.org

Langhout, R., Buckingham, S., Kaur Oberoi, A., Chávez, N.R., Rusch, D., Esposito, F., Suarez-Balcazar, Y. (2018), Statement on the Effects of Deportation and Forced Separation on Immigrants, their Families, and Communities, https://doi.org/10.1002/ajcp.12256

Mental Health America (2021), Youth Data. Available at: https://www.mhanational.org/issues/2021/mental-health-america-youth-data

Migration Policy Institute (MPI) (2020-2021), Analysis of U.S. Census Bureau data from the pooled 2014–18 American Community Survey (ACS) and the 2008 Survey of Income and Program Participation (SIPP). Available at: https://www.migrationpolicy.org/data/unauthorized-immigrant-population/county/53077

Molinar, Gustavo (2020), (Re) Defining Resilience: A Perspective Of 'Toughness' In BIPOC Communities. Available at: https://www.mhanational.org/blog/re-defining-resilience-perspective-toughness-bipoc-communities

Montgomery, C., & Rupp, A. A. (2005). A meta-analysis exploring the diverse causes and effects of stress in teachers. *Canadian Journal of Education, 28*, 458–486.

Nader, Kathleen (2012), Violence Prevention and School Climate Reform, National School Climate Center. Available at: https://files.eric.ed.gov/fulltext/ED573695.pdf

National Academies of Sciences, Engineering, and Medicine (2019), Monitoring Educational Equity. Washington, DC: The National Academies Press. https://doi.org/10.17226/25389 .

National Criminal Justice Reference Service, 2013

National Immigration Forum (2018), Fact Sheet: Immigrants and Public Benefits. Available at: https://immigrationforum.org/article/fact-sheet-immigrants-and-public-benefits/

National Network of State Teachers of the Year (2018), Rebuilding the Ladder of Educational Opportunity. Available at: https://files.eric.ed.gov/fulltext/ED595318.pdf

Northwest Harvest (2021), Hunger in Washington. Available at: https://www.livestories.com/statistics/hunger-in-washington/washington/yakima-county-community-snapshot

Organisation for Economic Co-operation and Development (2013), Measuring Well-being and Progress: Well-being Research. Available at: https://www.oecd.org/statistics/measuring-well-being-and-progress.htm

Panchal, N., Kamal, R., Orgera, K., Cox, C., Garfield, R., Hamel, L., Munana, C., & Chidambaram, P. (August 21, 2020). The Implications of COVID-10 for Mental Health and Substance Use. Retrieved from https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

Patrikakou, Eva. (2005). School-family partnerships: Fostering children's school success. Teacher College Press.

Patterson GR, Reid JB, Dishion TJ. Antisocial Boys. Castalia; Eugene, OR: 1992. [Google Scholar]

Pearce, Diana M., PhD. (2020), The Self-Sufficiency Standard for Washington State. Available at: http://www.selfsufficiencystandard.org/sites/default/files/selfsuff/docs/WA2020_SSS.pdf

Perou, R., Bitsko, R.H., Blumberg, S.J., et al. (2013) Mental Health Surveillance among Children—United States, 2005-2011. MMWR Surveillance Summaries, 62, 1-3. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/23677130

Pierson, James (2019), Addressing Economic Justice in the Face of Inequality. Available at: https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/economic-justice/addressing-economic-justice-in-the-face-of-inequality/

Resnick et al., 1997 Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health. JAMA. https://www.mdft.org/mdft/media/files/Resnick-et-al-(1997)-Protecting-adolescents-from-harm-National-longitudinal-study-on-adolescent-health-JAMA.pdf

Robert Wood-Johnson Foundation (2021), Healthy Communities. Available: https://www.rwjf.org/en/our-focus-areas/focus-areas/healthy-communities.html

Schroeder, S, 2007, September 20). We Can Do Better – Improving the Health of the American People. The New England Journal of Medicine. 357, 1221-1228

Seattle Children's Hospital, (2019), Community Health Assessment. Available at: https://www.seattlechildrens.org/globalassets/documents/about/community/2019-community-health-assessment-cha.pdf

Simmons, D. N., Brackett, M. A., & Adler, N. (2018). Applying an equity lens to social, emotional, and academic development. Edna Bennett Pierce Prevention Research Center, Penn State University. Retrieved from https://dpi.wi.gov/sites/default/files/imce/sspw/pdf/SEL_-_Equity.pdf

Snyder et al. 1997 (1997). The development and validation of the children's hope scale. Journal of Pediatric Psychology, 22, 399-421.

Spergel, I.A (1995). *The Youth Gang Problem.* New York, NY: Oxford University Press.

Starks, MA Aaron, Sharkova, PhD, Irina V. and Mancuso, PhD David (Jan 2021), Risk and Protection Profile for Substance Abuse Prevention for Sunnyside, Wahluke and Yakima. Community Outcome & Risk Evaluation. Washington State Department of Social & Health Services.

Substance Abuse and Mental Health Services Administration (SAMHSA), Key Substance Use and Mental Health Indicators in the United States: https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR1PDFW090120.pdf

Thornberry, T. P. (1998). *Membership in youth gangs and involvement in serious and violent offending.* In R. Loeber & D. P. Farrington (Eds.), *Serious & violent juvenile offenders: Risk factors and successful interventions* (p. 147–166). Sage Publications, Inc.

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion (2020), Healthy People 2030. Available at: https://health.gov/healthypeople/objectives-and-data/social-determinants-health

United States Census Bureau (2020), 2015-2019 American Community Survey. Available at: https://data.census.gov/cedsci/

United Way Worldwide Annual Report (2011). Retrieved from http://unway.3cdn.net/f58b3b8a9b4f33a573_tvm62lh6v.pdf

University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps (2021), Health Rankings. Available at: https://www.countyhealthrankings.org/explore-health-rankings

Virginia Mason Memorial (2019), Community Health Needs Assessment. Available at: https://www.yakimamemorial.org/pdf/about/community-hna-2019.pdf

Wanapum Heritage Center (2017-21), Our History. About the Wanapum. Available at: https://wanapum.org/about/

Washington Immigrant Solidarity Network, El Centro de la Raza, Northwest Health Law Advocates (2020), Washington State Health Equity for Immigrants Report. With support from the ACLU of Washington. Available at: https://static1.squarespace.com/static/5c9a7904f8135a221909597f/t/60108dca76080474a5e2d6a3/1611697623906/WA+Health+Equity+for+Immigrants_Full+Report_2020.pdf

Washington Office of Superintendent for Public Instruction (2021), 2018-2020 Report Card. Available at: https://washingtonstatereportcard.ospi.k12.wa.us/

Washington State Department of Health (2018), Food Insecurity and Hunger. Available at: https://www.doh.wa.gov/Portals/1/Documents/Pubs/160-015-MCHDataRptFoodInsecHunger.pdf

Washington State Department of Health (2018), Washington State Health Assessment. Available at: https://www.doh.wa.gov/Portals/1/Documents/1000/2018SHA_FullReport.pdf

Washington State Department of Health (2021). COVID-19 Vaccination Coverage by Race and Ethnicity and Age in Washington State. Available at: https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/data-tables/348-791-COVID19VaccinationCoverageRaceEthnicityAgeWAState.pdf

Washington State Department of Health (December 2020), Provider alert regarding increased concern of suicide risk in youth during COVID-19. Available at: https://www.hca.wa.gov/assets/program/covid-19-provider-alert-regarding-suicide-risk-in-youth.pdf

Washington State Employment Security Department (2021), Population Reference Bureau analysis of the U.S. Census Bureau, Household Pulse Survey. Available at: https://esd.wa.gov/labormarketinfo/monthly-employment-report

Washington State Department of Social and Health Services (2021). *Risk and Protection Profile for Substance Abuse Prevention in Washington Communities*. Olympia, WA: Washington State Department of Social and Health Services. Retrieved from: https://www.dshs.wa.gov/ffa/research-and-data-analysis/community-risk-profiles

Washington State Office of Financial Management (2021) 2020 Population Trends. WA State Office of Financial Management, Small Area Estimate Program (SAEP), Estimates of Total Population for School Districts by County Part. Available at: https://www.ofm.wa.gov/sites/default/files/public/dataresearch/pop/april1/ofm_april1_poptrends.pdf

Wehmeyer, M. L., & Field, S. (2007). Instructional and assessment strategies to promote the self-determination of students with disabilities. Thousand Oaks, CA: Corwin. WHO 2016

Yakama Nation (2020), Yakama Nation History. Available at: https://www.yakama.com/about/ youth.GOV (2021). Co-occurring Disorders. Available at: https://youth.gov/youth-topics/youth-mental-health/co-occurring

Appendix A: Healthy Youth Survey Response Rates, 2010-2018

Sunnyside School District

Grade	2010	2012	2014	2016	2018
6th	76%	74%	86%	84%	79%
8th	91%	77%	76%	79%	74%
10th	No Data	No Data	59%	72%	69%
12th	No Data	No Data	No Data	50%	51%

The following guidance may be used when reviewing your results. However, if a particular group(s) of students did not complete the survey and therefore did not contribute to your results, there may be limitations to your results even if you have a high participation rate (i.e., if differences exist between students who *did* and who *did not* complete the survey). There may be value in discussing the potential limitations when using the results in this report.

- 70% or greater participation–Results are probably representative of students in this grade.
- 40–69% participation–Results may be representative of students in this grade.
- Less than 40% participation–Results are likely not representative of students in this grade but do reflect students who completed the survey.

Appendix B: Interview and Focus Group Questions

Staff Questions

1. What do you feel are the most pressing mental health issues facing students in your school district/community?
2. Do you consider that these issues are being addressed? If so, how?
3. What are some of the ways that the school is addressing these needs/concerns? What would you like to see more of? <*Probe: Can you provide examples?*>
4. If children in your class/school/district needed mental health support, would you know how to access school-based services?
5. Does the school connect students and families to community-based providers if additional support is needed? <*Probe: Who in the district makes these connections with/for you?*>
6. What are the most significant gaps and barriers in resources, coordination, etc. in this area?
7. Do you consider that teachers and administrators at your school/district receive enough training and are prepared to detect and respond to the students' mental health concerns/issues? <*Probe: Can you provide an example?*>
8. Are there school-based campaigns to reduce stigma and promote awareness of mental health wellness? Do you think these would be well received in the community? <*Probe: Can you explain what those are and how you know about them?*>
9. What are the people, places, and things that make your community healthy, safe, and strong and why are they important? These could include organizations, leaders, coalitions initiatives, policies, or physical/environmental attributes.
10. What ideas do you have for how the school can be more supportive of staff, students, and families with regards to mental health?
11. Is there anything else about mental health in your school or district that you would like to share?

Student Questions

1. What do you feel are the main mental health issues that students in your school face?
2. Have you been encouraged to take care of your mental health from the adults in your family?
3. Were you taught about mental health in school?
4. When you're going through it, do you know of programs or services at your school that can help you? How about in your community?
5. Does your school have spaces/times during the school day for you and your friends to talk about things you're going through?
6. Are there adults at school who talk to you when you are upset about something or have a problem? <*Probe: Who?*> How about in your family? And in your community?
7. What ideas do you have for how the school can be more supportive of your and your friends' mental health?

8. Is there anything else about mental health in your school or district that you would like to share?

Parent Questions - English

2. What do you feel are the most pressing mental health issues facing students in your kid's school and in your community?
3. Do you consider that these issues are being addressed? If so, how?
4. What are some of the ways that the school is addressing these needs/concerns? What would you like to see more of? <*Probe: Can you provide examples?*>
5. Are you aware of any school campaigns to reduce mental health stigma or promote awareness of mental health wellness (adult/child)? Do you think these would be well received in the community? <*Probe: Can you explain what those are and how you know about them?*>
6. Do you consider that school teachers and administrators are prepared to detect and respond to the students' mental health concerns/issues? <*Probe: Can you provide an example?*>
7. What does the district/school do to create a positive and safe environment for your student/family? What could it do better? <*Probe: What does this look like to you? Can you provide an example?*>
8. If your child needed mental health support, would you know how to access services at the school? <*Probe: Have you received information about a referral process or information about services and supports at the school?*> How about in your community?
9. How connected do you feel to the school? Are there opportunities for parents/caregivers to offer feedback on mental health services provided at the school? <*Probe: Can you provide examples?*>
10. What could the school do more of or do differently to better involve parents/caregivers?
11. Do you feel like your family's cultural background is recognized, respected, and valued by the school? If so, how (e.g., language)? If not, how could this be improved? <*Probe: Can you provide examples?*>

Parent Questions - Spanish

1. ¿Cuáles creen que son los principales problemas mentales que enfrentan los estudiantes de la escuela de su hijo o de los jóvenes en su comunidad?
2. ¿Considera que se están abordando estos temas? ¿Si es así, cómo?
3. ¿Cuáles son algunas de las formas específicas en que la escuela está abordando estas necesidades / preocupaciones? ¿Qué más le gustaría que se hiciera? <*Indague: ¿Puede dar un ejemplo?*>
4. Si su hijo necesitara apoyo de salud mental, ¿sabría usted cómo acceder a los servicios en la escuela? <*Indague: ¿Ha recibido información sobre servicios y apoyos en la escuela?*> ¿Y en su comunidad?
5. ¿Considera que los maestros y administradores escolares están preparados para detectar y responder a las inquietudes / problemas de salud mental de los estudiantes? <*Indague: ¿Puede darnos un ejemplo?*>
6. ¿Qué hace el distrito / escuela para crear un ambiente positivo y seguro para su estudiante / familia? ¿Qué podría hacer mejor? <*Indague: ¿Qué le parece esto? ¿Puede darnos un ejemplo?*> ¿Conoce alguna campaña escolar para reducir el estigma de la salud mental o promover la

conciencia sobre el bienestar de la salud mental (adulto / niño)? ¿Cree que serían bien recibidos en la comunidad? <*Indague: ¿Puede explicar qué son y cómo los conoce?*>

7. ¿Hay factores culturales que afecten al estigma en torno a la salud mental? <*Indague: Yo soy latina, y a veces es difícil hablar sobre salud mental con mi familia. ¿Cree que necesitamos más gente Latina como proveedores de salud mental? En otras escuelas hemos visto que incluso cuando tienen servicios o programas de salud mental, los estudiantes o las familias no los utilizan. ¿Tiene la cultura algo que ver con eso?*>
8. ¿Siente que la escuela reconoce, respeta y valora la cultural de su familia? Si es así, ¿cómo? *(por ejemplo, idioma)* Si no es así, ¿cómo podría mejorarse esto? <*Indague: ¿Puede proporcionar ejemplos?*>
9. ¿Qué tan conectado se siente con la escuela? ¿Hay oportunidades para que los padres o adultos responsables de los jóvenes ofrezcan sugerencias sobre los servicios de salud mental que se brindan en la escuela? <*Indague: ¿Puede proporcionar ejemplos?*>
10. ¿Qué más podría hacer la escuela o hacer de manera diferente para involucrar mejor a los padres y adultos responsables de los jóvenes?

WASHINGTON PROJECT AWARE FY 2020

Community Health Assessment Wahluke School District

"Empowering and Inspiring Students for All Opportunities in Life." – District Mission

June 2021

Prepared for:
Washington Office of Superintendent for Public Instruction

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Introduction

In October 2020, the Washington Office of Superintendent of Public Instruction (OSPI) was awarded a five-year Project AWARE (Advancing Wellness and Resilience in Education) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). OSPI serves as the lead agency for a consortium of three partner school districts, or Local Education Agencies (LEAs): Sunnyside School District, Wahluke School District and Yakima School District. This project, *"Beyond Co-Location: Integrating and Embedding Education and Mental Health Systems"* addresses the national Project Aware initiative. The building of collaborative partnerships between state and local systems, specifically education and mental health, strengthens the system's capacity to promote the healthy development of school-aged youth and to prevent youth violence through an integrated multi-tiered system of support (MTSS) framework.

In addition to efforts at the state level to integrate education and mental health, strengthen MTSS initiatives, develop sustainable regional mental health support networks, and document practices that are scalable to other regions in Washington, the specific goals of the AWARE project are to:

1) Increase ***awareness*** of mental health issues among school-aged youth through the development, implementation, and sustainability of a comprehensive school-based system of mental health services and supports.
2) Train school personnel and other adults who interact with school-aged youth to detect and ***respond*** to mental health issues.
3) ***Connect*** school-aged youth who may have behavioral health issues and their families to needed services.

A best practice related to the implementation of an MTSS framework is the conduct of a behavioral health assessment and resource mapping to document existing school and community-based services across tiered-levels of supports. Through this process, both needs *and* strengths are incorporated, thereby centering communities, their culture, and history; elevating community voices; and making equity and antiracism the framework (not simply a lens) in which assessments and strategic planning take place. By including assets, we can paint a more complete picture of communities, illustrate their resilience, and identify opportunities for maximizing existing resources.

The purpose of this assessment process is to:

1. Highlight community strengths and disparities and articulate how these will be addressed through the implementation of Project AWARE.
2. Ensure assessment findings inform Project AWARE's goals, activities, and outcomes.
3. Use community assessment findings to inform project partners in the design and implementation of school-based mental health services and supports.

This report contains the findings for the Wahluke School District Regional Community Health Assessment conducted by Maike & Associates in the spring of 2021.

Methodology

Key data points and the latest research findings were used to assess the well-being of Wahluke students and families. Much of the data comes from public records, such as national and state census data. State, county, and school district data were also collected from the Risk and Protection Profile for Substance Abuse Prevention in Washington Communities (January 2021). Annually, the Washington State Department of Social & Health Services, Research & Data Analysis Division, produces these reports, which include technical notes on the methodological approaches used to obtain data reported at the district-level.

Additionally, Wahluke School District 6th, 8th, 10th, and 12th grade students participate in the Washington State Healthy Youth Survey (HYS) in the fall of even numbered school years. The HYS is sponsored by the Department of Health, the Office of Superintendent of Public Instruction, the Department of Social and Health Services, the Department of Commerce, the Family Policy Council, and the Liquor Control Board in cooperation with schools throughout the state. The survey measures health risk behaviors known to contribute to the health and safety of youth. Survey results serve two important functions: first, providing needs assessment data for program planning; and second, giving a measure of the global effectiveness of statewide prevention and health promotion. The regular collection of HYS data is crucial for tracking progress toward improved outcomes. (Survey response rates, by grade and survey year, can be found in Appendix A).

Other major data sources used for this assessment include the County Health Rankings & Roadmaps, a program of the University of Wisconsin Population Health Institute, which provides a snapshot of a community's health using county-level data. Rankings are based on a model of population health and include data from Behavioral Risk Factor Surveillance System, Mapping Medicare Disparities Tool, American Community Survey 5-year estimates, Census Population Estimates, and other sources. For many measures, data are available by race/ethnicity within a county.

Another major component of this work was to conduct in-depth qualitative interviews and focus groups with key district informants to better understand the nature, depth, and breadth of current school-based social, emotional, and behavioral strategies being implemented. The main purpose of the interview was to obtain a deeper understanding of the scope of resources, services, or programs available to students and staff within each respondent or group of respondents' roles. We also sought to identify barriers or challenges that could hinder the implementation of school-based mental health services.

Participants included staff at the elementary, Jr high and high school levels, including classroom teachers, school counselors and paraeducators, as well as parents and students. Contact and scheduling of focus groups and interviews was coordinated by the LEA district. In all, 27 individuals participated in the interview and focus group process.

Each participant was asked to answer questions from their perspective, with regard to their specific experience and expertise. As such, not all respondents answered all questions and not all questions were asked of all respondents. Individual teacher interviews were approximately 30-45 minutes and

focus groups lasted 90 minutes each. Completed interviews were transcribed, coded for themes, analyzed, and are summarized in the following sections. (See Appendix B for focus and interview questions by group).

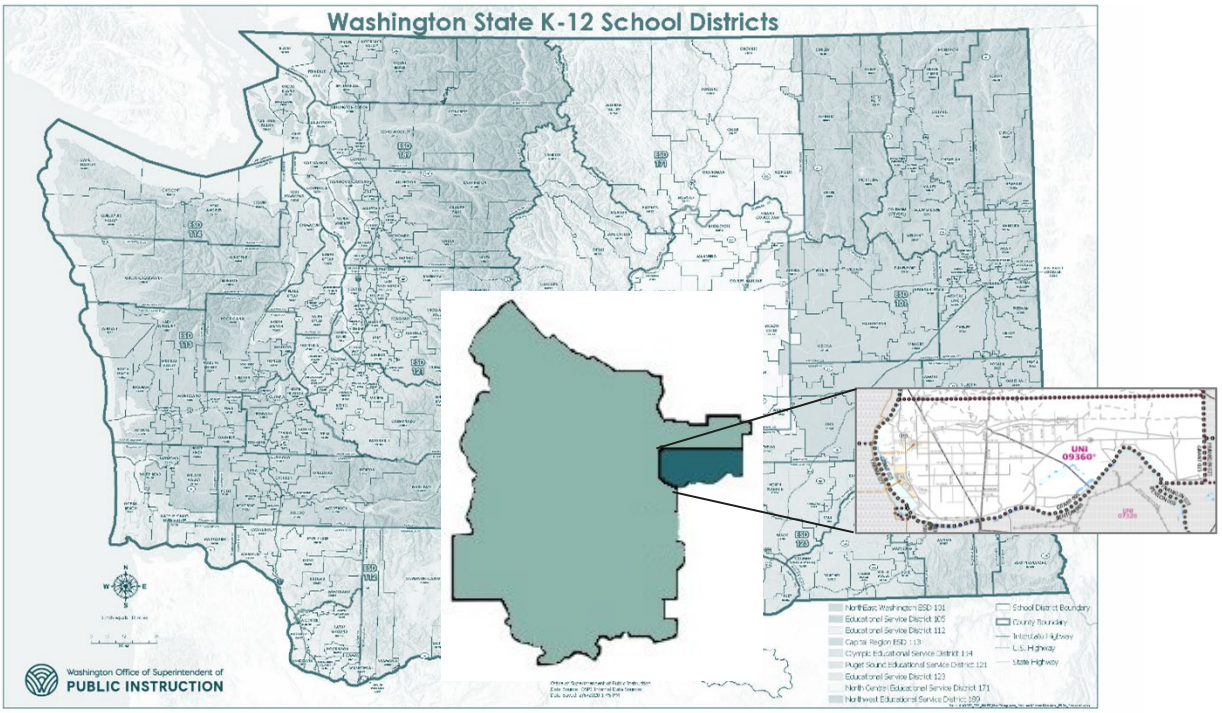
Participants were asked to identify the most pressing social, emotional, behavioral health issues facing students in their school district community. These questions asked were framed around the three goals of Project AWARE outlined previously. Throughout this report, we use this information to provide a snapshot of key indicators, and include trend data, as well as comparisons over time to the state, and county, as appropriate, and when available. This process is an essential component of the school-based mental health systems review for the Wahluke School District.

District and Community Demographics

Geographic Description

The Wahluke School District is in central Washington, on the eastern side of the Cascade Mountain range. It is designated as a single "A" school district with a 100-acre school campus located close to the Columbia River and backed by the Saddle Mountains to the north. The district serves Pre-K-12th grade students from the municipalities of Mattawa and Desert Aire and the surrounding region of Grant County. The district has three elementary buildings (Pre-K-5), one junior high school (grades 6-8), a comprehensive high school (grades 9-12), and one alternative school (grades 7-12). The district employs 160 certified staff members and 145 classified employees.

Educational Service District (ESD) 105, one of nine regional ESDs across the state, provides services and supports to the district, along with 24 other public-school districts and more than 20 state-approved private and tribal schools located in the south-central region of the state.



The Wahluke School District is located within the service boundaries of ESD 105 in Washington State.

Covering 2,791 square miles, Grant County is the fourth-largest county in Washington by area. The county is situated on the original land of the Wanapum, or River People, who have lived on the Columbia River from time immemorial (https://wanapum.org/about/). The county's economy is agriculture-based, with irrigated agriculture and processing of apples, cherries, onions, asparagus, peaches, and many other crops, being the two main industries. In recent years, Grant County has become a magnet for software and manufacturing companies thanks to its low-cost electricity, transportation options, and high-speed fiber optic network (Washington Employment Security Department, 2020).

Mattawa is a small, incorporated city located in the flat desert of Eastern Washington, between the Saddle Mountains and the Columbia River, with a total area of 0.74 square miles. Desert Aire, a census-designated place, is located just five miles from Mattawa on the Columbia River, near the southwest corner of Grant County.

Population

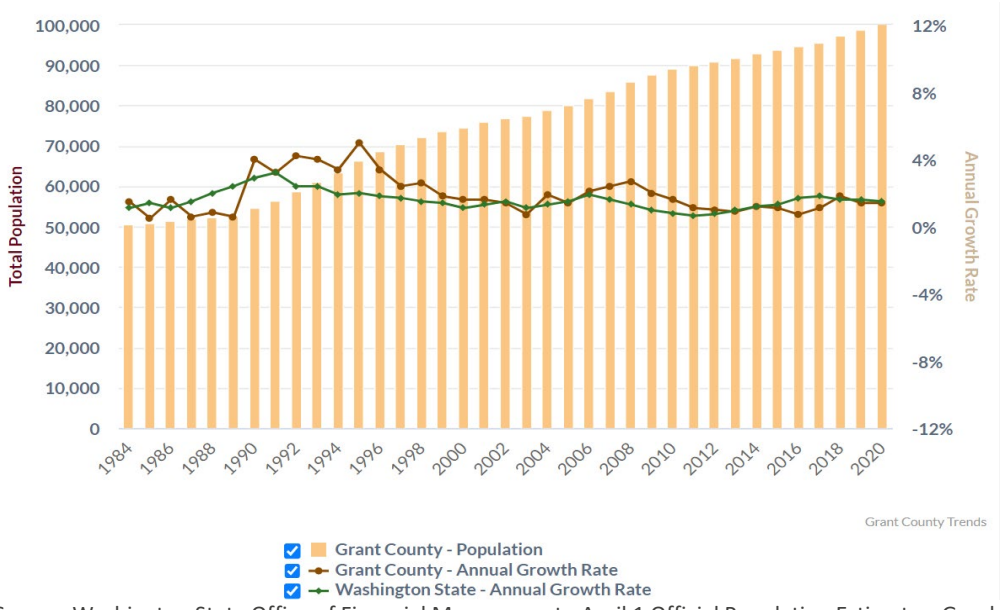
The population in Grant County is estimated at 95,502, with a density of 33.3 persons per square mile, considerably less than the state average (101.2 persons/square mi). The city of Mattawa has an estimated population of 4,758, and the town of Desert Aire has a population of 2,712 persons. The Wahluke School District area is comprised of an estimated 9100 residents (not just enrolled students).

	Washington State	Grant County	Wahluke School District*
Total Population	7,404,107	95,502	9,078

*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

Population Change

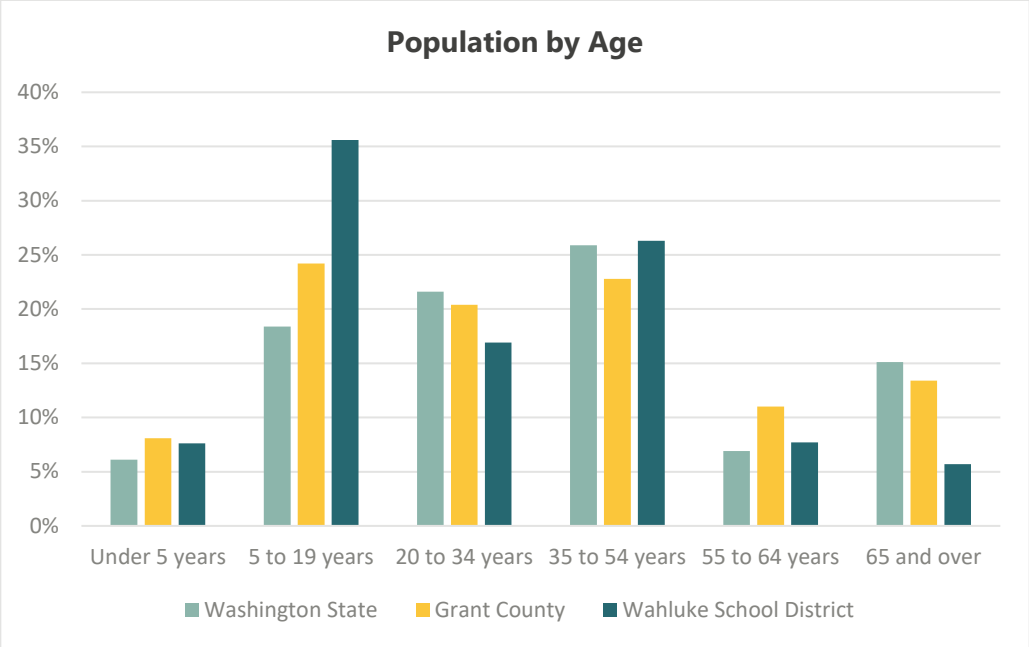
Washington state's population grew by 109,800 persons, or 1.5%, between 2019 and 2020. Migration was the primary driver behind the state's population growth (OFM, 2021). Grant County, from 2019 to 2020, grew by 1.4%. – similar to the state rate. In comparison, the Wahluke School District area grew by 736 persons or 8.1% during the same timeframe.



Source: Washington State Office of Financial Management - April 1 Official Population Estimates. Graphic:

Age and Sex Distribution[1]

While one quarter (24.5%) of Washington's population is 19 years or younger, 32% of people living in Grant County, and 43% of district's residents fall within that age distribution suggesting a younger population as compared to the state.



*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

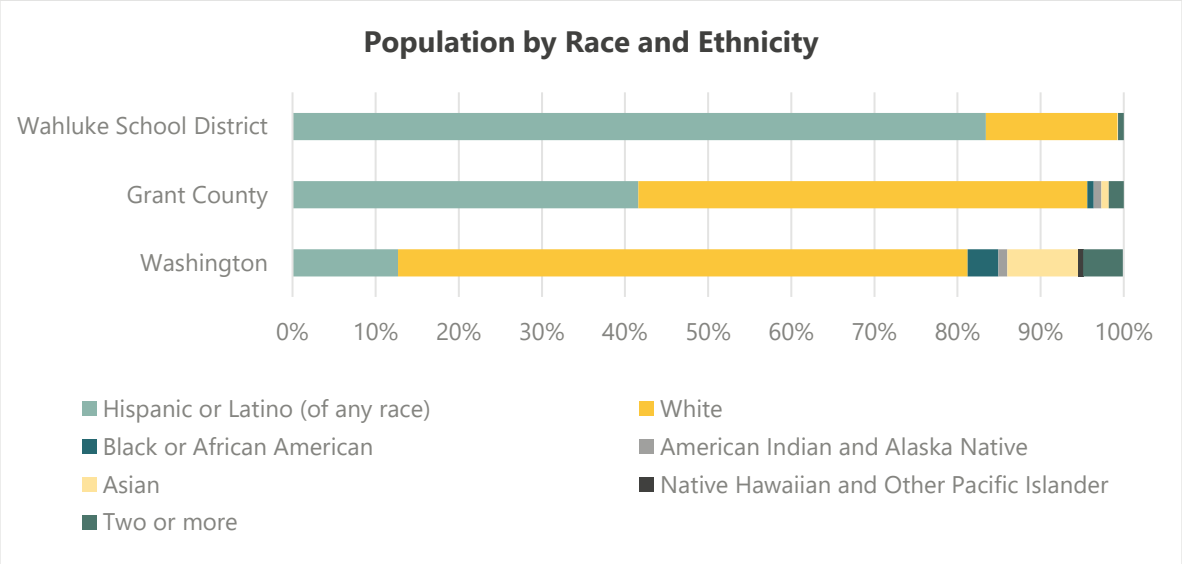
Census data indicate that females comprise about half the population in the state (50.3%) and the county (49.2%), with slightly fewer females (46.7%) in the Wahluke School District area.

District Population: At the beginning of the 2020-21 school year, there were 2,561 students enrolled in the district (down from 2,578 in school year 2019-2020). Among these students, slightly more were male (52.2%) than female (47.8%).

Race and Ethnicity

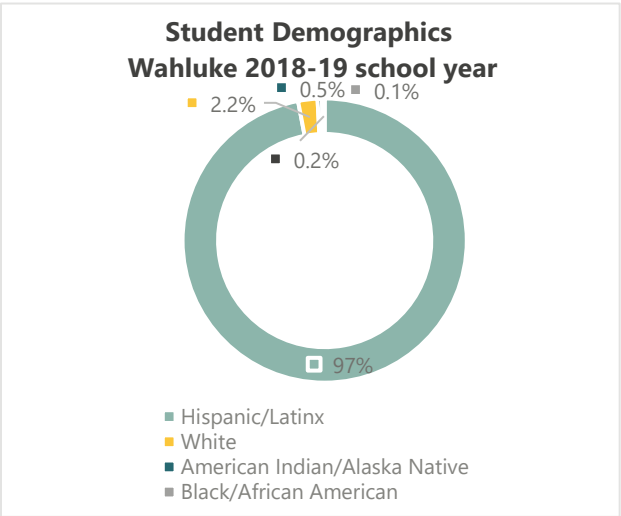
The percentage of people living in the Wahluke School District area of Hispanic/Latinx origin is twice that of the Grant County (83.4% vs. 41.6%), and significantly above the state average (12.7%).

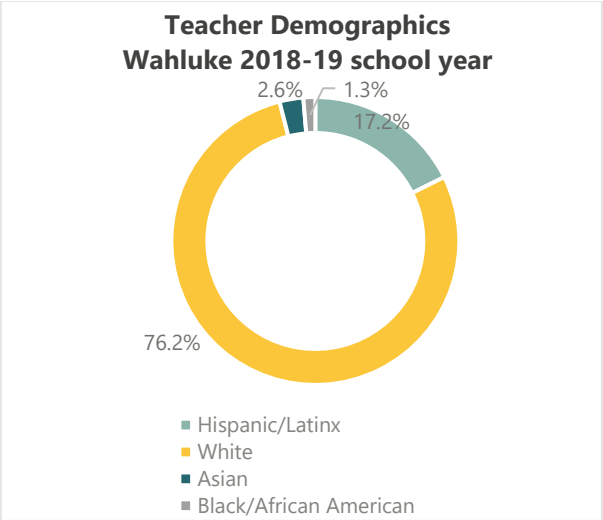
[1] This report uses the Census Bureau definition of sex and gender: "sex is based on the biological attributes of men and women (chromosomes, anatomy, hormones), while gender is a social construction whereby a society or culture assigns certain tendencies or behaviors the labels of masculine or feminine" (Census Bureau, 2021). While the Census Bureau tracks a person's biological sex and not gender, the Office of Superintendent of Public Instruction Report Card tracks gender.



*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

District Population: In the 2018-19 school year, nearly all students in the Wahluke School District identified as Hispanic/Latinx (97%) and 2% as white. In contrast, 17% of teachers identify as Hispanic/Latinx and 76% as white. Nearly half (48%) of students and 69% of classroom teachers in the Wahluke School District identified as female. Statewide, 87% of the classroom teachers identify as white and 74% as female.



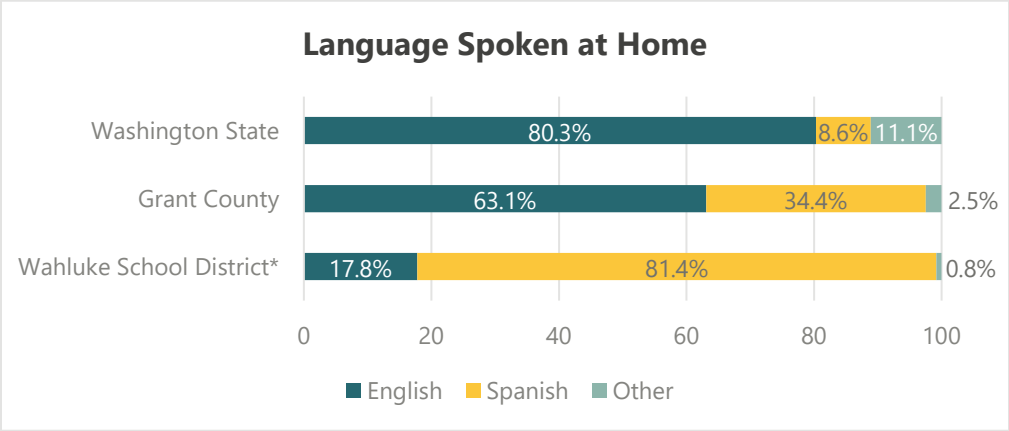


Source: OSPI Report Card, 2018-19

Additionally, nearly all students (92% or 2,341 individuals) identified as low income, with 52% English Language Learners, and 48% classified as migrant.

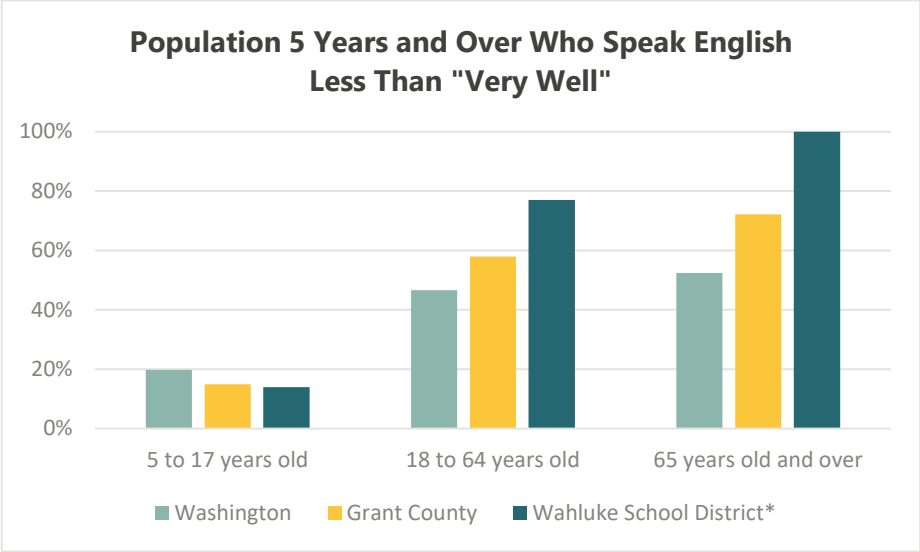
Language Spoken at Home and English-speaking Ability

Most residents (81.4%) within the Wahluke School District community speak a language other than English, with Spanish being the predominant language spoken at home. This compares to approximately 37% of families in the county, and 9% of the population statewide.



*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

Over three-quarters of adults aged 18-64 in the Wahluke School District area speak English less than "very well." That suggests that while many students (86%) speak both English and Spanish, most of their parents and caregivers communicate better in Spanish.



*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

Summary and Implications

The Wahluke District region has seen a higher population growth rate since 2019 as compared to Grant County and the state. Community demographics indicate a relatively young population, overall, make up the district and its surrounding communities. Most residents are of Hispanic/Latinx origin and are predominantly Spanish speaking. School-level enrollment data also reflect a student population that is comprised of nearly all Hispanic/Latinx youth.

Community connectedness and family were at the top of the list for all interview and focus group respondents in terms of assets and strengths of the Wahluke School District.

> *"If I were to say what's the most important thing to our (district) parents, it's their family. It's their kids. This is why they came from wherever they came from, because they want a better life for their kids. Our parents may not show it like you would normally think—they don't go to PTA meetings, they didn't give me anything for Teacher Appreciation Week—, sure, but if there's going to be after-school reading to help my kid, 'OK sign me up.' (…) We often have parents for late night conferences coming at 5 o'clock and they apologize, 'Oh, I'm so sorry I just got done working with onions. I'm so sorry I smell like an onion.' So family, first and foremost, and it's not just family—it's extended family."*
>
> —School staff member

Yet parents and students raised issues and concerns about implicit and explicit biases, and their family's cultural background not being recognized, respected, or valued by their children's school.

> *"We don't feel supported. They see that we are farmworkers, brown, short, and discriminate against us. That they are better or their job is better." (…) "The community is not given the opportunity. (The current administrators) have already been working here for years. And the children are aware of how they differentiate them."*
>
> —Parents

> *"There have been discriminatory, racist, and homophobic comments (said) to students. Teachers let it slide."*
>
> —Student

Some staff members agree that this impacts the education and mental health support available to the students and families:

> *"At the school, we just need to really consider the population we're working with and try to figure out ways on how to better offer what we have. (We need) to re-evaluate how we are offering (mental health) information to our community. I feel like a lot of parents can benefit from it and we just need to really consider the type of community we have and consider how we can offer these resources and this information."*
>
> —School staff member

These findings indicate a strong need to ensure Project AWARE services and supports are culturally and linguistically responsive and relevant to the population of students, families, and community members served. Moreover, given the higher-than-average percentage of young people and families who make up the region it is likely that the district will see even more growth in the enrollment population in the

coming years. As the district plans for service implementation the following areas of focus are suggested (as appropriate):

- Ensure inclusion of family voice to reduce linguistic isolation for those families with limited English abilities.
- Provide training opportunities for the community and families that meet the linguistic and daily life (e.g., farm work) considerations of the community, both in transportation to/from services, and access to services that have the capacity to serve a primarily Spanish speaking population.
- Create opportunities for systems and providers to offer and to expand access to healthcare and educational services in Spanish.

Upstream Determinants of Health and Educational Opportunities

Health and education are both influenced by many factors, and they also influence each other. Good health—both physical and mental—is critical to children's success in school. At the same time, education is one of the conditions that impacts health outcomes. Health is more than healthcare. In fact, only 20% of someone's overall health is affected by access and quality of healthcare (Schroeder, 2007). Although Washington generally performs better than other states in terms of health indicators, health disparities do exist in the state, and not all communities show consistent good quality health.

Because Project AWARE's goals are centered around the interconnectedness of the education and behavioral healthcare systems, it is important to consider the numerous social and environmental factors that affect the whole person, and thus the whole community. The following section describes some of the upstream determinants of health (and education), their connection with health equity, and the degree to which these factors are present in the Wahluke School District area.

Definitions

There are many factors that influence the health of a community. Assuring that positive social factors are present in people's lives is a key approach to achieving **health equity**. Health equity is "giving special attention to the needs of those at greatest risk of poor health, based on social conditions" (Seattle Children's Hospital, 2019). That doesn't mean "sameness" or equality since some populations need more or different access and services to achieve health. Ultimately, healthy equity occurs "when everyone has the opportunity to 'attain their full health potential' and no one is 'disadvantaged from achieving this potential because of their social position or other socially determined circumstance'" (Brennan Ramirez LK, 2008).

Health inequities cause health disparities, defined as health differences that are closely linked with economic, social, or environmental disadvantage. "**Health disparities** adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic-status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion" (Healthy People 2020).

On the educational side, the ways in which race, ethnicity, ZIP code, socioeconomic status, English proficiency, and other factors impact students' educational aspirations, achievement, and attainment (Great Schools Partnership, 2014) is known as the **opportunity gap.** While the opportunity gap looks at the inputs of the system, the **achievement gap** refers to significant disparities in academic outcomes between different groups of students, such as white and BIPOC (black, indigenous, people of color) students. These results are grounded in the **structural racism** of the education system, which is historically centered in whiteness, and are amplified by government-mandated reporting metrics such as standardized test scores, grades, and graduation rates (National Network of State Teachers of the Year, 2018). Unlike individual racism, structural racism encompasses larger systems that work to create and maintain dominant white culture to the detriment of people of color.

The conditions in which people are born, grow, live, and age shape both health and educational opportunity. These are known as **social determinants of health (and education)** and are grouped into five domains according to Healthy People 2030 (US Department of Health).

Health care access and quality Influenced by health insurance, services and medication affordability and access, health literacy, among other issues.	**Economic stability/ wellness** Refers to people's access to jobs and their ability to keep steady employment.	**Education access and quality** Which is impacted by family's income, disability, discrimination, and other interrelated factors.	**Neighborhood and built environment** Including transportation systems, affordable and quality housing, and access to safe air and water, and access to public lands and services.	**Social and community context** Takes into consideration safe and positive family relations, community support and a sense of belonging.

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion

Below, we describe findings for the Wahluke School District area aligned with these five areas of social determinants of health and education.

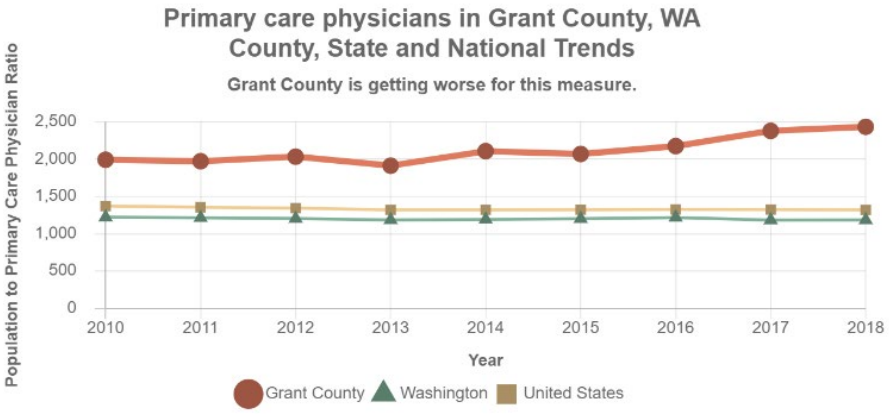
Health Care Access and Quality

Access to quality health care that is affordable, close to home, with the services that people need, and that is culturally sensitive, contribute to the overall wellbeing of individuals and communities.

Access to Care

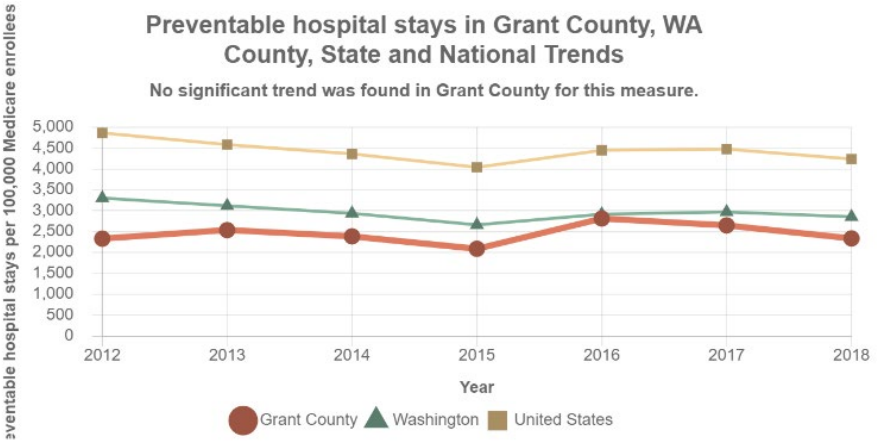
Access to health care, which includes primary, specialty, emergency, dental and mental health care, encompasses the ability of an individual or family to visit a healthcare provider when needed, as well as the quality and accessibility of the interaction with the healthcare system. Family education, health insurance coverage, health literacy, supports to navigating healthcare services, in-language services, access to interpreters and translated information are all elements of health care access. At the same time, barriers to navigating the healthcare system, such as insurance eligibility requirements, lack of insurance coverage, lack of care coordination, long wait times, and the challenges of travelling to appointments impact access to care.

In Grant County, the ratio of residents to primary care providers (2,430:1) has persistently been well above state and national norms and is getting worse over time (County Health Rankings, 2021).



Graphic: County Health Rankings. Note: Lower is better.

County health ranking data (2021) indicate that the rate of preventable hospital stays per 100,000 persons countywide has remained mostly stable since 2012, and below state and national averages.



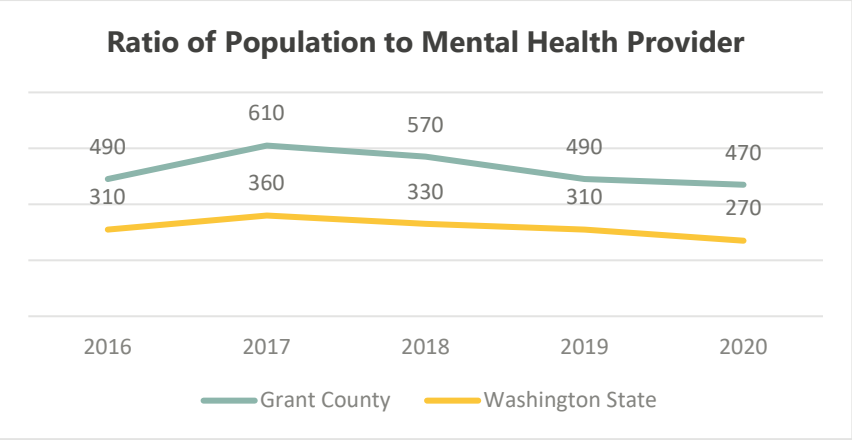
Source: County Health Rankings 2021 (using 2018 data)

Shortage of Mental Health Workforce

According to Seattle Children's Hospital (2019), Washingtonians are concerned about the lack of community resources that make it challenging to access mental and behavioral health care. Further, findings indicate that community members statewide stress the importance of having providers that reflect the community's diversity; urge the need to address geographical disparities in access to care for more rural areas; and residents note that specialty care is especially difficult to access.

While access to care has improved, the ratio of mental health providers (including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses specializing in mental health care) per population, if the population were equally distributed across providers, has remained consistently lower in Grant County than in Washington. Data

indicate that access to mental health providers in Grant County has improved, with a ratio of persons to providers of 470:1 in 2020 – a considerable improvement from 2017 (610:1). In Washington, ratios range from 2,250:1 to 220:1, with an overall ratio of 270:1.

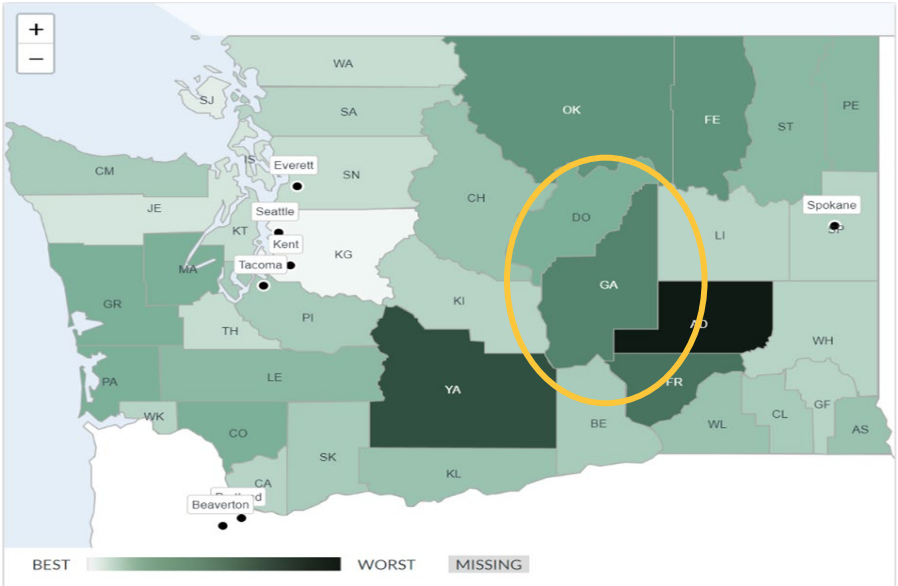


Source: County Health Rankings 2021. Note: Higher number is worse.

Quality of Life

Quality of life refers to how healthy people feel while they are alive. "It represents the well-being of a community, and underscores the importance of physical, mental, social, and emotional health from birth to adulthood" (County Health Rankings & Roadmaps). In general, more people in Grant County consider themselves to be in poor or fair health than persons elsewhere in the state.

Percentage of Adults Reporting Fair or Poor Health (age-adjusted)



Source: 2021 County Health Rankings using data from 2018

COVID-19 Pandemic

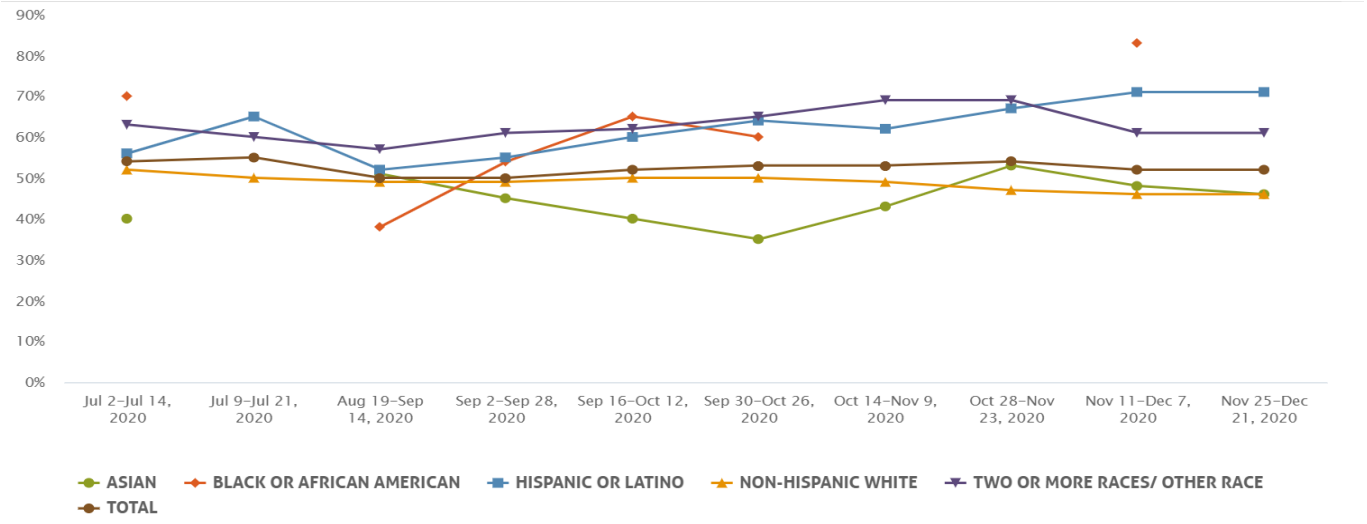
On March 13, 2020, the United States government declared a national emergency concerning the novel coronavirus disease, COVID-19; thus, officially marking the start of the pandemic in the U.S. Since then, the U.S. Census Bureau, along with other federal and state agencies, have collected and tracked data to measure household experiences resulting from the COVID-19 pandemic.

In Washington state, socio-economic consequences of the pandemic include:

- Since March 13, 2020, half of Washingtonians living in households with children have lost employment. The percentage is higher for Hispanic/Latinx households (71%) and households of two or more races (61%) (see graph).
- The percentage of adults ages 18 to 24 who reported that they or a household member lost employment income steadily increased from 47% in June-July 2020 to 63% in Nov-Dec 2020.
- One in six adults (16%) living in households with children have little or no confidence in their ability to pay their next rent or mortgage payment on time.

While everyone has experienced the effects of the COVID-19 global pandemic in one way or another, the health, social, and economic consequences for BIPOC families and communities have been more severe. The pandemic exacerbated long-standing systemic racism. Racism is *the* reason why BIPOC communities have been disproportionately impacted by COVID-19 (CDC, 2021; Mental Health America, 2020; and others). In fact, women, Black, Hispanic, and mixed-race respondents reported a higher prevalence of adverse behavioral health outcomes due to worry and stress related to the pandemic as compared to men, white, and Asian participants (Panchal, Kamal, Orgera, Cox, Garfield, Hamel, Munana, & Chidambaram, 2020).

Adults Living in Households with Children who Lost Employment Income since March 13, 2020, in Washington by Race/Ethnicity



Source: Population Reference Bureau analysis of the U.S. Census Bureau, Household Pulse Survey, 2021.
Graphic: KIDS COUNT Data Center, datacenter.kidscount.org – A project of the Annie E. Casey Foundation

BIPOC communities have also been hit harder by infection rates. For example, public health data in October 2020 showed that 31% of Washington state cases were Hispanic/Latinx, even though they comprise only 13% of the state population.

Other pandemic-related disparities facing the Hispanic/Latinx population in the state include:

- Lack of insurance - Approximately 20% of Hispanic/Latinx people are uninsured. In comparison, Washington's uninsured rate went from just over 6% pre-Covid, to 13% in May 2020 (Office of Financial Management, 2021).
- Working conditions – The most common occupations held by Hispanic/Latinx people in the U.S. (cleaning, construction, agriculture, and service industries) were considered "essential" at the beginning of the pandemic and workers continued working on-site, increasing their risk of becoming infected (Baquero et. al., 2020).
- Housing conditions – Many Hispanic/Latinx families live in multigenerational households, which contributes to social cohesion. It also increases the risk of infection. In June 2020, Yakima County saw an increase in COVID cases among Hispanic/Latinx individuals, attributed to lack of personal protective equipment (PPE), lack of physical distancing guidelines, crowded housing conditions, and poor sanitation in work (Baquero et. al., 2020).
- Language barriers - Limited access to information, lower levels of health literacy, and wide-spread misinformation across media and social media have been a big challenge to preventing the spread of COVID (Baquero et. al., 2020).
- COVID response – BIPOC populations have received fewer doses of the COVID-19 vaccine compared to non-Hispanic white people. While Latinx/Hispanic account for approximately 32% of cases, only 4.7% of Washington residents who have received the vaccine (as of February 2021) were Hispanic (Washington DOH, 2021).

Summary and Implications

Access to healthcare in the county has gotten increasingly worse over time, with a shortage of both primary care physicians and mental health providers. Identified health inequities are further evidenced by poorer and worsening quality of life among residents in part as a result of the COVID-19 pandemic. Among BIPOC communities these challenges are even more dire, with higher rates of infection, and increased likelihood of unemployment as compared to white residents.

For interview participants, the limited access to local, accessible, and culturally sensitive care was at the top of the list of factors related to quality healthcare:

> *"We have the little community mental health place, but scheduling with them is very difficult because they're always coming from Moses Lake or outside the area. So, they're not always here and they're not always available. I wish we had a practice here or a community, maybe tele-health services, some sort of services and awareness, something that was more accessible to local people that can't always afford to travel or take time off work, because I know during harvest our families can't take time off work. That's extremely frowned upon."*
>
> —School staff member

Participants mentioned difficulties related to the geographic isolation of Mattawa and not having enough providers within the community. At the same time, some parents and youth don't feel comfortable sharing their issues and concerns because this is a small community, where everyone knows each other—including healthcare providers.

> *"It was very hard to get (my son) services because they come from so far away. Scheduling was difficult (…) I questioned the quality of access to care that is available here for our students, especially because I just don't feel like there's a lot of opportunities for them to receive counseling services and mental health help."*
>
> —School staff member

> *"I struggled for a long time to find quality care and I had to go outside and that I had to drive an hour away and that's me taking an hour off of work and taking him out of school and going an hour away and then coming back and not a lot of people have access to that either."*
>
> —Parent

An overarching goal of Project AWARE is to *connect school-aged youth who may have behavioral health issues and their families to needed services*. Research and data reported in this section demonstrate that health inequities and consequences of systemic racism faced by the BIPOC population impact access to quality healthcare. Although much of these data are focused on the state and county levels, the healthcare disadvantages facing the Hispanic/Latinx communities are clear. As such, it is important to consider the ways in which grant-funded services and supports can increase the number of behavioral health services available to students and families in the Wahluke School District, but also how these systems can improve equitable access to quality healthcare services.

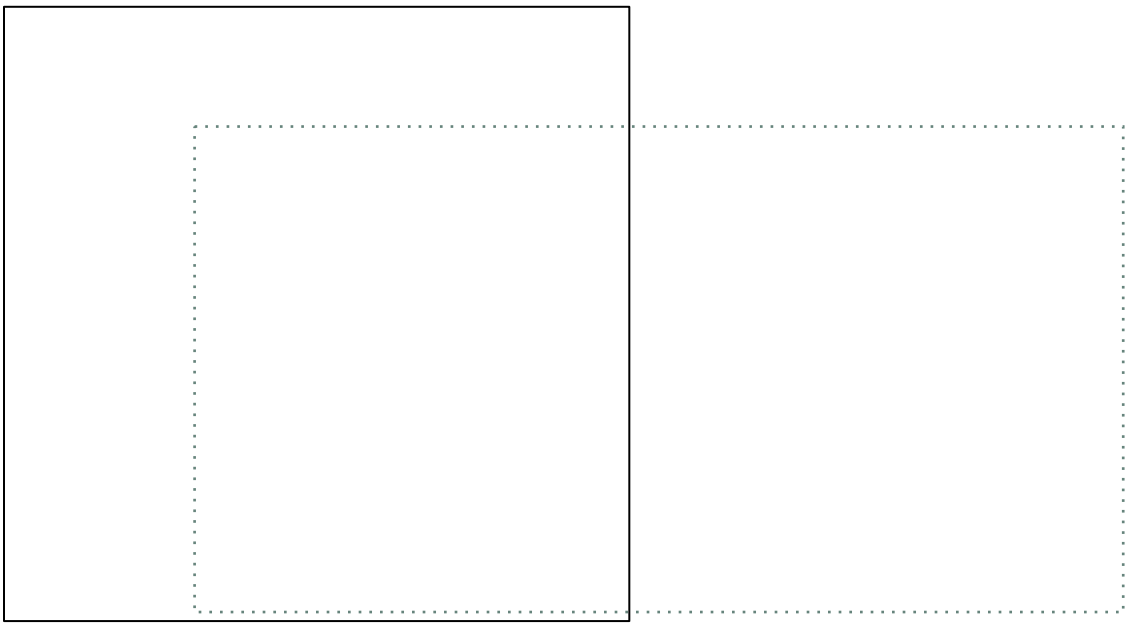
Community Assets and Resources

Below are available assets and resources located within Grant County and the Wahluke School District area:

- Grant County Health District (GCHD) provides public health services that promote healthy lifestyles and protect the Grant County community against diseases and injuries. GCHD programs include adult immunizations, communicable disease prevention, food establishment inspections, septic system permitting and inspections, birth and death certificates, injury prevention, and healthy eating and active living. The GCHD serves the communities of Mattawa, Desert Aire, Schwana, Beverly, and the Wahluke Slope.
- Columbia Basin Health Association provides outpatient healthcare services to residents of Mattawa and surrounding communities. It offers primary medical care, specialized services, and pharmacy.
- Othello Community Hospital is a 25-bed facility located in Othello, Adams County. It is the closest hospital facility to Mattawa and Desert Aire, located 45 minutes away. It offers emergency department, surgery, pharmacy, and laboratory.

Economic Stability and Well-Being

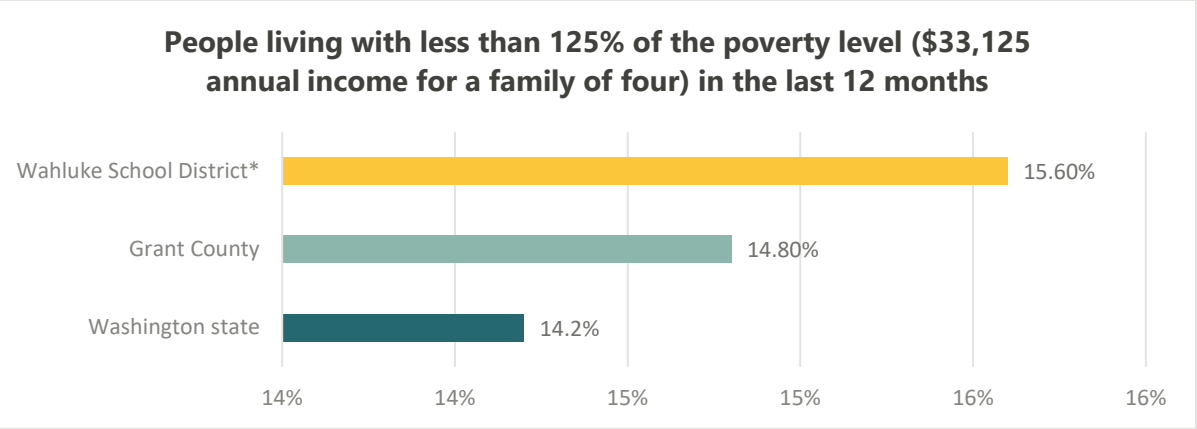
There have been increasing concerns about the relevance of traditional economic indicators to measure well-being, including poverty (Organisation for Economic Co-operation and Development, 2013). Current metrics often look at individual or household outcomes, rather than the collective well-being. For example, the number of people living below the poverty line does little to show a community's overall well-being (The New Economy Washington Report, 2019). Economic well-being can be understood as having present and future economic security, including the ability for people to meet their daily basic needs and to make choices that give them a sense of security, satisfaction, and fulfillment over time (Council on Social Work Education, 2016).



Source: 2021 County Health Rankings using 2019 US Census Bureau data

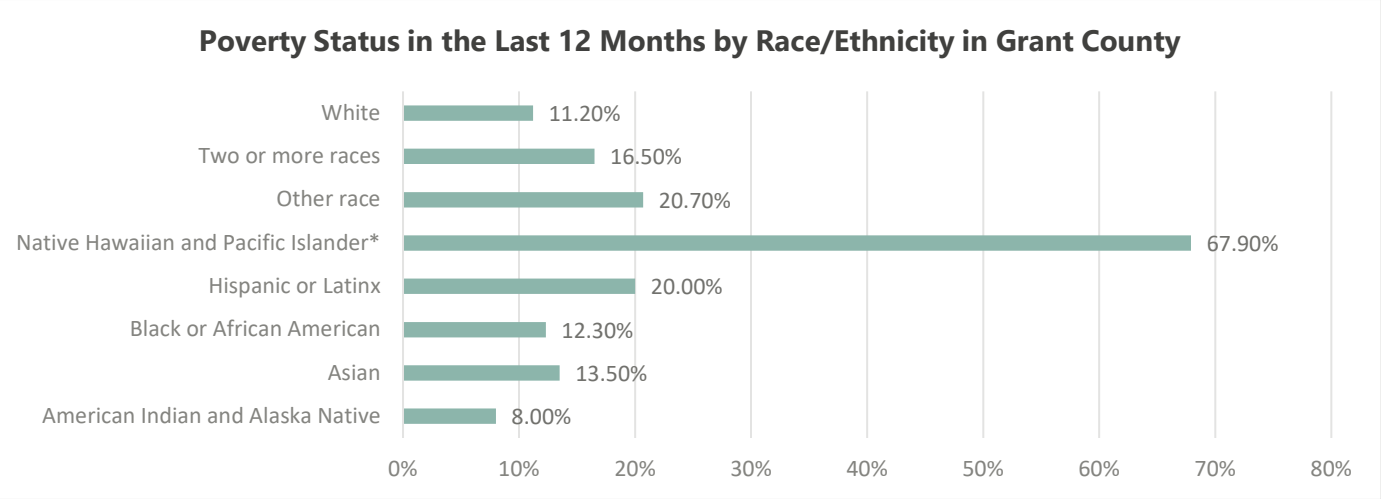
In Grant County, the median household income in 2019 was estimated at $57,200 – well below the Washington estimate of $78,700. Data show disparities in income by race and ethnicity, with white residents averaging $4,200 above the county average, and lower household income among Asian, Black, and Hispanic/Latinx.

In the Wahluke School District, nearly one in six individuals (15.6%) live below the federal poverty level (less than $12,490 annual income).



Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

Data further demonstrate the disparate rate of poverty across race/ethnicity among Wahluke School District area residents. While 18% of Hispanic/Latinx individuals and 19% of residents of other non-white races live in poverty, just 4% of white residents do (American Community Survey, 2015-2019: 5-year estimate). The disparities are similar for Grant County, as the graph below shows.



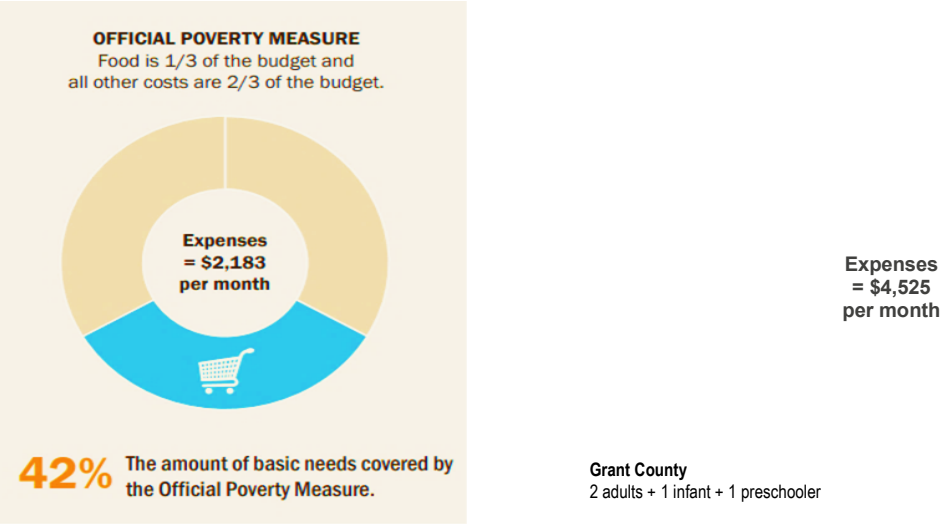
*Note: Native Hawaiian and Pacific Islander individuals account for 0.02% of the total Grant County population.
Source: American Community Survey, 2015-2019: 5-year estimates

Self-Sufficiency Standard by County

Another measure of economic well-being is the Self-Sufficiency Standard. The standard calculates how much income a family must earn to meet basic needs (including taxes) without public subsidies (e.g., public housing, food stamps, Medicaid, or childcare) and without private/informal assistance (e.g., free babysitting by a relative or friend, food provided by churches or local food banks, or shared housing). The calculation takes into account family composition as well as where a family resides in Washington state.[2]

[2] See http://www.selfsufficiencystandard.org/the-standard

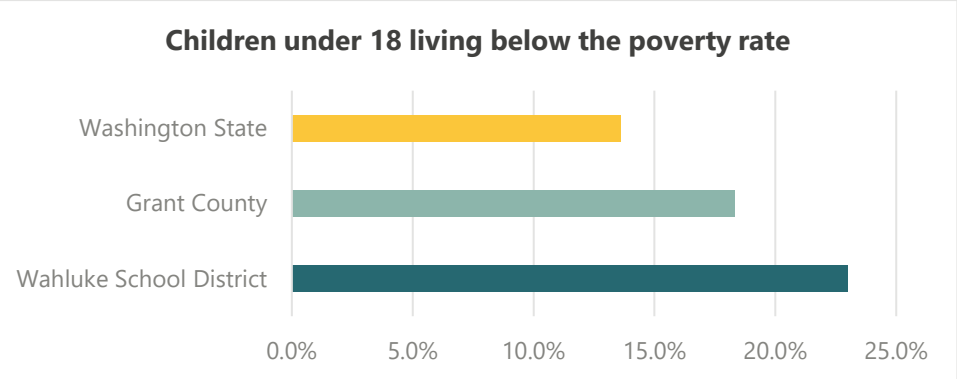
The self-sufficiency standard is different from the official poverty measure in that it calculates the real costs of meeting all basic needs – housing, childcare, food, transportation, etc. – while the latter is based only on the cost of food. Specifically, the federal poverty guidelines established household expenses for a family of four at $2,183 per month ($26,200 annually). Conversely, the self-sufficiency standard estimates expenses for this same family living in Grant County at $4,525 ($54,300 annually) or 215% of the federal poverty guidelines.



Source: Pearce, Diana M., PhD, The Self-Sufficiency Standard for Washington State, 2020

Children (age 18 and under) in Low-income Families

Poverty can negatively impact children's educational achievements, health, and lifetime earnings. Income-related health disparities appear to be growing over time. As such, policies that promote economic equity may have broad health effects (Seattle Children's Hospital, 2019). In the Wahluke School District area, 23% of children under the age of 18 live below the poverty rate – nearly twice the state average.



Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

Income Inequality

Income inequality is the gap in income between richer and poorer households. Because inequalities in income can accentuate differences in social class and status and serve as a social stressor, income inequality can have broad health impacts, including increased risk of mortality, poor health, and loss of social connectedness (County Health Rankings, 2021).

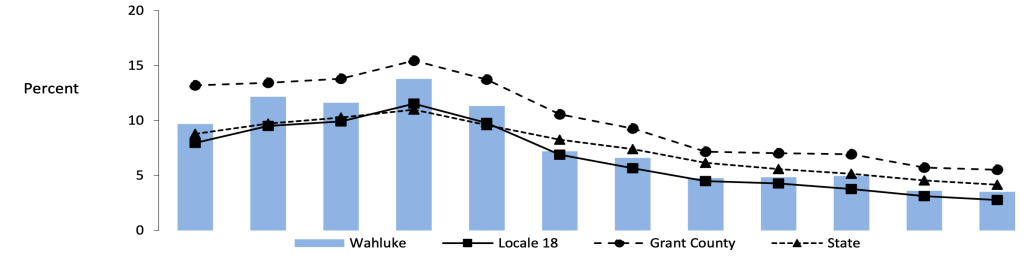
Specifically, income inequality is the ratio of household income at the 80th percentile to that at the 20th percentile, i.e., when the incomes of all households in a county are listed from highest to lowest, the 80th percentile is the level of income at which only 20% of households have higher incomes, and the 20th percentile is the level of income at which only 20% of households have lower incomes. A higher income inequality ratio indicates greater division between the top and bottom ends of the income spectrum. Grant county has a slightly lower income inequality ratio than Washington (4.0 vs. 4.4, state).

Temporary Assistance to Needy Families

Temporary Assistance for Needy Families or TANF assists families with children when the parents or caregivers cannot provide for the family's basic needs. The program provides temporary cash to families. Although Washington state's budget for TANF has decreased significantly in the last few years, the number of TANF recipients has increased considerably – up by nearly 30% – since 2019 from 53,513 total recipients in October 2019 to 68,748 in September 2020, with this likely due to the economic impact of the pandemic (Administration for Children and Families, 2021). In general, children account for about 70% of total TANF recipients.

The following graph shows the decline in the percentage of children aged 0-17 receiving TANF benefits. These data illustrate that the number of families eligible for services has decreased overtime with this due to time limits (a person can receive TANF benefits for up to five years) and other post-recession policy restrictions imposed to the program in 2011. Most recently, however, due to the COVID-19 pandemic emergency, families who have exhausted the 60-month time limit will not be denied benefits. In the Wahluke School District the percentage of child recipients in 2019 was below both the state and county average.

Temporary Assistance to Needy Families (TANF), Child Recipients, aged 0-17



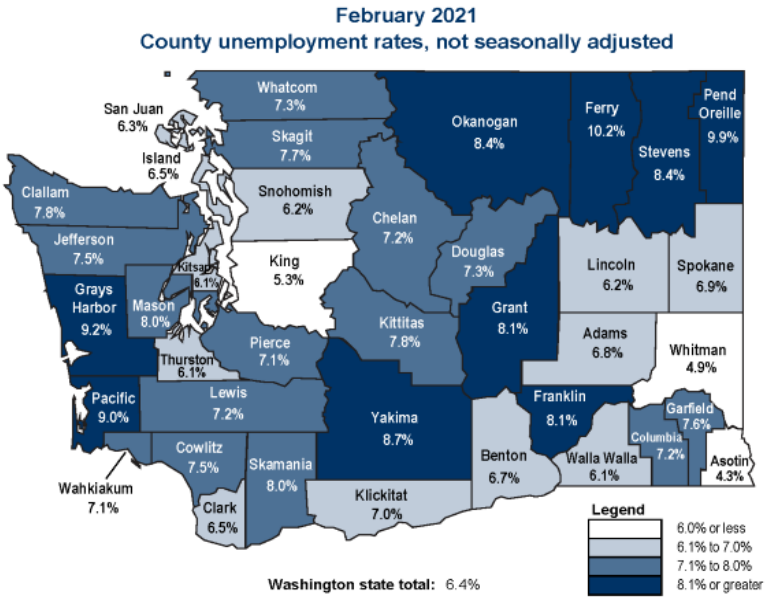
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
State	8.78	9.72	10.28	10.99	9.58	8.25	7.41	6.15	5.58	5.16	4.56	4.16
Grant County	13.19	13.43	13.80	15.45	13.73	10.56	9.27	7.17	7.03	6.93	5.73	5.52
Locale 18	7.97	9.50	9.91	11.53	9.78	6.90	5.66	4.50	4.27	3.77	3.12	2.77
Wahluke	9.68	12.16	11.61	13.78	11.33	7.20	6.61	4.76	4.85	4.96	3.62	3.51
TANF Children	286	373	367	437	360	230	209	152	157	165	122	118
Children, birth-17	2,955	3,067	3,161	3,171	3,177	3,193	3,160	3,191	3,240	3,328	3,370	3,361

Note: "A locale covers an area large enough to provide a stable population for rates and minimize the choppiness caused by small number issues." Locale 18 includes Royal, Wahluke, Cle Elum-Roslyn, Damman, Easton, Kittitas S.D. Kittitas, and Thorp School

Source: Washington State Department of Social & Health Services, 2021

Employment

Many aspects of employment including job security, working conditions, and financial compensation influence health. Unemployment has been linked to heart conditions, arthritis, depression and other mental health illnesses, and unhealthy coping behaviors such as substance abuse (Virginia Mason Memorial, 2019).



Source: Washington State Employment Security Department, 2021

Ranching, agriculture, and food processing industries provide the most jobs in Grant County. In 2019, the total nonfarm employment growth was slow, with an estimated downturn of 0.5 percent from 2018, a reversal of growth seen since the 2008 recession. Grant county's unemployment rate (not seasonally adjusted) in February 2021 exceeded the state rate by nearly two percentage points (8.1% vs. 6.4%, state) (Washington State Employment Security Department, 2021).

Summary and Implications

Findings in this section demonstrate that the Wahluke School District's regional community is impacted by several economic disadvantages, including economic instability, income inequality, and higher rates of poverty and social service utilization as compared to the county and the state.

The responses from interview and focus group participants related to poverty and economic stability were mixed. There were concerns from staff about many families struggling. Parent participants of the focus group shared that farming paid decent wages "as long as you are willing to work hard."

In designing services and supports for students, families, staff, and community members, is it imperative that these factors are considered for a multitude of reasons. For example, we know that poverty and economic insecurity are underlying issues that are closely linked to embedded racial inequities. Black, Indigenous, and people of color are disproportionately poor as a result of oppression, historical disadvantages, and discriminatory practices that have been institutionalized (Delgado, R and Stefanic, J. in Critical Race Theory, cited by Seattle Children's Hospital, 2019). This creates and perpetuates barriers to services, resources, and opportunities (Seattle Children's Hospital, 2019).

For low-income youth affected by poverty, access to treatment for mental health issues can be challenging. In fact, one study found that more than 90% of low-income adolescents went untreated (Behrens et al., 2013; California Health Interview Survey, 2005). Moreover, schools in high poverty areas

tend to experience higher levels of teacher burnout, turnover, and general changes in school leadership – all of which negatively impact the school climate which in turn impacts student mental health (Beteille et al., 2011; Greenberg et al., 2016).

Community Assets and Resources

Some of the available resources that could contribute to people's economic stability and well-being and are located within Grant County and the Wahluke School District area include:

- The Grant County Economic Development Council, facilitates business-related activities in the county. The council shares resources and data related to industries and demographics, including the Cost-of-Living Index (COLI). The COLI is a city-to-city cost comparison that tracks the cost of groceries, housing, transportation, health care, utilities, and other goods and services.
- Big Bend Community College, located in Moses Lake, offers workforce training programs, some of them in Spanish. Students can also earn high school completion and an Associate's degree in several fields.
- SkillsSource teaches workplace basics in cooperation with school districts, community colleges and employers in Adams, Chelan, Douglas, Grant, and Okanogan counties.
- Columbia Basin Job Corps is a no-cost education program that provides technical and academic training to people ages 16 through 24. Programs offered include building maintenance, carpentry, computer networking, nursing assistant, pharmacy technician, and welding. It is located in Moses Lake.
- Opportunities Industrialization Center (OIC) of Washingtonworks to eliminate unemployment, poverty, illiteracy, and racism so all people can live with greater human dignity. It offers trainings, workshops, food and resource distribution, career training, housing repair assistance, financial education, and more. OIC serves Grant, Yakima, and Adams counties.

Education Access and Quality

Education is associated with better health. Higher education also has implications for access to better jobs and increased income. Several indicators are associated with better quality education, including kindergarten readiness and high school completion (Washington State Health Assessment, 2018).

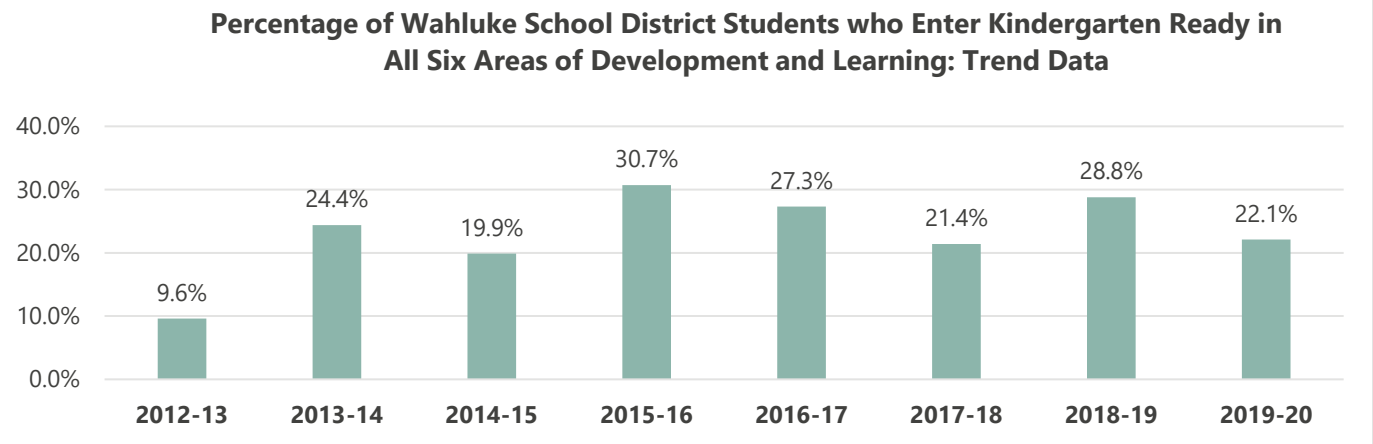
There is increased interest in tracking equity in education. In fact, the Monitoring Educational Equity report calls for a national system *to not simply track progress toward educational goals but to also identify disparities in outcomes and opportunity* (National Academies of Sciences, Engineering, and Medicine, 2019). The report proposes two sets of indicators to track disparities:

- *Disparities in students' educational outcomes*, including kindergarten readiness; K-12 learning and engagement; and educational attainment.
- *Disparities in students' access to resources and opportunities* including extent of racial, ethnic, and economic segregation; equitable access to early childhood education, high-quality curricula, and instruction; and access to supportive environments.

In the following section, we cover some of these educational equity indicators (as data allow).

Kindergarten Readiness

WaKIDS, the Washington Kindergarten Inventory of Developing Skills, includes an assessment that is administered during the first two months of kindergarten. Teachers observe students across six areas of development and learning: Social-Emotional, Physical, Language, Cognitive, Literacy, and Math. Although the only requirement for kindergarten in Washington is to be five years of age by August 31, children who demonstrate readiness in all six areas have a greater likelihood of success in kindergarten and beyond.



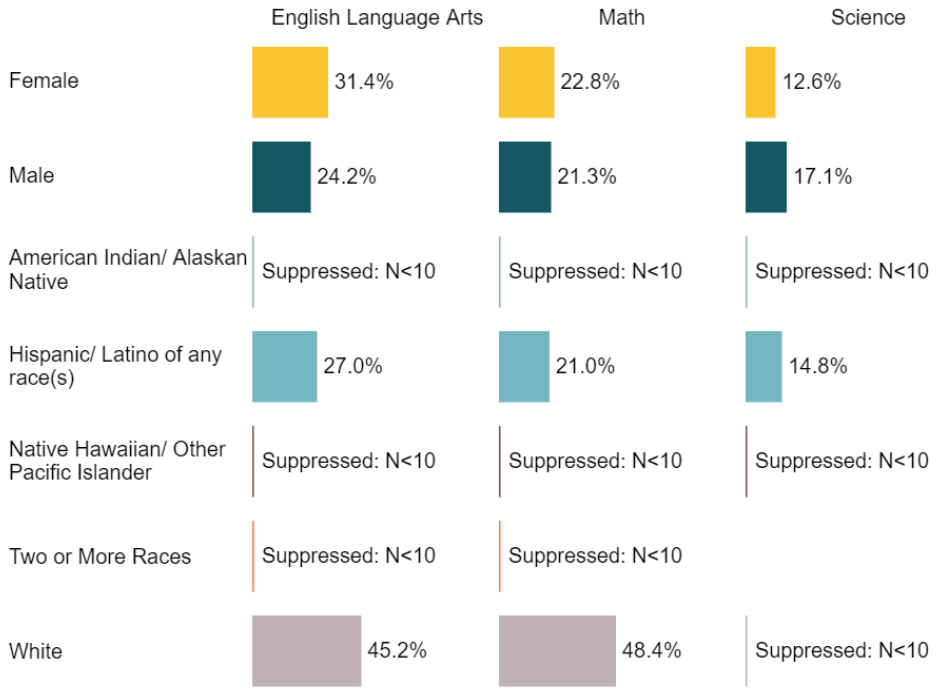
Source: OSPI Report Card, Wahluke School District

Kindergarten readiness in the Wahluke School District is trending upward from the 2012-13 school year; however, the percentage of students ready for kindergarten has varied considerably across years. For example, between the 2018-19 and 2019-20 school years, fewer children demonstrated readiness across the six skill areas. During the 2019-2020 school year, 22.1% of Wahluke kindergartens were assessed as meeting all six skill areas, compared to 51.5% of children statewide.

K-12 Learning and Engagement

Every spring, students in specific grades are assessed in Math, English Language Arts (ELA), and Science. In the 2018-19 school year, most Wahluke School District students did not meet academic standards across the areas of focus. In general, students who identify as white outperformed their Hispanic/Latinx counterparts in ELA and Math (data were not available for Science). Additionally, findings indicate that students in the district who are English language learners, not housed, migrant, and have disabilities underperform in state assessments compared to their peers who do not meet these characteristics.

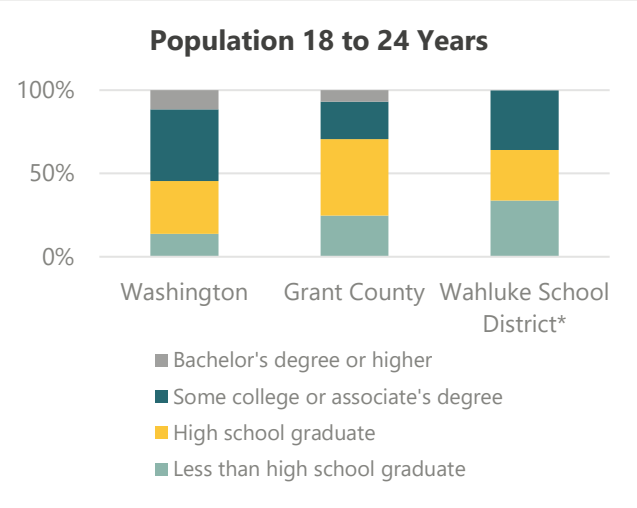
Student Performance by Demographics (percentage that met state standards)

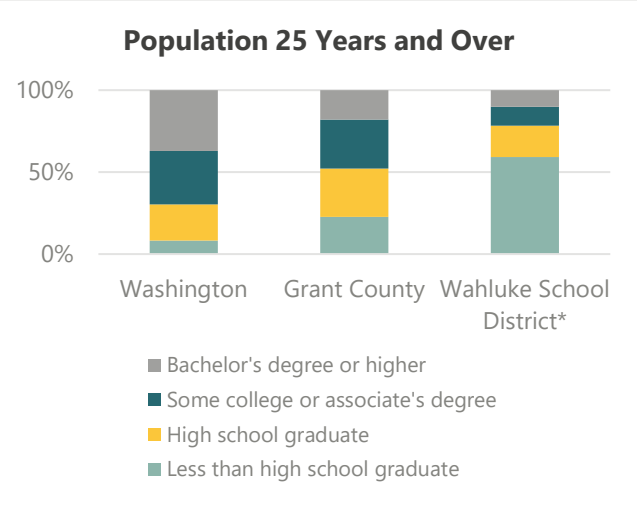


Source: Wahluke Report Card, OSPI, 2018-19

Educational Attainment

We know that graduating from high school is a critical step towards a successful adulthood. Findings demonstrate significant disparities in educational attainment between the Wahluke School District regional population and the rest of state.

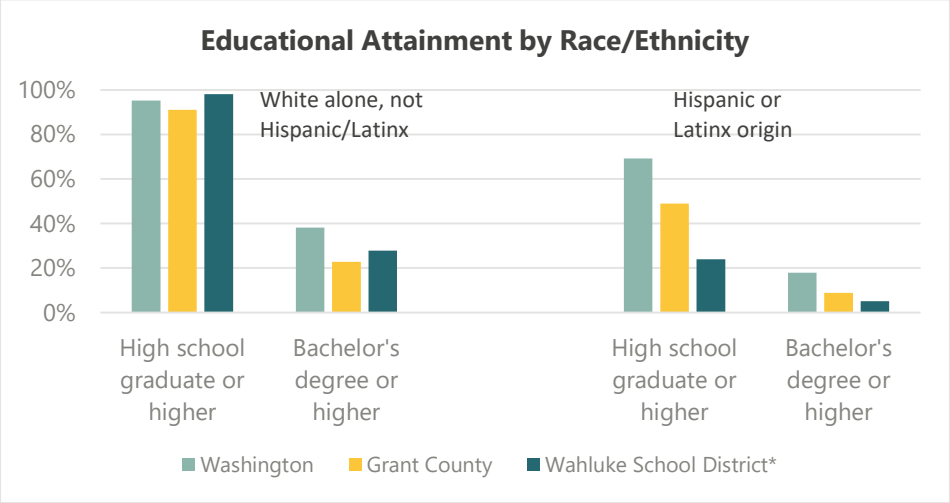




*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates

Age: Regardless of age, more residents within the district region have not completed high school compared to the state average. Additionally, while 8.3% of Washingtonians over the age of 25 did not graduate from high school, a large majority (59.2%) of people who live within the Wahluke School District area has less than a high school degree.

Race/Ethnicity: There are also disparities in educational attainment regarding race and ethnicity, as demonstrated in the below chart. While 98.2% of the residents within the district area who identify as white have completed high school or higher and 27.9% have earned a bachelor's degree, 24% of people who identify as Hispanic/Latinx have a high school diploma or higher and 5.1% have a bachelor's degree or higher – similar to statewide trends.



"Overall, more Washingtonians are completing high school, but disparities remain particularly for the Hispanic community" (Department of Health, 2018).

Source: U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates

*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)

Sex: Countywide, males ages 18 to 24 are six times more likely to have not completed high school as compared to females. In the district region, about one third of individuals 18 to 24 years (regardless of sex) did not graduate from high school. Additionally, only 7.0% of males and 14.0% of females 25 years and over have earned a bachelor's degree or higher – well below the state average.

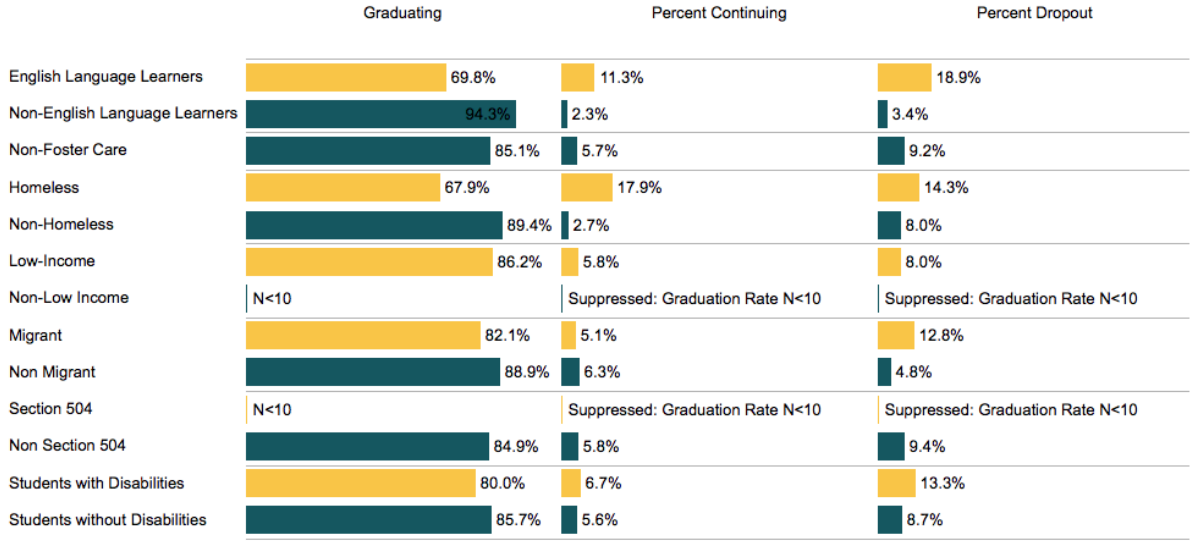
	Washington		Grant County		Wahluke District*	
	Male	Female	Male	Female	Male	Female
Population 18 to 24 years						
Less than high school graduate	15.3%	12.2%	41.1%	7.0%	32.3%	35.1%
High school graduate	35.3%	27.9%	40.3%	52.0%	38.1%	23.9%
Some college or associate's degree		46.2%	17.2%	27.9%	29.6%	41.0%
Bachelor's degree or higher	9.6%	13.7%	1.4%	13.1%	0.0%	0.0%
Population 25 years and over						
Less than high school graduate	9.1%	8.3%	23.6%	21.7%	65.0%	52.2%
High school graduate	22.8%	21.2%	30.7%	28.3%	19.4%	18.9%
	32.1%	34.5%	26.9%	32.8%	8.6%	14.8%
Bachelor's degree or higher		36.1%	18.9%	17.1%	7.0%	14.0%

*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

On Time Graduation

Since 2015, the percentage of Wahluke School District students who have graduated from high school within four years has increased steadily from 56.6% (Class of 2015) to 85.1% (Class of 2020), above the state average (82.9%). This upward trend in graduation rates is demonstrated among both female and male students. However, an opportunity gap exists with a higher percentage of females graduating in four years as compared to their male peers. Specifically, 88.3% of females and 81.3% of male students graduated on-time in 2020 – a 7-percentage point gap. Among students who identify as Hispanic/Latinx, there has also been an increase in on-time graduation rates overtime, with 85.2% of the Class of 2020 meeting graduation requirements, exceeding the state average (82.9%).

Percentage of Students Graduating Within 4 years, by Student Program and Characteristics (2020)



Source: Washington State Report Card Wahluke School District. Note: "Section 504" is a federal law that protects students from discrimination based on disability.

For the Class of 2020, data show academic success disproportionately impacts some student groups. In fact, on-time graduation rates for students identified as homeless, English language learner, or migrant are lower, with these students being more likely to drop out of school than their peers.

Racial, Ethnic, and Economic Segregation

Residential segregation has been linked to negative health consequences, poor-quality housing, violence, reduced educational and employment opportunities, and other adverse conditions (County Health Rankings, 2021). The County Health Rankings define racial/ethnic residential segregation as the degree to which two or more groups live separately from one another in a geographic area. "The index of dissimilarity is a demographic measure of the evenness with which two groups (non-white and white residents, in this case) are distributed across the component geographic areas (census tracts, in this case) that make up a larger area (counties, in this case)" (ibid). According to the Monitoring Educational Equity report (2019), despite integration efforts, racial and economic segregation have continued to increase in recent decades.

> "School segregation—both racial and economic—poses one of the most formidable barriers to educational equity" (National Academies of Sciences, Engineering, and Medicine, 2019).

The 2021 County Health Rankings use the index of dissimilarity where higher values indicate greater residential segregation between non-white and white county residents, with scores ranging from 0 (complete integration) to 100 (complete segregation). The score represents the percentage of either non-white or white residents that would have to move to different geographic areas in order to produce a distribution that matches that of the larger area. For Grant County, the index score is 35 while for Washington it is 38, indicating Grant County has slightly lower segregation than Washington State as a whole.

Access to Early Childhood Education

The Educational Service District (ESD) 105, which serves the Wahluke School District, offers the state-funded Early Childhood Education and Assistance Program (ECEAP) to many communities in its region. ECEAP provides free preschool, family support, and child health coordination to eligible children and their families. ESD 105 offers ECEAP in Yakima, Toppenish, Union Gap, and Cle Elum/Roslyn, while providing support to local providers in the surrounding Wahluke communities. The ESD also offers Head Start and Migrant/Seasonal Head Start services at different locations in the area (see ESD 105), with these offered within the Mattawa community by a local provider. The district partners with community-based agencies to deliver early childhood services and provides limited ECEAP support through its pre-K program. There are two pre-school programs offered through the district: Developmental Pre-school and Mattawa Elementary Pre-school.

Access to High-Quality Curricula and Instruction

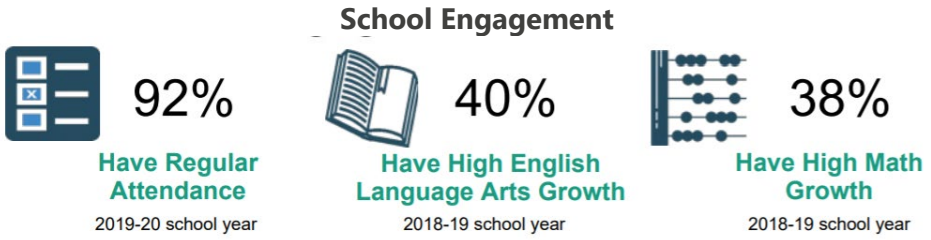
The National Academies of Sciences, Engineering, and Medicine (2019) highlights the interaction between students and teachers, students' access to a rich coursework, and the teachers' qualifications, experience, and diversity as indicators of quality learning. Several measures that OSPI tracks and reports annually illustrate students' access to curricula and instruction. The data below show disparities between the district and statewide averages. For example, the district falls below the state average for funds expended per-pupil and fewer master's-level (or higher) teachers as compared to the state.

Per-pupil expenditure	Average class size	Years of teaching experience	Teachers held full certificates	Teachers with a master's degree or higher	Teachers considered "experienced"	Years of experience as principal/ leader
$11,835 Wahluke **$14,213 WA**	**19 pupils Wahluke** **18 WA**	**7.7 years Wahluke** **12.8 WA**	**80% Wahluke** **92% WA**	**43% Wahluke** **61% WA**	**52.5% Wahluke** **72% WA**	**4 years Wahluke** **6.8 WA**

Source: Office of Superintendent of Public Instruction

Access to computers and the internet is a growing need for students and has been particularly critical during the COVID-19 pandemic when students accessed education remotely or in a "hybrid" model. While many households (82%) in the Wahluke School District have internet connection, 387 households still do not have access. In comparison, 91.3% of Washington households and 83% of Grant County households have internet access (Census 2019: ACS 5-Year Estimates).

Academic Engagement



Graphic: Office of Superintendent of Public Instruction

Findings on school engagement demonstrates a high level of participation by Wahluke students with nearly all (92%) attending regularly during the 2019-20 school year. Further, during the 2018-19 academic year, 40% of students illustrated high growth in ELA, above the state norm (33.6%), with 38% exhibiting high growth in Math, again, exceeding the state average (33.7%).

Discipline Practices

During the 2018-19 school year, 149 or 5.8% of the 2,578 students enrolled in Wahluke School District received a short-term or long-term suspension, emergency expulsion, or expulsion for a discipline related incident (down from 6.6% in the 2017-2018 school year). Statewide the discipline rate was 4.0%. In reviewing data by student group, disparate application of disciplinary actions is apparent. Particularly, findings show:

- Hispanic/Latinx students were sanctioned more often as compared to white youth (5.8% vs. 4.3%, respectively);
- Students with disabilities are twice as likely to be disciplined compared to those without disabilities (10.7% vs. 5.0%, respectively);
- Non-English Learners have higher discipline rates as compared to those who are English Learners (6.4% vs. 5.3%, respectively);
- Higher rates are noted for non-low income than low-income students (7.0% vs. 5.6%, respectively); and
- Non-migrant students are somewhat more likely to be disciplined as compared to migrant youth (6.3% vs. 5.2%, respectively).

Summary and Implications

Interview and focus group participants named how sensitivity and understanding about cultural nuances is an issue affecting education. They mentioned, for example, how acknowledging students' work/school responsibilities would allow for more time management and flexibility in the schedule.

> *"Kids need to go back home to take care of siblings or work with the animals or in the fields. (Offer) more clubs and activities for kids built-in during school, including art, outside time, and electives."* —Student

> *"Honestly, I feel like many of our teachers don't live here in our community. I think there is a gap between understanding the culture. I feel like they're not aware of the things that are going on.* —School staff member

The Wahluke School District has experienced some improvements in kindergarten readiness, and graduation rates overtime. However, inequities in reaching these educational milestones exist. Further, findings indicate a considerable gap in the racial and ethnic diversity between the student population and classroom teachers. Results also show disparate application of disciplinary actions among student groups.

We know that graduating from high school is a critical step towards a successful adulthood. In fact, youths that dropout are more likely to have difficulties with employment and earning a satisfactory living. These deficits contribute to a greater likelihood of other social and personal problems including mental, emotional, and behavioral disorders (Annie E. Casey Foundation 2014). We also know that engaged students are more likely to earn better grades, perform well on standardized tests, and stay in school (Fredricks, Blumenfeld, & Paris 2004), and less likely to engage in health-risk behaviors, including substance use, violence-related behaviors, and risky sexual behaviors (United Way Worldwide, 2011).

A report conducted in Washington state found that exclusionary discipline practices disproportionally impacted BIPOC youth, and students of low socioeconomic status (Mosehauer, McGrath, Nist, Pillar, 2012). At the institutional level, the use of exclusionary discipline practices and policies that are disproportionately applied to students of color marginalize these youth, and limits opportunities for social, emotional, and academic development. Additionally, at the individual level, school staffs' implicit biases produce low expectations and set up students of color and marginalized youth to disengage from the school environment (Simmons, Brackett & Adler 2018).

Project AWARE focuses specifically on increasing universal behavioral health supports for youth, including youth's social-emotional skills. Social and emotional learning (SEL) provides students with competencies necessary to lead productive and healthy lives. SEL refers to life skills that support students (and adults) to experience, manage, and express emotions; foster sound decision making; and build interpersonal relationships. These skills protect children and youth against adverse risk-taking behaviors, emotional distress, and conduct problems, thus, contribute to health, academic achievement, and success later in life.

When considering AWARE programming, implementation efforts should identify populations disproportionally affected by low educational attainment, engagement, or disciplinary actions, and ensure supports are implemented equitably to meet the needs of a diverse array of youth, whether those learning through special education, or ELL programming, or facing challenges outside of school such as high mobility (migrant) or homeless living conditions. In the development of the supports, efforts should ensure both student and parent voices are included in the process from selection to implementation.

Community Assets and Resources

Some of the available resources related to education access and quality available in Grant County are:

- Educational Service District 105 is the multi-resource support site for the schools and education partners in south central Washington, including portions of Grant County. ESD 105 provides cost-effective ways related to school and student success, health, and safety, and professional development, administrative, business, and financial support, and new technology.
- Wahluke School District serves the communities of Mattawa, Beverly, Schwana, and Desert Aire. All district facilities are in a 60-acre campus in Mattawa and include: Mattawa, Morris Schott, and Saddle Mountain Elementary schools; Sentinel Tech Alternative School; Wahluke Junior High and Wahluke High School.
- Inspire Development Centers is a community-based nonprofit organization that provides culturally responsive services to families and children through programs such as Migrant and Seasonal Head Start Program, Migrant and Seasonal Early Head Start, and Early Childhood Assistance (ECAP). It has locations in eight Washington counties including Yakima and Grant.

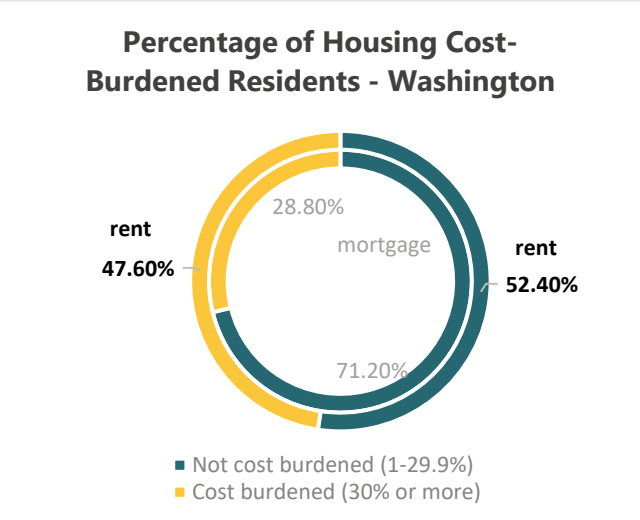
Neighborhood and Built Environment

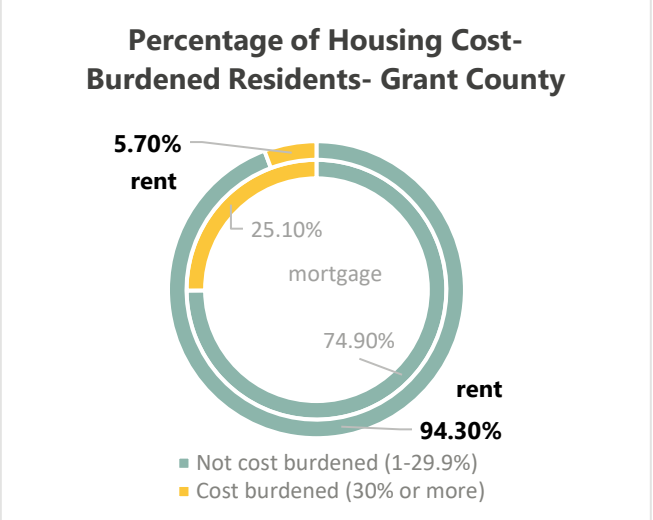
Place matters. Where people live has a significant impact on their health and well-being. Oftentimes, there are persistent disparities among people living just a few blocks apart, in part because of their neighborhood and surrounding environment, such as having grocery stores that offer a variety of food options, especially healthy ones, or access to parks or other green spaces. Living in places with limited availability of grocery stores and lack of access to fresh fruits and vegetables – often referred to as "food deserts" – is correlated with premature death and high prevalence of obesity (Washington State Department of Health. Food Insecurity and Hunger, 2018). Ensuring access to healthy food, affordable housing, parks and recreation, and reliable transportation for everyone improves health in communities (Robert Wood-Johnson Foundation, 2021).

Housing

Quality, safe, and affordable housing is critical for the well-being of kids and families. Families who pay more than they can afford for housing may not have enough left to cover other basic needs such as food, healthcare, and childcare. A widely used measure to assess housing affordability is known as the "30-percent rule" or housing cost burden.

In Washington, nearly half of renters (47.6%) and 28.8% of homeowners are considered cost burdened. Conversely, in Grant County fewer homeowners or renters face that level of financial challenge, with an estimated one quarter of mortgage holders (25.1%) and 6 percent of renters cost burdened.





Source: U.S. Census Bureau, 2019 American Community Survey 1-Year Estimates

Houselessness/Housing Instability

Houselessness is the lack of stable, safe, permanent, and adequate housing. People experiencing houselessness may be unsheltered or staying in emergency shelters or transitional housing. At the same time, houselessness can result in illness due to exposure to communicable disease, violence, and poor nutrition.

Annually, communities across the country complete the Point-in-Time (PIT) count which determines the number of individuals who are unhoused, either experiencing houselessness or housing instability. In January 2019, the PIT in Grant County found there were 148 unhoused people, representing 84 households. Of the total number of persons who are houseless, 71 (48%) were individuals from 20 households with minor children (Point-In-Time Count, County Total, 2019).

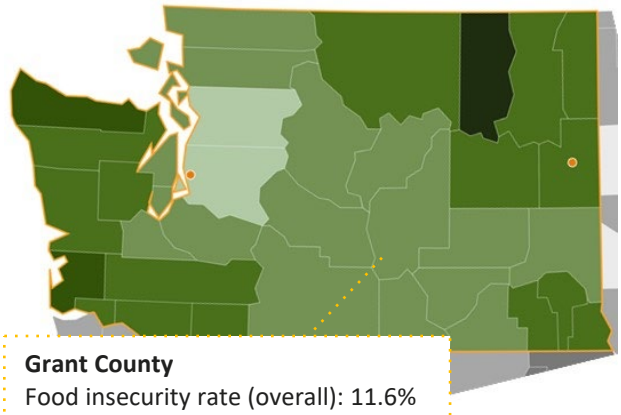
Houselessness "is often caused by a complex combination of interwoven social and health factors. Poor physical and mental health can both cause and result in homelessness. Illness or injury can lead to lost income, the loss of a job and health insurance leading to a downward spiral in health" (Washington Department of Health, 2018)

Additionally, each fall school districts report the number of students living in unstable housing circumstances to OSPI. OSPI uses a broader definition of "houseless" that includes students who are living "doubled up" and "couch surfing" as such the number of children reported by OSPI as houseless are historically higher than those of the PIT. In October of the 2020-21 school year, there were 305 students experiencing houselessness in the Wahluke School District school year, representing 11.9% of the student population. (OSPI Report Card, 2020-21).

Food Security

Hunger and food insecurity in children are associated with psychosocial problems, frequent colds, anemia, asthma, headaches, impaired cognitive functions, and poorer academic achievement (Washington State Department of Health, 2018). A recent study of people that experienced frequent hunger in childhood found a correlation to low self-control, and interpersonal violence later in life (Piquero, 2016).

Food insecurity is the limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in a socially acceptable way. (DOH, 2018)



Grant County
Food insecurity rate (overall): 11.6%
Food insecurity rate (child): 16.5%

Source: Feeding America, 2018

Food security means a person has access to enough food to have a healthy life. Food insecure households are not always food insecure at all times and vice versa. Food security is measured by the food environment index, which combines the percentage of the population that is low-income and do not live close to a grocery store, and the percentage of the population that are food insecure. The index scale ranges from 0 (worst) to 10 (best). The food environment index in Grant County is worse than Washington state (7.7 vs. 8.2, state) (County Health Rankings, 2020). According to a recent report, 16.5% of children in Grant County (before COVID-19) experienced food insecurity, with over one-in-ten persons (11.6%), countywide, food insecure (Feeding America, 2018).

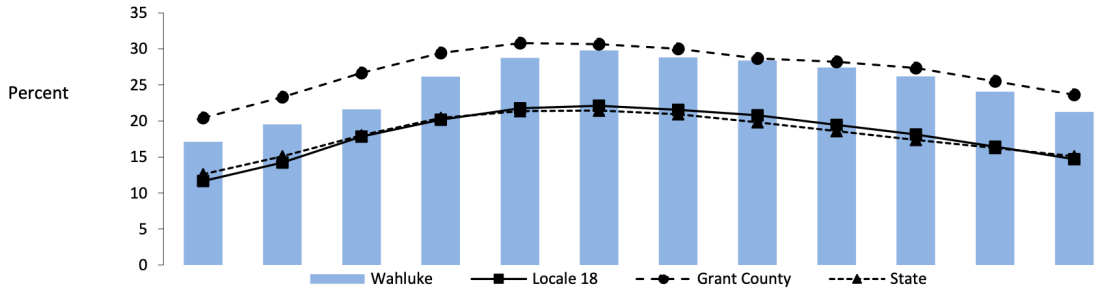
Government assistance programs have been shown to reduce child food insecurity rates and lessen the impacts of food insecurity among children (Seattle Children's Hospital, 2019). These programs include the Supplemental Nutrition Assistance Program (SNAP), national school meal programs, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) – all indicators of extreme family economic deprivation.

Supplemental Nutritional Assistance Program (SNAP)

The federally funded Supplemental Nutrition Assistance Program (SNAP), formerly known as the food stamp program, helps children and families with low incomes afford food. SNAP is the nation's largest nutrition assistance program, with more than 35 million children and families participating. An estimated 60% of households with children under the age of 18 in the Wahluke School District area participate in SNAP, above the 38.4% in Grant county and 44.3% in Washington (Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates).

The figure below demonstrates that the rate of persons (not households) receiving SNAP services has declined since peaking in 2013 at the state, county, and school-district levels. However, usage rates for Grant County and the district region have consistently exceeded state averages across all reporting years.

Supplemental Nutritional Assistance Program (SNAP)



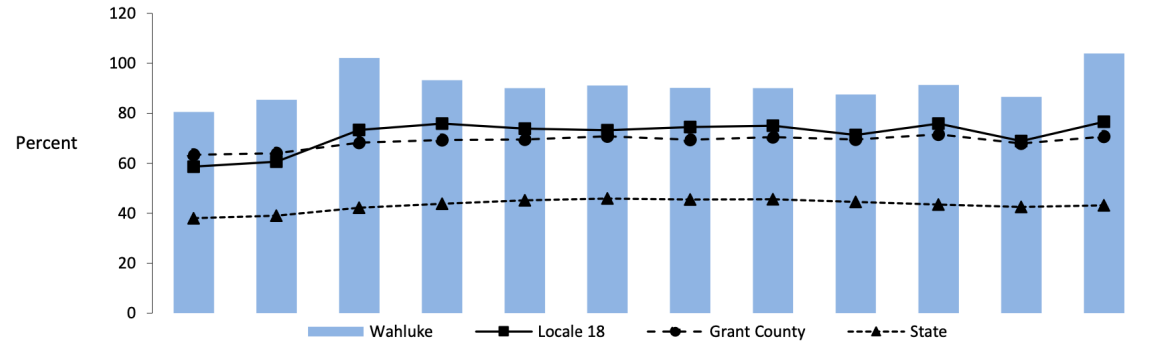
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
State	12.60	15.11	18.00	20.44	21.35	21.45	20.95	19.80	18.58	17.38	16.26	15.09
Grant County	20.43	23.31	26.65	29.43	30.81	30.66	30.01	28.68	28.22	27.34	25.50	23.62
Locale 18	11.65	14.23	17.84	20.19	21.76	22.11	21.54	20.78	19.46	18.12	16.43	14.69
Wahluke	17.10	19.53	21.62	26.17	28.74	29.81	28.83	28.40	27.43	26.19	24.08	21.27
Recipients	1,325	1,574	1,789	2,202	2,450	2,557	2,466	2,465	2,422	2,380	2,235	1,993
All Persons	7,748	8,060	8,273	8,414	8,525	8,578	8,554	8,681	8,830	9,087	9,280	9,369

Source: Washington State Department of Social & Health Services, 2021

Free or Reduced-Price Meals Program

The national school meals program provides breakfast, lunch, afterschool snack, meals during the summer months, and afterschool meals to children with low incomes attending public, private, and charter schools, as well as residential childcare institutions (RCCIs). In 2019, 71% of children in Grant County and 43% in Washington were eligible for free or reduced-price lunch. In comparison, 100% of the 2,459 students enrolled in Wahluke School District were eligible to participate in the free and reduced meal program, significantly above the state average.

Students Eligible for Free or Reduced Price Lunch



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
State	38.01	39.04	42.22	43.75	45.17	45.87	45.50	45.60	44.51	43.49	42.50	43.16
Grant County	63.39	64.03	68.28	69.32	69.53	70.83	69.41	70.47	69.57	71.57	67.92	70.66
Locale 18	58.67	60.59	73.35	75.88	73.85	73.23	74.54	75.06	71.33	75.87	68.92	76.61
Wahluke	80.60	85.42	102.16	93.26	90.10	91.18	90.18	90.08	87.57	91.39	86.54	103.94
Eligible Students	1,508	1,681	1,891	1,952	1,930	1,984	2,047	2,079	2,065	2,101	2,134	2,556
Enrolled Students	1,871	1,968	1,851	2,093	2,142	2,176	2,270	2,308	2,358	2,299	2,466	2,459

Source: Washington State Department of Social & Health Services, 2021

Transportation

Transportation, including active transportation (walking, biking), access to transportation, and income spent on transportation, is another social determinant of health. Access to childcare, health care, and education can be difficult for people with low incomes, individuals with mental illnesses, or those without a car. In a regional survey conducted for the Central Washington Hospital's 2019 Community Health Assessment, transportation was identified as a regional challenge and a top barrier to healthcare access. Participants listed transit schedules, access to transit, limited to no services in rural areas, cost, and safety of vehicles among the barriers related to transportation (Central Washington Hospital, 2019).

Summary and Implications

Although findings indicate that housing is more affordable in Grant County as compared to elsewhere, Wahluke School District families face a multitude of other societal and financial challenges. These include food insecurity, homelessness, and lack of transportation options. Rates of food insecurity in the region are higher than state averages, with utilization of food assistance (both through SNAP and the free and reduced priced meals program) well above state rates, with 100% of students eligible for reduce priced school meals.

One of the interview/focus group respondents described housing in the area as "really tricky": individuals and families may not be considered homeless even though their living arrangements may not be conducive to health, wellbeing and education success.

> *You'd have about four or five, six families living together and living in (crowded) situations. Even though you might be sharing your house or your structure with four others, they're homeless. They say, Oh, I've got a roof over my head, even though I'm living out of a shed on the back part of the property.*
>
> —School staff member

Food insecurity has been an issue, as well. In this regard, mutual aid has been critical in supporting one another: "community members are helping community members," as a participant shared. Food pantries have distributed boxes of food. How to cook or refrigerate the food is problematic:

> *A lot of our family living situations are not ideal. They may need assistance in keeping things cold or assistance in how to prepare that food because they don't have power electricity.*
>
> —School staff member

Research has shown that food insecurity is associated with a wide range of adolescent mental health disorders, such as past-year mood, anxiety, behavior, and substance disorders, even when controlling for other aspects of socio-economic status (McLaughlin, et. al, 2012). Other research has found that children from chronically food insecure homes were approximately one-and-a-half times more likely to have internalizing problems and two times more likely to have externalizing problems, when compared to children in food secure homes (Slopen et.al, 2010).

Considering the societal, environmental, and logistical barriers facing youth and families, it is critical to embed community-based services and supports within the school system to increase access while reducing barriers.

Community Assets and Strengths

Some of the community resources that contribute to ensuring access to healthy food and affordable housing in Grant County include:

- The Homeless Task Force of Grant County is a non-profit organization that strives to make a difference in the lives of those that are without shelter by coordinating resources and involving organizations to build a comprehensive system to end homelessness. The taskforce focuses on strategies to move individuals and families to permanent housing and self-sufficiency.
- Mattawa Area Food Bank is a non-profit, volunteer only hunger relief agency created in 2006. It provides nutritious foods to people who are food insecure. It serves Mattawa, Beverly, Schwanna, and the surrounding area.

Social and Community Context

Relationships are important for physical and mental health and well-being. The social and community context domain includes issues related to social cohesion, safety, civic participation, discrimination, and incarceration, among others.

Immigration Status

Immigration is a consequence of social factors that influence health, such as poverty, educational opportunities, and political persecution. Immigration itself is also a social determinant of health (Castañeda et. al. 2014). "Heightened immigration enforcement in recent years, including historic levels of deportation, has resulted in negative impacts on health and well-being" (ibid). Fear of deportation and actual deportation have many social, economic, and health impacts on individuals and families (Langhout et. al., 2018).

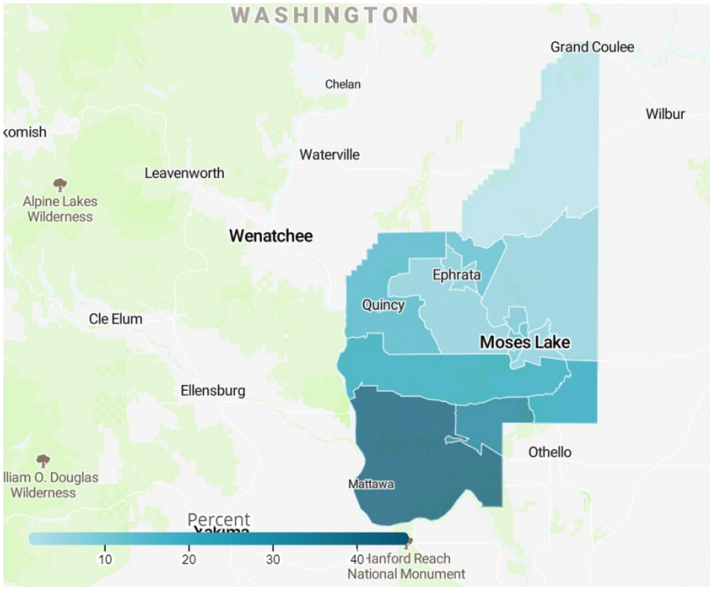
While the number of undocumented immigrants is difficult to measure, in 2018 an estimated 11 million undocumented people lived in the U.S. including 240,000 in Washington state, representing approximately 5.2% of the total state population. Among the implications of immigration status on health and well-being are the restrictions to accessing programs that offer public health coverage (Washington State Health Equity for Immigrants Report 2020).

Undocumented immigrants, including DACA (Deferred Action for Childhood Arrivals) holders, are ineligible to receive most federal public benefits, including SNAP and TANF. They may, however, be eligible for a handful of benefits to protect life or guarantee safety in emergency situations, such as

access to healthcare and nutrition under the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) (National Immigration Forum, 2018).

The Wahluke School District area and surrounding communities have the highest concentration of foreign-born residents in Grant County. In fact, an estimated 46% of the population living in the designated census tract (114.02) was born outside of the U.S. compared to 19.2% countywide (Hunger in Washington with Census tract data, 2013-2017).

Foreign-Born Population by Census Tract, Grant County (2013-2017)



Source: Hunger in Washington

School Climate and Safety

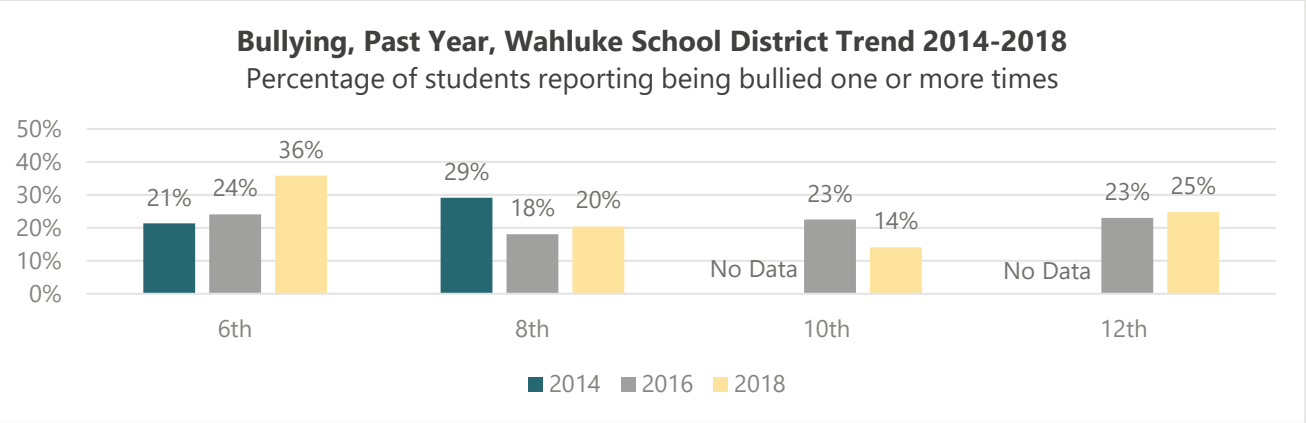
As previously noted, since 2002, the Healthy Youth Survey, sponsored by the Department of Health, the Office of Superintendent of Public Instruction, the Department of Social and Health Services, the Department of Commerce, the Family Policy Council, and the Liquor Control Board, in cooperation with Washington schools, has been administered every other year in the fall to students in grades 6, 8, 10, and 12 across the state. The survey measures health risk behaviors known to contribute to the health and safety of youth.

Bullying

Data from the past three HYS survey administrations[3] on the percentage of youth in Wahluke School District reporting being a victim of bullying show that a larger percentage of 6th graders reported victimization in 2018 than in previous years. In contrast, rates were lower among 8th and 10th graders, and stable among 12th grade youth. The rates of reported bullying in the district are comparable to statewide levels.

A recent study released by the University of Michigan (2020) found that *"Bully victimization damages how people view themselves in adolescence and that negative view can linger into adulthood, contributing to poor mental health."*

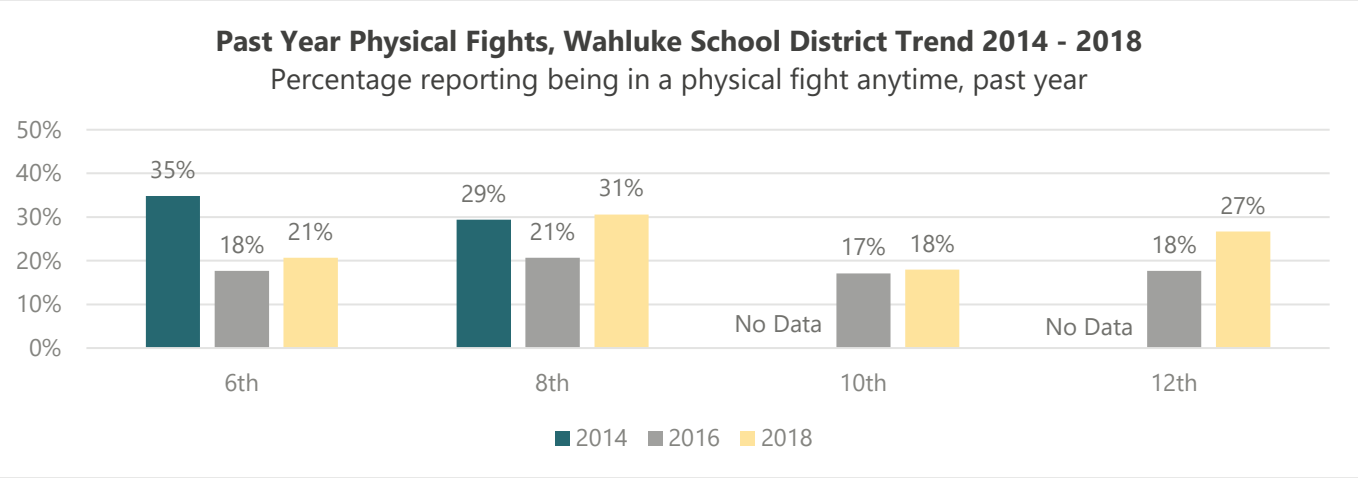
[3] NOTE: Due to low response rates, data for 10th and 12th grade students are only available for the 2016 and 2018 survey periods.



Source: Healthy Youth Survey (2014-2018) at askhys.net

Physical Fighting and Weapon Carrying

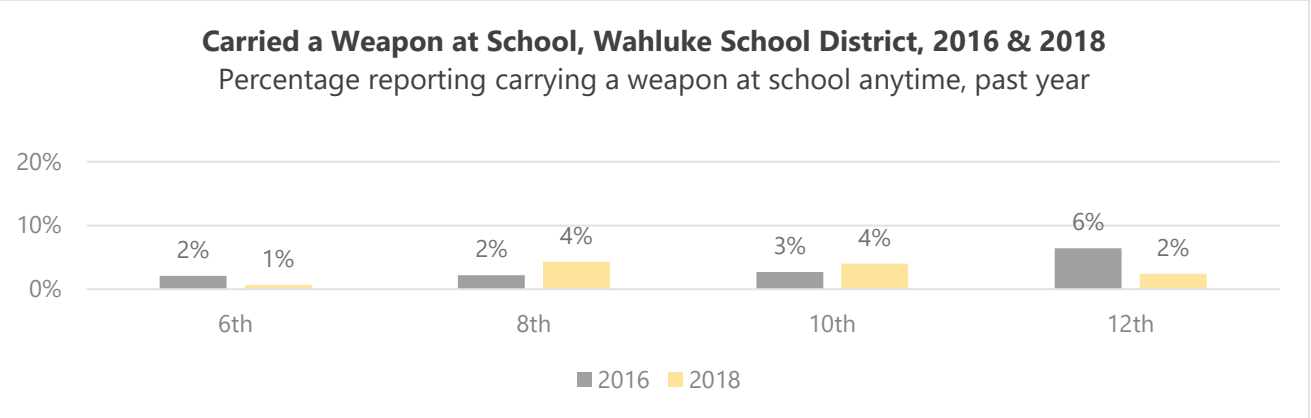
The following figures show the percentage of youth that reported engaging in behaviors related to intentional injury of others.



Source: Healthy Youth Survey (2014-2018) at askhys.net

The percentage of youth reporting being in at least one physical fight in the past year varies greatly among grade levels and across survey periods. In 2018, one-in-five 6th graders and nearly one-third of 8th graders engaged in this type of behavior. At the high school-level, a higher percentage of 12th grade students reporting being in a physical fight than 10th grade youth (27% vs. 18%, respectively).

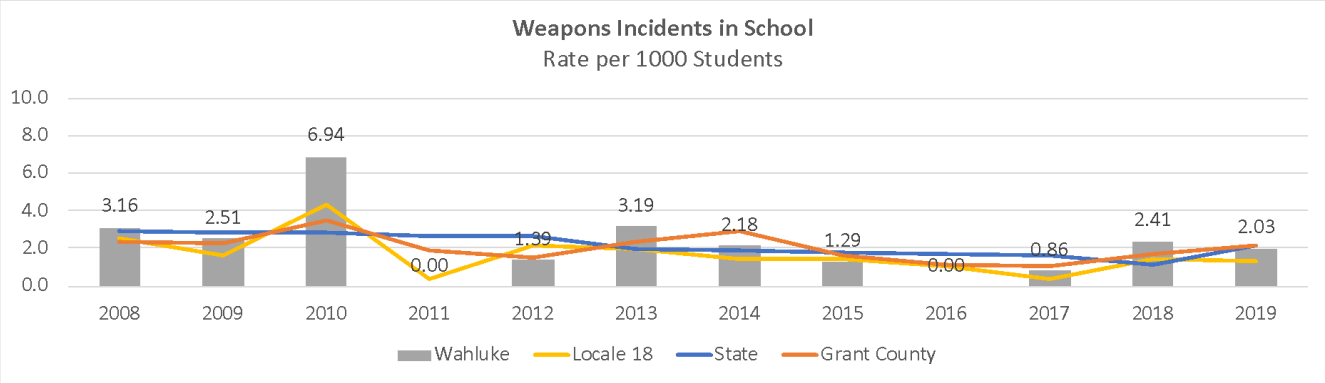
The graph below shows the percentage of Wahluke School District HYS respondents that reported carrying a weapon at school during the previous school year.



Source: Healthy Youth Survey (2016-2018) at askhys.net

These data demonstrate that weapon carrying is relatively rare, with a small percentage of Wahluke youth reporting such behavior. In 2018, from 1% to 4% of students reported taking a weapon to school at least once during the school year, with this somewhat more likely among 8th and 10th graders.

The below figure shows the rate of weapons incidents reported in schools between 2008-2019.[4] In general, incidents of guns and other weapons on school property are rare events both locally and statewide. In 2019, the rate of reported weapon incidents in the Wahluke School District was at or below state and county rates, with this declining as compared to 2018.

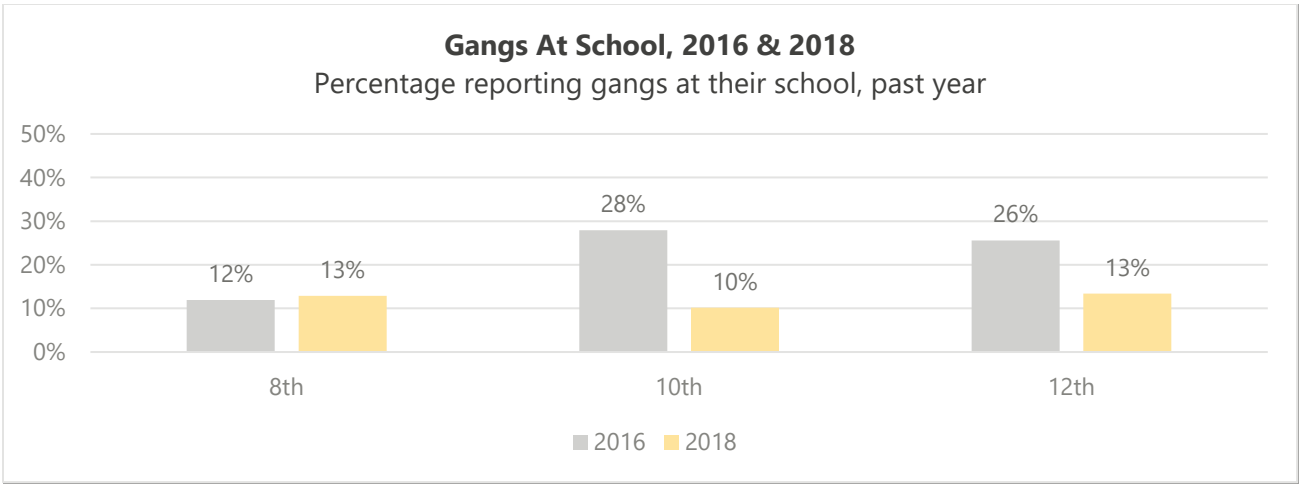


Source: Office of Superintendent of Public Instruction, Information Services, Safe and Drug-free Schools: Report to the Legislature on Weapons in Schools RCW 28A.320.130

Gangs in Schools

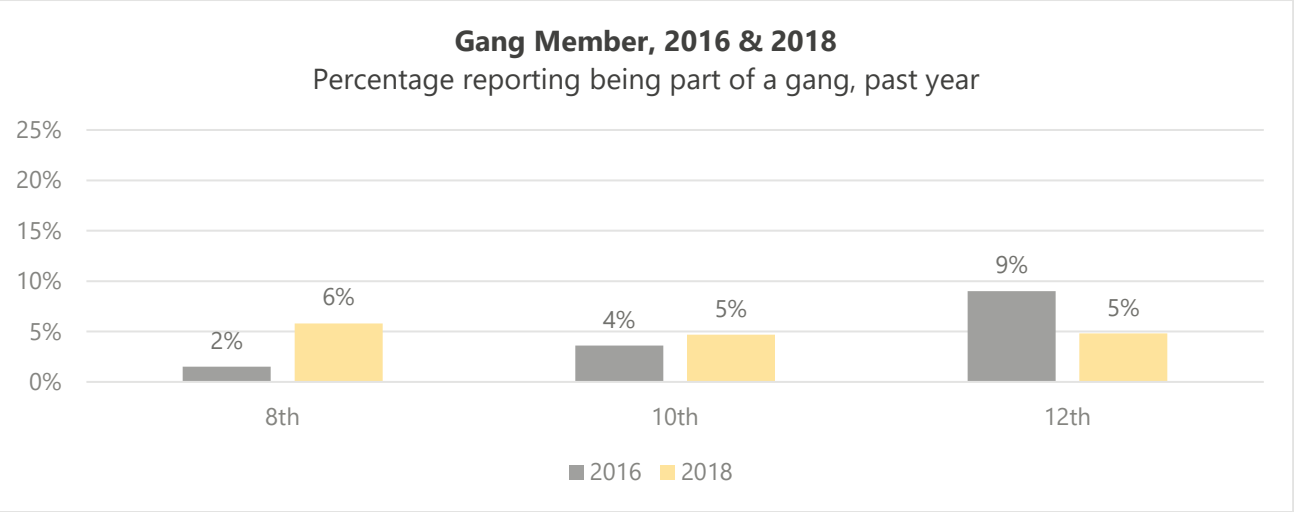
In response to the HYS question, "Are there gangs at your school?" between 10%–13% of Wahluke School District students in 2018 responded in the affirmative. Among high-school-aged youth the presence of gangs in schools declined from 2016 levels, while perceptions of gang activity remained unchanged for 8th grade youth.

[4] The reported incidents involving guns and other weapons at any grade level per 1000 students enrolled in October of all grades.



Source: Healthy Youth Survey (2016, 2018) at askhys.net

The HYS also asks students if they had been a member of a gang during the past 12 months. Gangs are defined as "a group of people with a leader who act together often for violent or illegal activities" (HYS, 2018). Few students, across grade levels, acknowledged gang membership in 2018. However, there was a threefold increase in the percentage of 8th graders reporting gang membership as compared to 2016. The rate of gang membership across grades in 2018 is similar to state norms.



Source: Healthy Youth Survey (2016, 2018) at askhys.net

Summary and Implications

Findings show that bullying victimization rates among 6th grade students has increased, with more 8th and 12th graders engaging in physical fighting, and growing gang involvement among 8th grade youth between 2016 and 2018. On a more positive note, rates of weapon carrying on school grounds, and youth perception of gangs at school have declined since 2016.

Interview and focus group participants shared that the community generally feels safe, and how "they have been able to control the gangs at school." At the same time, people raised concerns about the lack of concerted and coordinated efforts to prevent issues before they escalate.

> *A young man known by many in community, he was hyper and depressed when he was little kid. (There was alcoholism and neglect in his family.) Now that he shoots a gun, they pay attention to him to accuse him; never before to help him."*
>
> —Parent

> *"I just really want to emphasize that there's a lot of great things starting to happen as a district, and a lot of great people that can provide services and that kind of stuff, but we need to all sit down together and really structure the way that we're providing these services to our population, so they are aware of it."*
>
> —School staff member

Research has shown that being a target or victim of bullying has immediate and long-term psychological and social effects, influencing a young person's academic achievement and psychosocial adjustment into adulthood (Espelage & DeLaRue 2012). One of the most effective ways to address bullying in the school setting is to improve the school's climate and culture (Fein et al., 2004).

Not surprisingly, there are numerous consequences of gang/group membership. Research findings show that youth involved with gangs engage in higher levels of delinquency than their peers who are not involved with gangs and are more than twice as likely to carry a gun, and three times as likely to sell drugs as compared to youth who are not involved with gangs (Bjerragaard and Lizotte 1995; Cahill and Hayeslip 2010; Hill, Lui, Hawkins 2001; Spergel 1995; Thornberry 1998). Moreover, group/gang involved youth are considerably more likely to be victims of violence than other individuals (Howell 2013).

Gang problems disproportionately occur in schools that serve areas of concentrated poverty and social disorganization, where many families experience economic hardship and the unemployment rate is high (National Criminal Justice Reference Service, 2013). As demonstrated in previous sections of this assessment, the Wahluke community faces a number of these social and environmental factors.

Research on school related protective factors indicates that when students are provided with meaningful opportunities to participate and are recognized and rewarded for their contributions, they are less likely to engage in delinquent or risky health behaviors. In addition, Arthur et al. (2005) found that reduction of risk factors and substance use and increased protective factors among school populations are linked to improved student academic outcomes.

Research has also demonstrated that a positive school climate is a crucial component of violence prevention that can influence behavioral outcomes (e.g., lower rates of aggression, victimization, and dropout), and may enhance youth's resilience factors (National School Climate Center, 2012). As such, it is essential to embed not only a robust set of positive school-wide behavioral expectations (enforced fairly and consistently) but also to ensure on-going social-emotional (SEL) skill building for all youth. In addition, as part of the build out of a multi-tiered system of supports, the district should also consider selective (Tier 2) and individualized (Tier 3) interventions that can provide further pro-social behavioral

support for youth that may be at increased risk for, or already involved in gang-related activity as well as ensuring that family members are engaged in intervention services across all levels.

Community Assets and Strengths

Below are available assets and resources supporting Grant County and the Wahluke District region:

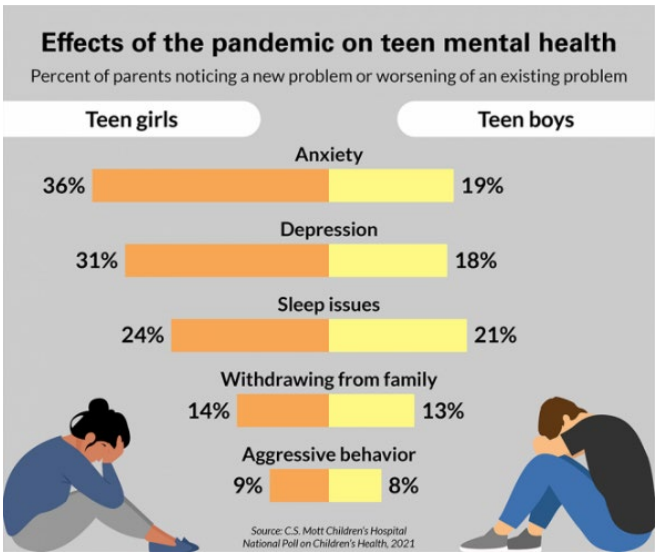
- The Washington Office of Refugee and Immigrant Assistance (ORIA) partners with organizations across the state to offer services that are culturally respectful and in the preferred language of immigrants and refugees.
- Washington Immigrant Solidarity Network (WAISN) is the largest immigrant-led coalition in Washington state, composed of immigrant and refugee-rights organizations and individuals. It strives to protect, serve, and strengthen communities across the state. It's hotline (1-844-724-3737) serves as avenue for immigrant and refugee communities to report Immigration Custom and Enforcement (ICE)/Custom Border Patrol (CBP) activity in their community, report the detention of a group or individual, and obtain information or referral assistance.
- Washington COVID-19 Immigrant Relief Fund is a pool of funding created during the coronavirus pandemic by and for immigrants to support people ineligible for federal stimulus money or unemployment benefits due to their immigration status.
- Grant County Sheriff: The Gang Unit aims to reduce criminal activity by individuals who are identified or suspected of being gang members or associates. The unit prioritizes crimes of violence, weapons possession, drug dealing, and criminal activity in or around schools.
- Our Lady of the Desert is a Catholic parish located in Mattawa, established in 1987 and organized under the Diocese of Yakima. It offers mass services in English and Spanish.
- Mattawa-Desert Aire Lions Club is a volunteer-run organization that supports the communities on different issues, including scholarships for local high school students and free hearing and eye exams for the community.

Mental and Behavioral Health and Well-Being

Mental health disorders are prevalent among school-aged children (aged 13-16) with approximately one-in-five impacted by a diagnosable mental health or learning disorder (Center for Disease Control and Prevention, May 2013). Despite growing knowledge and awareness of mental health issues among school-aged children, there remains a persistent gap between the number of children needing mental health supports and those that receive it. In fact, the average delay (nationally) between the onset of mental health symptoms and intervention is 8 to 10 years, with many children never receiving services (Behrens, 2013; Gall et al., 2000; Kataoka et al., 2002).

In Washington state, young people face major barriers to getting mental health care. In fact, the 2021 Mental Health America report ranks Washington among the lowest states regarding access to care for youth mental health (Mental Health America, 2021). Experts agree that because schools offer unparalleled access to youth, the education system is key to providing children with the needed behavioral health care. Yet historically Washington's education system has failed to adequately address issues related to students' mental health and well-being. For example, public schools employ, on average, one psychologist for every 1,000 students, far below the national standard of one psychologist for every 500-700 students (The Seattle Times, April 4, 2021).

In addition to the existing needs and traditional barriers that students and families face when accessing behavioral health care, including racism, these are likely exacerbated by the ongoing uncertainty and distress of the COVID-19 pandemic. "Nationally, emergency visits for mental health issues jumped by 31% among 12- to 17-year-olds during the pandemic" (The Seattle Times, April 4, 2021 citing the Centers for Disease Control). The need in our state has grown exponentially prompting Governor Jay Inslee to declare a youth mental health crisis in March 2021.



Teachers and other adults in schools have important health and wellness needs, too. Findings from a poll conducted by the Kaiser Family Foundation in mid-July 2020 found that 53% of adults surveyed reported that their mental health had been negatively impacted as a result of worry and anxiety over the COVID-19 pandemic – up significantly from the 32% of adults reporting such in March (Panchal, Kamal, Orgera, Cox, Garfield, Hamel, Munana, & Chidambaram, 2020).

Stress among teachers has also been linked to poor job performance and decreased student outcomes. Indeed, students of highly stressed teachers demonstrated lower levels of academic performance and social adjustment (Jennings & Greenberg, 2009). When high job demands and stress are combined with low social-emotional competence, teacher performance and classroom management deteriorate (Montgomery & Rupp, 2005).

Overwhelmingly, interview participants identified that the most pressing mental health issues facing youth in the Wahluke School District were depression and anxiety. Staff, parents, and students themselves identified increased social anxiety due to COVID, as well as depression (diagnosed or not) because of isolation. The COVID pandemic and its economic, social, and health impacts was on everybody's mind, even as the community transitions to school hybrid models and more social interaction.

"The pandemic was like salt on the wound of what we were experiencing." —Student

These areas of concern are not new, however. Participants acknowledge that there have been ongoing behavioral challenges related to home and life instability, Adverse Childhood Experiences (including poverty, domestic violence, divorce and separation, single parenting, and violence), lack of choices for youth, and intergenerational trauma.

> *"I think there's a lot of need of everything here in our community and in our school. We've had a couple of suicides a couple years ago from former students."* —School staff member

There was vast agreement that cultural norms and biases related to mental health exist among Hispanic/Latinx community members. There is widespread lack of knowledge about the science of mental health and illnesses (their signs, symptoms, and treatment options), as well as school- and community-based resources.

> *"We parents come from several places. We are not well. We have our traumas. But we don't understand it, we don't look for help, and we don't have the words to express it."*
>
> —Parent

Students generally agree. Parents, they say, don't believe in mental health, and sharing issues with others (including mental health professionals) may be frowned upon. "Whatever happens in the family, stays in the family - good or bad."

> *"If kids are depressed, they won't tell parents because parents will scold them. They are afraid of them."* —Parent

Among the Hispanic/Latinx community in the area, there seems to be a gap between the adults (majority foreign-born) and the youth (majority second generation immigrants—born in the U.S. with at least one foreign-born parent) in terms of understanding and acceptance of mental health. The youth shared how Hispanic/Latinx adults see depression as "being lazy" or "being on the phone too much". Other comments include:

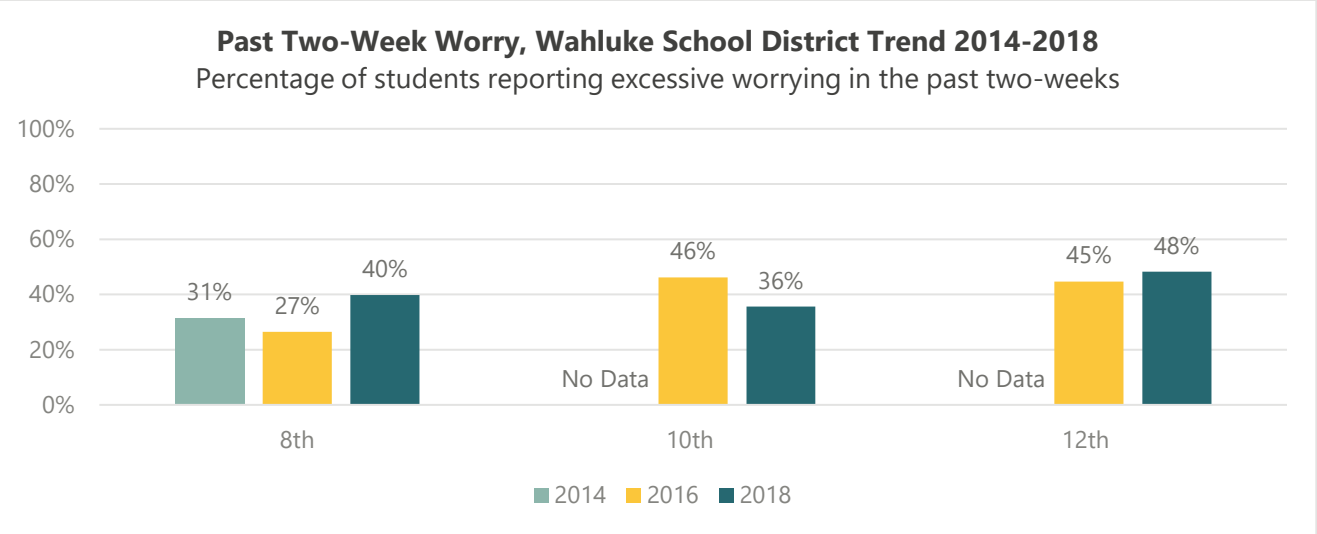
> *"It's not easy to talk with parents. There is no space for that."*
> *"Parents are tough. Parents say "tough it up", that we are softer than them."*
> *"Parents expect you to be grateful for what you have."*

Emotional Well-being

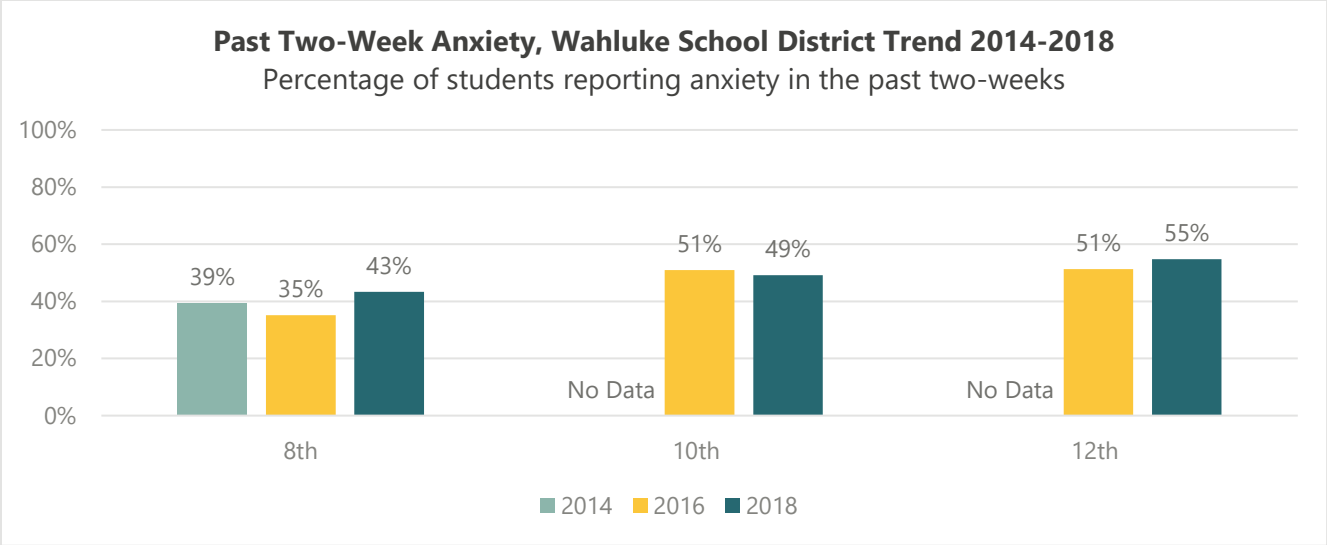
Emotional well-being refers to the emotional quality an individual experiences, and can be influenced by a variety of demographic, economic, and situational factors. The implications of decreased emotional well-being are related to some of the most common mental disorders in school-aged youth, including depression, anxiety, attention-deficit hyperactivity disorder (ADHD), and behavioral or conduct problems (Perou, R., Bitsko, R, Blumberg, S, et al., 2013), all of which can negatively affect their ability to function in the school, home, and community settings.

Worrying and Anxiety: In 2014, two mental health related questions were added to the HYS for 8th, 10th, and 12th grade youth: "*How often over the past 2 weeks were you bothered by not being able to stop or control worrying?"* and, *"How often over the last 2 weeks, were you bothered by feeling nervous, anxious, or on edge?"*

The follow figures show the rates of reported past two-week excessive worrying and anxiety among Wahluke's 8th, 10th, and 12th grade youth. In 2018, from 36% to 48% of students reported excessive worrying, with rates increasing among 8th and 12th grade youth between 2016 and 2018. Findings further show in 2018 from 43% to 55% of students reported feeling anxious during the previous two weeks, with rates increasing among 8th and 12th grade respondents.

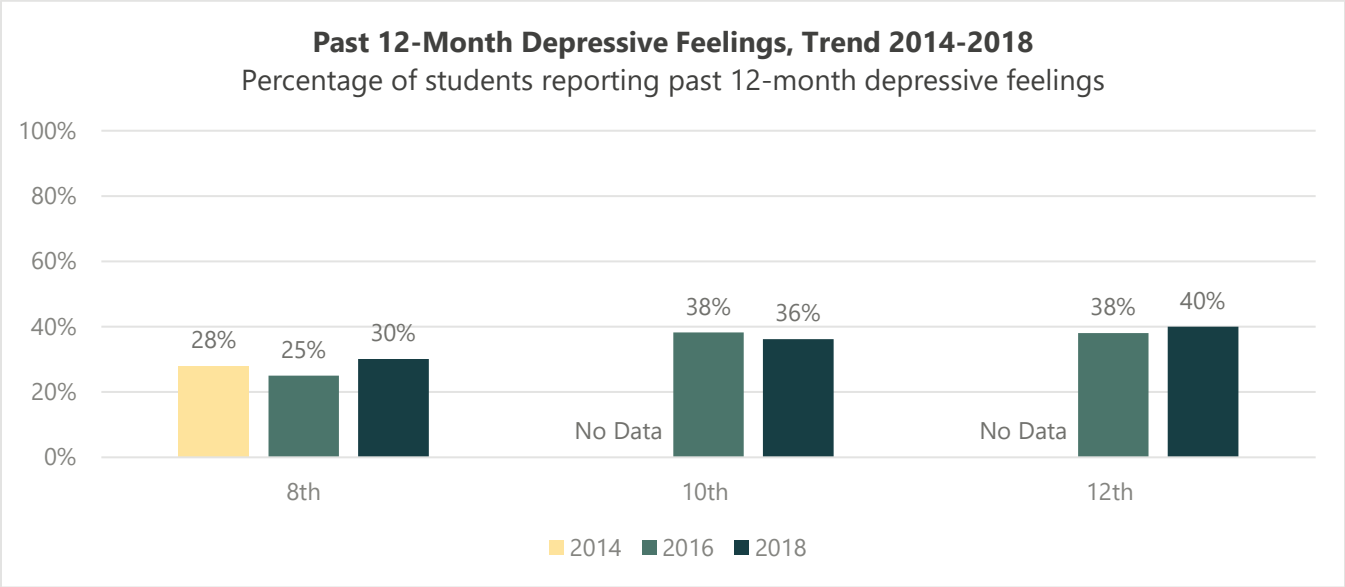


Source: Healthy Youth Survey (2014-2018) at askhys.net



Source: Healthy Youth Survey (2014-2018) at askhys.net

The HYS also asks youth about the frequency of feelings of depression, asking students, *"During the past 12 months, did you ever feel so sad or hopeless almost every day for two or more weeks in a row that you stopped doing some usual activities?"* Findings show that rates of past year depression among 8th, 10th, and 12th grade youth have been relatively stable across years. In 2018, 30% of 8th graders, 36% of 10th graders, and 40% of 12th grade youth reported feeling sad or hopeless. Putting these data into perspective, **an estimated 92 8th graders, and 84 10th grade youth reporting symptoms of depression** in the past year.[5]



Source: Healthy Youth Survey (2014-2018) at askhys.net

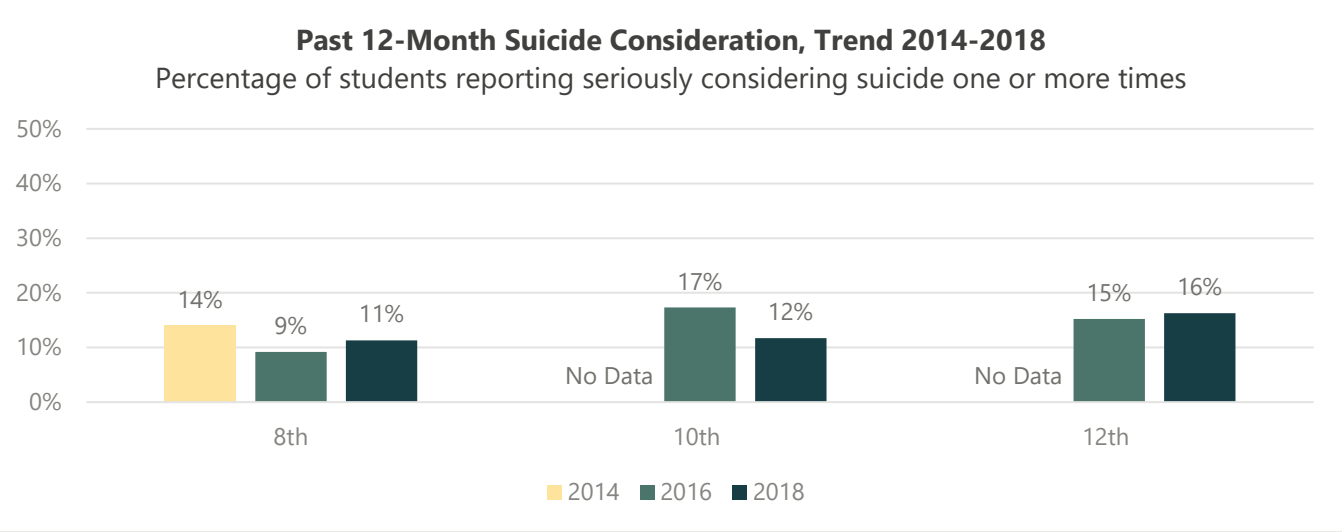
[5] Extrapolations figures are based on the enrollment for 8th and 10th grade students in 2018 and assume a representative sample of students responded. Response rates (2018) 8th Grade: 72%, 10th Grade: 74%

Suicide

Nationally, rates of suicide were rising, even before the pandemic. For teens between the ages of 15 and 19 suicide rates increased by 76% between 2007 and 2017, with the suicide rate for 10-to 14-year-olds nearly tripling over that same time period (US Center for Disease Control, 2019).[6] Since the pandemic, the Centers for Disease Control and Prevention (CDC) estimates that nationally, one in four people under age 18 have struggled with suicidal thoughts. Rates were particularly high among certain other populations, including young adult respondents aged 18–24 (25.5%), Hispanic respondents (18.6%), Black respondents (15.1%), and essential workers (21.7%) (WA State DOH, December 2020)

Since inception, the HYS has asked a series of questions about suicide. The following figures show responses to the following three questions, by grade level: "*During the past 12 months did you ever seriously consider attempting suicide?", "During the past 12 months did you make a plan about how you would attempt suicide?",* and *"During the past 12 months, how many times did you actually attempt suicide (any)?"*

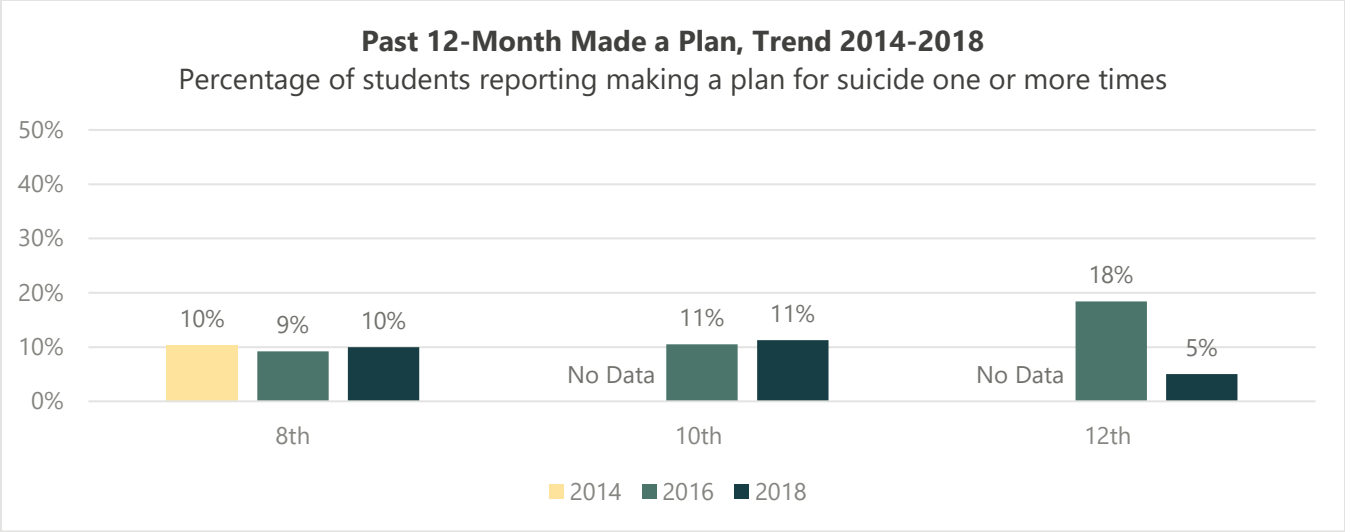
The figure below shows the percentage of 8th, 10th, and 12th grade Wahluke youth who reported past year suicide ideation.



Source: Healthy Youth Survey (2014-2018) at askhys.net

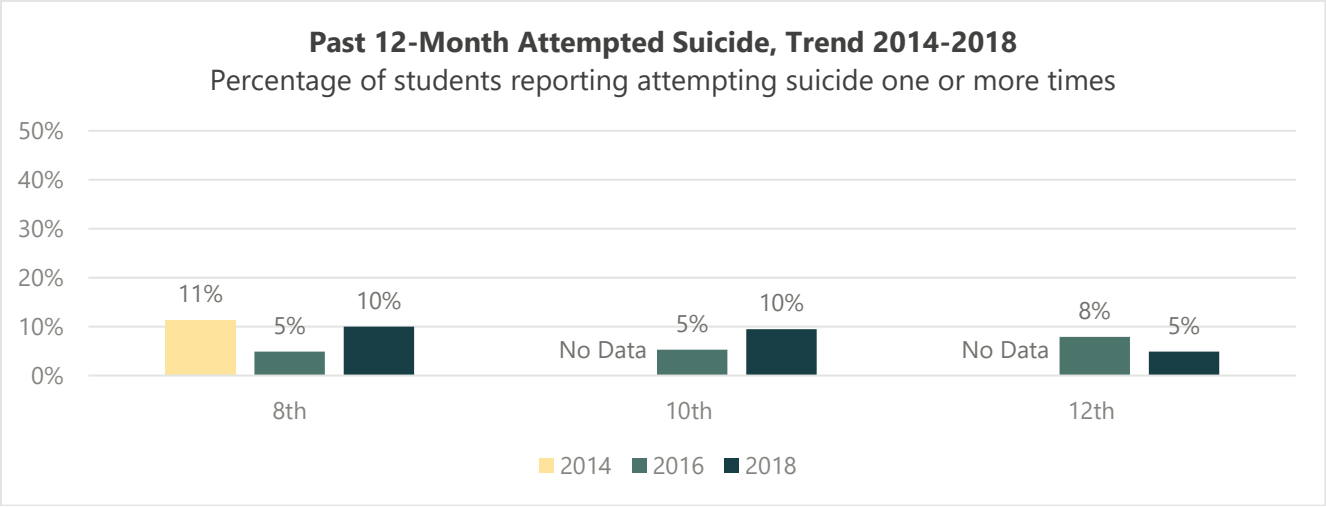
These data indicate that rates of suicidal ideation have varied among 8th grade youth since 2014, with over one-in-ten considering suicide in 2018. Rates among 10th grade youth have declined and have remained stable for 12th grade between 2016 and 2018. According to these data, approximately **24 8th grade youth and 21 10th graders seriously considered suicide** in 2018.

Death Rates Due to Suicide and Homicide Among Persons Aged 10–24: United States, 2000–2017, see https://www.cdc.gov/nchs/products/databriefs/db352.htm



Source: Healthy Youth Survey (2014-2018) at askhys.net

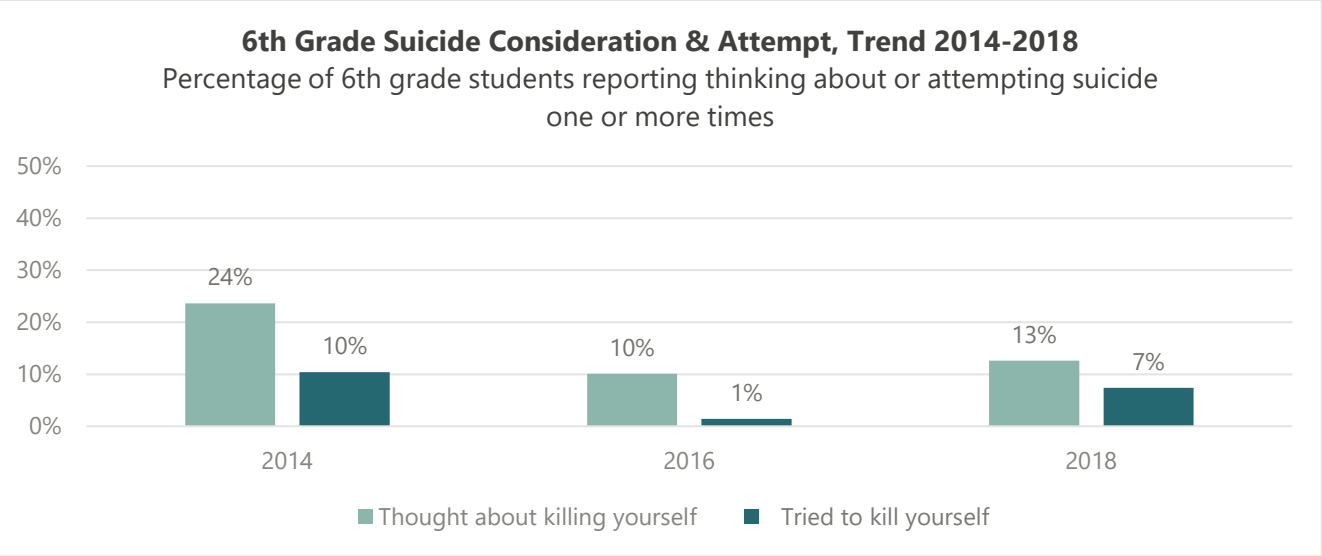
Rates of reported plan making for suicide show that these types of actions have remained stable among 8th and 10th grade youth and decreased considerably among 12th grade respondents from 2016 to 2018. In 2018, one-in-ten 8th and 10th grade youth had made a plan to commit suicide on at least one occasion.



Source: Healthy Youth Survey (2014-2018) at askhys.net

The above figure illustrates the percentage of 8th, 10th, and 12th grade students that reported attempting suicide on one or more occasions in the past year. In 2018, 10% of 8th graders, 10% of 10th graders, and 5% of 12th grade students attempted suicide. For 8th and 10th grade students these findings demonstrate an alarming upward trend with rates twice that reported in 2016. According to these data, **nearly 40 8th (21) and 10th (17) grade students attempted suicide** at least once in the previous year.

The HYS also asks 6th grade youth the following two questions about suicide: *Have you ever seriously thought about killing yourself? Have you ever tried to kill yourself?*

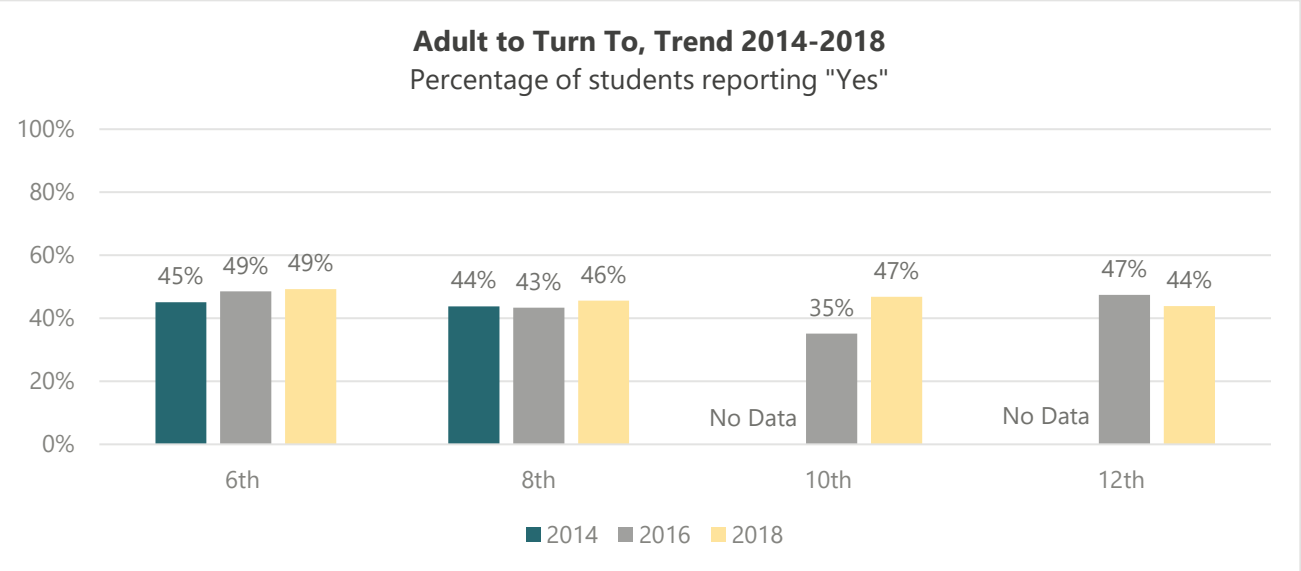


Source: Healthy Youth Survey (2014-2018) at askhys.net

Among Wahluke 6th graders lifetime suicide ideation has decreased considerably since 2014 ; nonetheless, over one-in-ten students reported these thoughts in 2018. Although, suicide attempts have declined since 2014, these data show a large increase between 2016 and 2018 (1% vs. 7%, respectively). In 2018, **approximately 15 6th grade students reported attempting suicide** at least once in their lifetimes.

Help Seeking

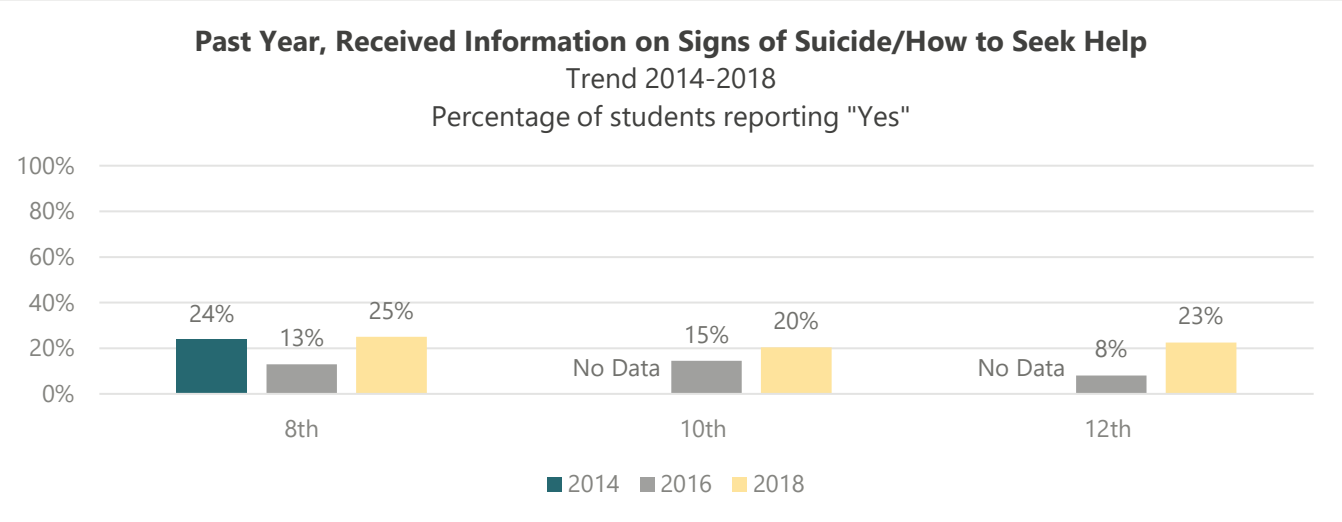
The HYS asked students, "When you feel sad or hopeless, are there adults that you can turn to for help."



Source: Healthy Youth Survey (2014-2018) at askhys.net

These data show the percentage of students that reported having an adult to turn to if/when they feel sad of hopeless. Results indicate that a similar percentage – just under half – of youth across grade levels reported having such an adult in their lives.

The final figure shows the percentage of students who recalled receiving information regarding the signs of suicide and how to seek help (for themselves and others). These data indicate that just one-in-four or fewer youth reported receiving this type of information in 2018, substantially below averages statewide (45.1%, 8th grade; 51.6%, 10th grade; and 49.1%, 12th grade).



Source: Healthy Youth Survey (2014-2018) at askhys.net

During the assessment interviews, school staff mentioned different resources available including counselor, social worker, family community parent liaison, principal, PBIS, and care referral team. Parents and youth shared a general lack of awareness about available resources and "where to go for help"; parents sometimes feel embarrassed to ask for help. At the same time, there is uncertainty that follow-through occurs and that care is actually offered and provided at home, at school, or in the community.

> *"It's like I fill out all the forms and everything and we have a meeting and it's kind of like they talk about it. And then it seemed like nothing ever really happened unless you had a kid who is really, like violent, threatening to kill people, that kind of thing. But it's kind of like you fill out the referral and maybe they will get some extra help. Maybe they won't."*
>
> —Teacher

For some students the schools may be the only safe place they have. Both youth and adult participants expressed concerns about many incidents at school maybe being related to life at home. Yet, youth yearn for a stronger, genuine, culturally sensitive bonding between them and their teachers and other caring adults. Both youth and school staff feel that there is no time during school for teachers to communicate with students without pulling them outside of class.

Staff commended the school counselors and admitted there is a limited number of mental health support to work with the many students that need it. There was all-around praise for the Community Prevention Coalition and encouragement about the recently created Open Ear Club.

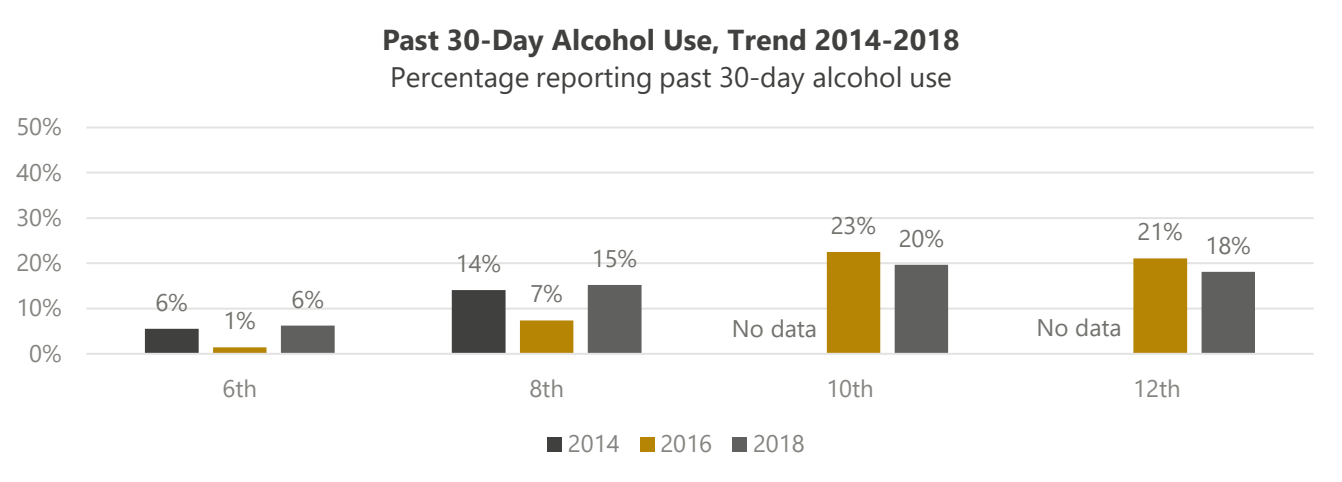
Adolescent Substance Use

Alcohol Use

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

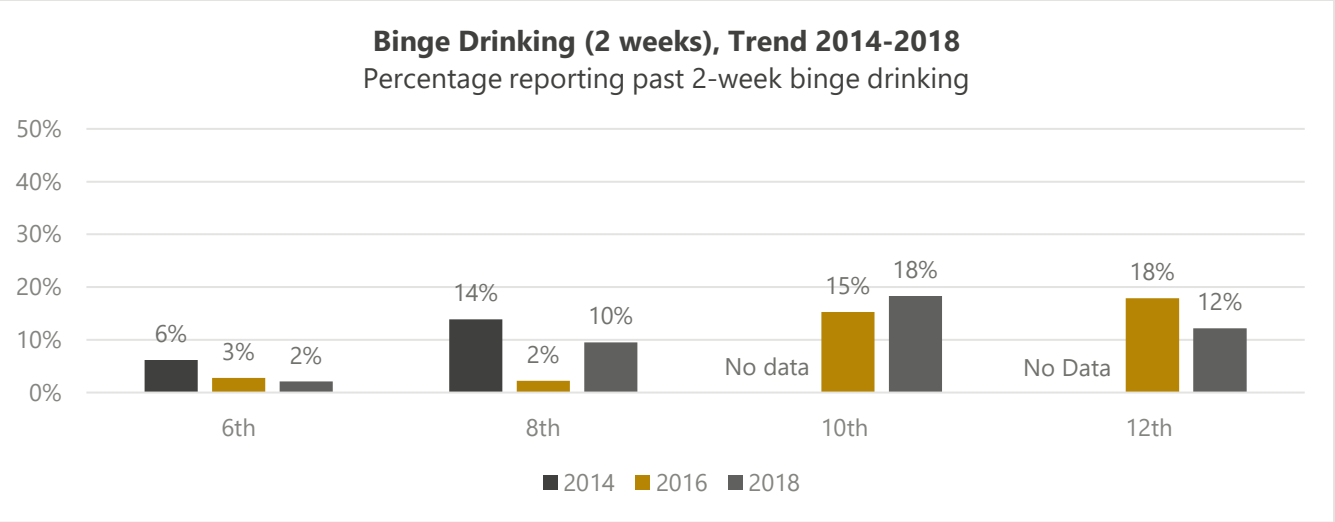
> *"While multiple factors influence suicidal behaviors, substance use—especially alcohol use—is a significant factor that is linked to a substantial number of suicides and suicide attempts. This "nexus" between substance use and suicide provides an opportunity for behavioral health leaders to develop a cohesive strategy within a public health framework to reduce suicidal behaviors and suicide rates."* – SAMSHA Brief (2016)

The following figures illustrate past-30 day and binge drinking rates among survey participants. Rates of recent alcohol use (past 30-day) among Wahluke students fluctuated among 6th and 8th grade students across survey periods, increasing between 2016 and 2018. Among 10th and 12th grade youth, past 30-day use declined slightly with about one-in-five high school-aged youth reporting alcohol use in 2018.



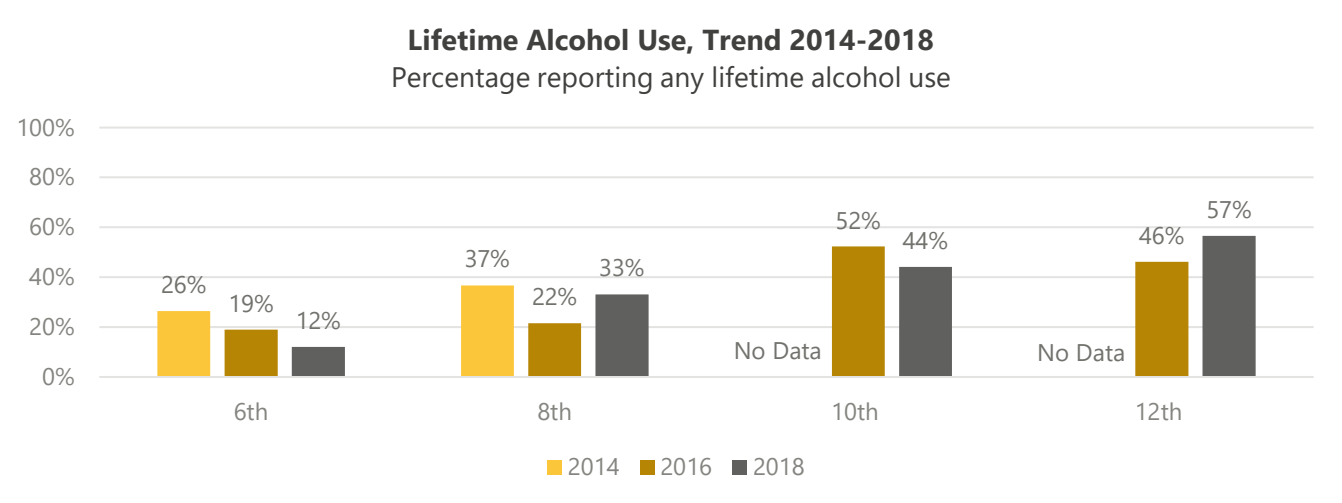
Source: Healthy Youth Survey (2014-2018) at askhys.net

Findings further demonstrate that binge drinking rates among 8th and 10th graders increased between 2016 and 2018. In fact, one-in-ten 8th graders and one-in-five 10th grade youth reported engaging in binge drinking behaviors. In contrast, rates of heavy use declined among 6th and 12th graders.



Source: Healthy Youth Survey (2014-2018) at askhys.net

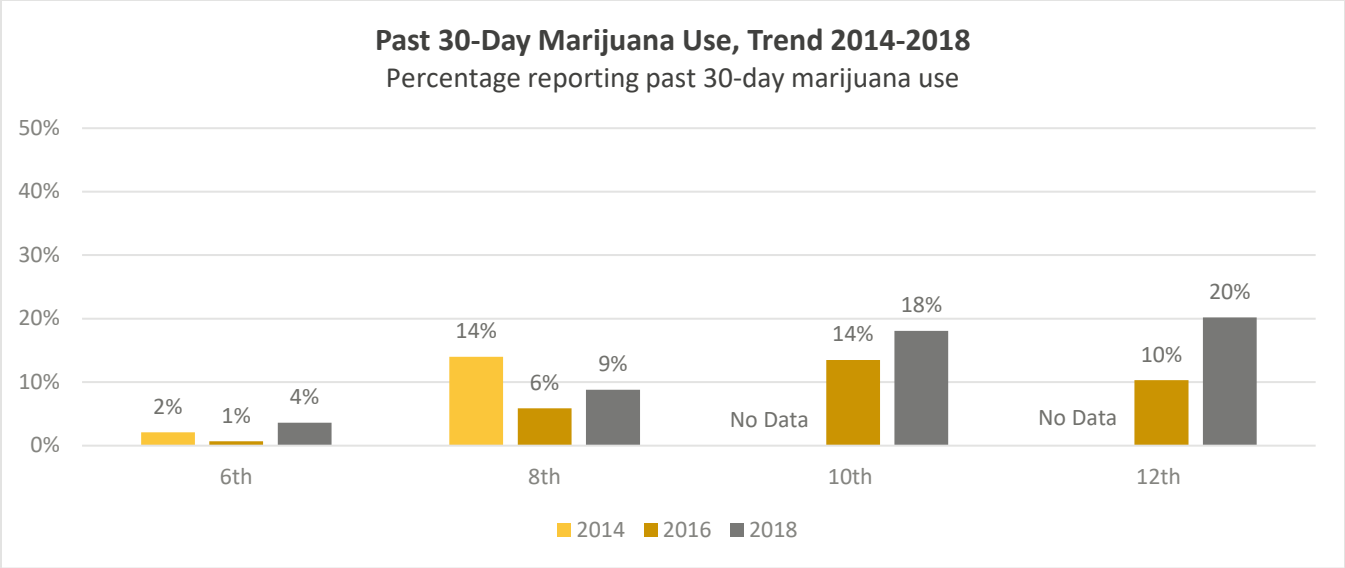
Lifetime alcohol use among Wahluke students indicate that considerably fewer 6th graders reported lifetime use in 2018 as compared to 2014, whereas 8th grade rates fluctuated, and increased between 2016 and 2018. Among high school-aged respondents, fewer 10th graders reported lifetime alcohol use in 2018, while the percentage of 12th graders with lifetime alcohol use increased from the 2016 rate.



Source: Healthy Youth Survey (2014-2018) at askhys.net

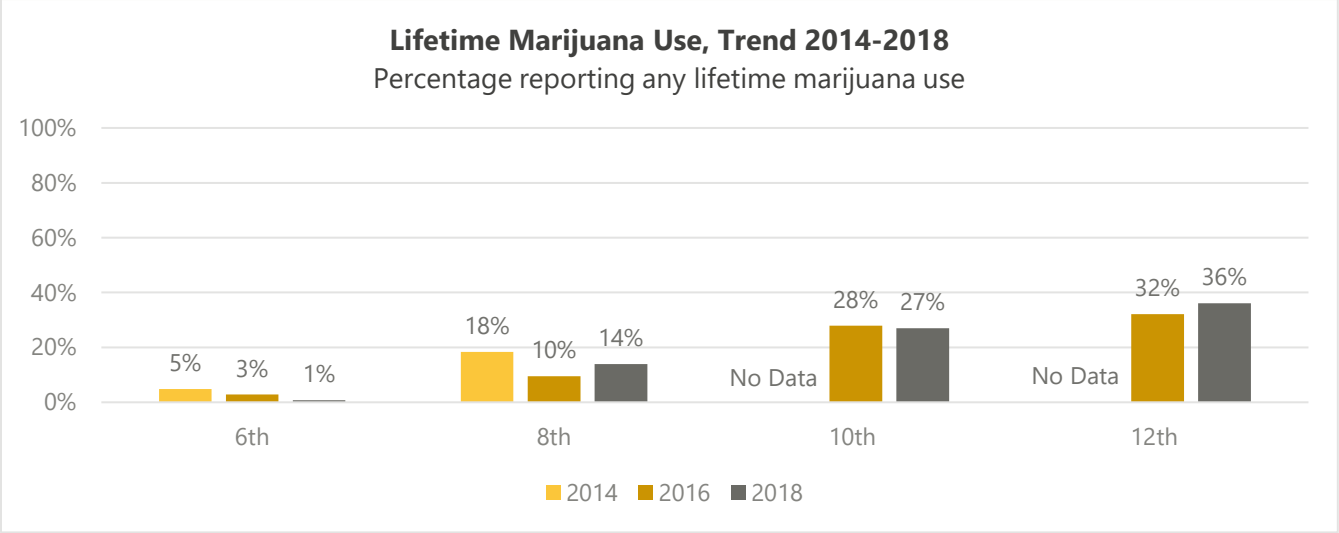
Marijuana Use

Past 30-day marijuana use among 6th grade youth fluctuated over the survey periods, with use declining between 2016 and 2018. For 8th grade respondents, nearly one-in-ten reported recent use in 2018, reflecting an increase as compared to 2016. Among 10th and 12th grade students, rates of current use increased between 2016 and 2018. In fact, findings show that the rate of past 30-day marijuana use doubled in 2018 as compared to 2016 among 12th grade respondents.



Source: Healthy Youth Survey (2014-2018) at askhys.net

The final figure shows lifetime marijuana use rates for Wahluke students. Among 6th and 8th graders, the percentage reporting lifetime marijuana use has declined since 2014 (like lifetime alcohol use), although rates increased somewhat between 2016 and 2018 for 8th grade participants. In comparison, lifetime use of marijuana among 10th grade students was stable but increased slightly for 12th grade participants across survey years.



Source: Healthy Youth Survey (2014-2018) at askhys.net

Summary and Implications

Findings show a disturbing trend of increased mental and emotional stress among Wahluke School District students in 2018. Including a rise in excessive worrying among 8th graders and increasing or sustained levels of anxiety among 8th, 10th, and 12th grade youth. Even more troubling is the percentage

of youth who acknowledge symptoms of depression – from 30% to 40%– as well as sustained levels of suicide ideation across grade groups. Further, one-in-ten 8th and 10th grade students reported attempting suicide in 2018. Unfortunately, only one-in-four or fewer youth reported receiving information on signs of suicide or help seeking during the school year. Additionally, these results indicate increased or sustained levels of alcohol and marijuana use in 2018. In fact, past 30-day alcohol use more than doubled among 8th graders, while twice as many 12th graders reporting any recent marijuana use as compared to 2016.

Adolescents may begin using alcohol and other drugs to deal with the impacts of depression or anxiety; on the other hand, frequent drug use by teens may also cause or precipitate those disorders. The research related to substance use by adolescent youth is clear. In fact, drug use in adolescents frequently overlaps with other mental health problems. For example, a teen with a substance use disorder is more likely to have a mood, anxiety, learning, or behavioral disorder too (NIDA, 2014). Further, adolescent substance use can impact physical, cognitive, and neurological development, leading to lifelong health and wellness issues.

Research also suggests a strong link between early substance using behaviors and mental health. For example, estimated rates of co-occurring mental illness among adolescents with substance use disorders range from 60 to 75 percent (youth.gov). Among adolescents with no prior substance use, the rates of first-time use of drugs and alcohol in the previous year are higher in those who have had a major depressive episode than in those who did not (SAMHSA, 2010). Without a means to counteract the negative effects of early substance use, these issues can affect youth well into adulthood.

All of the parents, students, and school staff who spoke with us shared that in the Wahluke School District area, young people face barriers to getting mental health care. They acknowledge that teachers, other school staff, and parents/caregivers have important health and wellness needs. The main issues include stigma and awareness, access to providers, lack of coordination, and absence of a multi-tier systems of support.

Stigma and awareness

There is a large need for stigma reduction and mental health awareness efforts for students, staff, families, and the community around mental health and seeking help. Stigma is a major factor in the community. This is also tied to cultural norms around mental health.

> *"One of the things that is a challenge is the stigma behind mental health. Stigma begins at home, it carries on throughout the students, and so I feel like there's a big gap between students and parents knowing what really is mental health."* —School staff member

Coordination

According to most participants, the education, healthcare, and community systems are not set up to systematically address student mental health needs. It feels like hit and miss on referral pathways, and on the ability for students to engage in services. Generally, issues are not addressed comprehensively. Some momentum around social emotional learning and mental health wellness was growing before COVID, but the disruption interrupted supports and created new issues for students and staff.

We want teachers to be more consistent and more formal on how to refer a student for support. We're asking, what is it exactly that you're concerned with, for example, social-emotionally. Then there's a team that would evaluate the referral and then from there as a team we will determine what services this student might need. This is the first year that we're starting this.

—School staff member

Communication between parents, teachers and students appears to be a significant issue. Parents do not feel that issues are being communicated to them; students feel that issues shared with counselors or teachers shouldn't be shared with parents and guardians; and both parents and teachers perceive a lack of parent engagement (as it pertains to parent conferences, for example) and of teachers (as it relates to "really caring about the kids" and not so much about academics).

"We need an adult figure who can offer more validation. Students have their perspective. Our voice should matter because we are here. —Student

Staff training

Participants were asked if they felt staff received enough training to detect and respond to students' mental health concerns. Responses were unanimously, "No."

"There should be teacher trainings about how parents and kids feel."

—Student

"We learn about ACEs. That's about it. So, no terms [definitions], nothing much further than that. Which is sad because I get ACEs, but what about the anxiety, the nervousness, the low self-esteem? That, not so much." —School staff member

Staff shared that they "don't feel like everybody has those tools and necessarily knows what to do."

"The burnout is bad this year and we're going to lose some really good teachers if we don't address their mental health needs. Teachers are not willing to do a training if it cuts into their time to actually prepare a classroom. Give them a moment where you have like a para(professional teacher) come in for a second. To communicate with them like this is important, we allocated time for it. And they're given a mental break."

—School staff member

There was also agreement that some training has been offered, but it's been inconsistent. The schools and district have tried multiple strategies and curriculums, including SRSS screener, SEL and Second Step, PAX, and PBIS. Implementation and consistency have been difficult due to limited in-person interactions of teachers with students.

"We started really pushing social, emotional training and different things like that, but I feel like consistency needs to be key there (…) Different training will come in and override what you received training on the first time." —School staff member

Ideas for improvement

All participants were also asked to give their ideas for how the school/district can be more supportive of staff, students, and families with regards to mental health. This is a summary of their suggestions.

> *"A place (at the school) to be alone when I'm upset; having space to be alone and reset is empowering; to be alone and self-regulate."*
>
> *"More time to hang out outside!"*
>
> *"More support for LBGTQ students; trans rights"*
>
> —Students
>
> *"Support for both kids and parents"*
>
> *"The community needs help: more recreational things, more activities, leagues for the children, classes."*
>
> *"Don't make the campaigns or trainings about 'mental health'; instead: 'how to live better, socialize better' - and have food!*
>
> —Parents
>
> *"(Offer) mental health training for school staff by professionals outside of the district (e.g., not from peers, but from outside experts that know how to engage and teach adults); more staff that can provide Tier 2 and Tier 3 services; more and better services and supports offered in a culturally and linguistically appropriate manner; more family engagement opportunities that match the schedules of adults working in agriculture; stronger teacher voice; and a focus on adult and staff mental health and wellness.* —School staff member

Project AWARE's overarching goals are tied specifically to increasing the mental and behavioral health supports available to youth and families in each of the participating districts. Services aligned with increasing identification and referral of students to Tier 2 (Selective) and Tier 3 (Intensive) services are key components to this project. These supports should be based on the needs identified from these findings, as well as the continual use of data-based decision making to identify those youth most at risk of a mental health crisis.

Community Assets and Resources

Community resources to improve the mental and behavioral health and well-being of people in Grant County and the Wahluke District region include:

- Grant Mental Healthcare has five office locations and a 24-hour crisis line (**509-765-1717 or 1-800-852-2923**). They offer a full range of mental health services including children, family, and adult services, supported employment, individual therapy, geriatric behavioral health, community support, and Wrap Around with Intensive Services (WISe).
- The Washington Recovery Help Line is available for all people in Washington regardless of income or insurance: **1-866-789-1511** (open all day, every day)

- Wahluke Community Coalition: The coalition's mission is to promote a healthier, drug and alcohol-free community through education, advocacy, and prevention strategies. In 2019, the coalition was awarded a Drug-Free Communities grant from SAMHSA to add a paid position to increase their capacity and strategies locally to prevent youth alcohol, tobacco, and other drug use.

Source: Wahluke Community Coalition

- Mattawa Suicide Prevention Group: The goal of the work group is to plan strategies to assist the local community in suicide prevention. This group is open to anyone who would like to join their community effort to address mental health and work on suicide prevention strategies.
- New Hope provides free and confidential services for victims of domestic violence, sexual assault, and crime. Advocates staff a hotline (800-560-6027) all day, every day. They also provide crisis intervention, medical advocacy, support groups, trainings, and information and referral.

Protective Factors & Resilience

The research literature is rich with information related to how risk factors can serve as predictors of student problem behaviors. Students with multiple risk factors, or few protective factors, are much more likely than their peers to engage in delinquent behaviors including violence, alcohol, tobacco, or other drug use, and are more likely to drop out of school. Elevated risk factors may be balanced and offset by the presence of protective factors. Protective factors are conditions or attributes in individuals, families, communities, or the larger society that mitigate or eliminate risk in families and communities, thereby increasing the health and well-being of children and families (Hawkins, et 1994; Hawkins, Catalano, Miller, 1992). Moreover, strengths, or protective factors, present in BIPOC communities, such as strong family ties and cultural identity, help to overcome the negative influences risks, challenges, and the effects of trauma.

Resilience, the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress can further counter the impacts of risks (American Psychological Association, 2020). Because Black, Indigenous, and other People of Color (BIPOC) face multigenerational trauma, systemic racism, and cultural barriers, resilience looks different for them as compared to the rest of society. For example, Hispanics/Latinx living in the United States may face stresses due to immigration and acculturation, poor educational opportunities, poverty, discrimination, and inadequate access to health care. Therefore, for BIPOC individuals "being resilient is an act of resistance and survival, while [also celebrating] the joys across and within each community" (Molinar, 2020).

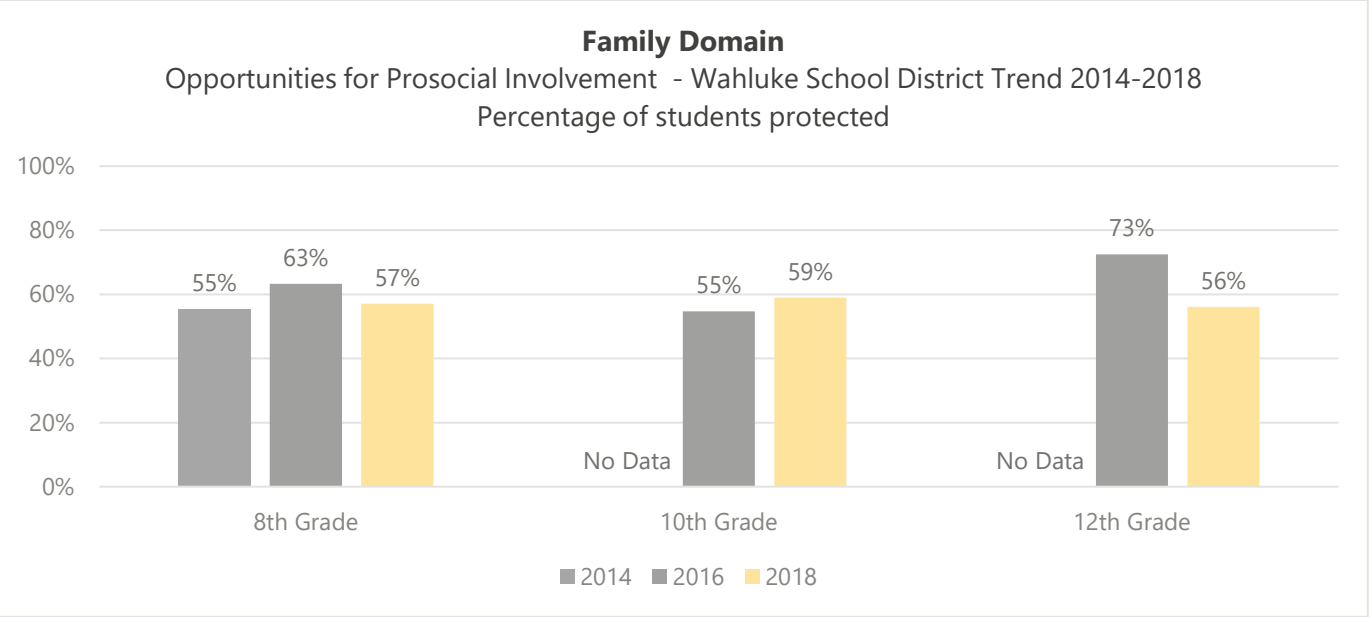
This section of the report highlights identified strengths within the Wahluke School District community that mitigate adversities and provide opportunities to thrive. It also includes data about the disproportionate distribution of protective factors and highlights how the conditions for mitigation of risks is dependent upon an individual's race, ethnicity, sex, gender, income, or other characteristics.

Composite Protective Factors

The following information is from the Healthy Youth Survey Risk and Protective Factor Scale results. These composite scales are comprised of multiple survey questions that assess students' views on the presence of protective factors across multiple domains: family, school, peer-individual, and community. For each Protective Factor scale, the percentage of students who are resilient is reported; higher percentages indicate that fewer students are likely to engage in problem behaviors. The following figures show trend results of these composite scales for 8th, 10th, and 12th grade students for the 2014, 2016, and 2018 surveys periods.

Family Domain

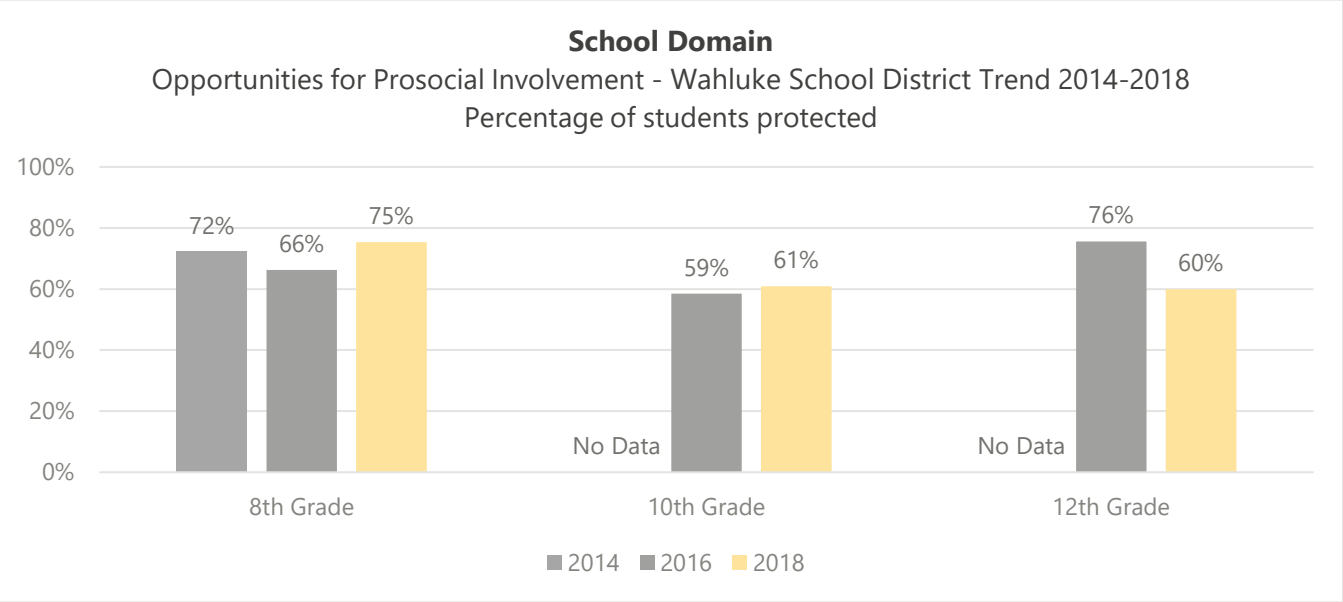
The family protective factor domain assesses students' perception of opportunities and rewards for prosocial involvement and include questions such as "My parents give me lots of chances to do fun things with them", and "If I had a personal problem, I could ask my mom or dad for help."



Source: Healthy Youth Survey (2014-2018) at askhys.net

School Domain

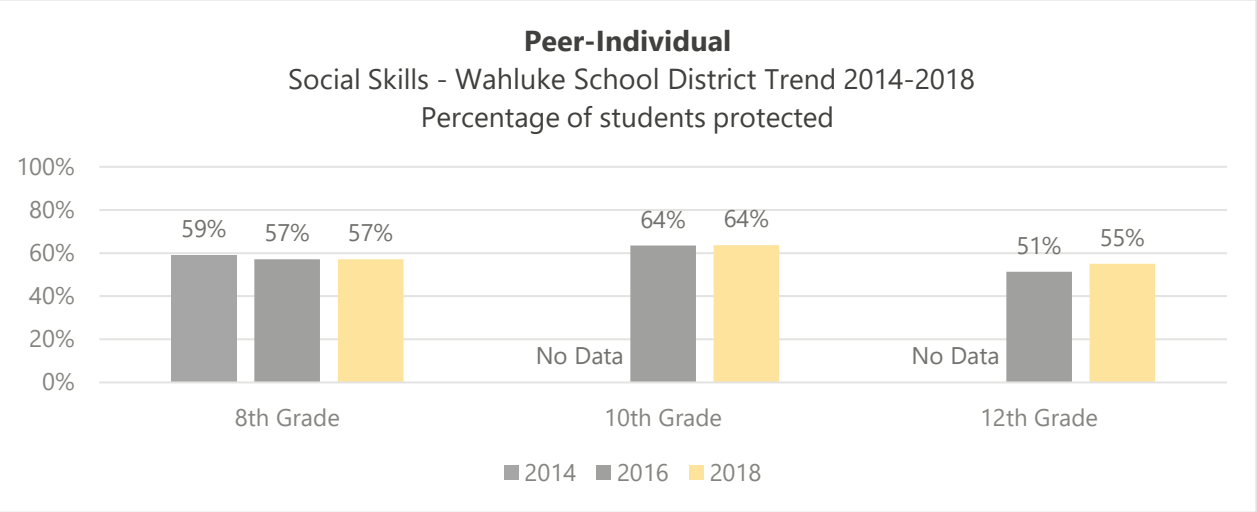
Factors assessed in the school protective factor domain include opportunities for prosocial involvement. Questions include: "There are lots of chances for students in my school to talk with a teacher one-on-one" and, "There are lots of chances for students in my school to get involved in sports, clubs, and other school activities outside of class."



Source: Healthy Youth Survey (2014-2018) at askhys.net

Peer-Individual Domain

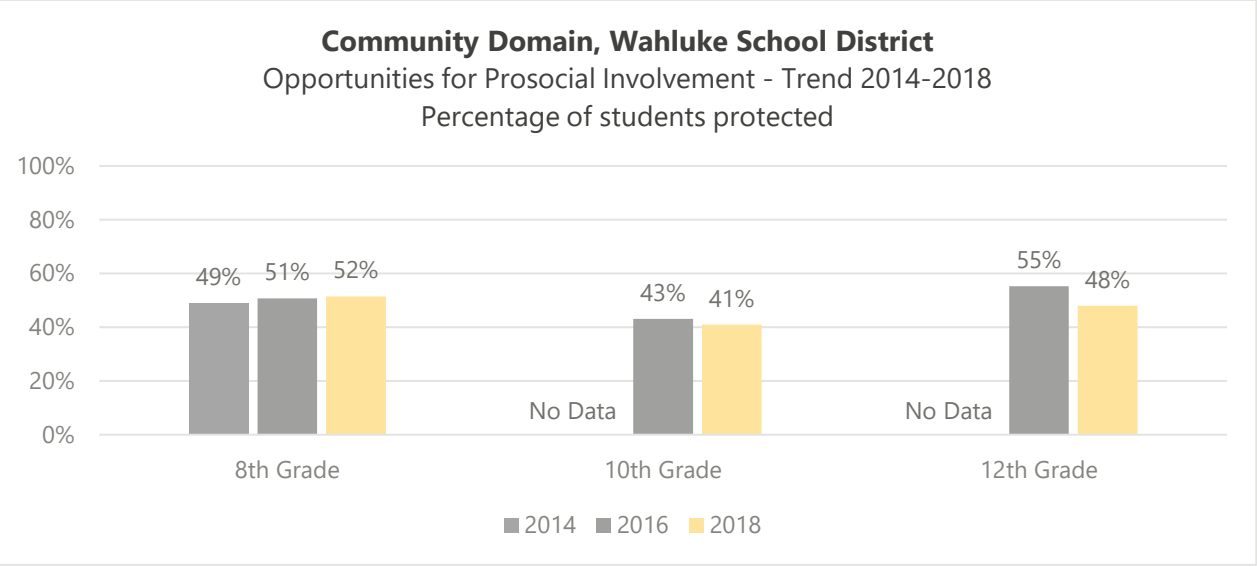
Protective factors assessed here are linked to the presence of social skills. For example, students are asked: "You are at a party at someone's house and one of your friends offers you a drink containing alcohol. What would you say or do?"



Source: Healthy Youth Survey (2014-2018) at askhys.net

Community Domain

Protective factors within the community domain also include opportunities and rewards for prosocial involvement. These include opportunities for youth to engage with pro-social adults (e.g., "There are adults in my neighborhood or community I could talk to about something important.") and pro-social activities such as sports teams, and recreation e.g., Boys and Girls Clubs, YMCA, or other youth-centered clubs.



Source: Healthy Youth Survey (2014-2018) at askhys.net

Findings

In general, these data show that in 2018 most Wahluke 8th, 10th, and 12th grade students reported resiliency across multiple domains. These protections were highest, across grade levels and survey years, in the school domain. In fact, students reported multiple opportunities for prosocial involvement including engagement in decision making related to classroom rules and class discussions, high-levels of student-to-teacher interaction, and involvement in school-based clubs, sports, or other extracurricular school activities. However, the perception of protection declined as students aged. At the peer-individual level, the majority of 8th, 10th, and 12th graders acknowledged protective factors specifically related to social skills that reduce their risks for delinquent and substance using behaviors. Findings were similar across survey periods, with protection somewhat higher among 10th grade youth as compared to their younger and older youth.

Perceptions of the presence of family protective factors was similar across grade levels in 2018, with many students reporting involvement in family-based prosocial opportunities such as decision-making, family outings, and talking to parents about personal problems. In contrast, fewer students across grade levels identified community protective factors. Nonetheless, on average nearly half of these students reported pro-social opportunities in and around their communities, such as access to positive adult role models in their neighborhood as well as recreational activities, and youth-focused service organizations.

Children's Hope Scale

We end this report on a note of hope. Hope reflects a future orientated mindset and motivational process by which an individual has an expectation toward attaining a desirable goal. Research has linked hope with overall physical, psychological, and social well-being (Hellman, Worley, and Munoz, 2016). Further, if youth do not perceive themselves to have the capacity to pursue their goals, they may be less likely to make changes in their behaviors, or in the ways that they think and feel about themselves (Jiang, Otis, Weber, and Scott, 2018).

In 2018, a version of the Children's Hope Scale (Snyder et al. 1997) was added to the Healthy Youth Survey. Computed from four questions,[7] the scale is "based on the premise that children are goal directed and that their goal-related thoughts can be understood according to two components (Snyder et al., 1997, p. 400). These are: agency – one's ability to initiate and sustain action towards goals; and pathways – one's capacity to find a means to carry out goals.

The data in the table show responses by grade level.

[7] Questions include: I can think of many ways to get the things in life that are important to me; I am doing just as well as other kids my age; When I have a problem, I can come up with lots of ways to solve it; and, I think the things I have done in the past will help me in the future. Response format is a 6-point Likert scale (1= None of the time, 2= A little of the time, 3= Some of the time, 4 = A lot of the time, 5 = Most of the time, 6 = All of the time).

Healthy Youth Survey Hope Scale (2018)	8th Grade	10th Grade	12th Grade
No or Very Little Hope	3%	7%	10%
Slightly Hopeful	21%	21%	28%
Moderately Hopeful	29%	35%	33%
Highly Hopeful	48%	37%	30%

Source: Healthy Youth Survey (2018) at askhys.net

Findings indicate that among Wahluke youth, most were at least moderately hopeful about their future. Overall, nearly all students expressed some level of hope for the future, with younger students expressing higher hope as compared to high school-aged youth. In fact, data show a reduction in the percentage of youth that are "highly hopeful" as students age, with hopefulness declining by 18 percentage points between 8th and 12th grade (48%, 8th grade vs. 30%, 12th grade).

Summary and Implications

Results indicate that most Wahluke 8th, 10th, and 12th grade students reported resiliency across multiple domains in 2018, with these highest, across grade levels and survey years, in the school domain. These findings suggest that students identified opportunities for prosocial involvement in the school setting as well as high-levels of student-to-teacher interaction, and engagement in school-based activities. Other areas of strengths included positive peer-individual factors, and family protective factors. These types of protective factors at the community domain were less likely to be identified by students. Findings also demonstrated that most Wahluke youth were at least moderately hopeful about their future, however, the sense of hopefulness declined as students aged.

Protective factors are conditions or attributes in individuals, families, communities, or the larger society that mitigate or eliminate risk in families and communities, thereby increasing the health and well-being of children and families. Elevated risk factors may be balanced and offset by the presence of protective factors. Research has found that students with higher levels of protective factors may be more resilient to the effects of the negative influences of risk factors. Resilience, the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress can counter these impacts.

Strong families and healthy communities are key parts of this process, and together with schools, can help a child transition into adulthood. A large body of research shows that family engagement in schools improves student achievement, reduces absenteeism, and restores parents' confidence in their children's education. Parental involvement also facilitates children's cognitive, social, and emotional functioning and has been linked to increased self- esteem, improved behavior, and more positive attitudes toward school (Christenson & Havsy, 2004; Patrikakou, Weissberg, Redding, & Walberg, 2005).

All assessment participants were asked to list some of the protective factors or, in other words, the people, places, and things that make the Wahluke School District a healthy and safe community. The following are some of their comments.

"This is a small community. Everyone knows everyone else. Because we are such a small community and because we do have limited resources out here, I feel like we do have that support from one another."

"Farming. It feels like our culture."

"Basketball, soccer, and football… Sports are a big deal."

"I just feel like we're moving in the right direction. I feel like even though we are a small community and we're limited with resources I feel like we do a pretty good job kind of reaching out to others and trying to do the best we can but the little that I've known and heard about this AWARE grant I feel like we're definitely moving in the right direction. So I'm excited and I look forward to that."

With the overarching goals of Project AWARE to increase awareness of mental health issues, and to detect, connect. and respond to student mental health needs, the Wahluke School District has the opportunity to not only increase access to behavioral and mental health care for students and families, but also to support systems-level changes to enhance family-school-community partnerships and family engagement. As such, it is imperative that Project AWARE services and supports are designed in a manner that supports and builds upon existing protective factors, across domains, to ensure that youth are ready and able to overcome challenges and are successful academically, personally, and professionally.

References

ACR Business Consulting (2019), Yakima County Homeless Point-in-time Count. Available at: https://yakimacounty.us/DocumentCenter/View/22119/2019-Yakima-County-Point-in-Time-Report?bidId

Administration for Children and Families, U.S. Department of Health & Human Services (2021), Temporary Assistance for Needy Families (TANF). Available at: https://www.acf.hhs.gov/sites/default/files/documents/ofa/fy2020_tanf_caseload_1.pdf

American Psychological Association (2012), Building your resilience. Available at: https://www.apa.org/topics/resilience

Annie E. Casey Foundation. Kids Count Data Book (2014). Retrieved from, http://www.aecf.org/m/resourcedoc/aecf-2014kidscountdatabook-2014.pdf

Astria Health (2018), Community Health Needs Assessment and Improvement Plan. Available at: https://www.astria.health/site/files/file_manager/page/shared/2018-astria-chna-action-plan-final-03012019.pdf

Baquero, B., Gonzalez, C., Ramirez, M., Chavez Santos, E., & Ornelas, I. J. (2020). Understanding and Addressing Latinx COVID-19 Disparities in Washington State. *Health education & behavior : the official publication of the Society for Public Health Education*, *47*(6), 845–849. https://doi.org/10.1177/1090198120963099

Behrens, D., Lear, J.G., & Price, O.A. (2013). Improving access to children's mental health care: Lessons from a study of eleven states. The George Washington University: Washington, D.C. http://www.healthinschools.org/wp-content/uploads/2016/10/March2013-StatePrograms_d5_color_FINAL.pdf

Beteille, T., Kalogrides, D., & Loeb, S. (2011). Stepping Stones: Principal Career Paths and School Outcomes. NBER Working Paper No. w17243.

Bjerragaard and Lizotte (1995). Gun Ownership and Gang Membership. *Journal of Criminal Law and Criminology* Volume: 86 Issue: 1 Dated: (Fall 1995) Pages: 37-58. Office of Justice Programs, U.S. Department of Justice. https://www.ojp.gov/ncjrs/virtual-library/abstracts/gun-ownership-and-gang-membership

Brennan Ramirez LK, B.E., Metzler M., (2008), Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health, Centers for Disease Control and Prevention, Editor. Department of Health and Human Services: Atlanta, GA

Cahill and Hayeslip (2010). Findings From the Evaluation of OJJDP's Gang Reduction Program. Office of Juvenile Justice and Delinquency Prevention. Office of Justice Programs, U.S. Department of Justice https://www.ojp.gov/pdffiles1/ojjdp/230106.pdf

California Health Interview Survey. (2005). Los Angeles, CA: UCLA Center for Health Policy Research, 2007.

Castañeda, H, Holmes, S.M., Madrigal, D.S., DeTrinidad Young, M-E., Beyeler, N., Quesada, J. (2014), Immigration as a Social Determinant of Health. *Annual Review of Public Health,* 36:1, 375-392

Center for Disease Control and Prevention (May 2013), Mental health symptoms in school-aged children in four communities. Available at: https://www.cdc.gov/childrensmentalhealth/features/school-aged-mental-health-in-communities.html

Christenson, S. L., & Havsy, L. H. (2004). Family-school-peer relationships: Significance for social, emotional, and academic learning. In J. E. Zins, R. P. Weissberg, M. C. Wang, & H. J. Walberg (Eds.), *Building academic success on social and emotional learning: What does the research say?* (p. 59–75). Teachers College Press.

Commission on Social Determinants of Health (CSDH), (2008), Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health, World Health Organization: Geneva

Conway, Swendsen, Husky, He, & Merikangas (2016). Association of Lifetime Mental Disorders and Subsequent Alcohol and Illicit Drug Use: Results From the National Comorbidity Survey–Adolescent Supplement: https://www.jaacap.org/article/S0890-8567(16)00070-8/fulltext

Council on Social Work Education *(2016),* Working Definition of Economic Well-Being. Available at: https://www.cswe.org/Centers-Initiatives/Initiatives/Clearinghouse-for-Economic-Well-Being/Working-Definition-of-Economic-Well-Being

Espelage & DeLaRue (2012). School Bullying: Its Nature and Ecology. *International Journal of Adolescent Medicine and Health, 24(1), 3-10.*

Furfaro, Hanna (April 4, 2021). Washington students are facing a mental health crisis. Here's why schools are on the front lines. *The Seattle Times.* Available at: https://www.seattletimes.com/education-lab/washington-students-are-facing-a-mental-health-crisis-heres-why-schools-are-on-the-front-lines/

Gall, G., Pagano, M.E., Desmond, M.S., Perrin, J.M., & Murphy, J.M. (2000). Utility of psychosocial screening at a school-based health center. *The Journal of School Health 70*(7), 292-298.

Great Schools Partnership (2014). The Glossary of Education Reform. Available at: https://www.edglossary.org/

Greenberg, M.T., Brown, J.L., & Avenavoli, R.M. (2016). Teacher stress and health: Effects on teachers, students, and schools. Robert Wood Johnson Foundation. http://www.rwjf.org/en/library/research/2016/07/teacher-stress-and-health.html

Hawkins, J.D., et al. (1992). Risk and protective factor framework: Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin,* 112(1), 64-105.

Healthy Youth Survey, 2010-2018. Retrieved from AskHYS.net

Hellman, C. H. Worley, J. A., & Munoz R. T. (2016) A Primer On Hope As A Theory of Change for Human Service Providers. Available at https://thurstonthrives.org/wp-content/uploads/2016/05/Hope-White-Paper.pdf

Hill, Lui, Hawkins (2001). Early Precursors of Gang Membership: A Study of Seattle Youth. Office of Juvenile Justice and Delinquency Prevention. Office of Justice Programs, U.S. Department of Justice. https://www.ojp.gov/pdffiles1/ojjdp/190106.pdf

Howell, James C. (2013). *Chapter One: Why Is Gang-Membership Prevention Important?* Changing Course: Preventing Gang Membership. National Institute of Justice, National Center for Injury and Prevention Control. https://storage.googleapis.com/edcompass/quantum/materials/1216_Gang-Membership-Updated.pdf#page=9

Jennings, P. A., & Greenberg, M. T. (2009). The prosocial classroom: Teacher social and emotional competence in relation to student and classroom outcomes. *Review of Educational Research, 79*, 491–525.

Jiang, X., Otis, K. L., Weber, M., & Huebner, E. S. (2018). *Hope and adolescent mental health.* In M. W. Gallagher & S. J. Lopez (Eds.), *Oxford library of psychology. The Oxford handbook of hope* (p. 299–312). Oxford University Press.

Kataoka, S.H., Zhang, L., & Wells, K.B. (2002). Unmet need for mental health care among U.S. children: variation by ethnicity and insurance status. *American Journal of Psychiatry, 159*(9), 1548-55.

KIDS COUNT Data Center, A project of the Annie E. Casey Foundation (2021). Available at: datacenter.kidscount.org

Langhout, R., Buckingham, S., Kaur Oberoi, A., Chávez, N.R., Rusch, D., Esposito, F., Suarez-Balcazar, Y. (2018), Statement on the Effects of Deportation and Forced Separation on Immigrants, their Families, and Communities, https://doi.org/10.1002/ajcp.12256

Mental Health America (2021), Youth Data. Available at: https://www.mhanational.org/issues/2021/mental-health-america-youth-data

Migration Policy Institute (MPI) (2020-2021), Analysis of U.S. Census Bureau data from the pooled 2014–18 American Community Survey (ACS) and the 2008 Survey of Income and Program Participation (SIPP). Available at: https://www.migrationpolicy.org/data/unauthorized-immigrant-population/county/53077

Molinar, Gustavo (2020), (Re) Defining Resilience: A Perspective Of 'Toughness' In BIPOC Communities. Available at: https://www.mhanational.org/blog/re-defining-resilience-perspective-toughness-bipoc-communities

Montgomery, C., & Rupp, A. A. (2005). A meta-analysis exploring the diverse causes and effects of stress in teachers. *Canadian Journal of Education, 28*, 458–486.

Nader, Kathleen (2012), Violence Prevention and School Climate Reform, National School Climate Center. Available at: https://files.eric.ed.gov/fulltext/ED573695.pdf

National Academies of Sciences, Engineering, and Medicine (2019), Monitoring Educational Equity. Washington, DC: The National Academies Press. https://doi.org/10.17226/25389 .

National Immigration Forum (2018), Fact Sheet: Immigrants and Public Benefits. Available at: https://immigrationforum.org/article/fact-sheet-immigrants-and-public-benefits/

National Network of State Teachers of the Year (2018), Rebuilding the Ladder of Educational Opportunity. Available at: https://files.eric.ed.gov/fulltext/ED595318.pdf

Northwest Harvest (2021), Hunger in Washington. Available at: https://www.livestories.com/statistics/hunger-in-washington/washington/yakima-county-community-snapshot

Organisation for Economic Co-operation and Development (2013), Measuring Well-being and Progress: Well-being Research. Available at: https://www.oecd.org/statistics/measuring-well-being-and-progress.htm

Panchal, N., Kamal, R., Orgera, K., Cox, C., Garfield, R., Hamel, L., Munana, C., & Chidambaram, P. (August 21, 2020). The Implications of COVID-10 for Mental Health and Substance Use. Retrieved from https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

Patrikakou, Eva. (2005). School-family partnerships: Fostering children's school success. Teacher College Press.

Patterson GR, Reid JB, Dishion TJ. *Antisocial Boys*. Castalia; Eugene, OR: 1992. [Google Scholar]

Pearce, Diana M., PhD. (2020), The Self-Sufficiency Standard for Washington State. Available at: http://www.selfsufficiencystandard.org/sites/default/files/selfsuff/docs/WA2020_SSS.pdf

Perou, R., Bitsko, R.H., Blumberg, S.J., et al. (2013) Mental Health Surveillance among Children—United States, 2005-2011. MMWR Surveillance Summaries, 62, 1-3. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/23677130

Pierson, James (2019), Addressing Economic Justice in the Face of Inequality. Available at: https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/economic-justice/addressing-economic-justice-in-the-face-of-inequality/

Resnick et al., 1997 Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health. JAMA. https://www.mdft.org/mdft/media/files/Resnick-et-al-(1997)-Protecting-adolescents-from-harm-National-longitudinal-study-on-adolescent-health-JAMA.pdf

Robert Wood-Johnson Foundation (2021), Healthy Communities. Available: https://www.rwjf.org/en/our-focus-areas/focus-areas/healthy-communities.html

Schroeder, S, 2007, September 20). We Can Do Better – Improving the Health of the American People. The New England Journal of Medicine. 357, 1221-1228

Seattle Children's Hospital, (2019), Community Health Assessment. Available at: https://www.seattlechildrens.org/globalassets/documents/about/community/2019-community-health-assessment-cha.pdf

Simmons, D. N., Brackett, M. A., & Adler, N. (2018). Applying an equity lens to social, emotional, and academic development. Edna Bennett Pierce Prevention Research Center, Penn State University. Retrieved from https://dpi.wi.gov/sites/default/files/imce/sspw/pdf/SEL_-_Equity.pdf

Snyder et al. 1997 (1997). The development and validation of the children's hope scale. Journal of Pediatric Psychology, 22, 399-421.

Spergel, I.A (1995). *The Youth Gang Problem.* New York, NY: Oxford University Press.

Starks, MA Aaron, Sharkova, PhD, Irina V. and Mancuso, PhD David (Jan 2021), Risk and Protection Profile for Substance Abuse Prevention for Sunnyside, Wahluke and Yakima. Community Outcome & Risk Evaluation. Washington State Department of Social & Health Services.

Substance Abuse and Mental Health Services Administration (SAMHSA), Key Substance Use and Mental Health Indicators in the United States: https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR1PDFW090120.pdf

Thornberry, T. P. (1998). *Membership in youth gangs and involvement in serious and violent offending.* In R. Loeber & D. P. Farrington (Eds.), *Serious & violent juvenile offenders: Risk factors and successful interventions* (p. 147–166). Sage Publications, Inc.

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion (2020), Healthy People 2030. Available at: https://health.gov/healthypeople/objectives-and-data/social-determinants-health

United States Census Bureau (2020), 2015-2019 American Community Survey. Available at: https://data.census.gov/cedsci/

United Way Worldwide Annual Report (2011). Retrieved from http://unway.3cdn.net/f58b3b8a9b4f33a573_tvm62lh6v.pdf

University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps (2021), Health Rankings. Available at: https://www.countyhealthrankings.org/explore-health-rankings
Virginia Mason Memorial (2019), Community Health Needs Assessment. Available at: https://www.yakimamemorial.org/pdf/about/community-hna-2019.pdf

Wanapum Heritage Center (2017-21), Our History. About the Wanapum. Available at: https://wanapum.org/about/

Washington Immigrant Solidarity Network, El Centro de la Raza, Northwest Health Law Advocates (2020), Washington State Health Equity for Immigrants Report. With support from the ACLU of Washington. Available at: https://static1.squarespace.com/static/5c9a7904f8135a221909597f/t/60108dca76080474a5e2d6a3/1611697623906/WA+Health+Equity+for+Immigrants_Full+Report_2020.pdf

Washington State Office of Financial Management (2021) 2020 Population Trends. WA State Office of Financial Management, Small Area Estimate Program (SAEP), Estimates of Total Population for School Districts by County Part. Available at: https://www.ofm.wa.gov/sites/default/files/public/dataresearch/pop/april1/ofm_april1_poptrends.pdf

Washington Office of Superintendent for Public Instruction (2021), 2018-2020 Report Card. Available at: https://washingtonstatereportcard.ospi.k12.wa.us/

Washington State Department of Health (2018), Food Insecurity and Hunger. Available at: https://www.doh.wa.gov/Portals/1/Documents/Pubs/160-015-MCHDataRptFoodInsecHunger.pdf

Washington State Department of Health (2018), Washington State Health Assessment. Available at: https://www.doh.wa.gov/Portals/1/Documents/1000/2018SHA_FullReport.pdf

Washington State Department of Health (2021). COVID-19 Vaccination Coverage by Race and Ethnicity and Age in Washington State. Available at: https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/data-tables/348-791-COVID19VaccinationCoverageRaceEthnicityAgeWAState.pdf

Washington State Department of Health (December 2020), Provider alert regarding increased concern of suicide risk in youth during COVID-19. Available at: https://www.hca.wa.gov/assets/program/covid-19-provider-alert-regarding-suicide-risk-in-youth.pdf

Washington State Employment Security Department (2021), Population Reference Bureau analysis of the U.S. Census Bureau, Household Pulse Survey. Available at: https://esd.wa.gov/labormarketinfo/monthly-employment-report

Washington State Department of Social and Health Services (2021). *Risk and Protection Profile for Substance Abuse Prevention in Washington Communities.* Olympia, WA: Washington State Department of Social and Health Services. Retrieved from: https://www.dshs.wa.gov/ffa/research-and-data-analysis/community-risk-profiles

Wehmeyer, M. L., & Field, S. (2007). Instructional and assessment strategies to promote the self-determination of students with disabilities. Thousand Oaks, CA: Corwin. WHO 2016

Yakama Nation (2020), Yakama Nation History. Available at: https://www.yakama.com/about/

youth.GOV (2021). Co-occurring Disorders. Available at: https://youth.gov/youth-topics/youth-mental-health/co-occurring

Appendix A: Healthy Youth Survey Response Rates, 2014-2018

Wahluke School District

Grade	2014	2016	2018
6th	88%	77%	84%
8th	66%	88%	72%
10th	No Data	69%	76%
12th	No Data	58%	59%

The following guidance may be used when reviewing your results. However, if a particular group(s) of students did not complete the survey and therefore did not contribute to your results, there may be limitations to your results even if you have a high participation rate (i.e., if differences exist between students who *did* and who *did not* complete the survey). There may be value in discussing the potential limitations when using the results in this report.

- 70% or greater participation–Results are probably representative of students in this grade.
- 40–69% participation–Results may be representative of students in this grade.
- Less than 40% participation–Results are likely not representative of students in this grade but do reflect students who completed the survey.

Appendix B: Interview and Focus Group Questions

Staff Questions

1. What do you feel are the most pressing mental health issues facing students in your school district/community?
2. Do you consider that these issues are being addressed? If so, how?
3. What are some of the ways that the school is addressing these needs/concerns? What would you like to see more of? <*Probe: Can you provide examples?*>
4. If children in your class/school/district needed mental health support, would you know how to access school-based services?
5. Does the school connect students and families to community-based providers if additional support is needed? <*Probe: Who in the district makes these connections with/for you?*>
6. What are the most significant gaps and barriers in resources, coordination, etc. in this area?
7. Do you consider that teachers and administrators at your school/district receive enough training and are prepared to detect and respond to the students' mental health concerns/issues? <*Probe: Can you provide an example?*>
8. Are there school-based campaigns to reduce stigma and promote awareness of mental health wellness? Do you think these would be well received in the community? <*Probe: Can you explain what those are and how you know about them?*>
9. What are the people, places, and things that make your community healthy, safe, and strong and why are they important? These could include organizations, leaders, coalitions initiatives, policies, or physical/environmental attributes.
10. What ideas do you have for how the school can be more supportive of staff, students, and families with regards to mental health?
11. Is there anything else about mental health in your school or district that you would like to share?

Student Questions

1. What do you feel are the main mental health issues that students in your school face?
2. Have you been encouraged to take care of your mental health from the adults in your family?
3. Were you taught about mental health in school?
4. When you're going through it, do you know of programs or services at your school that can help you? How about in your community?
5. Does your school have spaces/times during the school day for you and your friends to talk about things you're going through?
6. Are there adults at school who talk to you when you are upset about something or have a problem? <*Probe: Who?*> How about in your family? And in your community?
7. What ideas do you have for how the school can be more supportive of your and your friends' mental health?
8. Is there anything else about mental health in your school or district that you would like to share?

Parent Questions - English

2. What do you feel are the most pressing mental health issues facing students in your kid's school and in your community?
3. Do you consider that these issues are being addressed? If so, how?
4. What are some of the ways that the school is addressing these needs/concerns? What would you like to see more of? <*Probe: Can you provide examples?*>
5. Are you aware of any school campaigns to reduce mental health stigma or promote awareness of mental health wellness (adult/child)? Do you think these would be well received in the community? <*Probe: Can you explain what those are and how you know about them?*>
6. Do you consider that school teachers and administrators are prepared to detect and respond to the students' mental health concerns/issues? <*Probe: Can you provide an example?*>
7. What does the district/school do to create a positive and safe environment for your student/family? What could it do better? <*Probe: What does this look like to you? Can you provide an example?*>
8. If your child needed mental health support, would you know how to access services at the school? <*Probe: Have you received information about a referral process or information about services and supports at the school?*> How about in your community?
9. How connected do you feel to the school? Are there opportunities for parents/caregivers to offer feedback on mental health services provided at the school? <*Probe: Can you provide examples?*>
10. What could the school do more of or do differently to better involve parents/caregivers?
11. Do you feel like your family's cultural background is recognized, respected, and valued by the school? If so, how (e.g., language)? If not, how could this be improved? <*Probe: Can you provide examples?*>

Parent Questions - Spanish

1. ¿Cuáles creen que son los principales problemas mentales que enfrentan los estudiantes de la escuela de su hijo o de los jóvenes en su comunidad?
2. ¿Considera que se están abordando estos temas? ¿Si es así, cómo?
3. ¿Cuáles son algunas de las formas específicas en que la escuela está abordando estas necesidades / preocupaciones? ¿Qué más le gustaría que se hiciera? <*Indague: ¿Puede dar un ejemplo?*>
4. Si su hijo necesitara apoyo de salud mental, ¿sabría usted cómo acceder a los servicios en la escuela? <*Indague: ¿Ha recibido información sobre servicios y apoyos en la escuela?*> ¿Y en su comunidad?
5. ¿Considera que los maestros y administradores escolares están preparados para detectar y responder a las inquietudes / problemas de salud mental de los estudiantes? <*Indague: ¿Puede darnos un ejemplo?*>
6. ¿Qué hace el distrito / escuela para crear un ambiente positivo y seguro para su estudiante / familia? ¿Qué podría hacer mejor? <*Indague: ¿Qué le parece esto? ¿Puede darnos un ejemplo?*> ¿Conoce alguna campaña escolar para reducir el estigma de la salud mental o promover la conciencia sobre el bienestar de la salud mental (adulto / niño)? ¿Cree que serían bien recibidos en la comunidad? <*Indague: ¿Puede explicar qué son y cómo los conoce?*>
7. ¿Hay factores culturales que afecten al estigma en torno a la salud mental? <*Indague: Yo soy latina, y a veces es difícil hablar sobre salud mental con mi familia. ¿Cree que necesitamos más gente Latina como proveedores de salud mental? En otras escuelas hemos visto que incluso cuando tienen servicios o programas de salud mental, los estudiantes o las familias no los utilizan. ¿Tiene la cultura algo que ver con eso?*>
8. ¿Siente que la escuela reconoce, respeta y valora la cultural de su familia? Si es así, ¿cómo? *(por ejemplo, idioma)* Si no es así, ¿cómo podría mejorarse esto? <*Indague: ¿Puede proporcionar ejemplos?*>

9. ¿Qué tan conectado se siente con la escuela? ¿Hay oportunidades para que los padres o adultos responsables de los jóvenes ofrezcan sugerencias sobre los servicios de salud mental que se brindan en la escuela? *<Indague: ¿Puede proporcionar ejemplos?>*
10. ¿Qué más podría hacer la escuela o hacer de manera diferente para involucrar mejor a los padres y adultos responsables de los jóvenes?

WASHINGTON PROJECT AWARE FY 2020

Yakima School District Community Health Assessment

"Focusing on every student, every day: strengthening community through education." **– District vision**

June 2021

Prepared for:
Washington Office of Superintendent for Public Instruction

Washington Office of Superintendent of
PUBLIC INSTRUCTION

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Introduction

In October 2020, the Washington Office of Superintendent of Public Instruction (OSPI) was awarded a five-year Project AWARE (Advancing Wellness and Resilience in Education) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). OSPI serves as the lead agency for a consortium of three partner school districts, or Local Education Agencies (LEAs): Sunnyside School District, Wahluke School District and Yakima School District. This project, *"Beyond Co-Location: Integrating and Embedding Education and Mental Health Systems"* addresses the national Project Aware initiative. The building of collaborative partnerships between state and local systems, specifically education and mental health, strengthens the system's capacity to promote the healthy development of school-aged youth and to prevent youth violence through an integrated multi-tiered system of support (MTSS) framework.

In addition to efforts at the state level to integrate education and mental health, strengthen MTSS initiatives, develop sustainable regional mental health support networks, and document practices that are scalable to other regions in Washington, the specific goals of the AWARE project are to:

1) Increase ***awareness*** of mental health issues among school-aged youth through the development, implementation, and sustainability of a comprehensive school-based system of mental health services and supports.
2) Train school personnel and other adults who interact with school-aged youth to detect and ***respond*** to mental health issues.
3) ***Connect*** school-aged youth who may have behavioral health issues and their families to needed services.

A best practice related to the implementation of an MTSS framework is the conduct of a behavioral health assessment and resource mapping to document existing school and community-based services across tiered-levels of supports. Through this process, both needs *and* strengths are incorporated, thereby centering communities, their culture, and history; elevating community voices; and making equity and antiracism the framework (not simply a lens) in which assessments and strategic planning take place. By including assets, we can paint a more complete picture of communities, illustrate their resilience, and identify opportunities for maximizing existing resources.

The purpose of this assessment process is to:

1. Highlight community strengths and disparities and articulate how these will be addressed through the implementation of Project AWARE.
2. Ensure assessment findings inform Project AWARE's goals, activities, and outcomes.
3. Use community assessment findings to inform project partners in the design and implementation of school-based mental health services and supports.

This report contains the findings for the Yakima School District Regional Community Health Assessment conducted by Maike & Associates in the spring of 2021.

Methodology

Key data points and the latest research findings were used to assess the well-being of Yakima students and families. Much of the data comes from public records, such as national and state census data. State, county, and school district data were also collected from the Risk and Protection Profile for Substance Abuse Prevention in Washington Communities (January 2021). Annually, the Washington State Department of Social & Health Services, Research & Data Analysis Division, produces these reports, which include technical notes on the methodological approaches used to obtain data reported at the district-level.

Additionally, Yakima School District 6th, 8th, 10th, and 12th grade students participate in the Washington State Healthy Youth Survey (HYS) in the fall of even numbered school years. The HYS is sponsored by the Department of Health, the Office of Superintendent of Public Instruction, the Department of Social and Health Services, the Department of Commerce, the Family Policy Council, and the Liquor Control Board in cooperation with schools throughout the state. The survey measures health risk behaviors known to contribute to the health and safety of youth. Survey results serve two important functions: first, providing needs assessment data for program planning; and second, giving a measure of the global effectiveness of statewide prevention and health promotion. The regular collection of HYS data is crucial for tracking progress toward improved outcomes. (Survey response rates, by grade and survey year, can be found in Appendix A).

Other major data sources used for this assessment include the County Health Rankings & Roadmaps, a program of the University of Wisconsin Population Health Institute, which provides a snapshot of a community's health using county-level data. Rankings are based on a model of population health and include data from Behavioral Risk Factor Surveillance System, Mapping Medicare Disparities Tool, American Community Survey 5-year estimates, Census Population Estimates, and other sources. For many measures, data are available by race/ethnicity within a county.

Another major component of this work was to conduct in-depth qualitative interviews and focus groups with key district informants to better understand the nature, depth, and breadth of current school-based social, emotional, and behavioral strategies being implemented. The main purpose of the interview was to obtain a deeper understanding of the scope of resources, services, or programs available to students and staff within each respondent or group of respondents' roles. We also sought to identify barriers or challenges that could hinder the implementation of school-based mental health services.

Participants included staff at the middle school level, including classroom teachers, behavior interventionists and school counselors. Other key informants included parents and high school students. Contact and scheduling of focus groups and interviews was coordinated by the LEA district. In all, 20 individuals participated in the interview and focus group process.

Each participant was asked to answer questions from their perspective, with regard to their specific experience and expertise. As such, not all respondents answered all questions and not all questions were asked of all respondents. Individual teacher interviews were approximately 30-45 minutes, with

focus groups lasting 90 minutes each. Completed interviews were transcribed, coded for themes, analyzed, and are summarized in the following sections. (See Appendix B for focus and interview questions by group).

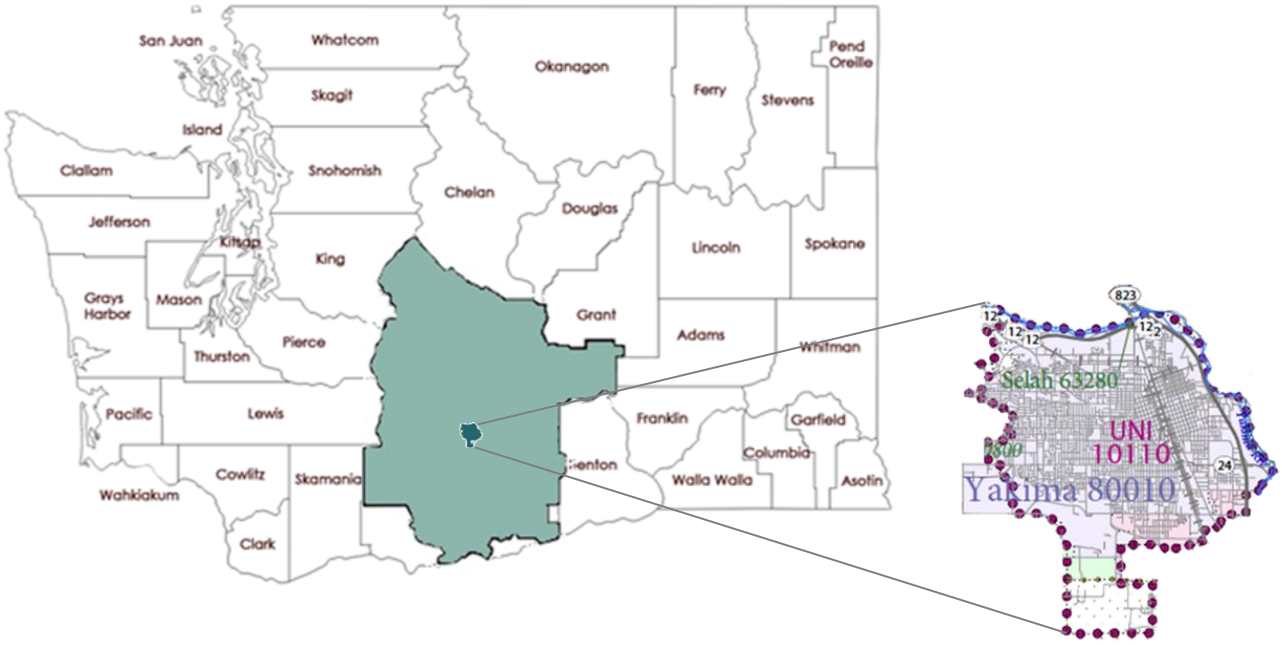
Participants were asked to identify the most pressing social, emotional, behavioral health issues facing students in their school district community. These questions asked were framed around the three goals of Project AWARE outlined previously. Throughout this report, we use this information to provide a snapshot of key indicators, and include trend data, as well as comparisons over time to the state, and county, as appropriate, and when available. This process is an essential component of the school-based mental health systems review for the Yakima School District.

District and Community Demographics

Geographic Description

The Yakima School District is in central Washington, located within the boundaries of the City of Yakima, on the eastern side of the Cascade Mountain range. The district is the 20th largest in the state, with the second largest Latinx-majority population statewide. It serves students who primarily live within the boundaries of the City of Yakima. The Yakima School District serves students in one Pre-K-12 early learning school, 13 elementary schools (grades K-5), one K-8 elementary/middle school, four middle schools (grades 6-8 grade), and six high schools, including an online school and a technical skills center (grades 9-12).

Educational Service District (ESD) 105, one of nine regional ESDs across the state, provides services and supports to the district, along with 24 other public-school districts and more than 20 state-approved private and tribal schools located in the south central region of the state.



Yakima School District is located within the service boundaries of ESD 105 in Washington State.

Covering 4,293.4 square miles, Yakima County is the second-largest county in Washington by land area, and ninth-largest by population. The county is situated on the original land of the people of the Confederated Tribes and Bands of the Yakama Nation that extended in all directions along the Cascade Mountain Range to the Columbia River and beyond (https://www.yakama.com/about/). Today, the Yakama Nation Reservation, covers over 1.3 million acres, and is located within Yakima county (U.S. Census). The county's economy is agriculture-based, with vineyards, pastures, orchards, and hops the main crops. The Yakima River provides irrigation for the farmlands throughout the valley.

The city of Yakima is situated in the Upper Valley of Yakima County, with a total land area of 28.69 square miles. Incorporated in 1886, the city is the county seat, and the 11th largest city in the state. The Naches River forms the northern border of the city, with the Yakima River running through the city.

Population

The population in Yakima County is estimated at 249,697, with a density of 58.2 persons per square mile, considerably less than the Washington state average (101.2 persons/square mi). The city of Yakima has an estimated population of 93,637. The Yakima School District region is comprised of an estimated 78,107 residents (not just enrolled students).



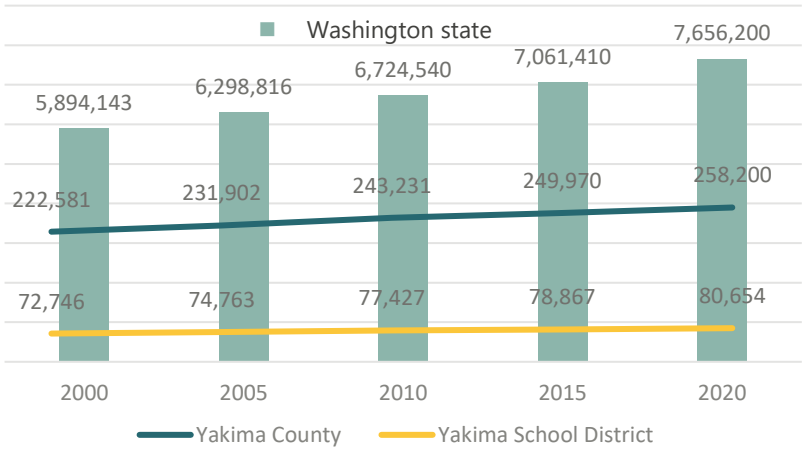
	Washington State	Yakima County	Yakima School District*
Total population	7,404,107	249,697	78,107

*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

Population Change

Washington state's population grew by 109,800 persons, or 1.5%, between 2019 and 2020. Migration was the primary driver behind the state's population growth (OFM, 2021). Over the past decade, Yakima County had an annual average population growth rate of less than 1 percent, slightly below the growth experienced at the state level (1.5%). Growth within the Yakima School District was just over 1%, slightly below the state average.

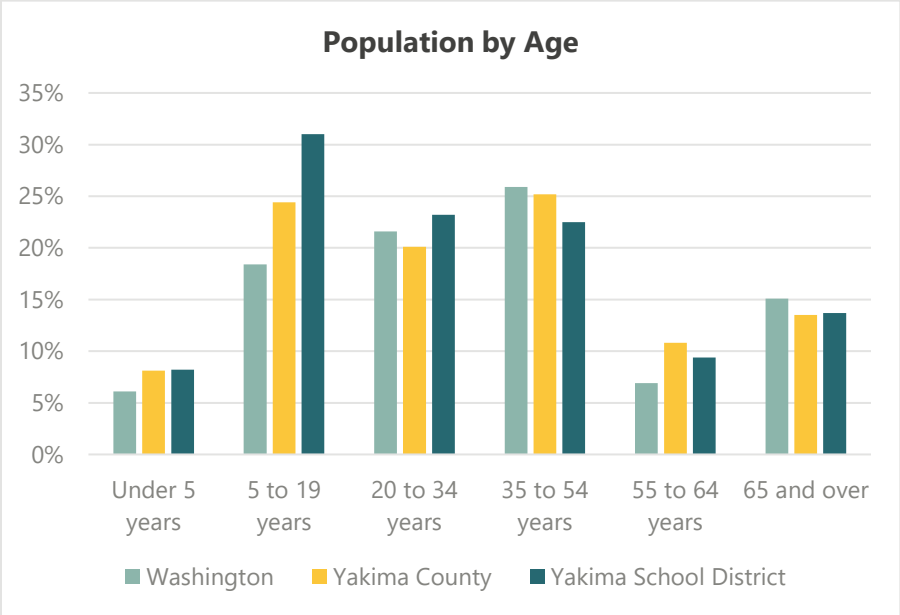
Population Change



Source: WA State Office of Financial Management, Small Area Estimate Program (SAEP), Estimates of Total Population for School Districts by County Part

Age and Sex Distribution

While one quarter (24.5%) of Washington's population is 19 years or younger, one third (32.5%) of people living in Yakima County, and 39% of the district's residents fall within that age distribution[1].



*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

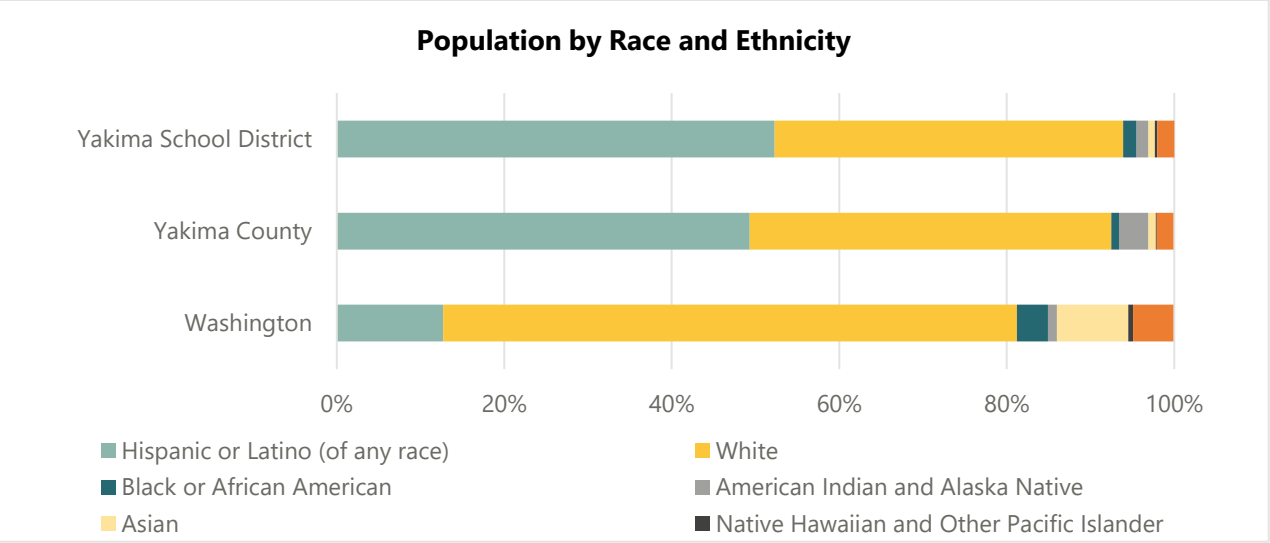
Census data indicate that females comprise half the population in the state (50.3%) and the county (50.4%), with a similar percentage in the Yakima School District region (50.1%).

District Population: At the beginning of the 2020-2021 school year, there were 15,879 students enrolled in the district (down from 16,419 in school year 2019-2020). Among these students, slightly more were male (50.6%) than female (49.4%).

Race and Ethnicity

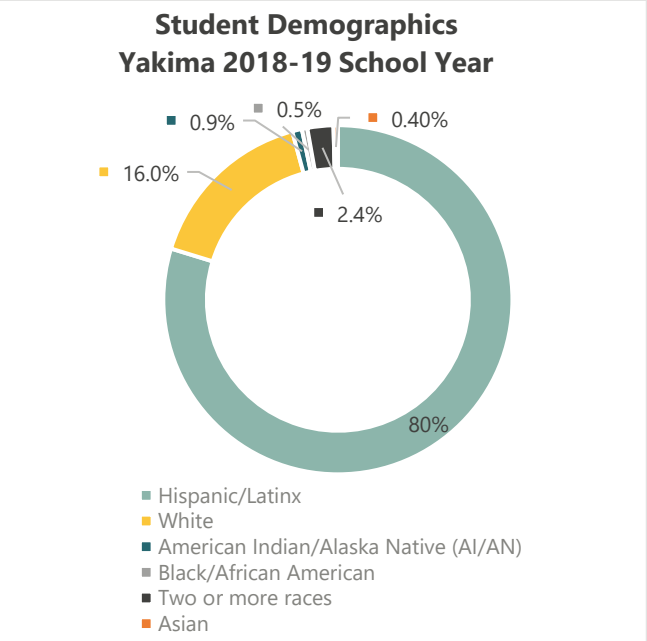
The percentage of people who are Hispanic/Latinx in the Yakima School District region is slightly higher than that of Yakima County, and significantly higher than the state average (52.3% vs. 49.3% vs. 12.7%).

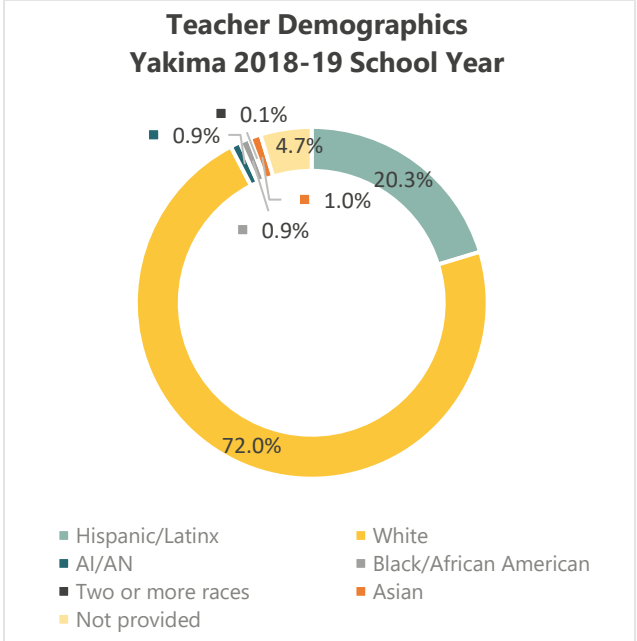
[1] This report uses the Census Bureau definition of sex and gender: "sex is based on the biological attributes of men and women (chromosomes, anatomy, hormones), while gender is a social construction whereby a society or culture assigns certain tendencies or behaviors the labels of masculine or feminine" (Census Bureau, 2021). While the Census Bureau tracks a person's biological sex and not gender, the Office of Superintendent of Public Instruction Report Card tracks gender.



*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

District Population: In the 2018-19 school year, 49.5% of students and 72% of classroom teachers in the Yakima School District identified as female. Among racial/ethnic groups, most of the student body identified as Hispanic/Latinx of any race (80.1%), compared to 20.3% of classroom teachers. Statewide, 74% of the classroom teachers identify as female and 87% as white.



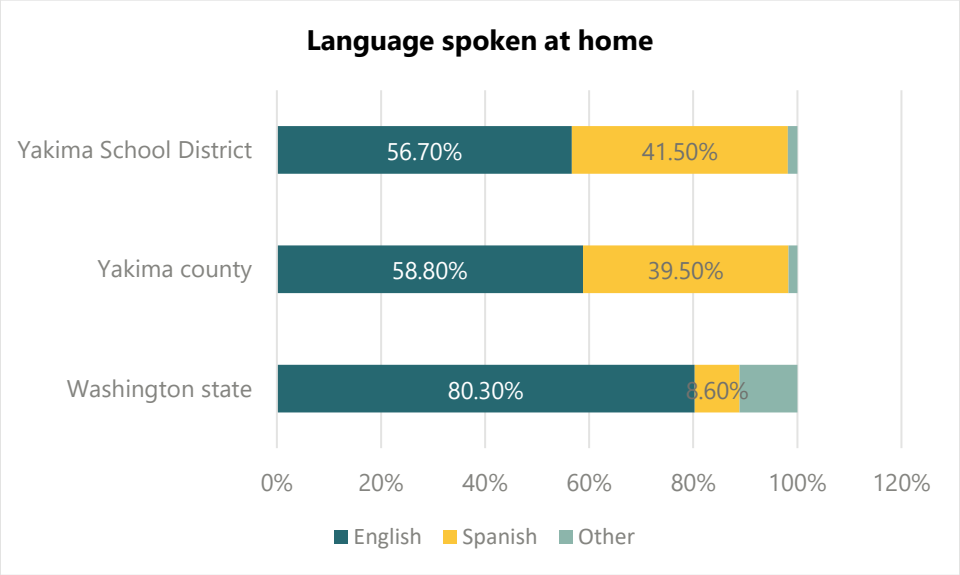


Source: OSPI Report Card, 2018-19

Additionally, many students (82.1% or 13,461 individuals) identified as low income, 31.1% as English Language Learners, 15.9% as having disabilities, and 10.9% as migrant.

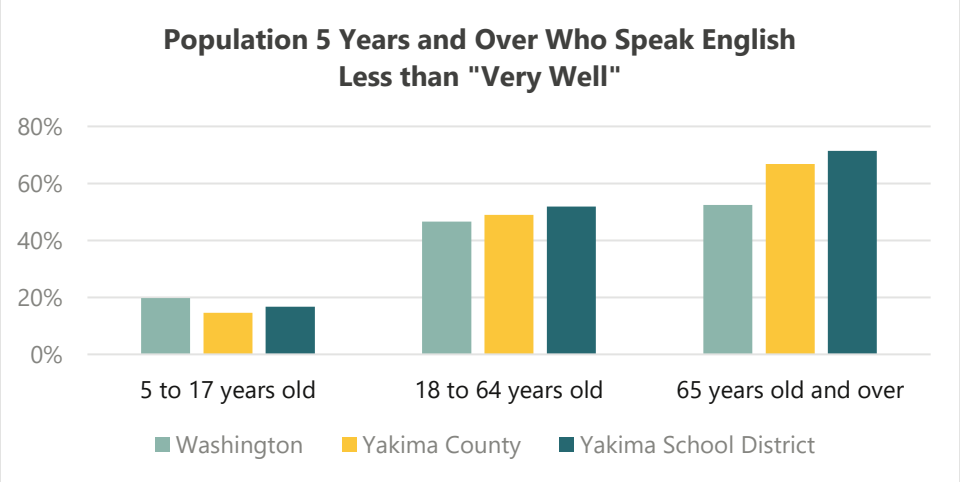
Language Spoken at Home and English-speaking Ability

Just over 40% of the residents within the Yakima School District community speak a language other than English, similar to the county rate (40%), and higher than the population statewide (9%).



*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

Of those in the Yakima School District who speak Spanish as their preferred language, almost half of adults 18 to 64 and nearly two thirds of adults 65 and older in the Yakima School District region speak English less than "very well." That suggests that while many students (83%) speak both English and Spanish, most of their parents and caregivers communicate better in Spanish.



*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

Summary and Implications

The Yakima District region has seen a higher population growth rate since 2019 as compared to Yakima County and the state. Community demographics indicate a relatively young population, overall, with nearly 40% of the regional population 19 years of age or younger. The demographic make-up indicates a highly diverse population as compared to the state, with a majority of residents of Hispanic/Latinx origin, many of whom are predominantly Spanish speaking. School-level enrollment data also reflect a student population that is comprised of a majority Hispanic/Latinx youth.

Community connectedness and family were at the top of the list for all respondents in terms of assets and strengths of the Yakima School District.

> *"I think families are really close knit in Yakima. They're very supportive. The large families that you know get together and care about each other and are involved in each other's lives, and so I think that's really good thing in Yakima."* —School staff member

> *"People care about the kids in the community."* —School staff member

At the same time, some participants raised concerns about a lack of culturally and linguistically responsive school staff and mental health support available to students and families. Some participants feel that schools must gain the families' trust, understanding that there are cultural norms that hinder families from asking for help or requesting support. Parents shared:

> *"Sometimes we feel ashamed to express our needs and feelings. It's very difficult."*

> *"I am embarrassed to speak up."*

Staff agree:

> *"There is a need for adjusting different cultures and getting rid of that stigma. In the American culture, you have to demand stuff. In the Hispanic culture, you drop off the kids at the door and the teachers, 'profesores', they know best. That's what Hispanic parents are used to. Here is the opposite. If you want something for your child, you have to ask for it and sometimes even demand it. As the saying goes, 'if you don't ask, you go hungry'—a really hard thing for Hispanic parents to do is self-advocating like that. "In the Spanish culture it's kind of like, we do the parenting - you do the schooling. And so, they drop their kids off with the expectation that we're going to do what needs to be done to fix the kids and make them successful in society. And when we drop them back off at the end of the day, they take over, the other half of it. They don't cross team."*

> *"I'm bilingual. [That] helps me bridge, create a relationship with parents, families, and communities, and helps me to establish more trust and more openness, and have those conversations. And I feel like conflict is necessary. So, we've got to get to that point where we bring it up, even if the parents aren't comfortable. The community will rise to the task I think, and support the kids."*

These findings indicate a strong need to ensure Project AWARE services and supports are culturally and linguistically responsive and relevant to the population of students, families, and community members served. Moreover, given the higher-than-average percentage of young people and families who make up the region it is likely that the district will see even more growth in the enrollment population in the coming years. As the district plans for service implementation, the following areas of focus are suggested (as appropriate):

- Ensure inclusion of family voice to reduce linguistic isolation for those families with limited English abilities.
- Provide training opportunities for the community and families that meet the linguistic and daily life (e.g., agricultural work) considerations of the community, both in transportation to/from services, and access to services that have the capacity to serve a primarily Spanish speaking population.
- Create opportunities for systems and providers to offer and to expand access to healthcare and educational services in Spanish.

Upstream Determinants of Health and Educational Opportunities

Health and education are both influenced by many factors, and they also influence each other. Good health—both physical and mental—is critical to children's success in school. At the same time, education is one of the conditions that impacts health outcomes. Health is more than healthcare. In fact, only 20% of someone's overall health is affected by access and quality of healthcare (Schroeder, 2007). Although Washington generally performs better than other states in terms of health indicators, health disparities do exist in the state, and not all communities show consistent good quality health.

Because Project AWARE's goals are centered around the interconnectedness of the education and behavioral healthcare systems, it is important to consider the numerous social and environmental factors that affect the whole person, and thus the whole community. The following section describes some of the upstream determinants of health (and education), their connection with health equity, and the degree to which these factors are present in the Yakima School District region.

Definitions

There are many factors that influence the health of a community. Assuring that positive social factors are present in people's lives is a key approach to achieving **health equity**. Health equity is "giving special attention to the needs of those at greatest risk of poor health, based on social conditions" (Seattle Children's Hospital, 2019). That doesn't mean "sameness" or equality, since some populations need more or different access and services to achieve health. Ultimately, healthy equity occurs "when everyone has the opportunity to 'attain their full health potential' and no one is 'disadvantaged from achieving this potential because of their social position or other socially determined circumstance'" (Brennan Ramirez LK, 2008).

Health inequities cause health disparities, defined as health differences that are closely linked with economic, social, or environmental disadvantage. "**Health disparities** adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic-status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion" (Healthy People 2020).

On the educational side, the ways in which race, ethnicity, ZIP code, socioeconomic status, English proficiency, and other factors impact students' educational aspirations, achievement, and attainment (Great Schools Partnership, 2014) is known as the **opportunity gap.** While the opportunity gap looks at the inputs of the system, the **achievement gap** refers to significant disparities in academic outcomes between different groups of students, such as white and BIPOC (Black, Indigenous, people of color) students. These results are grounded in the **structural racism** of the education system, which is historically centered in whiteness, and are amplified by government-mandated reporting metrics such as standardized test scores, grades, and graduation rates (National Network of State Teachers of the Year, 2018). Unlike individual racism, structural racism encompasses larger systems that work to create and maintain dominant white culture to the detriment of people of color.

The conditions in which people are born, grow, live, and age that shape both health and educational opportunity are known as **social determinants of health (and education)**, and are grouped into five domains according to Healthy People 2030 (U.S. Department of Health).

Health care access and quality
Influenced by health insurance, services and medication affordability and access, health literacy, among other issues

Economic stability/ wellness
Refers to people's access to jobs and their ability to keep steady employment.

Education access and quality
Which is impacted by family's income, dis/ability, discrimination and other interrelated factors.

Neighborhood and built environment
Including transportation systems, affordable and quality housing, access to safe air and water, and access to public lands and services

Social and community context
Takes into consideration safe and positive family relations, community support, and a sense of belonging.

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion

Below, we describe findings for the Yakima School District region aligned with these five areas of social determinants of health and education.

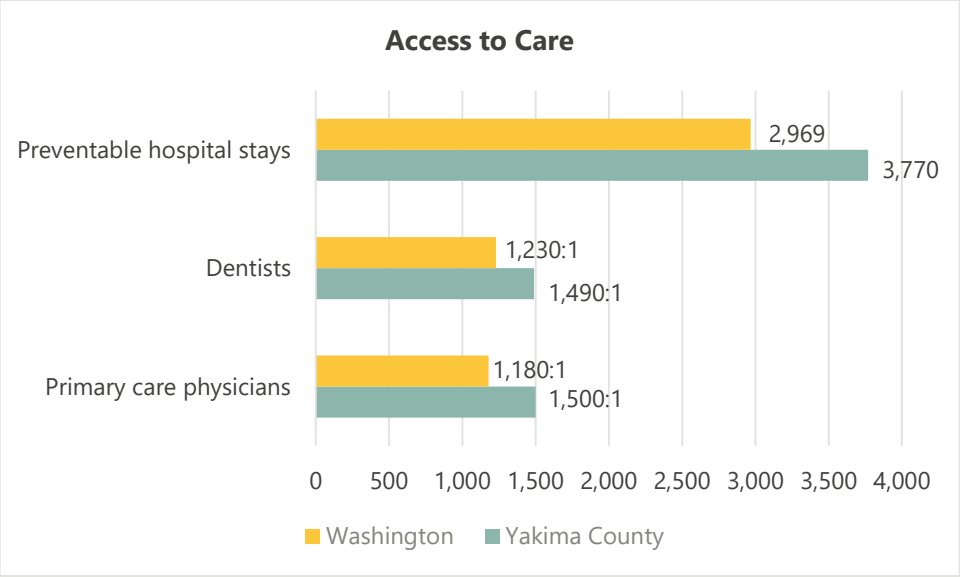
Health Care Access and Quality

Access to quality health care that is affordable, close to home, with the services that people need, and that is culturally sensitive, contribute to the overall wellbeing of individuals and communities.

Access to Care

Access to health care, which includes primary, specialty, emergency, dental, and mental health care, encompasses the ability of an individual or family to visit a healthcare provider when needed, as well as the quality and accessibility of the interaction with the healthcare system. Family education, health insurance coverage, health literacy, supports to navigating healthcare services, in-language services, access to interpreters, and translated information are all elements of health care access. At the same time, barriers to navigating the healthcare system, such as insurance eligibility requirements, lack of insurance coverage, lack of care coordination, long wait times, and the challenges of travelling to appointments impact someone's access to care.

In Yakima County, the ratio of residents to primary and dental care providers is above state and national norms (County Health Rankings, 2021), meaning the public has access to fewer providers. County Health Rankings data (2021) also indicate that the rate of preventable hospital stays per 100,000 persons countywide is above the state average.

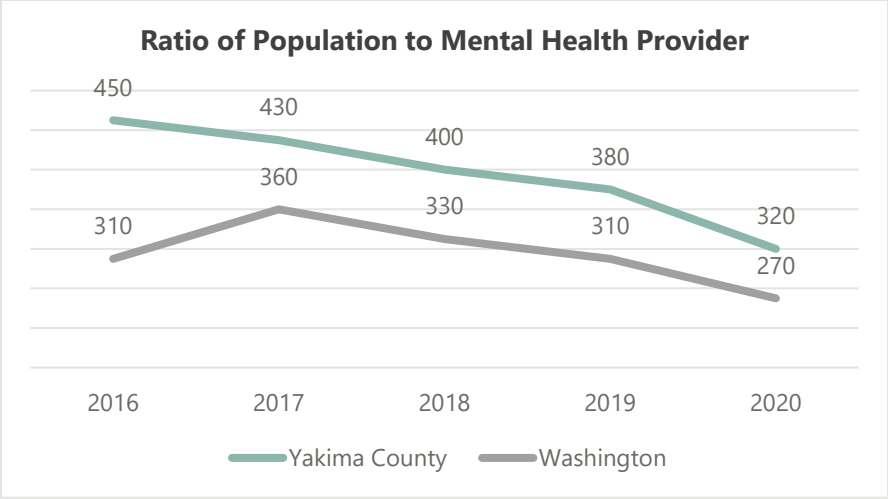


Source: County Health Rankings 2020 (using 2017 data). Note: lower is better.

Shortage of Mental Health Workers

According to Seattle Children's Hospital (2019), Washingtonians are concerned about the lack of community resources that make it challenging to access mental and behavioral health care. Further, findings indicate that community members statewide stress the importance of having providers that reflect the community's diversity; urge the need to address geographical disparities in access to care for more rural areas; and residents note that specialty care is especially difficult to access.

While access to care has improved, the rate of mental health providers (including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses specializing in mental health care) per population, if the population were equally distributed across providers, has gotten better over time. Data indicate that access to mental health providers in Yakima County is improving. In fact, in 2020, the ratio of persons to providers in Yakima County was 320:1 – a considerable improvement from 2016 (450:1). In Washington, ratios range from 2,250:1 to 220:1, with an overall ratio of 270:1.

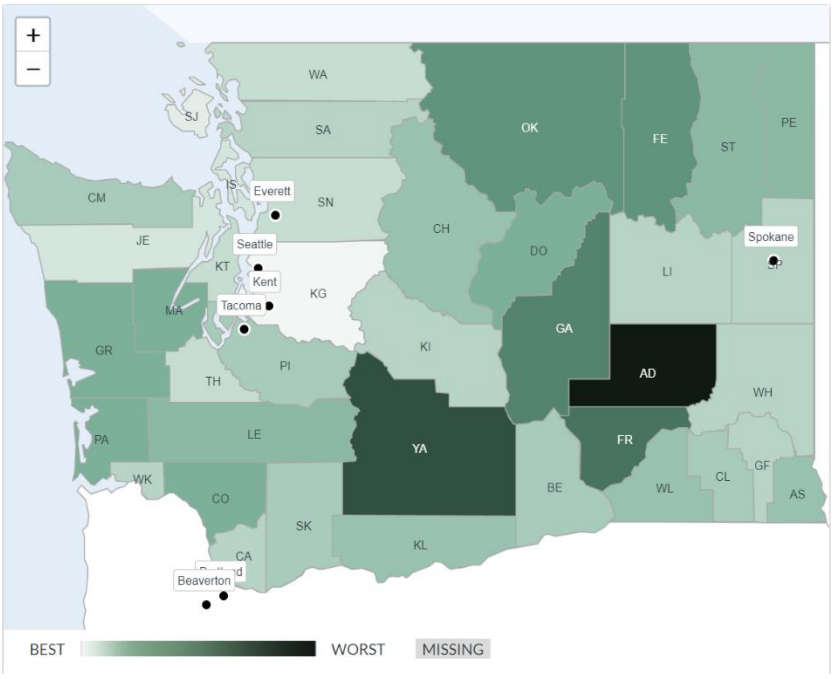


Source: *County Health Rankings 2021*. *Note: Higher number is worse.

Quality of Life

Quality of life refers to how healthy people feel while they are alive. "It represents the well-being of a community, and underscores the importance of physical, mental, social, and emotional health from birth to adulthood" (County Health Rankings & Roadmaps

Percentage of Adults Reporting Fair or Poor Health (Age-adjusted)



Source: 2021 County Health Rankings using data from 2018

In general, more people in Yakima County consider themselves to be in poor or fair health as compared to others in the state.

COVID-19 Pandemic

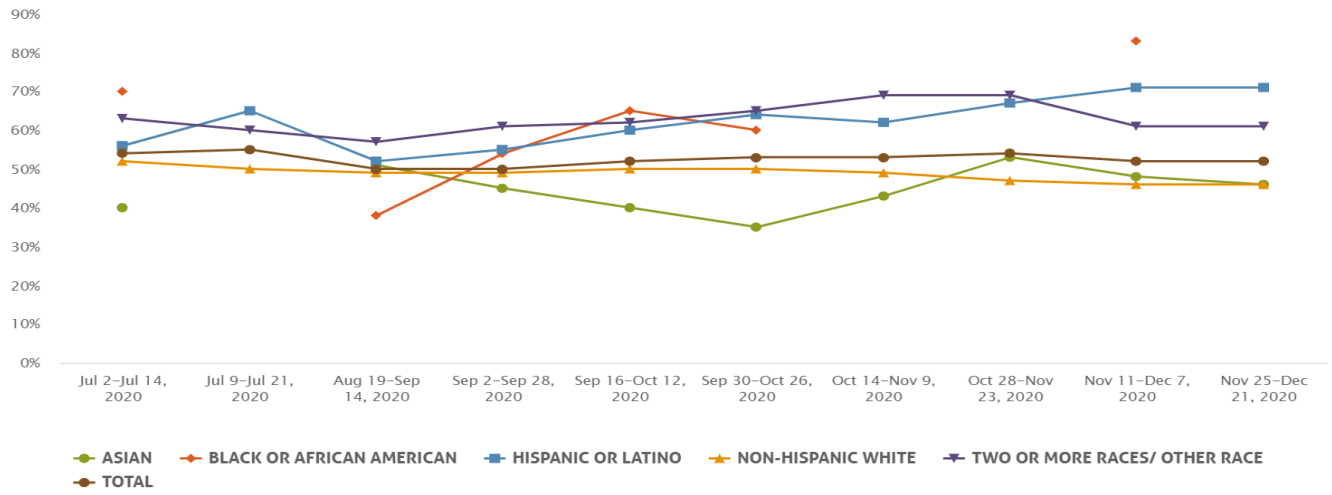
On March 13, 2020, the United States government declared a national emergency concerning the novel coronavirus disease, COVID-19; thus, officially marking the start of the pandemic in the U.S. Since then, the U.S. Census Bureau, along with other federal and state agencies, have collected and tracked data to measure household experiences resulting from the COVID-19 pandemic.

In Washington state, socio-economic consequences of the pandemic include:

- Since March 13, 2020, half of Washingtonians living in households with children have lost employment. The percentage is higher for Hispanic/Latinx households (71%) and households of two or more races (61%) (see graph).
- The percentage of adults ages 18 to 24 who reported that they or a household member lost employment income steadily increased from 47% in June-July 2020 to 63% in Nov-Dec 2020.
- One in six adults (16%) living in households with children have little or no confidence in their ability to pay their next rent or mortgage payment on time.

While everyone has experienced the effects of the COVID-19 global pandemic in one way or another, the health, social, and economic consequences for BIPOC families and communities have been more severe. The pandemic exacerbated long-standing systemic racism. Racism is *the* reason why BIPOC communities have been disproportionately impacted by COVID-19 (CDC, 2021; Mental Health America, 2020; and others). In fact, women, Black, Hispanic, and mixed-race respondents reported a higher prevalence of adverse behavioral health outcomes due to worry and stress related to the pandemic as compared to men, White, and Asian participants (Panchal, Kamal, Orgera, Cox, Garfield, Hamel, Munana, & Chidambaram, 2020).

Adults Living in Households with Children Who Lost Employment Income since March 13, 2020, in Washington by Race/Ethnicity



Source: Population Reference Bureau analysis of the U.S. Census Bureau, Household Pulse Survey, 2021.
Graphic: KIDS COUNT Data Center, datacenter.kidscount.org – A project of the Annie E. Casey Foundation

BIPOC communities have also been hit harder by infection rates. For example, public health data in October 2020 showed that 31% of Washington state cases were Hispanic/Latinx, even though they comprise only 13% of the state population.

Other pandemic-related disparities facing the Hispanic/Latinx population in the state include:

- Lack of insurance - Approximately 20% of Hispanic/Latinx people are uninsured. In comparison, Washington's uninsured rate went from just over 6% pre-Covid, to 13% in May 2020 (Office of Financial Management, 2021).
- Working conditions – The most common occupations held by Hispanic/Latinx people in the U.S. (cleaning, construction, agriculture, and service industries) were considered "essential" at the beginning of the pandemic and workers continued working on-site, increasing their risk of becoming infected (Baquero et. al., 2020).
- Housing conditions – Many Hispanic/Latinx families live in multigenerational households, which contributes to social cohesion. It also increases the risk of infection. In June 2020, Yakima County saw an increase in COVID cases among Hispanic/Latinx individuals, attributed to lack of personal protective equipment (PPE), lack of physical distancing guidelines, crowded housing conditions, and poor sanitation in work (Baquero et. al., 2020).
- Language barriers - Limited access to information, lower levels of health literacy, and wide-spread misinformation across media and social media have been a big challenge to preventing the spread of COVID (Baquero et. al., 2020).
- BIPOC populations have received fewer doses of the COVID-19 vaccine compared to non-Hispanic white people. While Latinx/Hispanic account for approximately 32% of cases, only 4.7% of Washington residents who have received the vaccine (as of February 2021) were Hispanic (Washington DOH, 2021).

Summary and Implications

Access to healthcare in the county has gotten increasingly worse over time, with a shortage of both primary care physicians and mental health providers. Identified health inequities are further evidenced by poorer and worsening quality of life among residents in part as a result of the COIVD-19 pandemic. Among BIPOC communities these challenges are even more dire, with higher rates of infection, and increased likelihood of unemployment as compared to white residents.

For interview and focus group participants, providers that accept insurance that is available to families is a barrier to accessing quality healthcare.

An overarching goal of Project AWARE is to *connect school-aged youth who may have behavioral health issues and their families to needed services*. Research and data reported in this section demonstrate that health inequities and consequences of systemic racism faced by the BIPOC population impact access to quality healthcare. Although much of these data are focused on the state and county levels, the healthcare disadvantages facing the Hispanic/Latinx communities are clear. As such, it is important to consider the ways in which grant-funded services and supports can increase the number of behavioral

health services available to students and families in the Yakima School District, but also how these systems can improve equitable access to quality healthcare services.

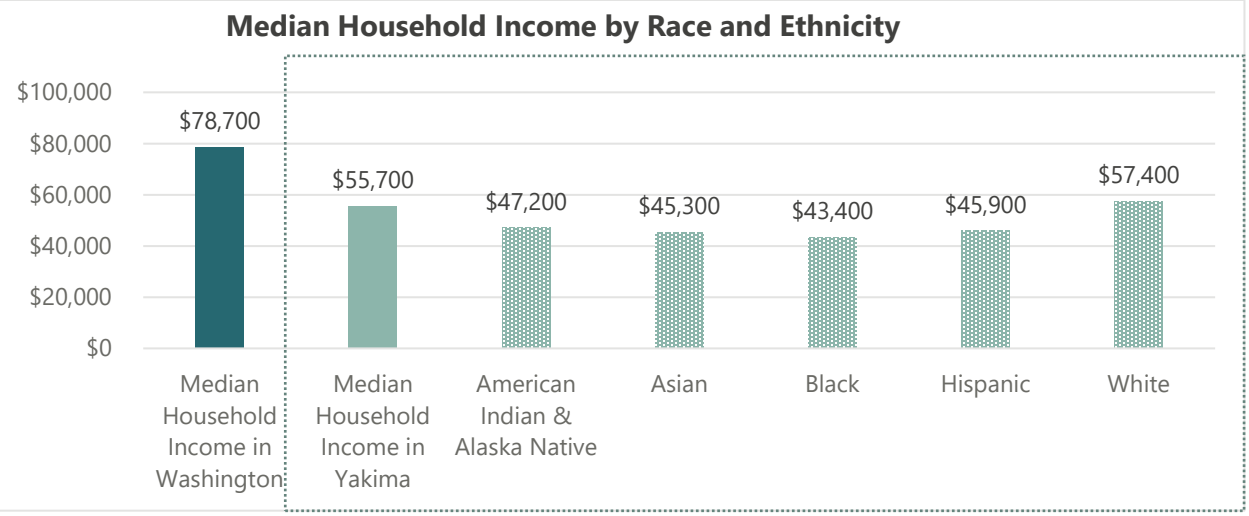
Community Assets and Resources

Some of the valuable organizations and assets that contribute to the health and well-being of young people and families in the Yakima School District area include:

- The Yakima Health District protects and improves Yakima County's public health. Its services include adult immunizations, communicable disease prevention, injury prevention, and program that promote healthy eating and physical activity.
- Hospitals: There are two main hospitals that serve Yakima County and Yakima School District region. Both non-profit hospitals in the area have committed to increasing access to behavioral health and substance abuse services as part of their most current Community Implementation Plans.
    - Astria Health is the parent non-profit owner of Astria Sunnyside Hospital and Astria Regional Medical Center, a 214-bed facility located in Yakima.
    - Yakima Valley Memorial is a 226-bed nonprofit community hospital that has served the Yakima valley for more than 60 years.
- Children's Village provides services to children with special health care needs and their families, including medical specialty clinics, developmental screening, dental services, and mental health counseling.
- Yakima Neighborhood Health Services has community clinics in Yakima, Sunnyside and Granger. YNHS provides medical, dental, maternity, and pharmacy services to patients regardless of ability to pay. It also offers services to unhoused individuals.
- Yakima Valley Farm Workers Clinic is a healthcare system of over 40 clinics across Washington Oregon, offering pregnancy to behavioral to dental care.

Economic Stability and Well-Being

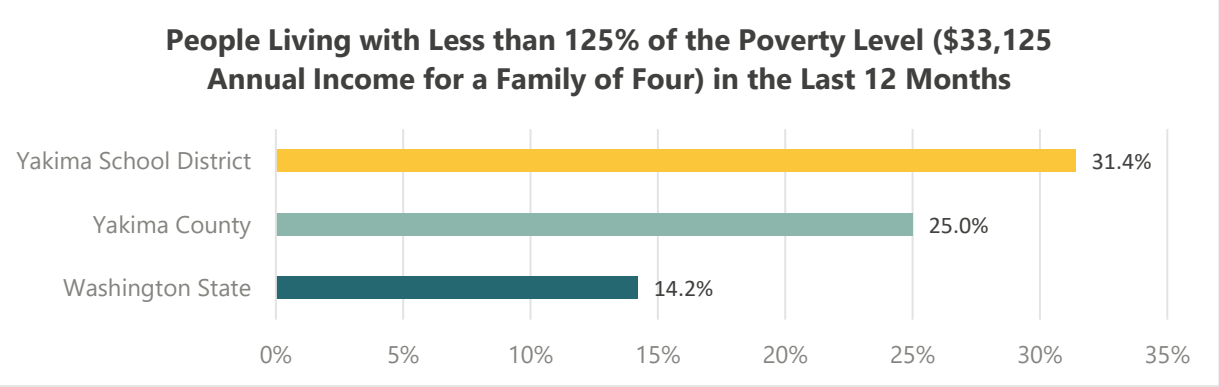
There have been increasing concerns about the relevance of traditional economic indicators to measure well-being, including poverty (Organisation for Economic Co-operation and Development, 2013). Current metrics often look at individual or household outcomes, rather than the collective well-being. For example, the number of people living below the poverty line does little to show a community's overall well-being (The New Economy Washington Report, 2019). Economic well-being can be understood as having present and future economic security, including the ability for people to meet their daily basic needs and to make choices that give them a sense of security, satisfaction, and fulfillment over time (Council on Social Work Education, 2016).



Source: 2021 County Health Rankings using 2019 US Census Bureau data

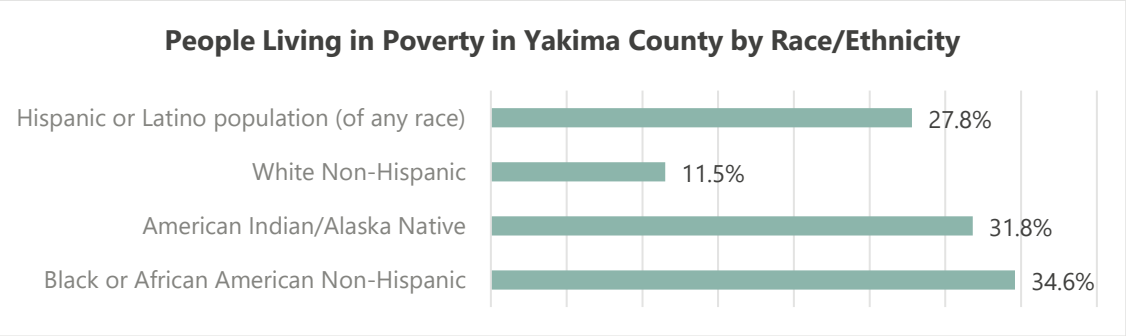
In Yakima County, the median household income in 2019 was estimated at $55,700 – well below the Washington estimate of $78,700. Data show disparities in income by race and ethnicity, with white residents averaging $1,700 above the county average, and lower household incomes among BIPOC residents.

Since 2011, the Census reports the number of people living in poverty using the Supplemental Poverty Measure (SPM), which measures the effects of transfers and taxes, medical expenses, and expenses related to work as a measure of economic well-being (Pierson, 2019). In the Yakima School District, nearly one third of families live with less than $33,125 annual income.



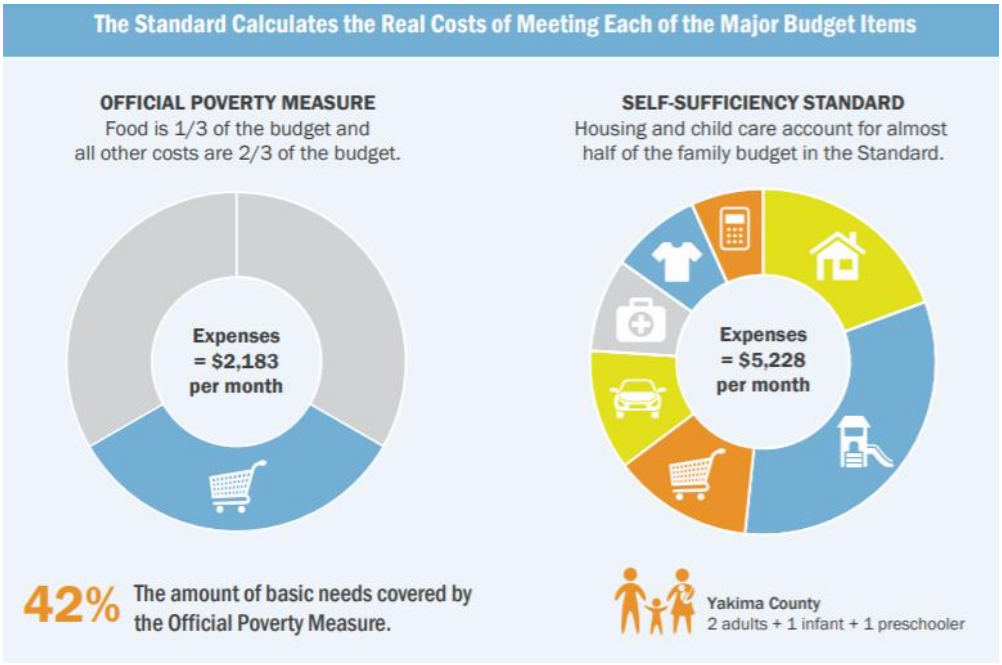
Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

Findings further demonstrate the disparate rates of poverty across race/ethnicity among county residents. In fact, 34.6% of Black/African Americans, 31.8% of American Indian/Alaska Natives, and 27.8% of Hispanic/Latinx residents live in poverty as compared to just 11.5% of white residents (Astria Health Community Health Needs Assessment, 2018).



Source: Astria Health Community Health Needs Assessment, 2018

Self-Sufficiency Standard by County



Source: Pearce, Diana M., PhD, The Self-Sufficiency Standard for Washington State, 2020

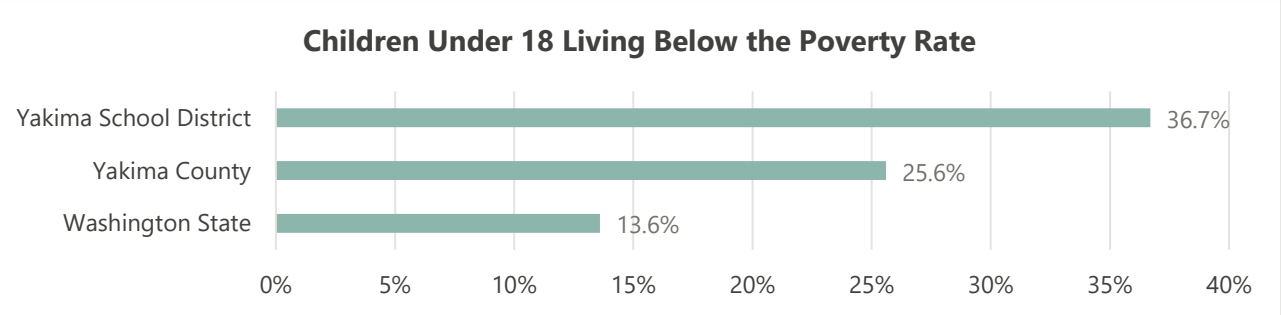
Another measure of economic well-being is the Self-Sufficiency Standard. The standard calculates how much income a family must earn to meet basic needs (including taxes) without public subsidies (e.g., public housing, food stamps, Medicaid, or childcare) and without private/informal assistance (e.g., free babysitting by a relative or friend, food provided by churches or local food banks, or shared housing). The calculation takes into account family composition as well as where a family resides in Washington state.[2] Specifically, the federal poverty guidelines establish household expenses for a family of four living in Yakima County at $,2183 per month ($26,200 annually). Conversely, the self-sufficiency standard estimates expenses for this same family at $5,228 ($56,765 annually) or 217% of the federal poverty guidelines.

Children (Age 18 and under) in Low-income Families

Poverty can negatively impact children's educational achievements, health, and lifetime earnings. Income-related health disparities are growing over time. As such, policies that promote economic

[2] See http://www.selfsufficiencystandard.org/the-standard

equity may have broad health effects (Seattle Children's Hospital, 2019). In Yakima County, 25.6% of youth under age 18 lived in poverty in 2019, nearly twice the state average; however, the percentage of youth living in poverty had decreased in the years before the pandemic. The percentage of children that live in low-income families in the Yakima School District is above the county rate (36.7%).



Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

Income Inequality

Income inequality is the gap in income between richer and poorer households. Because inequalities in income can accentuate differences in social class and status and serve as a social stressor income inequality can have broad health impacts, including increased risk of mortality, poor health, and loss of social connectedness (County Health Rankings, 2021).

Specifically, income Inequality is the ratio of household income at the 80th percentile to that at the 20th percentile, i.e., when the incomes of all households in a county are listed from highest to lowest, the 80th percentile is the level of income at which only 20% of households have higher incomes, and the 20th percentile is the level of income at which only 20% of households have lower incomes. A higher inequality ratio indicates greater division between the top and bottom ends of the income spectrum. Yakima County is doing better than Washington in maintaining income equality between those who have and those who do not (4.0 vs. 4.4, state).

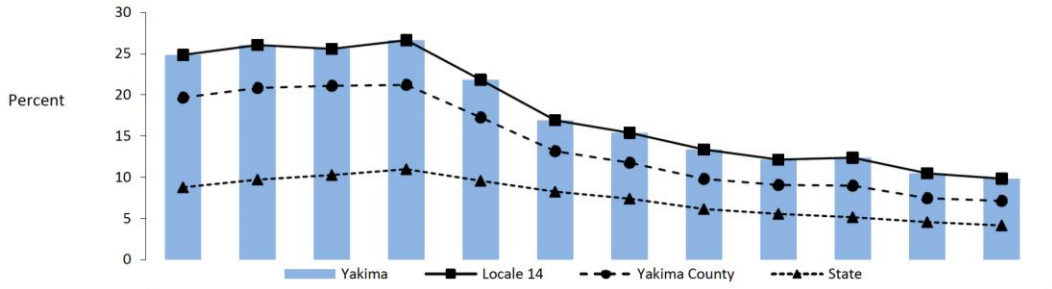
Temporary Assistance to Needy Families (TANF)

Temporary Assistance for Needy Families or TANF assists families with children when the parents or caregivers cannot provide for the family's basic needs. The program provides temporary cash to families. Although Washington state's budget for TANF has decreased significantly in the last few years, the number of TANF recipients has increased considerably – up by nearly 30% – since 2019 from 53,513 total recipients in October 2019 to 68,748 in September 2020, with this likely due to the economic impact of the pandemic (Administration for Children and Families, 2021). In general, children account for about 70% of total TANF recipients.

The following graph shows the decline in the percentage of children aged 0-17 receiving TANF benefits. These data illustrate that the number of families eligible for services has decreased over time with this due to time limits (a person can receive TANF benefits for up to five years) and other post-recession policy restrictions imposed on the program in 2011. Most recently, however, due to the COVID-19 pandemic emergency, families who have exhausted the 60-month time limit will not be denied benefits.

In the Yakima School District, the percentage of child recipients has consistently and considerably exceeded state averages across all reporting years.

Temporary Assistance to Needy Families (TANF), Child Recipients, Aged 0-17



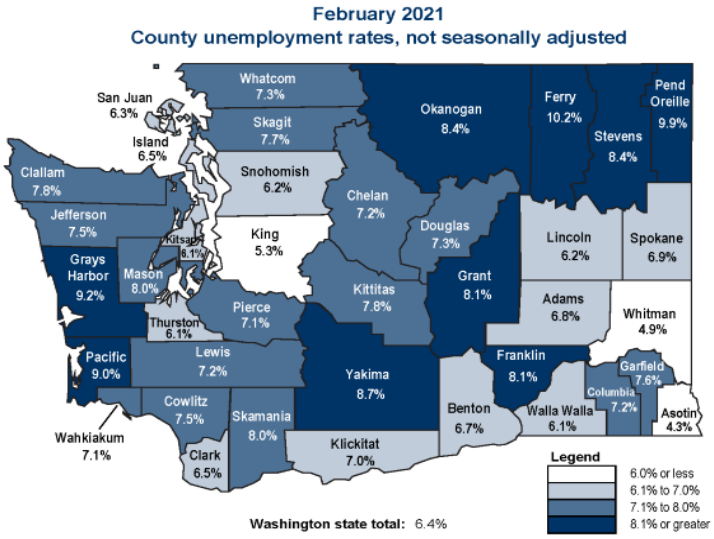
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
State	8.78	9.72	10.28	10.99	9.58	8.25	7.41	6.15	5.58	5.16	4.56	4.16
Yakima County	19.68	20.86	21.12	21.22	17.28	13.19	11.76	9.82	9.07	8.99	7.46	7.14
Locale 14	24.85	26.06	25.60	26.65	21.85	16.94	15.40	13.39	12.16	12.40	10.49	9.84
Yakima	24.85	26.06	25.60	26.65	21.85	16.94	15.40	13.39	12.16	12.40	10.49	9.84
TANF Children	5,546	5,834	5,771	6,006	4,946	3,883	3,574	3,150	2,918	2,949	2,495	2,328
Children, birth-17	22,316	22,391	22,544	22,537	22,641	22,917	23,213	23,531	24,005	23,781	23,776	23,666

Source: Washington State Department of Social & Health Services, 2021

Employment

Many aspects of employment including job security, working conditions, and financial compensation influence health. Unemployment has been linked to heart conditions, arthritis, depression and other mental health illnesses, and unhealthy coping behaviors such as substance abuse (Virginia Mason Memorial, 2019).

Agriculture, health services, and local government provide the most jobs in Yakima County. The unemployment rate (not seasonally adjusted) of 8.7% in February 2021 was one of the higher rates in the state, above the state rate of 6.4% (Washington State Employment Security Department, 2021).



Source: Washington State Employment Security Department, 2021

Summary and Implications

Findings in this section demonstrate that the Yakima School District's regional community is impacted by several economic disadvantages, including economic instability, income inequality, and higher rates of poverty and social service utilization as compared to the county and the state. In designing services and supports for students, families, staff, and community members is it imperative that these factors are considered for a multitude of reasons. For example, we know that poverty and economic insecurity are underlying issues that are closely linked to embedded racial inequities. Black, Indigenous, and people of color are disproportionately poor as a result of oppression, historical disadvantages, and discriminatory practices that have been institutionalized (Delgado, R and Stefanic, J. in Critical Race Theory, cited by Seattle Children's Hospital, 2019). This creates and perpetuates barriers to services, resources, and opportunities (Seattle Children's Hospital, 2019).

Many students and their parents experience lack of financial resources. Interviewees called out how the financial instability leads to other community problems, including the inability to spend quality time as a family.

> *"They're stressed economically. Ours is a very impoverished demographic. Our school is probably somewhere in the high 90s as far as free lunch. But they work a lot. They work hard. The parents are gone for the majority of the day. Some parents… I've had moms who come in crying at their conferences 'cause they're working two full-time jobs. They see their kids like two hours a week and they don't know what to do."* —School staff member

For low-income youth affected by poverty, access to treatment for mental health issues can be challenging. In fact, one study found that more than 90% of low-income adolescents went untreated (Behrens et al., 2013; California Health Interview Survey, 2005). Moreover, schools in high poverty areas tend to experience higher levels of teacher burnout, turnover, and general changes in school leadership – all of which negatively impact the school climate which in turn impacts student mental health (Beteille et al., 2011; Greenberg et al., 2016).

Community Assets and Resources

Some of the available resources that could contribute to people's economic stability and well-being and are located within Yakima County and the Yakima District region include:

- Opportunities Industrialization Center (OIC) of Washington works to eliminate unemployment, poverty, illiteracy, and racism so all people can live with greater human dignity. It offers trainings, workshops, food and resource distribution, career training, housing repair assistance, financial education, and more.
- Yakima County Development Association works to retain, expand, and recruit new businesses and industry.
- People for People offers employment and training opportunities through the Community Jobs, WorkFirst, and Workforce Innovation & Opportunity Act Adult programs, among others.

- Yakima Valley Technical Skills Center provides 23 free academic and hands-on technical career programs to high school students.

Education Access and Quality

Education is associated with better health. Higher education also has implications for access to better jobs and increased income. Several indicators are associated with better quality education, including kindergarten readiness and high school completion (Washington State Health Assessment, 2018).

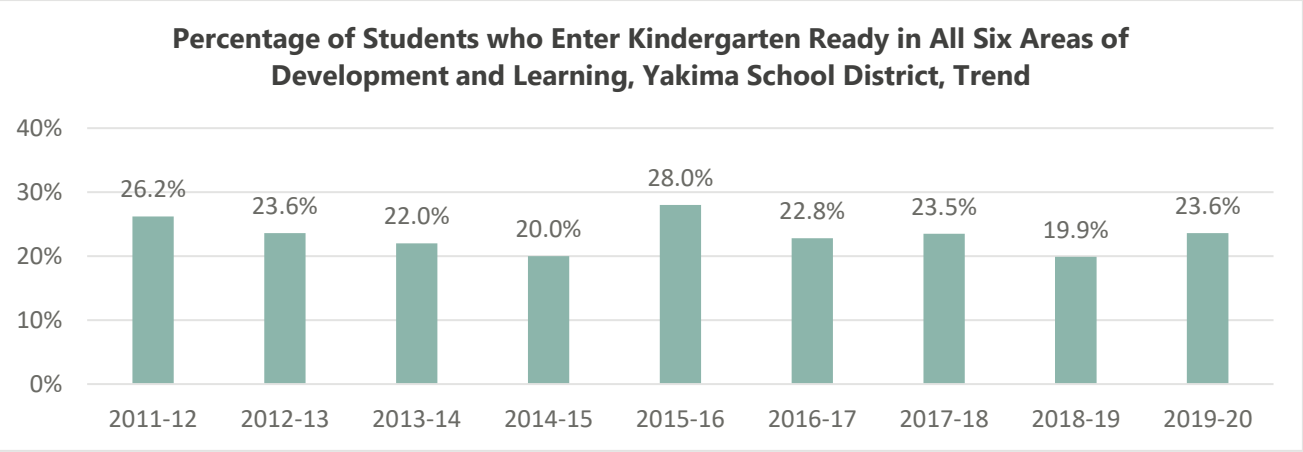
There is increased interest in tracking equity in education. In fact, the Monitoring Educational Equity report calls for a national system *to not simply track progress toward educational goals but to also identify disparities in outcomes and opportunity* (National Academies of Sciences, Engineering, and Medicine, 2019). The report proposes two sets of indicators to track disparities:

- *Disparities in students' educational outcomes*, including kindergarten readiness; K-12 learning and engagement; and educational attainment.
- *Disparities in students' access to resources and opportunities* including extent of racial, ethnic, and economic segregation; equitable access to early childhood education, high-quality curricula, and instruction; and access to supportive environments.

In the next section, we cover some of these educational equity indicators (as data allow).

Kindergarten Readiness

WaKIDS, the Washington Kindergarten Inventory of Developing Skills, includes an assessment that is administered during the first two months of kindergarten. Teachers observe students across six areas of development and learning: Social-Emotional, Physical, Language, Cognitive, Literacy and Math. Although the only requirement for kindergarten in Washington is to be five years of age by August 31, children who demonstrate readiness in all six areas have a greater likelihood of success in kindergarten and beyond.



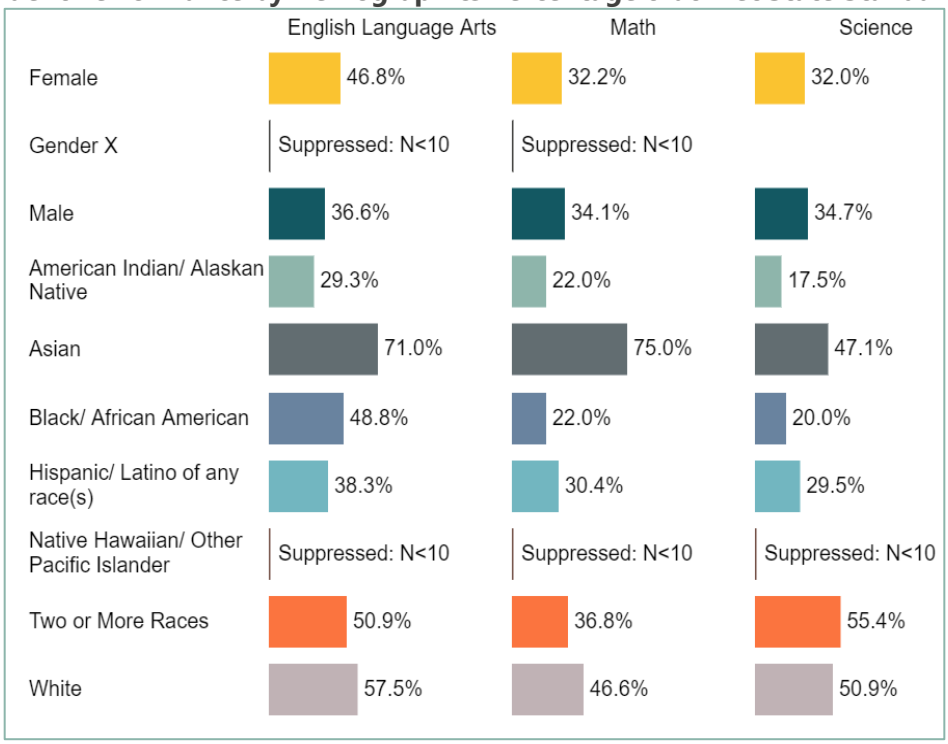
Source: OSPI Report Card, Yakima School District

Kindergarten readiness in the Yakima School District has fluctuated over the school years and is trending downward from its peak during the 2015-16 school year. However, between the 2018-19 and 2019-20 school years, more children demonstrated readiness across the six skill areas. During the 2019-2020 school year, 23.6% of Yakima kindergartens were assessed as meeting all six skill areas, compared to 51.5% of children statewide.

K-12 Learning and Engagement

Every spring, students in specific grades are assessed in Math, English Language Arts and Science. In the 2018-19 school year, an estimated one-third of students met the standards for math and science. Female students outperformed their male counterparts in meeting the state standard for English Language Arts (46.8% vs. 36.6%). Across racial/ethnic groups, students who identify as Asian or White performed better in all three subject areas as compared to other youth, with American Indian/Alaskan Native youth much less likely to meet standards. Additionally, findings indicate that students who are English language learners, foster care, not housed, low-income, migrant, and with disabilities under performed in state assessments compared to their peers who do not meet these characteristics.

Student Performance by Demographics Percentage that Met State Standards)

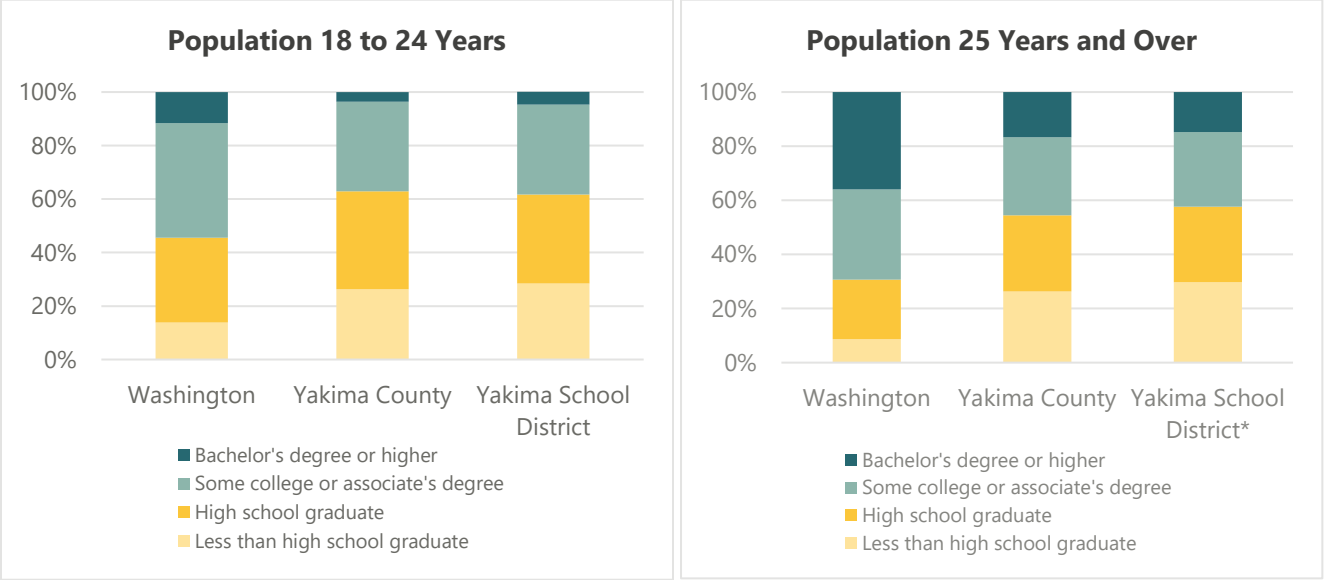


Source: Yakima Report Card, OSPI, 2018-19

Educational Attainment

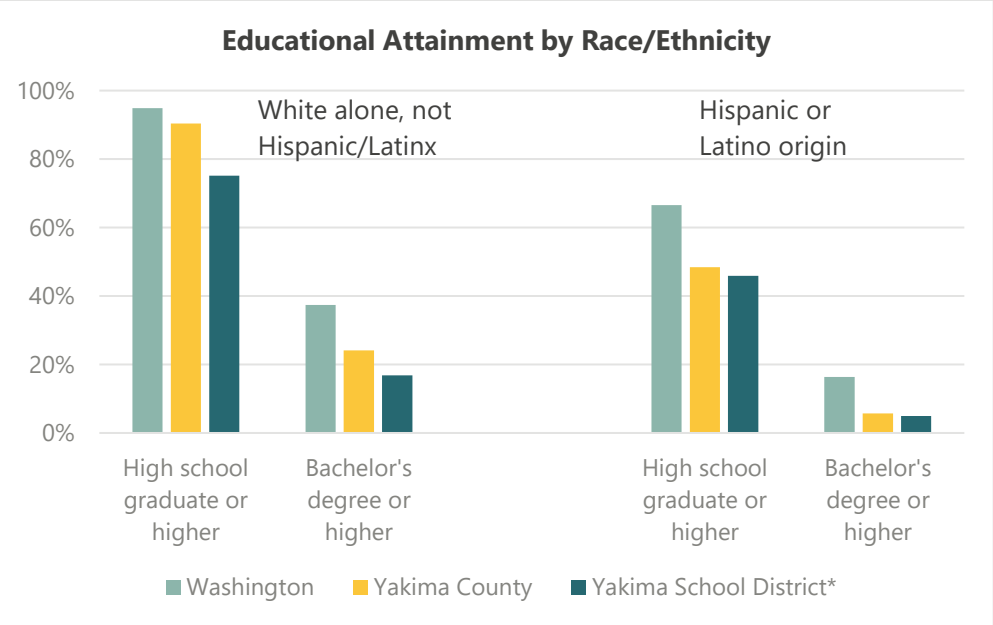
We know that graduating from high school is a critical step towards a successful adulthood. Data demonstrate significant disparities in educational attainment between the Yakima School District and the rest of state.

Age: Regardless of age, more residents within the Yakima School District region have not completed high school compared to the state average. Additionally, while 8.7% of Washingtonians over the age of 25 did not graduate from high school, over one-quarter (29.7%) of people over 25 who live within the Yakima School District area has less than a high school degree.



*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates

Race/Ethnicity: There are also disparities in educational attainment regarding race and ethnicity as demonstrated in the below chart. While 75.1% of the residents from the Yakima School District area who identify as white have completed high school and 16.8% have earned a bachelor's degree, just 45.9% of people who identify as Hispanic/Latinx have a high school diploma and 5% have a bachelor's degree or higher.



"Overall, more Washingtonians are completing high school, but disparities remain particularly for the Hispanic community" (Department of Health, 2018).

*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates

Gender: Countywide, males ages 18 to 24 are more likely to have not completed high school as compared to females. In the district region, one third of males 18 to 24 years did not graduate from high school compared to 22.9% of their female peers. Additionally, 14.0% of males and 15.6% females 25 years and over have earned a bachelor's degree or higher – below the state average.

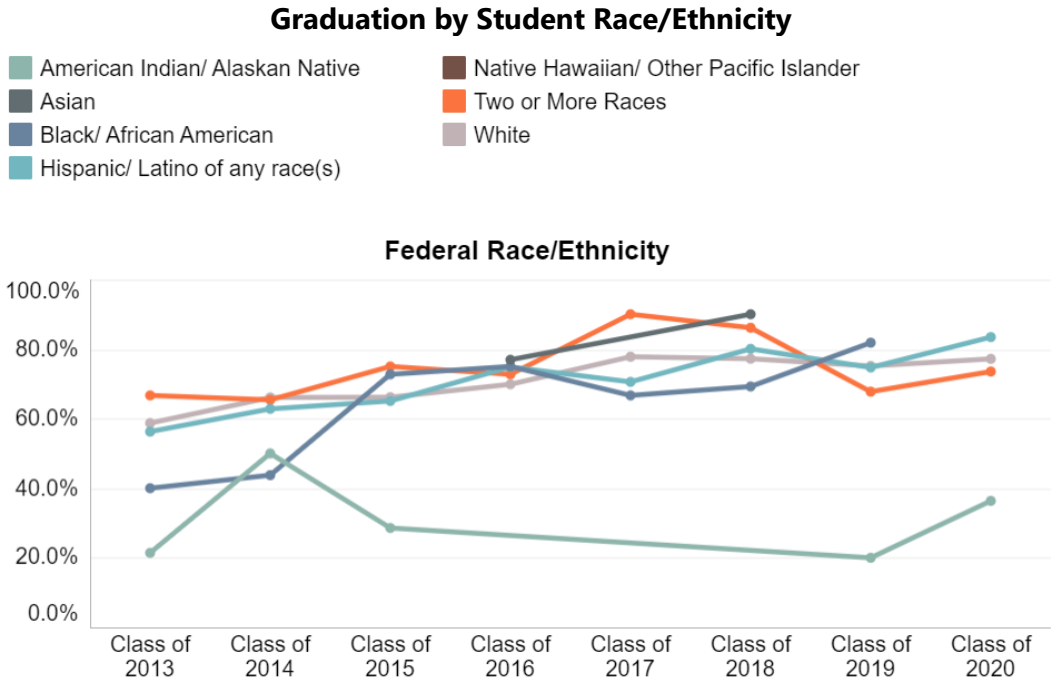
	Washington		Yakima County		Yakima District*	
	Male	Female	Male	Female	Male	Female
Population 18 to 24 years						
Less than high school graduate	15.3%	12.2%	29.7%	22.7%	33.4%	22.9%
High school graduate	35.3%	27.9%	36.9%	36.2%	31.3%	35.5%
Some college or associate's degree	39.9%	46.2%	30.3%	36.9%	30.9%	36.5%
Bachelor's degree or higher	9.6%	13.7%	3.1%	4.2%	4.4%	5.1%
Population 25 years and over						
Less than high school graduate	9.1%	8.3%	28.5%	24.2%	32.5%	26.8%
High school graduate	22.8%	21.2%	29.4%	26.9%	29.0%	26.8%
Some college or associate's degree	32.1%	34.5%	26.4%	31.3%	24.4%	30.7%
Bachelor's degree or higher	36.0%	36.1%	15.7%	17.7%	14.0%	15.6%

*Total population within the boundaries of the school district per Census counts (not just students enrolled in district schools)
Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

On-Time Graduation

Since 2013, the percentage of Yakima School District students who have graduated from high school within four years has increased from 56.6% (Class of 2013) to 81.8% (Class of 2020), similar to the state

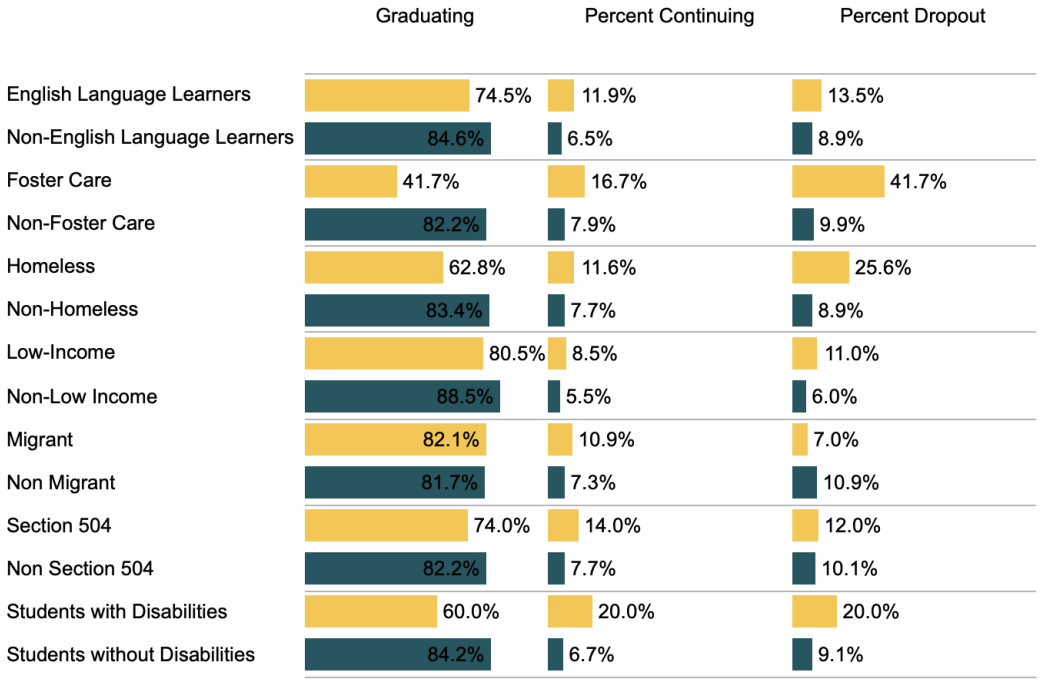
average (82.9%). This upward trend in graduation rates is also demonstrated among both female and male students and across racial groups.



Source: Washington State OSPI Report Card Yakima School District

However, opportunity gaps do exist. For example, a higher percentage of females graduate in four years as compared to their male peers, with 85.7% of females and 77.5% of male students graduating on-time in 2020–a 8.2-percentage point gap. Among students who identify as Hispanic/Latinx, there has also been an increase in on-time graduation rates over time, from 56.3% (Class of 2013) to 83.4% (Class of 2020) meeting graduation requirements. For the Class of 2020, data show disproportionality in reaching this academic milestone among student groups. In fact, on-time graduation rates for students identified as an English language learner (ELL), foster care, homeless, low-income, Section 504, and disabled are lower. Additionally, data further indicate that ELL, foster care, homeless, and students with disabilities dropped out at rates above the district average (10.2%).

Percentage of Students Graduating within 4 Years, by Student Program and Characteristics (2020)



Source: Washington State OSPI Report Card Yakima School District, 2020

Racial, Ethnic and Economic Segregation

Residential segregation has been linked to negative health consequences, poor-quality housing, violence, reduced educational and employment opportunities, and other adverse conditions (County Health Rankings, 2021). The County Health Rankings define racial/ethnic residential segregation as the degree to which two or more groups live separately from one another in a geographic area. "The index of dissimilarity is a demographic measure of the evenness with which two groups (non-White and White residents, in this case) are distributed across the component geographic areas (census tracts, in this case) that make up a larger area (counties, in this case)" (ibid). According to the Monitoring Educational Equity report (2019), despite integration efforts, racial and economic segregation have continued to increase in recent decades.

The 2021 County Health Rankings use the index of dissimilarity where higher values indicate greater residential segregation between non-white and white county residents, with scores ranging from 0 (complete integration) to 100 (complete segregation). The score represents the percentage of either non-white or white residents that would have to move to different geographic areas in order to produce a distribution that matches that of the larger area. For Yakima County, the index score is 30 while for Washington it is 38.

"School segregation—both racial and economic—poses one of the most formidable barriers to educational equity" (National Academies of Sciences, Engineering, and Medicine, 2019).

Access to Early Childhood Education

The Yakima School District has several programs designed for students ages 3-5:

- Developmental Preschool: for children who qualify for special education services in different developmental areas.
- Integrated Preschool: a program that offers early learning to students with and without special needs in the same classroom.
- Community preschool: where 4-year-old students develop skills to be ready for school.

The Educational Service District (ESD) 105, which serves the Yakima School District, offers the state-funded Early Childhood Education and Assistance Program (ECEAP) to many communities in its region. ECEAP provides free preschool, family support, and child health care coordination to eligible children and their families. ESD 105 offers ECEAP in Yakima, Toppenish, Union Gap, and Cle Elum/Roslyn, while providing support to local providers in the surrounding communities. The ESD also offers Head Start and Migrant/Seasonal Head Start services at different locations in the area (see ESD 105).

Access to High-Quality Curricula and Instruction

The National Academies of Sciences, Engineering, and Medicine (2019) highlights the interaction between students and teachers, students' access to a rich coursework, and the teachers' qualifications, experience, and diversity as indicators of quality learning. Several measures that OSPI tracks and reports annually illustrate students' access to curricula and instruction. The data below show disparities between the district and statewide averages. For example, the district falls below the state average for funds expended per-pupil, and fewer master's-level (or higher) teachers as compared to the state.

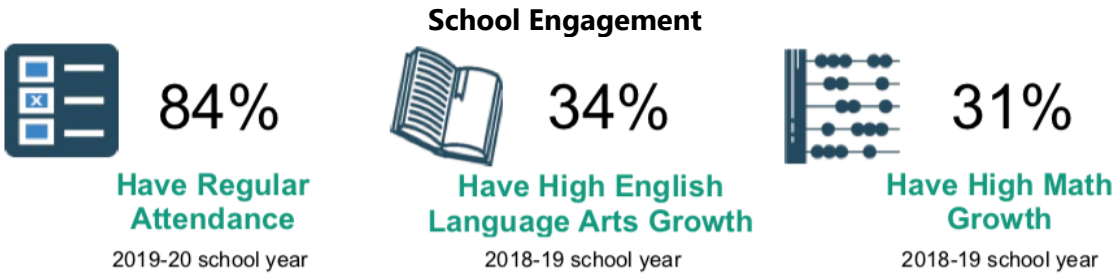
						
Per-pupil expenditure	Average class size	Years of teaching experience	Held full certificates	Teachers with a master's degree or higher	Teachers considered "experienced"	Years of experience as principal/ leader
$13,620 Yakima **$14,213 WA**	**19 Yakima** **18 WA**	**13.9 Yakima** **12.8 WA**	**89% Yakima** **92% WA**	**53% Yakima** **61% WA**	**78% Yakima** **72% WA**	**8.7 years Yakima** **6.8 WA**

Source: Washington Office of Superintendent of Public Instruction

Access to computers and Internet is a growing need for students and has been particularly critical during the COVID-19 pandemic when students accessed education remotely or in a "hybrid" model. While most households (75.3%) in the Yakima School District region have internet connection, 6,830

households still do not have access. In comparison, 91.3% of Washington households and 84% of Yakima County households have internet access (Census 2019: ACS 5-Year Estimates).

Academic Engagement



Graphic: Washington Office of Superintendent of Public Instruction

Findings on school engagement demonstrates a relatively high level of participation by Yakima students with most (84%) attending regularly during the 2019-20 school year. Further, during the 2018-19 academic year, 34% of students illustrated high growth in ELA, similar to the state norm (33.6%), with 31% exhibiting high growth in Math, slightly below the state average (33.7%).

Discipline Practices

During the 2018-19 school year, 860 or 4.9% of the 17,545 students enrolled in Yakima School District received a short-term suspension, long-term suspension, emergency expulsion, or expulsion for a discipline related incident (down from 7.8% in the 2017-2018 school year). Statewide the discipline rate was 4.0%. In reviewing data by student group, disparate application of disciplinary actions is apparent. Particularly, findings show:

- Male students were twice as likely as their female peers to be disciplined (10.2% vs. 5.3%).
- All BIPOC students, except Hispanic/Latinx youth, were disciplined at rates above the district average.
- Foster care youth were nearly three times more likely to be sanctioned as compared to non-foster care students (21.7% vs. 7.6%).
- Low-income youth were more likely to be disciplined as compared to non-low-income youth (8.6% vs. 4.2%).
- Section 504 students were considerably more likely to be disciplined as compared to and non-Section 504 youth (18.5% vs. 7.4%, respectively).
- Higher rates were also noted for students with disabilities compared to those without disabilities (11.6% vs. 7.2%, respectively).

Summary and Implications

The Yakima School District is showing slight improvements in kindergarten readiness, with student engagement and graduation rates increasing over time. However, inequities in reaching these educational milestones exist. For the Class of 2020, data show disproportionality in on-time graduation rates for students identified as an English language learner (ELL), foster care, homeless, low-income, Section 504, and disabled are lower. Further, findings indicate a considerable gap in the racial and ethnic diversity between the student population and classroom teachers. Results also show disparate application of disciplinary actions among student groups, particularly among Section 504 youth and those in the foster care system.

School staff participants spoke about the issue of school segregation and school transfers affecting education in the Yakima School District. Class size seems to also impact quality of interaction between teachers and students.

> *[I wish we had] "smaller class sizes so I could actually have an even better relationship with my kids."*
>
> *"I see a lot of students who transfer into my class and then they'll transfer out to a different school or a different school district. So, there's not a consistency in their learning. There's a lot of breaks. There's a lot of gaps."*
>
> *"Schools got segregated again. It's completely changed since I went to school. The furthest west is whiter. The furthest east is overcrowded; they're putting in portables. On the west side, it's an older population with less kids so they actually have had rooms that until recently they didn't even use in their buildings. It's evening out now."*

We know that graduating from high school is a critical step towards a successful adulthood. In fact, youths that dropout are more likely to have difficulties with employment and to earn a satisfactory living. These deficits contribute to a greater likelihood of other social and personal problems including mental, emotional, and behavioral disorders (Annie E. Casey Foundation 2014). We also know that engaged students are more likely to earn better grades, perform well on standardized tests, and stay in school (Fredricks, Blumenfeld, & Paris 2004), and less likely to engage in health-risk behaviors, including substance use, violence-related behaviors, and risky sexual behaviors (United Way Worldwide, 2011).

A report conducted in Washington state found that exclusionary discipline practices disproportionally impacted BIPOC youth, and students of low socioeconomic status (Mosehauer, McGrath, Nist, Pillar, 2012). At the institutional level, the use of exclusionary discipline practices and policies that are disproportionately applied to students of color marginalize these youth, and limits opportunities for social, emotional, and academic development. Additionally, at the individual level, school staffs' implicit biases produce low expectations and set up students of color and marginalized youth to disengage from the school environment (Simmons, Brackett & Adler 2018).

Project AWARE focuses specifically on increasing universal behavioral health supports for youth, including youth's social-emotional skills. Social and emotional learning (SEL) provides students with

competencies necessary to lead productive and healthy lives. SEL refers to life skills that support students (and adults) to experience, manage, and express emotions, foster sound decision making, and build interpersonal relationships. These skills protect children and youth against adverse risk-taking behaviors, emotional distress, and conduct problems, thus, contribute to health, academic achievement, and success later in life.

When considering AWARE programming, implementation efforts should identify populations disproportionally affected by low educational attainment, engagement, or disciplinary actions, and ensure supports are implemented equitably to meet the needs of a diverse array of youth, whether those learning through special education, or ELL programming, or facing challenges outside of school such as high mobility (migrant) or homeless living conditions. In the development of the supports, efforts should ensure both student and parent voices are included in the process from selection to implementation.

Community Assets and Resources

Some of the available resources related to education access and quality available in Yakima County and the Yakima School District area are:

- Educational Service District 105 is the multi-resource support site for the schools and education partners in south central Washington, including Yakima County. ESD 105 provides cost-effective ways related to school and student success, health, and safety, and professional development, administrative, business, and financial support, and new technology.
- Yakima School District offers K-12 education to youth who live in the City of Yakima. Its vision is to focus on every student, every day, strengthening community through education.
- Inspire Development Centers is a community-based nonprofit organization that provides culturally responsive services to families and children through programs such as Migrant and Seasonal Head Start Program, Migrant and Seasonal Early Head Start, and Early Childhood Assistance (ECAP). It has locations in eight Washington counties including Yakima and Grant.

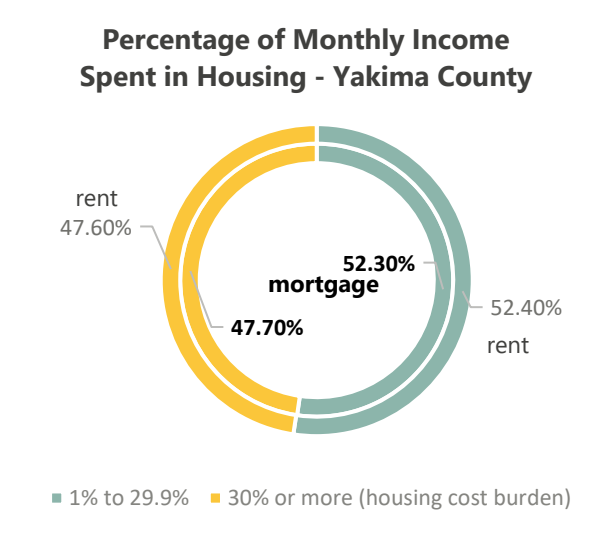
Neighborhood and Built Environment

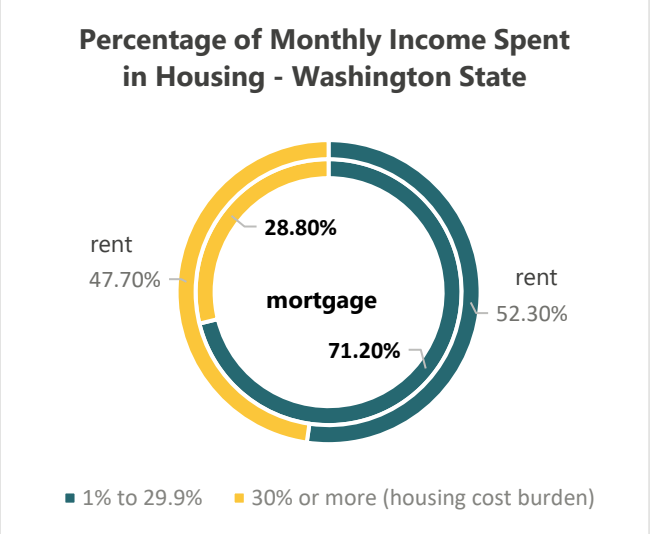
Place matters. Where people live has a significant impact on their health and well-being. Oftentimes, there are persistent disparities among people living just a few blocks apart, in part because of their neighborhood and surrounding environment such as having grocery stores that offer a variety of food options, especially healthy ones, or access to parks or other green spaces. Living in places with limited availability of grocery stores and lack of access to fresh fruits and vegetables – often referred to as "food deserts" – is correlated with premature death and high prevalence of obesity (Washington State Department of Health. Food Insecurity and Hunger, 2018). Ensuring access to healthy food, affordable housing, parks and recreation, and reliable transportation for everyone improves health in communities (Robert Wood-Johnson Foundation, 2021).

Housing

Quality, safe, and affordable housing is critical for the well-being of kids and families. Families who pay more than they can afford for housing may not have enough left to cover other basic needs such as food, healthcare, and childcare. A widely used measure to assess housing affordability is known as the "30-percent rule" or housing cost burden.

In Washington, nearly half of renters (47.7%) and 28.8% of homeowners are considered cost burdened. Conversely, in Yakima County homeowners and renters face similar levels of financial challenges, with 47.7% of mortgage holders, and 47.6% of renters cost burdened.





Source: U.S. Census Bureau, 2019 American Community Survey 1-Year Estimates

Houselessness/Housing Instability

Houselessness is the lack of stable, safe, permanent, and adequate housing. People experiencing houselessness may be unsheltered or staying in emergency shelters or transitional housing. At the same time, houselessness can result in illness due to exposure to communicable disease, violence, and poor nutrition.

> *"Homelessness is often caused by a complex combination of interwoven social and health factors. Poor physical and mental health can both cause and result in homelessness. Illness or injury can lead to lost income, the loss of a job and health insurance leading to a downward spiral in health"* (Washington Department of Health, 2018).

Annually, communities across the country complete the Point-in-Time (PIT) count which determines the number of individuals who are unhoused, either experiencing houselessness or housing instability. In January 2019, the PIT in Yakima County found there were 636 unhoused people. Of the total number of houseless persons counted, about 175 were unsheltered and 367 were in emergency shelters. "For the second year in a row, there is a large increase in unsheltered community members from the previous 8 years of data collected" (Yakima County Homeless Point-in-time Count, 2019). Out of the total PIT survey participants, 8% were 18 to 24 years old and 1% was under 18.

Additionally, each fall school districts report the number of students living in unstable housing circumstances to OSPI. OSPI uses a broader definition of "homeless" that includes students who are living "doubled up" and "couch surfing;" as such the number of children reported by OSPI as houseless are historically higher than those of the PIT. During the 2020-21 school year, there were 342 students identified as houseless in the Yakima School District, representing 2.2% of the student population (OSPI Report Card).

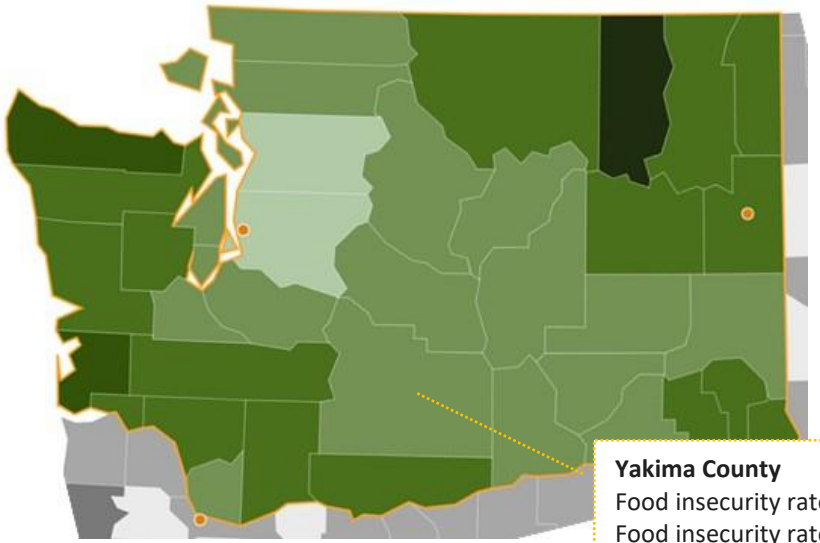
Food Security

Hunger and food insecurity in children are associated with psychosocial problems, frequent colds, anemia, asthma, headaches, impaired cognitive functions, and poorer academic achievement (Washington State Department of Health. Food Insecurity and Hunger, 2018). A recent study of people that experienced frequent hunger in childhood found a correlation to low self-control, and interpersonal violence later in life (Piquero, 2016).

Definition: Food insecurity is the limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in a socially acceptable way. (DOH, 2018)

Food security means a person has access to enough food to have a healthy life. Food insecure households are not always food insecure at all times and vice versa. Food security is measured by the food environment index, which combines the percentage of the population that is low-income and do not live close to a grocery store, and the percentage of the population that are food insecure. The index scale ranges from 0 (worst) to 10 (best). The food environment index in Yakima County is worse than Washington state (7.9 vs. 8.2, state) (County Health Rankings, 2020). According to a recent report, nearly one-in-five (19.3%) children in Yakima County (before COVID-19) experienced food insecurity, with over one-in-ten persons (12.4%), countywide, food insecure (Feeding America, 2018).

Food Insecurity



Source: Feeding America, 2018

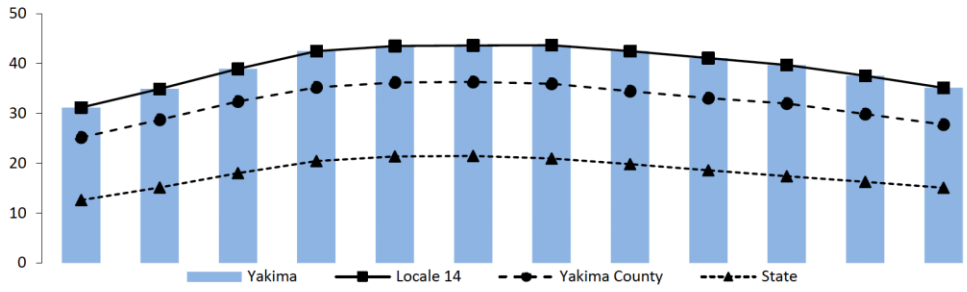
Government assistance programs have been shown to reduce child food insecurity rates and lessen the impacts of food insecurity among children (Seattle Children's Hospital, 2019). These programs include the Supplemental Nutrition Assistance Program (SNAP), national school meal programs, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) – all indicators of extreme family economic deprivation.

Supplemental Nutritional Assistance Program (SNAP)

The federally funded Supplemental Nutrition Assistance Program (SNAP), formerly known as the food stamp program, helps children and families with low incomes afford food. SNAP is the nation's largest nutrition assistance program, with more than 35 million children and families participating. An estimated 59.5% of households with children under the age of 18 in the Yakima School District receive SNAP, compared to 63.4% in Yakima county and 44.3% in Washington state (Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates).

The figure below demonstrates that the rate of persons receiving SNAP services has declined since peaking in 2013 at the state, county, and school-district levels. However, usage rates for Yakima County and the district region have consistently exceeded state averages across all reporting years. In 2019, the percentage of Yakima School District individuals participating in SNAP was more than twice the state average.

Supplemental Nutritional Assistance Program (SNAP)



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
State	12.60	15.11	18.00	20.44	21.35	21.45	20.95	19.80	18.58	17.38	16.26	15.09
Yakima County	25.15	28.70	32.36	35.23	36.19	36.30	35.91	34.43	33.07	31.97	29.85	27.76
Locale 14	31.16	34.90	38.92	42.48	43.50	43.61	43.65	42.45	41.10	39.71	37.50	35.13
Yakima	31.16	34.90	38.92	42.48	43.50	43.61	43.65	42.45	41.10	39.71	37.50	35.13
Recipients	23,850	26,908	30,184	32,979	33,878	34,154	34,380	33,475	32,456	31,531	29,867	28,052
All Persons	76,543	77,090	77,556	77,634	77,881	78,308	78,766	78,855	78,976	79,397	79,653	79,855

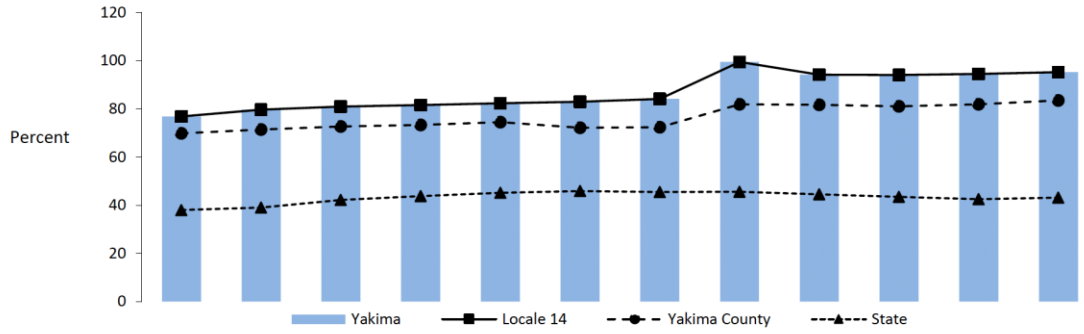
Source: Washington State Department of Social & Health Services, 2021

Free or Reduced-Price Meals Program

The national school meals program provides breakfast, lunch, afterschool snack, meals during the summer months, and afterschool meals to children with low incomes attending public, private, and charter schools, as well as residential childcare institutions (RCCIs). In 2019, 84% of children in Yakima County and 43% in Washington state were eligible for free or reduced-price lunch. In comparison, of

the 15,878 students enrolled in the Yakima School District, nearly all (95.2%) were eligible to participate in the free and reduced meal program, significantly above the state average.

Students Eligible for Free or Reduced Price Lunch



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
State	38.01	39.04	42.22	43.75	45.17	45.87	45.50	45.60	44.51	43.49	42.50	43.16
Yakima County	69.85	71.40	72.67	73.35	74.56	72.16	72.38	81.89	81.71	81.03	81.90	83.55
Locale 14	76.87	79.71	80.96	81.63	82.40	83.00	84.11	99.51	94.23	94.08	94.55	95.24
Yakima	76.87	79.71	80.96	81.63	82.40	83.00	84.11	99.51	94.23	94.08	94.55	95.24
Eligible Students	10,944	11,434	11,827	11,994	12,326	12,574	12,973	15,741	15,021	15,042	15,152	15,122
Enrolled Students	14,237	14,344	14,609	14,694	14,958	15,149	15,424	15,818	15,941	15,989	16,025	15,878

Source: Washington State Department of Social & Health Services, 2021

Transportation

Transportation, including active transportation (walking, biking), access to transportation, and income spent on transportation, is another social determinant of health. Access to childcare, health care, and education can be difficult for people with low incomes, individuals with mental illnesses, or those without a car. In a regional survey conducted for the Astria Health's 2018 Community Health Assessment, residents identified the burden of travel as a barrier to accessing healthcare or other services. Participants listed *transportation* as one of the top five barriers to improving health, in addition to housing, employment, education, and emotional/mental health (Astria Health, 2018).

Summary and Implications

Data presented in this section show that there are a number of environmental factors that may create increased barriers to services and supports for some of the Yakima community. For example, nearly half of both homeowners and renters face a financial burden to meeting housing costs, with an increasing number of unhoused individuals in the region. Rates of food insecurity in the region are higher than state averages, with utilization of food assistance (both through SNAP and the free and reduced priced meals program) well above state rates, with nearly all (95.2%) students eligible for reduce priced school meals.

Interview participants mentioned that not having adequate housing for their houseless neighbors was as a critical issue. They also shared that sports clubs are a strong community asset. A few of them

mentioned the boxing program run by the police department, and highlighted public facilities such as city parks and basketball courts.

> *"Our sports organizations really do a good job. I think the YMCA does a really good job with getting kids tightened up."*
>
> *"Sports [contribute] with the belonging and the camaraderie. And just being a part of a team and learning all the good things about that."*

Research has shown that food insecurity is associated with a wide range of adolescent mental health disorders, such as past-year mood, anxiety, behavior, and substance disorders, even when controlling for other aspects of socio-economic status (McLaughlin, et. al, 2012). Other research has found that children from chronically food insecure homes were approximately one-and-a-half times more likely to have internalizing problems and two times more likely to have externalizing problems, when compared to children in food secure homes (Slopen et.al, 2010).

Considering the societal, environmental, and logistical barriers facing youth and families, it is critical to embed community-based services and supports within the school system to increase access while reducing barriers.

Community Assets and Strengths

Some of the community resources that contribute to ensuring access to healthy food, affordable housing, and transportation in the Yakima District area include:

- Several food banks and mutual aid pantries operate in Yakima, including those operated by the Yakima Rotary, a member agency of Second Harvest.
- Yakima School District Food Distribution provides free breakfasts and lunches to students.
- The Yakima County Homeless Coalition (YHC) is the primary body that has been planning and coordinating to address homelessness activities in the Yakima Valley. The coalition includes over 40 local service providers and community members.
- Yakima Transit provides 10 fixed bus routes, paratransit, and vanpool services, as well as the Yakima-Ellensburg Commuter route along with Central Washington University and WSDOT.

Social and Community Context

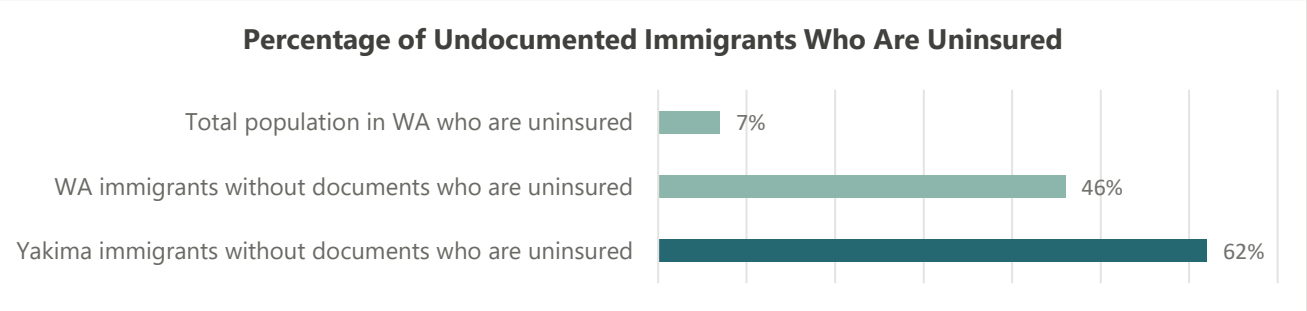
Relationships are important for physical and mental health and well-being. The social and community context domain includes issues related to social cohesion, safety, civic participation, discrimination, and incarceration, among others.

Immigration Status

Immigration is a consequence of social determinants of health such as poverty, educational opportunities, and political persecution. Immigration itself is also a social determinant of health (Castañeda et. al. 2014).

"Heightened immigration enforcement in recent years, including historic levels of deportation, has resulted in negative impacts on health and well-being" (ibid). Fear of deportation and actual deportation have many social, economic, and health impacts on individuals and families (Langhout et. al., 2018).

While the number of undocumented immigrants is difficult to measure, in 2018 an estimated 11 million undocumented people lived in the U.S. including 240,000 in Washington state, representing approximately 5.2% of the total state population. Among the implications of immigration status on health and well-being are the restrictions to accessing programs that offer public health coverage (Washington State Health Equity for Immigrants Report, 2020). Undocumented immigrants, including DACA (Deferred Action for Childhood Arrivals) holders, are ineligible to receive most federal public benefits, including SNAP and TANF. They may, however, be eligible for a handful of benefits to protect life or guarantee safety in emergency situations, such as access to healthcare and nutrition under the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) (National Immigration Forum, 2018).

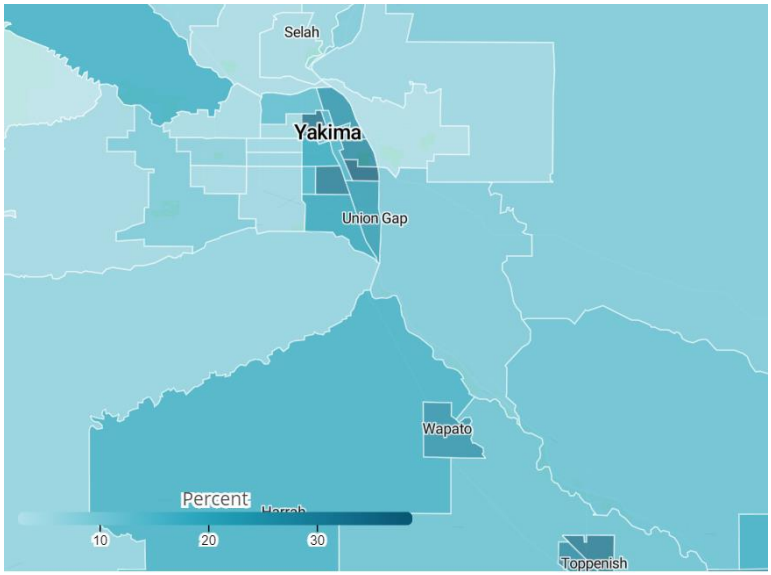


Source: 2018 data result from Migration Policy Institute (MPI) analysis of U.S. Census Bureau data from the pooled 2014–18 American Community Survey (ACS) and the 2008 Survey of Income and Program Participation (SIPP), weighted to 2018 unauthorized immigrant population estimates provided by Jennifer Van Hook of The Pennsylvania State University.

In 2018, 62% of undocumented immigrants in Yakima were uninsured, well above the 46% reported as such statewide, and significantly above the 7% of the overall population of the state.

The Yakima School District region and surrounding communities have a large percentage of foreign-born residents. Up to an estimated 38.8% of the population living in some of the designated census tracts within the district boundaries was born outside of the US as compared to 23.5% countywide (Hunger in Washington with Census tract data).

Foreign-Born Population by Census Tract
Yakima County (2013-2017)



Graphic: Hunger in Washington

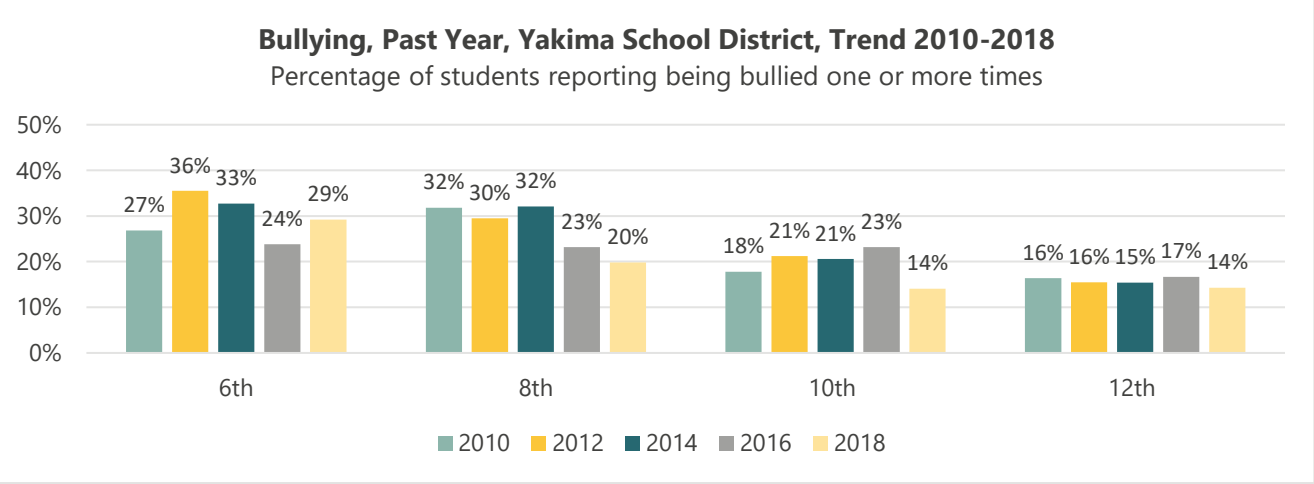
School Climate and Safety

As noted, since 2002, the Healthy Youth Survey has been administered every other year in the fall to students in grades 6, 8, 10, and 12 across the state. The survey measures health risk behaviors known to contribute to the health and safety of youth.

Bullying

Healthy Youth Survey data on the percentage of Yakima School District youth reporting being a victim of bullying show that, except among 6th graders, reports of bullying are trending downward. In fact, findings further indicate that, in 2018, bullying declined across 8th, 10th, and 12th grade levels to historically low rates as compared to previous years. Conversely, victimization rates increased among 6th graders, with 29% reporting being bullied at least once in the past year – reversing the downward trend since the 2012 survey period.

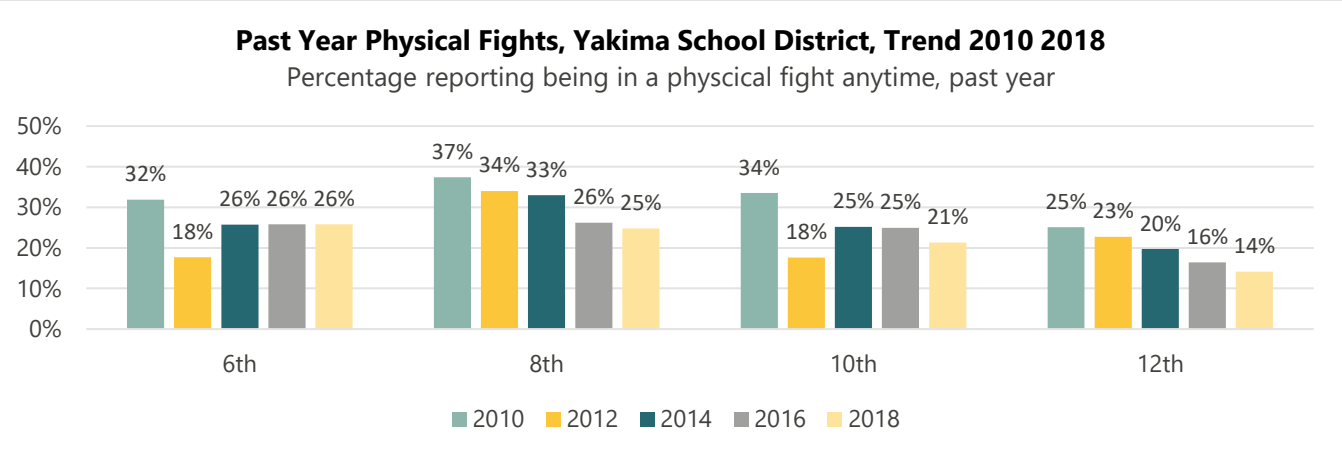
A recent study released by the University of Michigan (2020) found that *"Bully victimization damages how people view themselves in adolescence and that negative view can linger into adulthood, contributing to poor mental health."*



Source: Healthy Youth Survey (2010-2018) at askhys.net

Physical Fighting and Weapon Carrying

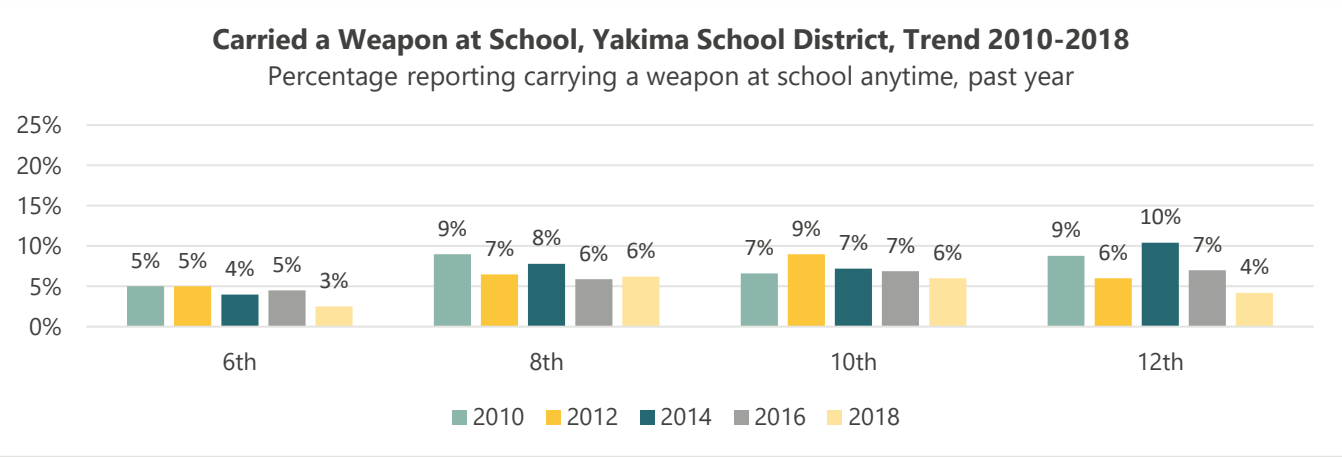
The following figures show the percentage of youth that reported engaging in behaviors related to intentional injury of others.



Source: Healthy Youth Survey (2010-2018 at askhys.net

Since 2010, the percentage of youth that reported being in at least one physical fight in the past year has declined across all grade groups. In 2018, one-in-four 6th graders and 8th graders reported engaging in this type of behavior. Among high school students, a higher percentage of 10th grade students reported fighting than 12th grade youth (21% vs. 14%, respectively).

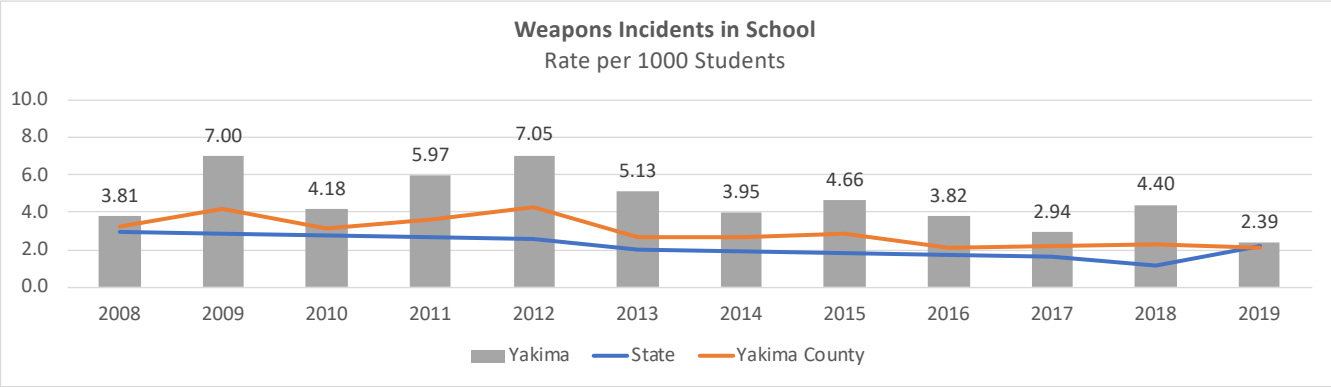
The graph below shows the percentage of HYS respondents that reported carrying a weapon at school during the previous school year.



Source: Healthy Youth Survey (2010-2018) at askhys.net

These data show that the percentage of youth that report carrying a weapon at school has fluctuated over the survey periods, but generally declined from 2010 rates. In 2018, fewer 6th and 12th graders reported engaging in this type of behavior as compared to 2016. Rates of weapon carrying among 8th and 10th grade youth remained mostly stable during this same timeframe, with 6% of these youth reporting bringing a weapon to school in 2018.

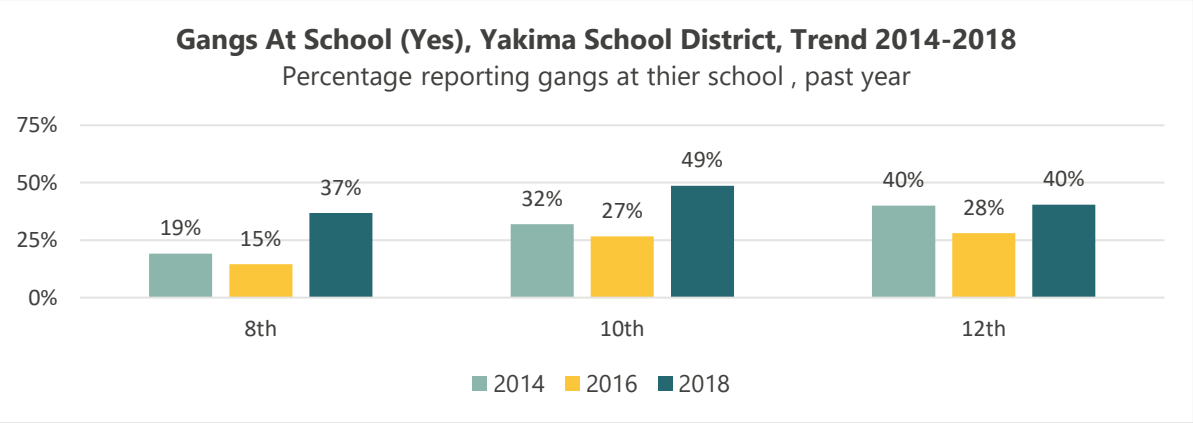
The below figure shows the rate of weapons incidents reported in schools between 2008-2019.[3] In general, incidents of guns and other weapons on school property are rare events with this true both locally and statewide, although in Yakima these rates have trended higher. Since rates peaked in 2012, the frequency of weapons incidents in the district have declined, following county and statewide trends, with the lowest incident rate reported in 2019.



Source: Washington Office of Superintendent of Public Instruction, Information Services, Safe and Drug-free Schools: Report to the Legislature on Weapons in Schools RCW 28A.320.130

Gangs in Schools

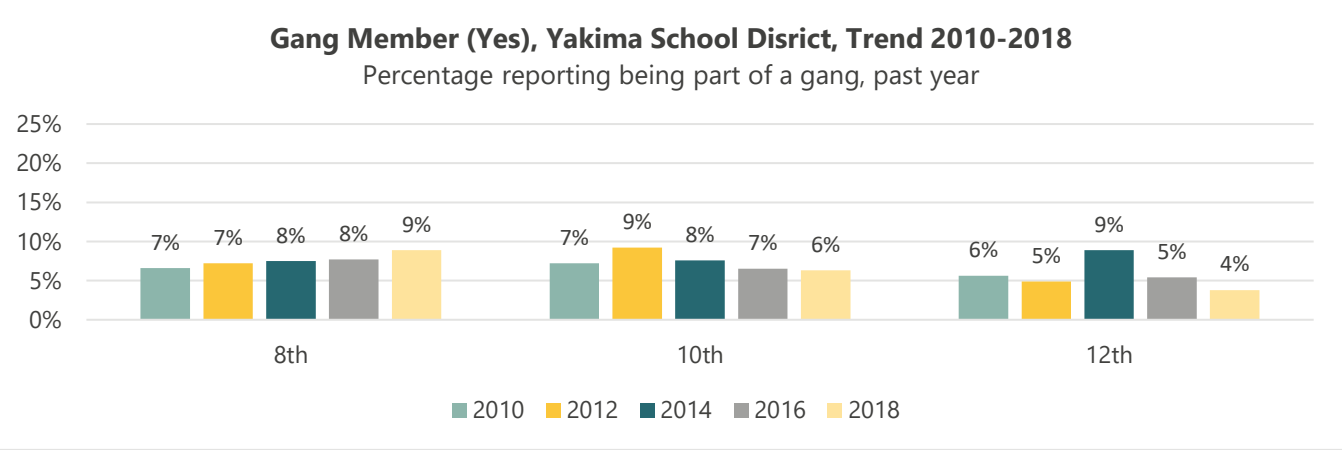
In response to the question, "Are there gangs at your school?" across all grade groups, perceptions of gang activity increased substantially between 2016 and 2018. In fact, nearly half of 10th graders, 40% of 12th graders, and 37% of 8th grade youth reported gangs in their schools in 2018.



Source: Healthy Youth Survey (2014-2018) at askhys.net

The HYS also asks students if they had been a member of a gang during the past 12 months. Gangs are defined as "a group of people with a leader who act together often for violent or illegal activities" (HYS, 2018). Although perceptions of gang activity increased in 2018 (as noted above), few students across grade levels acknowledged gang membership, and rates have remained mostly stable across survey years, with between 4%-9% of students claiming such behavior in 2018.

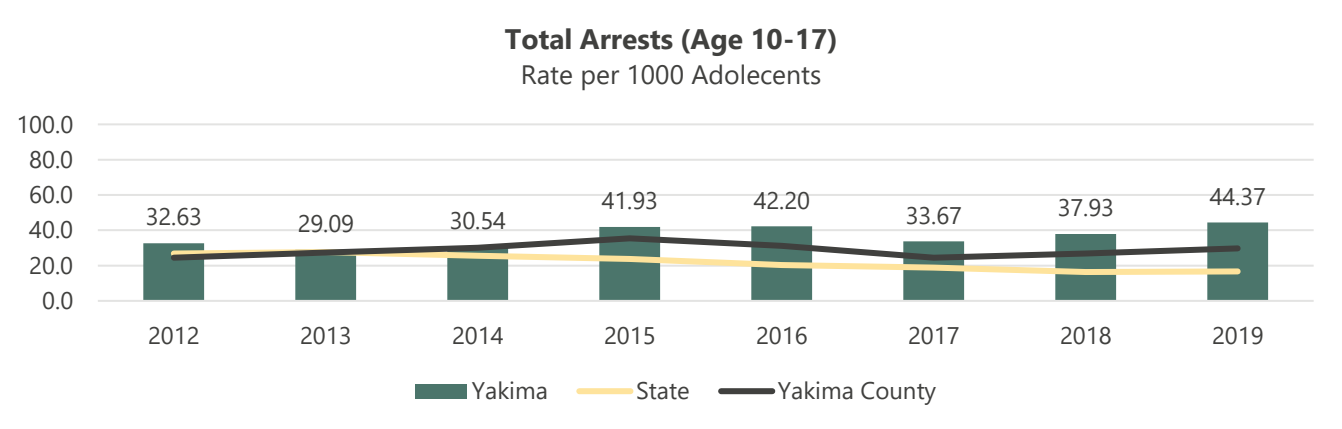
[3] The reported incidents involving guns and other weapons at any grade level per 1000 students enrolled in October of all grades.



Source: Healthy Youth Survey (2014-2018) at askhys.net

Arrests of Juveniles (Age 10-17)

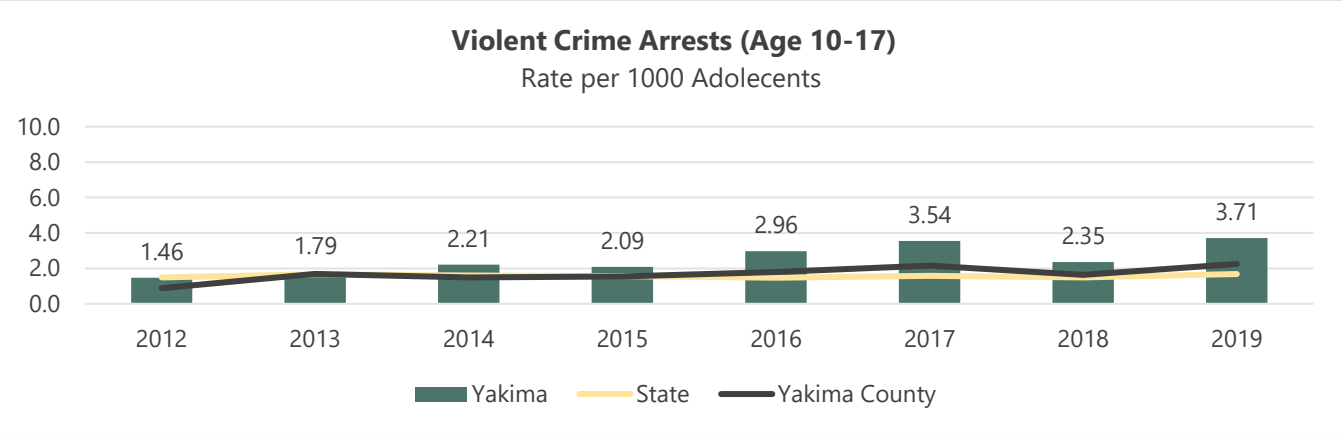
Data in the following two charts show adolescent arrest rates for youth ages 10-17 (per 1,000 adolescents age 10-17) for the Yakima School District, Yakima County, and Washington State.



Note: The arrests of adolescents (age 10-17) for any crime, per 1,000 adolescents. Source: Washington Association of Sheriffs and Police Chiefs (WASPC): National Incident-Based Reporting System (NIBRS).

The above graph shows the rate of juvenile arrests for any crime,[4] per 1,000 adolescents (age 10-17) at the state and local levels. Statewide there has been a significant and steady decline in the arrests of adolescents (age 10-17) since 2012. In fact, the 2019 arrest rate was 10.03 points lower as compared to 2012 at the state level (16.72 vs. 26.75, 2012), representing a 37.5% reduction. In contrast, juvenile arrest rates have increased at the district level. Specifically, in the Yakima School District, during this same time frame, there was a 11.7 percentage point rise in the arrest rates, representing a 36% increase in adolescent arrests – more than 2.5 times above the state rate.

[4] Reported crimes included Part One offenses: e.g., criminal homicide, forcible rape, robbery, aggravated assault, burglary, larceny, motor vehicle theft, and arson as well as others including forcible and non-forcible sex offenses, fraud, kidnapping, and drug violations. Overall, accounted in these data are arrests for 23 different offenses.



Note: The arrests of adolescents (age 10-17) for any crime, per 1,000 adolescents. Source: Washington Association of Sheriffs and Police Chiefs (WASPC): National Incident-Based Reporting System (NIBRS).

The above graph shows the rate of juvenile arrests for violent crimes (e.g., criminal homicide, forcible rape, robbery, and aggravated assault) at the state and local levels. As with the overall juvenile crime rates (age 10-17), statewide violent crime arrest rates have remained mostly steady, with a violent crime rate 1.68 (per 1000) in 2019. As noted with total arrest rates among Yakima School District youth, rates of violent crime arrests have also risen since 2012. In fact, as compared to 2012, arrests for violent crimes among juveniles shows a nearly three-fold increase in 2019 (3.71 vs. 1.46, 2012), with this well above the state rate (1.68).

Summary and Implications

In the school environment, results demonstrate that bullying victimization, physical fighting, and weapon incident rates have generally declined or remained stable. However, student perception of gang activity in their schools has increased among those surveyed with between 37%-49% reporting gangs in their school in 2018. Although few students, in general, acknowledge gang membership, 2018 rates have increased slightly among 8th grade youth. Arrest data also show increasing arrest rates for adolescent youth in recent years.

School staff who participated in the assessment interviews shared about difficulties facing the district families, including trauma, use of drugs, and gangs.

> *"Our students come from a distressed or difficult demographic. They're from fractured families and difficult situations at home, whether it's drugs, alcohol, gangs. Our school is very much kind of like an inner-city school. Kids coming from difficult backgrounds and with high levels of trauma in their life. They tend not to talk a lot and not open up a lot."*

Research has shown that being a target or victim of bullying has immediate and long-term psychological and social effects, influencing a young person's academic achievement and psychosocial adjustment into adulthood (Espelage & DeLaRue 2012). One of the most effective ways to address bullying in the school setting is to improve the school's climate and culture (Fein et al., 2004).

Not surprisingly, there are numerous consequences of gang membership. Research findings show that youth involved with gangs engage in higher levels of delinquency than their peers who are not involved with gangs are more than twice as likely to carry a gun, and three times as likely to sell drugs as compared to youth who are not gang involved (Bjerragaard and Lizotte 1995; Cahill and Hayeslip 2010; Hill, Lui, Hawkins 2001; Spergel 1995; Thornberry 1998). Moreover, gang involved youth are considerably more likely to be victims of violence than other individuals (Howell 2013).

Gang problems disproportionately occur in schools that serve areas of concentrated poverty and social disorganization, where many families experience economic hardship and the unemployment rate is high (National Criminal Justice Reference Service, 2013). As demonstrated in previous sections of this assessment, the Yakima community faces a number of these social and environmental factors.

Research on school related protective factors indicates that when students are provided with meaningful opportunities to participate and are recognized and rewarded for their contributions, they are less likely to engage in delinquent or risky health behaviors. In addition, Arthur et al. (2005) found that reduction of risk factors and substance use and increased protective factors among school populations are linked to improved student academic outcomes.

Research has also demonstrated that a positive school climate is a crucial component of violence prevention that can influence behavioral outcomes (e.g., lower rates of aggression, victimization, and dropout), and may enhance youth's resilience factors (National School Climate Center, 2012). As such, it is essential to embed not only a robust set of positive school-wide behavioral expectations (enforced fairly and consistently) but also to ensure on-going social-emotional (SEL) skill building for all youth. In addition, as part of the build out of a multi-tiered system of supports, the district should also consider selective (Tier 2) and individualized (Tier 3) interventions that can provide further pro-social behavioral support for youth that may be at increased risk for, or already involved in gang-related activity as well as ensuring that family members are engaged in intervention services across all levels.

Community Assets and Strengths

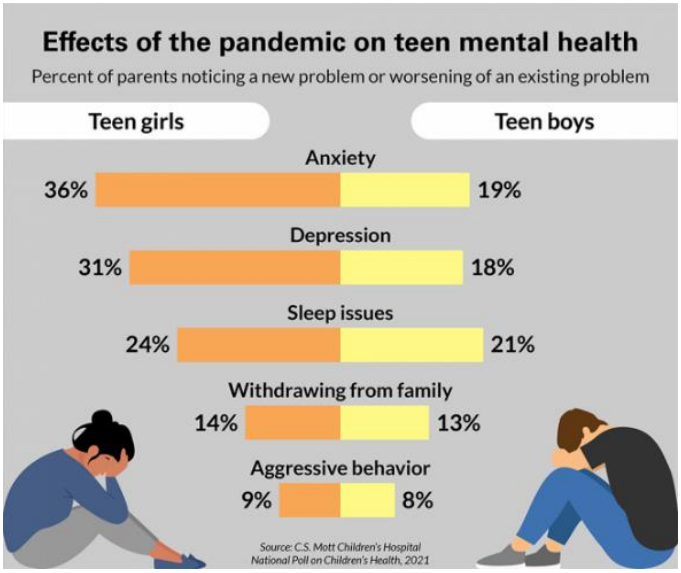
Below are available assets and resources supporting Yakima County and the Yakima District region:

- The Washington Office of Refugee and Immigrant Assistance (ORIA) partners with organizations across the state to offer services that are culturally respectful and in the preferred language of immigrants and refugees.
- Washington Immigrant Solidarity Network (WAISN) is the largest immigrant-led coalition in Washington state, composed of immigrant and refugee-rights organizations and individuals. It strives to protect, serve, and strengthen communities across the state. Its hotline (1-844-724-3737) serves as avenue for immigrant and refugee communities to report Immigration Custom and Enforcement (ICE)/Custom Border Patrol (CBP) activity in their community, report the detention of a group or individual, and obtain information or referral assistance.

Mental and Behavioral Health and Well-Being

Mental health disorders are prevalent among school-aged children (aged 13-16) with approximately one-in-five impacted by a diagnosable mental health or learning disorder (Center for Disease Control and Prevention, May 2013). Despite growing knowledge and awareness of mental health issues among school-aged children, there remains a persistent gap between the number of children needing mental health supports and those that receive it. In fact, the average delay (nationally) between the onset of mental health symptoms and intervention is 8 to 10 years, with many children never receiving services (Behrens, 2013; Gall et al., 2000; Kataoka et al., 2002).

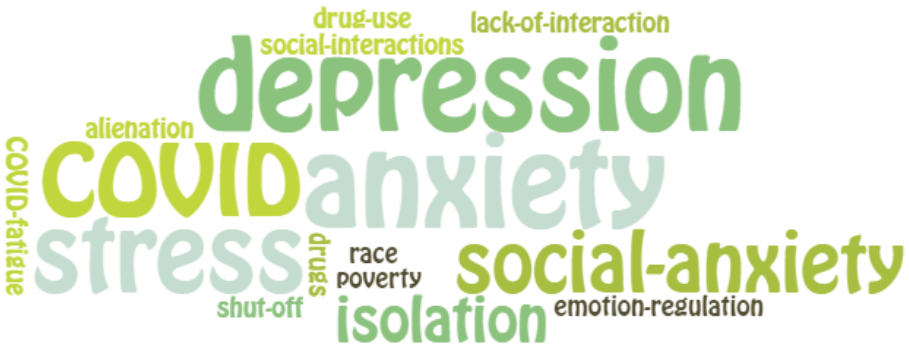
In Washington state, young people face major barriers to getting mental health care. In fact, the 2021 Mental Health America report ranks Washington among the lowest states regarding access to care for youth mental health (Mental Health America, 2021). Experts agree that because schools offer unparalleled access to youth, the education system is key to providing children with the needed behavioral health care. Yet historically Washington's education system has failed to adequately address issues related to students' mental health and well-being. For example, public schools employ, on average, one psychologist for every 1,000 students, far below the national standard of one psychologist for every 500-700 students (The Seattle Times, April 4, 2021).



In addition to the existing needs and traditional barriers that students and families face when accessing behavioral health care, including racism, these are likely exacerbated by the ongoing uncertainty and distress of the COVID-19 pandemic. "Nationally, emergency visits for mental health issues jumped by 31% among 12- to 17-year-olds during the pandemic" (The Seattle Times, April 4, 2021 citing the Centers for Disease Control). The need in our state has grown exponentially, prompting Governor Jay Inslee to declare a youth mental health crisis in March 2021.

Teachers and other adults in schools have important health and wellness needs, too. Findings from a poll conducted by the Kaiser Family Foundation in mid-July 2020 found that 53% of adults surveyed reported that their mental health had been negatively impacted as a result of worry and anxiety over the COVID-19 pandemic – up significantly from the 32% of adults reporting such in March (Panchal, Kamal, Orgera, Cox, Garfield, Hamel, Munana, & Chidambaram, 2020).

Stress among teachers has also been linked to poor job performance and decreased student outcomes. Indeed, students of highly stressed teachers demonstrated lower levels of academic performance and social adjustment (Jennings & Greenberg, 2009). When high job demands and stress are combined with low social-emotional competence, teacher performance and classroom management deteriorate (Montgomery & Rupp, 2005).



Overwhelmingly, participants of focus groups and interviews identified that the most pressing mental health issues facing youth in the Yakima School District were depression and anxiety. Staff, parents, and students themselves identified an increased social anxiety due to COVID, as well as depression (diagnosed or not) because of isolation. The COVID pandemic and its economic, social, and health impacts were on everybody's mind, even as the community transitions to hybrid school models and more social interaction.

> *"We've seen a significant decline in mental health. We've run a screener a couple times a year, where students answer their own questions. We've roughly doubled the number of students who identified as being depressed. And the question, 'do you think there's a staff member in the building who cares about you and your wellbeing?' We had maybe 20 or 30 at the beginning of the year who don't feel like there's any people in the building would care about those kinds of things. By the end of the year, we are at 112 students."* —School staff member

These areas of concern are not new, however. School staff members identified social determinants of health such as poverty and race as factors directly impacting youth's mental health.

> *"I think that they're having to deal with a lot of adult things that not even adults can handle."*

> *"Another mental health issue that I see is probably race and this feeling that most of the teachers here are white. However, 98% of the students are Hispanic, so there's already some sort of disconnect there. It would be hard when you don't see yourself reflected in that community and how to engage or understand what it looks like for you know, someone who's living a totally different life and with different opportunities. You wanna have the kids see themselves in the teacher, see themselves in the curriculum, and I feel like that's hard. The kids are alienated by what we teach them. And they don't really see the practical uses of it."*

> *"The kids have a lot of responsibilities at home [work, taking care of siblings] that take precedence over their schooling, and I don't know if that creates another discord. School is just an extraneous thing."*

Participants also shared that it is as critical to contribute to the mental health of teachers, school staff, and parents as it is to support the students.

> *"I know that some of the parents have gone through incredible trauma themselves."*

> *"I think a lot of adults in the building are suffering from just as much depression and anxiety as the students are, so it's kind of like the blind leading the blind."*

The parents who participated in the focus group feel that teachers are very receptive.

Students expressed that they mostly rely on their peers for support, although some consider that they have adults in their school that they can they can talk to when they need help:

> *"Honestly, I feel like a lot of students don't connect well with adults."*

> *"I have a group of friends at school with whom I can talk candidly about mental health. I've also worked to develop connections with my teachers, and once that foundation is built, I believe they often become more receptive to those types of concerns."*

> *"Man, I had a teacher that I really, really like connected with and I was able to talk to them about it and that helped."*

Participants spoke about cultural differences between the students and their parents or caregivers on how they 'fit' socially.

> *"There's a disconnect with their parents because their parents speak Spanish or are from kind of more working-class backgrounds, whereas the kids getting raised with phones, watching YouTube, watching Tik Tok where they see all these more materialistic things, and they speak English, so there's already a huge divide."* —School staff member

There also seems to be a cultural association about being depressed as not being strong enough.

> *"I really do feel like it is a cultural thing because like nobody wants to be considered crazy, whereas some cultures believe, 'yes, you should talk about your mental health; you should celebrate it'. But in some other ones, there's such a stigma around like anxiety or depression that it's that you're just not trying hard enough."* —Student

> *"I think it is a little bit of culture mixed into mental health because it's more of a stereotype like some like cultures are more headstrong and not as sensitive, like I'm Latina and it's not exactly the coolest thing to be sensitive and you have to be more tough and head strong when it comes to your emotions and it's not really talked about at all 'cause it's considered weak. So I don't really talk about my emotions much at home."* —Student

For some staff, however, there is no stigma—to the contrary, the younger generations may be blowing mental health issues almost out of proportion.

> *"This is kind of aged me I guess, but I feel like it's so much more out there than it ever was that it's just like kids throw out around the words anxiety and depression just like it's pop or soda, like it's nothing. So it's been interesting for us to kind of decipher what's really going on. It's kind of like bullying: not everything is bullying, but that word is just out there. It's like, "are you really being bullied? Or are you just mad at somebody because he's rude? I don't think that there's a stigma because that's just kind of the thing to do now is to be anxious and to be depressed. Kids get a lot of attention for those things, good and bad attention."* —School staff member

About half of the students who participated feel that they feel comfortable and able to talk about mental health with their parents.

"I personally receive a lot of support from my family. My parents are very worried about like my mental state not because of anything else other than really Covid. They just want to make sure that I'm alright and there's a lot going on this year that they were worried about just being alone in general and being isolated."

"My family has really always been open about mental health and always being open about our feelings. We've always communicated very openly so especially during Covid we've always like we've kept in touch and talked about how we're dealing with our issues."

"My parents, they don't really talk about mental health. I mean they don't really see it as… it's not our first priority. It's usually mostly about physical health and if we're OK."

"Sometimes for parents also pretty awkward when it comes to talking to their kids about feelings and emotions because some parents didn't grow up with emotions. Like my parents, they never were in the households where it was OK talking or expressing love. They hung out with their siblings or they did yard work and that's how you express gratitude or love, so I guess when they passed that down you don't really know how to express it 'cause that's what you've been taught."

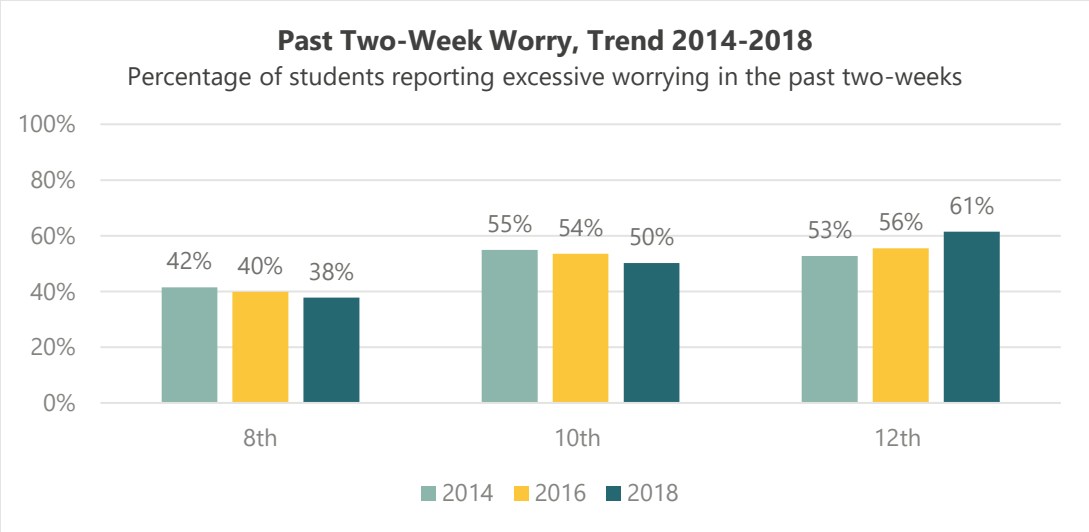
Emotional Well-being

Emotional well-being refers to the emotional quality an individual experiences, and can be influenced by a variety of demographic, economic, and situational factors. The implications of decreased emotional well-being are related to some of the most common mental disorders in school-aged youth, including depression, anxiety, attention-deficit hyperactivity disorder (ADHD), and behavioral or conduct problems (Perou, R., Bitsko, R, Blumberg, S, et al., 2013), all of which can negatively affect their ability to function in the school, home, and community settings.

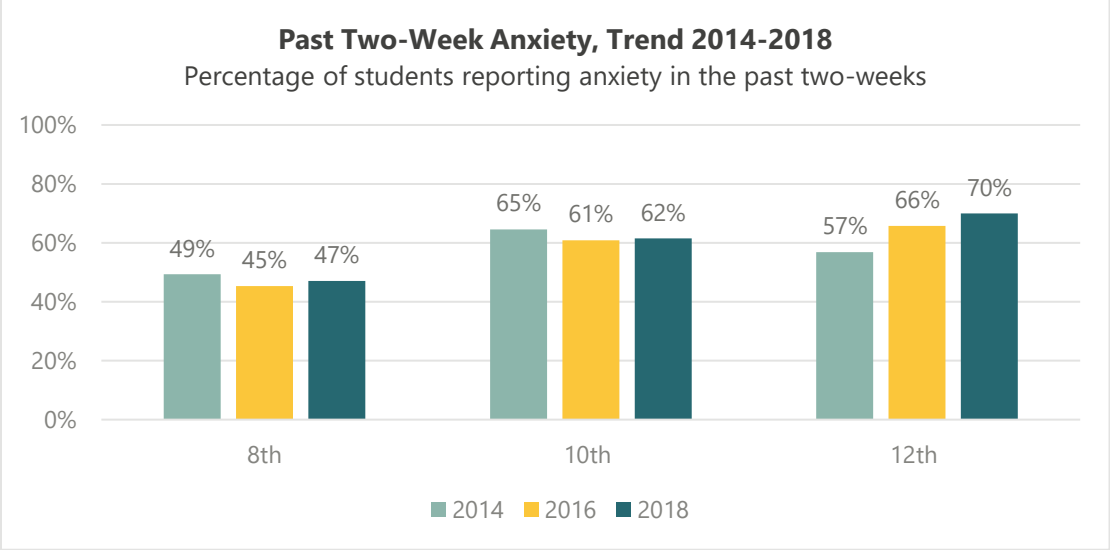
Since 2002, the Healthy Youth Survey, sponsored by the Department of Health, the Office of Superintendent of Public Instruction, the Department of Social and Health Services, the Department of Commerce, the Family Policy Council, and the Liquor Control Board, in cooperation with Washington schools, has been administered every other year in the fall to students in grades 6, 8, 10, and 12 across the state. The survey measures health risk behaviors known to contribute to the health and safety of youth, including mental health and well-being.

Worrying and Anxiety: In 2014, two mental health related questions were added to the HYS for 8th, 10th, and 12th grade youth: "*How often over the past 2 weeks were you bothered by not being able to stop or control worrying?"* and, *"How often over the last 2 weeks, were you bothered by feeling nervous, anxious, or on edge?"*

The following figures show rates of reported past two-week excessive worrying and anxiety among Yakima's 8th, 10th, and 12th grade youth. In 2018, 38% to 61% of students reported excessive worrying during the previous two weeks, with rates increasing among 12th graders from 2016. Findings further show in 2018 that from 47% to 70% of students reported feeling anxious, with rates rising among 12th grade youth between 2016 and 2018, while mostly unchanged among 8th and 10th graders.



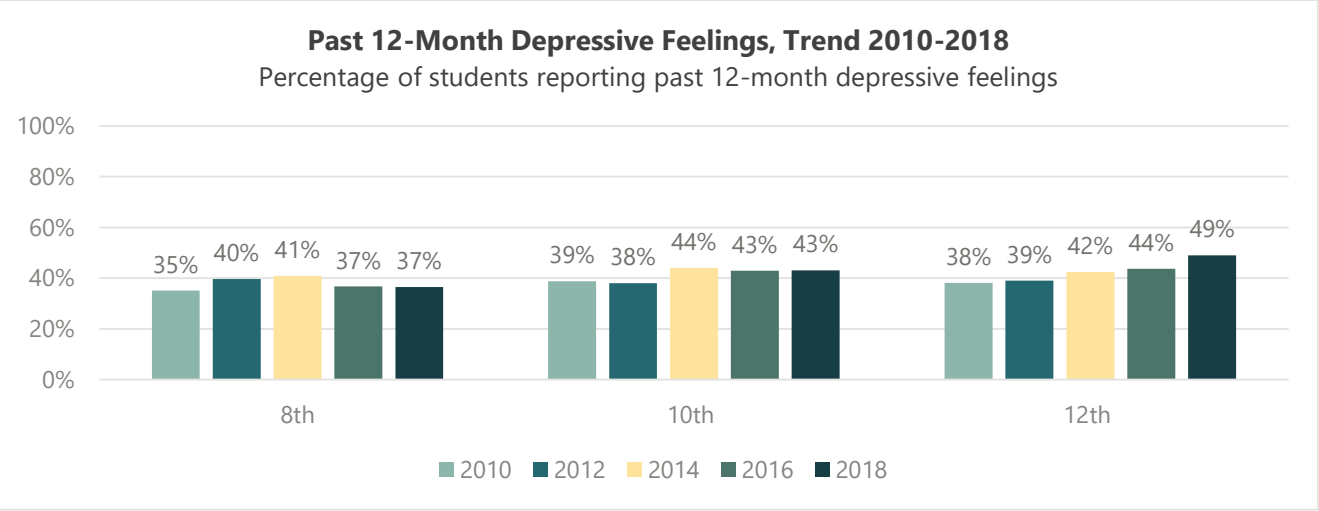
Source: Healthy Youth Survey (2010-2018) at askhys.net



Source: Healthy Youth Survey (2010-2018) at askhys.net

The HYS also asks youth about the frequency of feelings of depression asking students, *"During the past 12 months, did you ever feel so sad or hopeless almost every day for two or more weeks in a row that you stopped doing some usual activities?"* Findings show that rates of past year depression among 8th, and 10th grade youth were stable, and increased somewhat among 12th graders between 2016 and 2018. In 2018, 37% of 8th graders, 43% of 10th graders, and 49% of 12th grade youth reported feeling sad or hopeless. Putting these data into perspective, **an estimated 410 8th graders, and 494 10th grade youth reporting symptoms of depression** in the past year.[5]

[5] Extrapolations figures are based on the enrollment for 8th and 10th grade students in 2018 and assume a representative sample of students responded. Response rates (2018) 8th Grade: 74%, 10th Grade: 71%



Source: Healthy Youth Survey (2010-2018) at askhys.net

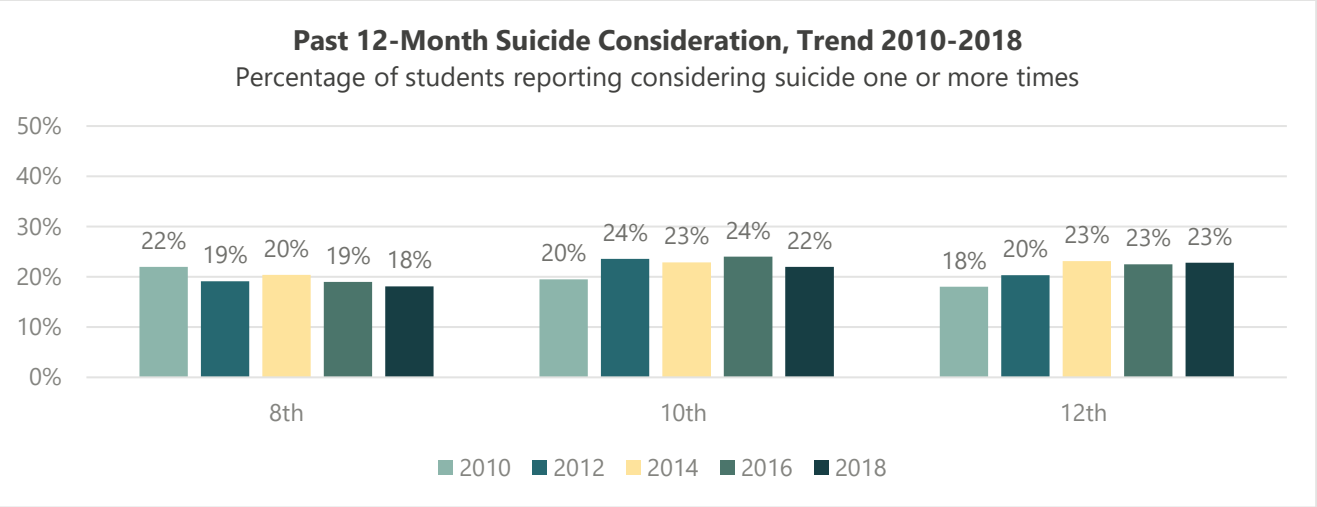
Suicide

Nationally, rates of suicide were rising, even before the pandemic. For teens between the ages of 15 and 19 suicide rates increased by 76% between 2007 and 2017, with the suicide rate for 10-to 14-year-olds nearly tripling over that same time period (US Center for Disease Control, 2019).[6] Since the pandemic, the Centers for Disease Control and Prevention (CDC) estimates that nationally, one in four people under age 18 have struggled with suicidal thoughts. Rates were particularly high among certain other populations, including young adult respondents aged 18–24 (25.5%), Hispanic respondents (18.6%), Black respondents (15.1%), and essential workers (21.7%) (WA State DOH, December 2020)

Since inception, the HYS has asked a series of questions about suicide. The following figures show responses to the following three questions, by grade level: "*During the past 12 months did you ever seriously consider attempting suicide?", "During the past 12 months did you make a plan about how you would attempt suicide?",* and *"During the past 12 months, how many times did you actually attempt suicide (any)?"*

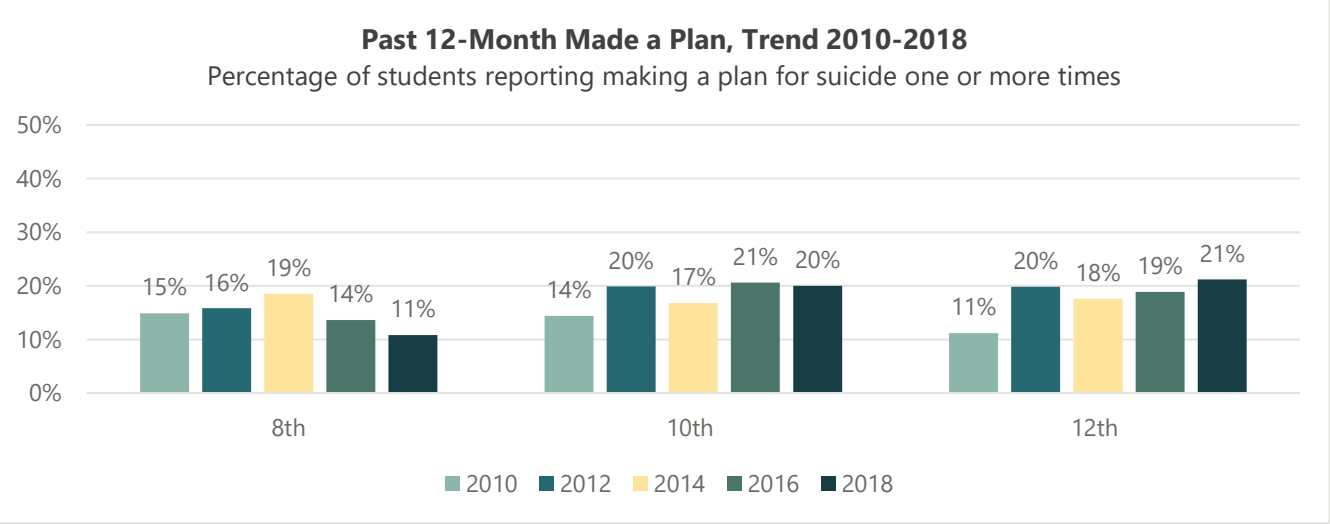
In the first figure below, data show the percentage of 8th, 10th, and 12th grade Yakima youth who reported past year suicidal ideation.

Death Rates Due to Suicide and Homicide Among Persons Aged 10–24: United States, 2000–2017, see https://www.cdc.gov/nchs/products/databriefs/db352.htm



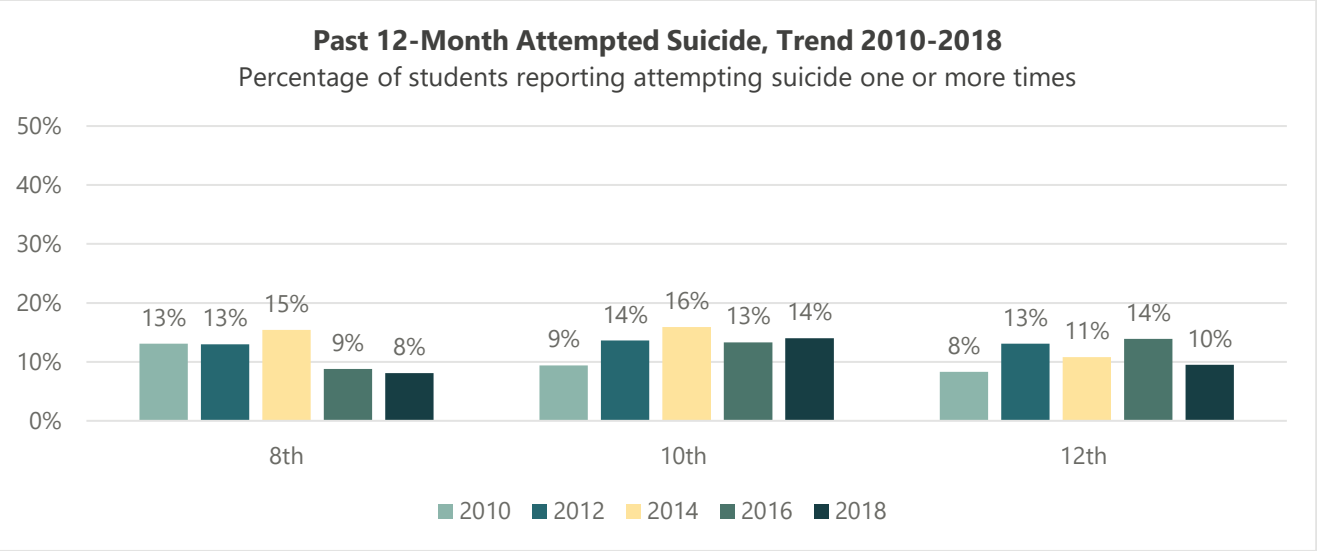
Source: Healthy Youth Survey (2010-2018) at askhys.net

These data indicate that rates of suicidal ideation have remained mostly stable across survey years and grade groups, with on average of one-in-five students considering suicide in 2018. According to these data, approximately **200 8th grade youth and 253 10th graders seriously considered suicide** in 2018.



Source: Healthy Youth Survey (2010-2018) at askhys.net

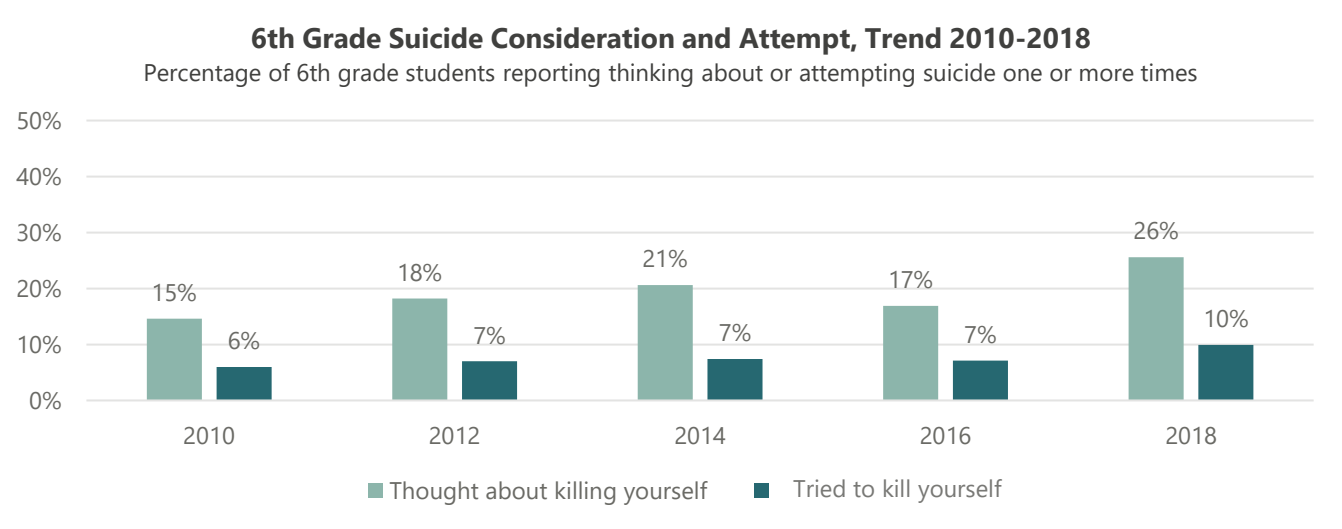
Rates of reported plan making for suicide show that these types of actions have decreased since 2014 among 8th grade youth while stable among 10th and 12th grade respondents. In 2018, one-in-five 8th graders, and one-in-ten 10th and 12th grade youth made a plan to commit suicide on at least one occasion.



Source: Healthy Youth Survey (2010-2018) at askhys.net

The above figure illustrates the percentage of 8th, 10th, and 12th grade students that reported attempting suicide on one or more occasions in the past year. In 2018, 8% of 8th graders, 14% of 10th graders, and 10% of 12th grade students attempted suicide. According to these data, approximately **250 8th (89) and 10th (161) grade students attempted suicide** at least once in the previous year.

The HYS also asks 6th grade youth the following two questions about suicide: *Have you ever seriously thought about killing yourself? Have you ever tried to kill yourself?*

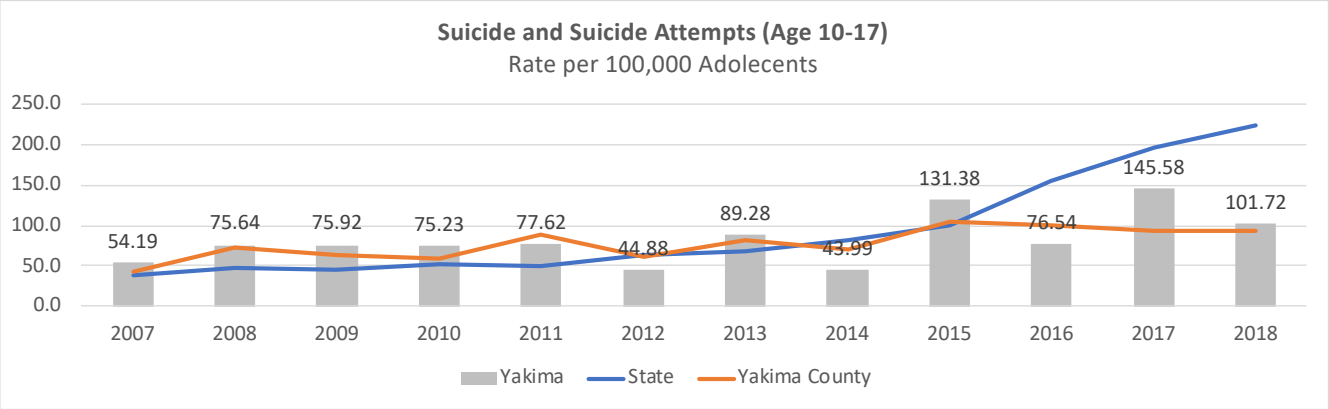


Source: Healthy Youth Survey (2010-2018) at askhys.net

Among Yakima 6th graders, lifetime suicidal ideation has increased considerably since 2010, with one-in-four students reporting these thoughts in 2018 – a rate that exceeds their older peers. Suicide attempts have also risen since 2010, with a 3-percentage point rise between 2016 and 2018 (7% vs. 10%,

respectively). In 2018, **more than 125 6th grade students reported attempting suicide** at least once in their lifetimes.

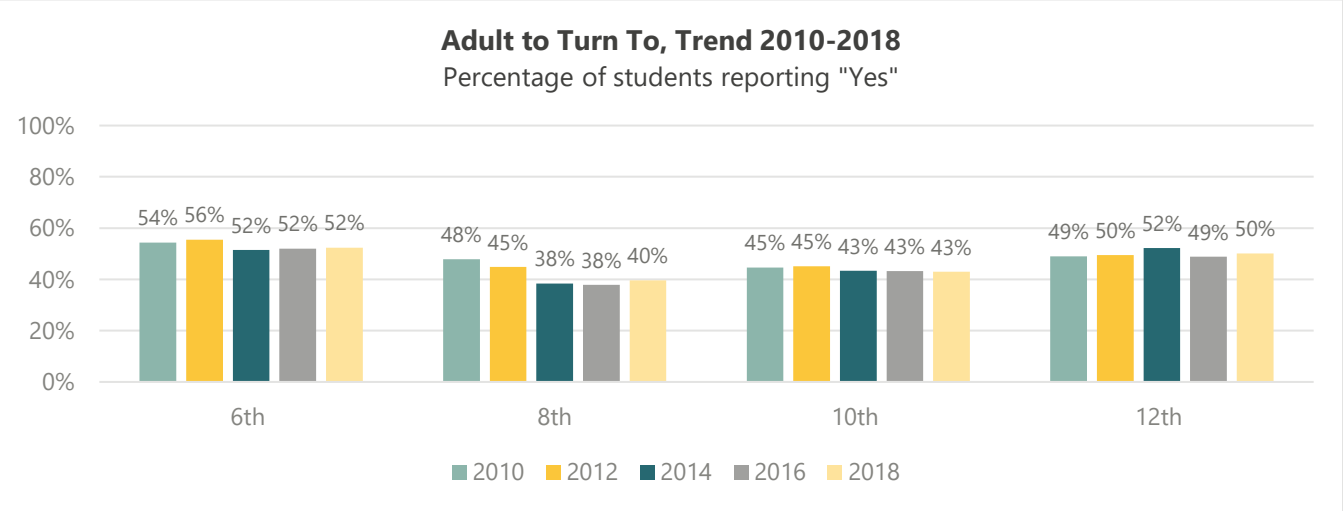
The following graph shows the rate of adolescent suicide and suicide attempts among youth aged 10-17 comparing Sunnyside School District to Locale 16, county, and statewide trends between 2007-2018. These data demonstrate the high and increasing rate of suicidal ideation and suicide among school-aged youth statewide in recent years, with the rate per 100,00 rising dramatically since 2007. In 2018, among the Yakima district youth population this rate declined as compared to the previous year and is trending below the state rate (101.72 vs. 224.2, state).



Source: Department of Health, Office of Hospital and Patient Data Systems, Comprehensive Hospital Abstract Reporting System (CHARS) and Department of Health, Center for Health Statistics Death Certificate Data

Help Seeking

The HYS asked students, "When you feel sad or hopeless, are there adults that you can turn to for help?"

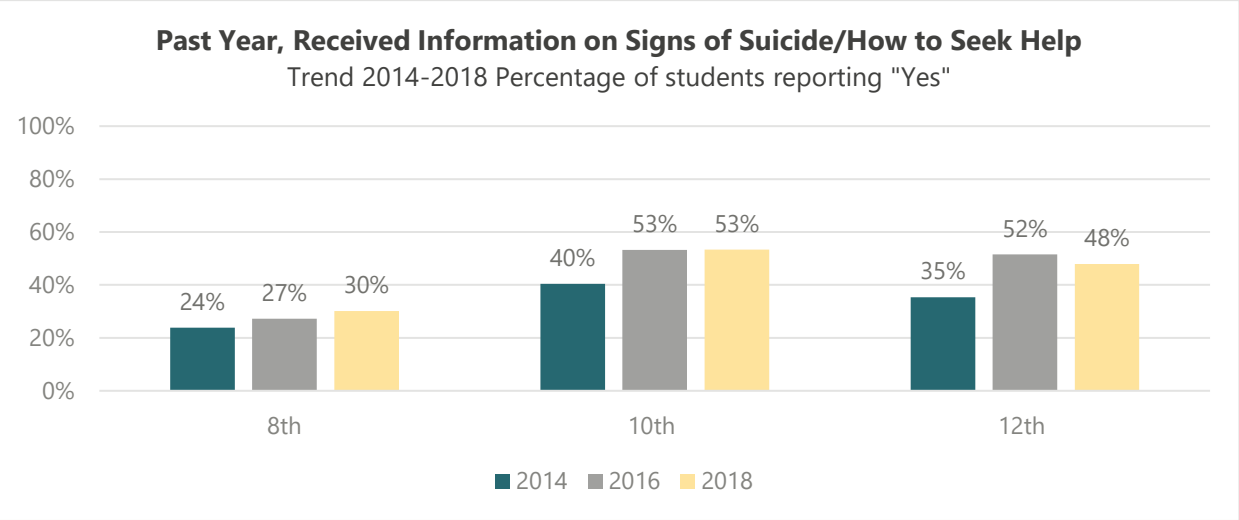


Source: Healthy Youth Survey (2010-2018) at askhys.net

These data show the percentage of students that reported having an adult to turn to if/when they feel sad or hopeless. In general, rates have remained mostly stable across survey years and grade levels.

Although, for both 8th and 10th graders, these students are somewhat less likely to report having an adult to turn to as compared their younger and older peers.

The final figure shows the percentage of students who recalled receiving information regarding the signs of suicide and how to seek help (for themselves and others). These data illustrate that in 2018, nearly half or more of 10th and 12th grade students reported receiving these types of information. In contrast, only 30% of 8th grade youth were aware of this information.



Source: Healthy Youth Survey (2014-2018) at askhys.net

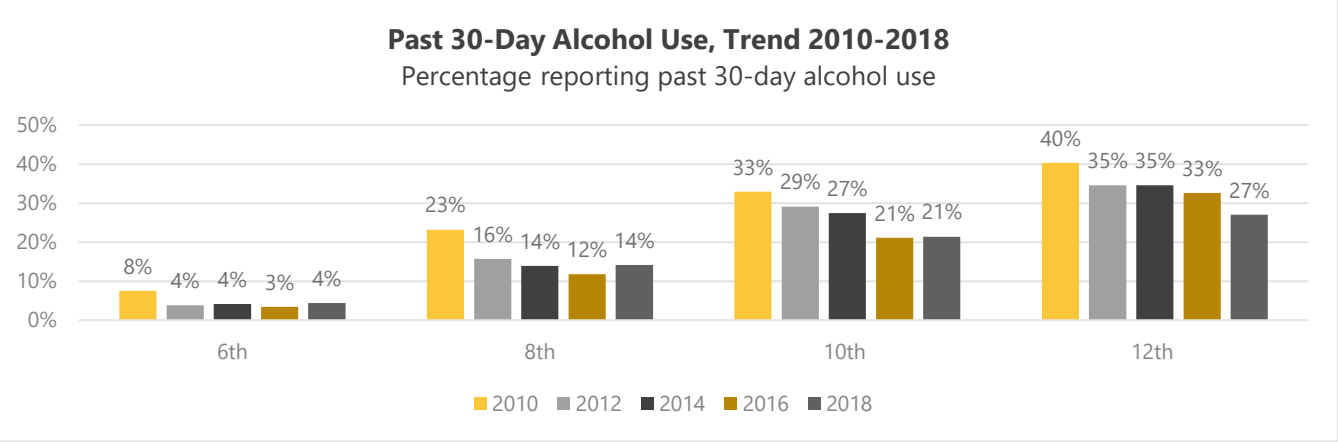
Adolescent Substance Use

Alcohol Use

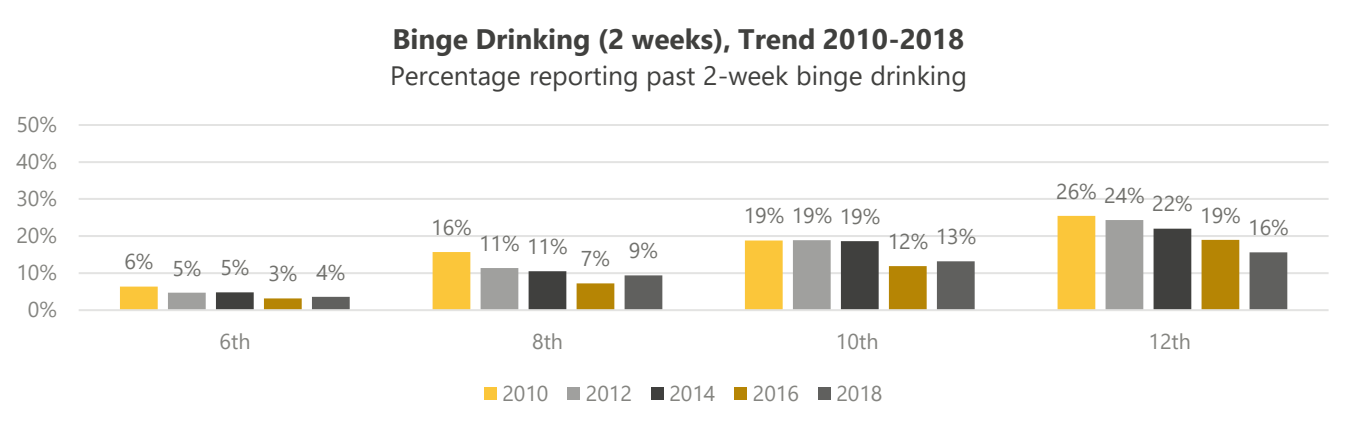
"While multiple factors influence suicidal behaviors, substance use—especially alcohol use—is a significant factor that is linked to a substantial number of suicides and suicide attempts. This "nexus" between substance use and suicide provides an opportunity for behavioral health leaders to develop a cohesive strategy within a public health framework to reduce suicidal behaviors and suicide rates." – SAMSHA Brief (2016)

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

The following figures illustrate past-30 day and binge drinking rates among survey participants. Rates of recent alcohol use (past 30-day) among Yakima students across grade groups is declining from 2010 levels – a trend seen statewide. However, data show a significant increase in alcohol use between 6th and 8th grades. In 2018, use increased slightly from 2016 levels among 8th graders, was stable at the 10th grade level, and declined among 12th graders.



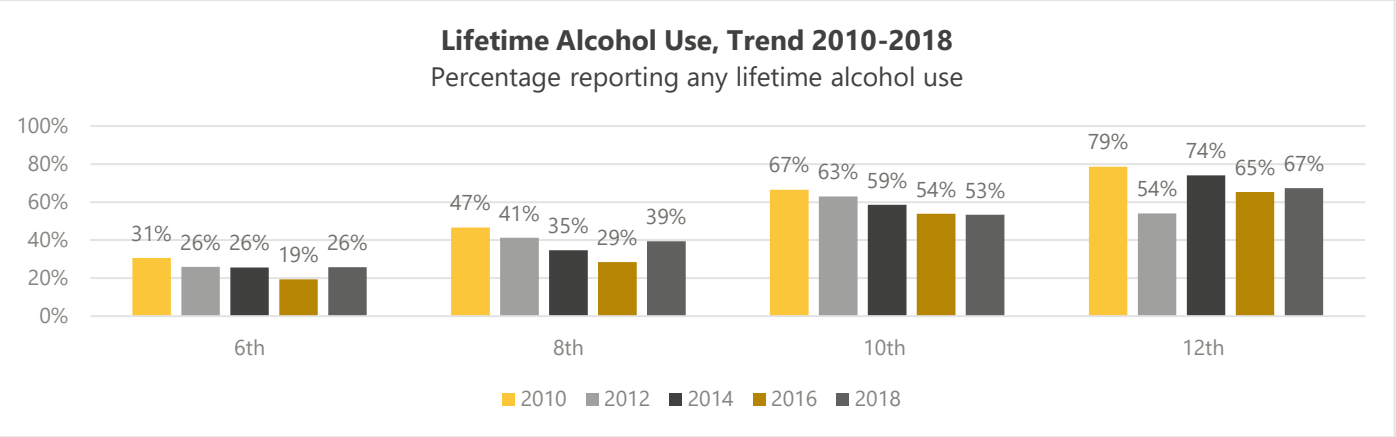
Source: Healthy Youth Survey (2010-2018) at askhys.net



Source: Healthy Youth Survey (2010-2018) at askhys.net

Although binge drinking rates among students across grades has declined from peak use levels, data show slight increases in binge drinking among 8th and 10th graders between 2016 and 2018. In contrast, among 12th grade respondents, fewer reported heavy use in 2018 compared to 2016.

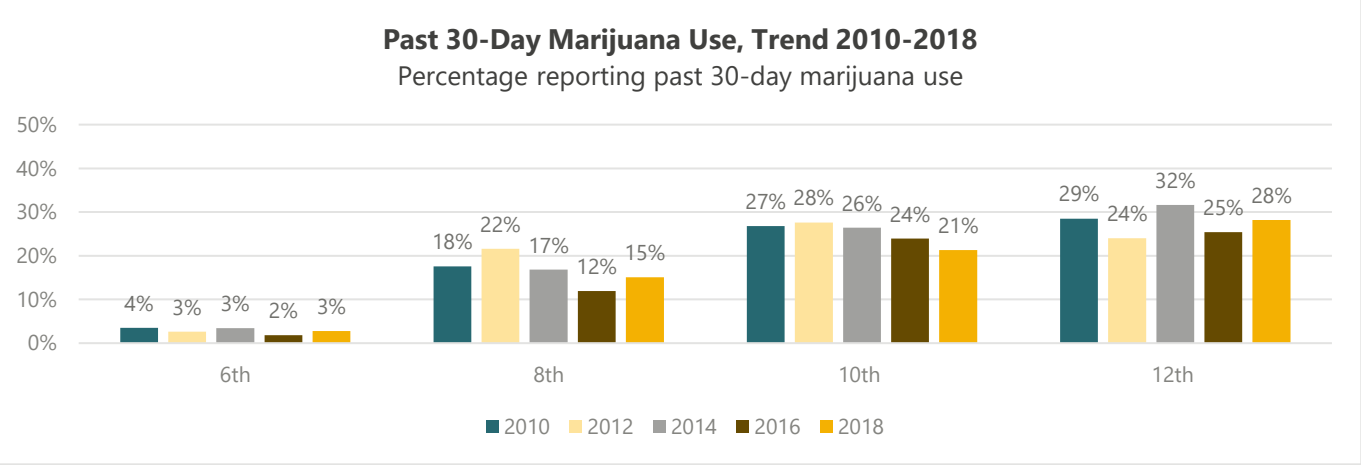
Lifetime alcohol use among Yakima students indicate that although rates have declined over time among 6th graders, slightly more reported use in 2018 as compared to 2016. Among 8th grade respondents, rates declined steadily between 2010 and 2016, but show a marked increase between 2016 and 2018. Among high school-aged respondents, reported lifetime alcohol use rates in 2018, were stable for 10th graders, with a slight uptick in the percentage of 12th graders with lifetime alcohol use as compared to 2016 rates.



Source: Healthy Youth Survey (2010-2018) at askhys.net

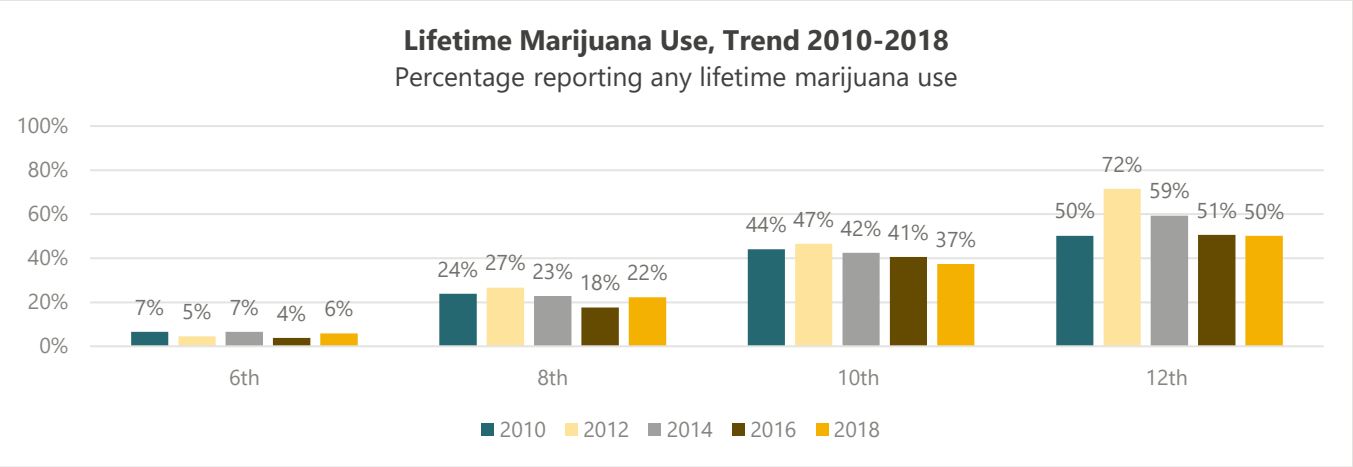
Marijuana Use

Past 30-day marijuana use among 6th grade youth has remained low over the survey periods, with few students reporting use in 2018. Like alcohol, use increased considerably between 6th and 8th grades. Among 8th grade respondents, use is down from its peak in 2012, although increased slightly between 2016 and 2018. At the high school-level, approximately one-in-five 10th and over one-in-four 12th graders reported past 30-day marijuana use in 2018, with use declining slightly among 10th graders while increasing for 12th graders from 2016 rates.



Source: Healthy Youth Survey (2010-2018) at askhys.net

The final figure shows lifetime marijuana use rates for Yakima students. Among 6th and 8th graders, the percentage reporting lifetime marijuana use increased between 2016 and 2018. In contrast, fewer 10th grade participants reported lifetime marijuana use, with rates stable among 12th graders in 2018 as compared to the previous survey period. Among Yakima youth, 6% of 6th graders, 22% of 8th graders, 37% of 10th graders, and 50% of 12th grade students reported any lifetime marijuana use in 2018



Source: Healthy Youth Survey (2010-2018) at askhys.net

Summary and Implications

Findings show a disturbing trend of increased mental and emotional stress among older youth in the Yakima School District, including a rise in excessive worrying and increasing levels of anxiety and depression among 12th grade youth. Reported rates of depression remained steady among 8th and 10th grade youth. Rates of suicide ideation and plan making among 8th, 10th, and 12th grade youth have remained relatively stable, with fluctuation in reports of attempts across the year. However, data show an alarming trend among 6th grade youth, with one-in-four 6th grade students reporting having thought about killing themselves in 2018 and one-in-ten reporting an attempt. In 2018, 30% of 8th graders, 53% of 10th graders, and 48% of 12th grade you reported receiving information on signs of suicide or help seeking during the school year.

On a positive note, these results also indicate decreased alcohol use and fluctuating but generally decreasing use of marijuana among students across grade levels over the survey years.

Everyone who spoke with us shared that in the Yakima School District area, young people face barriers to getting mental health care. They acknowledge that teachers and parents face severe health and wellness needs, too, and that the issues impacting everyone have many layers to it.

"The bandwidth that adults have right now is pretty short as well…"

The main issues include lack of awareness, lack of enough mental health providers in schools, gaps in coordination, inconsistency between schools, need for training across all groups, and difficulty engaging parents and caregivers.

<u>Awareness</u>
All participants asked for an increase in mental health education and awareness activities directed to parents and caregivers. There is widespread lack of knowledge about school- and community-based resources.

"Parents are looking for more. They're looking for more ways to support their student while they're at home. They're looking for the school and the structures that we provide here at school (in the classroom, in clubs, organizations, and sports) to be able to help build those skills within the students."

Both staff and parents strongly shared their concerns about lack of family engagement.

"At our school we have a hard time getting parents to kind of participate in anything and any of our activities, and so I don't know if it would be them just not coming because they don't come to anything, or if it's because they don't care about it." —School staff member

"The school doesn't have to do more. It's more about us, the parents. It makes me sad to see that many are not interested in coming to meetings to talk about our kids." —Parent

"Many parents don't come because they work late or they take turns to work during the day and at night." —Parent

Participants suggested engaging parents to plan and organize the activities, as well as increasing promotion through social media and word-of-mouth.

"I [think they would come to meetings] if they were part of it. If they had some input into it, and if there were ways to engage with multiple people within the community. Because you know, we send out these surveys and we do these different things. But sometimes I think we get the same players planning, and we need different people." —School staff member

<u>Lack of school-based mental health providers</u>

There was agreement among interview participants that there is a need for more therapists and highly-qualified mental health professionals in schools. Staff commended the school counselors and admitted there is a limited number of mental health support to work with the many students that need it.

"We don't have enough counselors. We don't have enough people."

"When it comes to actual depression and anxiety, it's difficult because usually those students self-identify or teachers identify them. We tend to forward off to the counselors, but counselors tend to be overworked as it is, and they always seem like they're at their wits end, so I think there's more clientele than they can handle."

"I feel like there needs to be more of a connection from trained professionals who specialize in this behavior to see through students and follow students from 6th grade to 7th grade, 7th to 8th, 8th into high school, rather than switching hands every year."

—School staff members

<u>Coordination</u>

School staff who participated in the assessment interviews consider that schools are doing the best that they can with the resources they have to address the mental health needs of students. They perceive there is little support coming from the district.

"We try to do the best we can to tackle as much of that as we can. There are two counselors and we have hundreds of kids. So of course, we can't do all of it. In terms of the district support, we have one staff member, but that's pretty much it; everything else just kind of comes from our counseling department and we seek out programs like our Character Strong programs. And we have PBIS, so we try to really promote the positive stuff, and we do that fairly regularly and with pretty good consistency."

"During this remote learning school year, my school has begun to use a curriculum called Second Step. Second Step really breaks down a particular situation and explains the reasons why it's happening. It allows students to reflect upon a good decision and what that could lead to, and a bad decision and how it could make that situation worse."

It appears that for many school staff, however, it is more a reactive system than a proactive one. Generally, issues are not addressed comprehensively.

"We have a SET team, so we have a team that would deal with kind of a secondary behavioral and emotional issues. So, our staff knows to refer our kids up to that team and then we would work with him with that team. We would kind of meet and try to decide what would be the best avenue of support. Granted, we only have a limited number of tools in our toolbox, so it's just kind of like which one of our somewhat adequate tools do we want to try to employ here?"

"I do think one of the big gaps is just getting everyone on the same page."

"If a kid has wrap around services, [they can be like] 'Oh hey, you know Johnny is working on this goal. Please encourage him towards that end.' Then we share information. But it's sporadic. It's not consistent, and I don't fault it on them or me. I mean, it's just very difficult to get all these players of the game, so to speak, together."

"We've had a couple of opportunities in the past where students are under some intensive assistance with like the WISE Program, and we'll have a meeting with their WISE counselors, their family and the staff, and we'll all get together and, kind of talk about it. It doesn't happen as often as it should."

<u>Consistency within and across schools</u>

Staff participants recognized that some efforts to support students' mental health are taking place differently at different schools—not as a district-wide approach.

"Each building is kind of responsible for carrying [the curriculum], and so across the four middle schools those services and supports will look different based on each approach."

[We have] "PBIS district wide and we decided to go with Character Strong for our lessons. It wasn't my favorite thing because it felt so scripted but then staff figured out how to work the lessons and which to focus on more based on what our kids need."

In some cases, there seems to be inconsistency in the implementation even within school buildings.

"Sometimes I feel like there's committees that receive certain training, but that's not the whole building. And so, the committee is in the know, but not the rest of the building. And that's not a system. Like you know if I'm gone…does the person next to me know?"

"We don't have an active program for making it part of the dialogue. We do have some social, emotional curriculum. It exists only during advisory, which is a limited class and a limited time structure with kids, though in the future the hope is to have a more robust social emotional learning curriculum."

Students seem to agree:

"We had a few advisory lessons regarding the topic but in the sense that it's regularly discussed and prioritized, it isn't as much of a priority."

Some of the school staff consider the school-by-school an appropriate approach.

"I wouldn't want to come in and have [the district] tell me how to reward our kids because we know what's worked. Amongst our middle schools, one does things for their PBIS. It's way different than us, and we've tried that, but it just didn't work for us for whatever reason or our staff, 'cause it's all about the buy-in."

Others questioned the sustainability of not having consistency across buildings, as well as the impact that the district would have if all schools acted in concert.

"Each building comes up with their own system for how kids can access available services. But then, how sustainable are those systems like, right?"

"I know each school is unique and each school has their own needs. Sometimes I see this school is one step ahead of this school; this goes one behind this. I think if we got all together and did one training, one event, it would set the tone for all the schools."

Follow-through

Overwhelmingly, school staff agreed that there is uncertainty that follow-through occurs and that care is actually offered and provided at home or in the community. It seems that there is not a good system for follow up between the school staff, the parents, and the community referrals.

"There's no connection. The families might not tell you whether they went or not. There is that kind of lack of follow through."

"I think that there is that the parents are not following through or maybe just untrusting of the organization, but they're just not following through with receiving the resources that they need to improve their situation."

For some students the schools may be the only safe place they have. Both youth and adult participants expressed concerns about many incidents at school maybe being related to life at home.

"They really use [schools] as a place to not have to worry about their stresses. So, they just come, and they get to be a kid, and they don't have to think about the stuff that happens at home (…) Their home things are going on in their homes." —School staff member

Staff training

Parents who participated in the focus group feel that the teachers and school staff are adequately prepared to address their youth mental health needs.

"I haven't received it because I haven't needed it but I know that when our family needs support, the school is capable of offering all of the help we may need."

However, school staff participants were asked if they felt they could use more training to detect and respond to students' mental health concerns. Responses were unanimously, "Yes."

"There needs to be more mental awareness and training. A lot of kids just get swept under the rug and move on but they never received the assistance they need."

"Anything that we can do to help staff kind of get the sense of what's going on in these kids' lives is helpful and I think they would eat that stuff up because it just helps them understand."

"It's going to better help our students or help us help our students, which they need and we want. Because, I mean, I can't think of a teacher that doesn't care about their kids and their students, and so if we can have even more stuff in our arsenal to help, I think that would always be good, yeah?"

They mentioned that some training has been offered (i.e., Dialectic Behavioral Therapy and Adverse Childhood Experiences), but they emphasized that they wouldn't be "at the place that we are able to respond to students' needs."

"I don't think any adult is fully adequately prepared to deal with the level of anxiety and depression students are going through these days."

Students agree that teacher education would be beneficial.

"I think staff education, mainly centered around teachers, would be helpful. Such training and support should be continuous. However, we should also be careful to avoid overloading our instructional staff."

"I think teachers should definitely be educated on what mental health issues look like, for example when someone is really anxious."

Many staff members expressed that during trainings, they would like to hear directly from the students themselves and their needs.

"I think that this could look like rather than talking out situations, it would be good to see situations to be able to have real life presentations from people who had struggled with mental health; who had struggled with their own daily life. Students who are at the high school level or college level could come back and be able to share their own experiences to teachers so that we can hear it."

Ideas for improvement

All participants were also asked to give their ideas for how the school/district can be more supportive of staff, students, and families with regards to mental health. This is a summary of their suggestions.

> *"Have enough counselors."*
>
> *"Have more licensed therapists in the building."*
>
> *"It'd be helpful to make some more partnerships within the community and to identify and really choose wisely the trainings we put on. Make sure they're really relevant, and that people want to attend."*
>
> *"Open group support - like groups after school where students are able to reflect, to kind of have like an organization, a group where they can be comfortable to express themselves and to be able to understand that they're not alone in their feelings (…) Be able to encourage one another, lift one another up and support each other, and gain that strength to improve their own mental health by helping others."*
>
> *"I think it would be reassurance that they are there for you."*
>
> *"It takes a village. We [need to] work together and support one another in that it has to be a consistent system that is both accessible and known."*

Adolescents may begin using alcohol and other drugs to deal with the impacts of depression or anxiety; on the other hand, frequent drug use by teens may also cause or precipitate those disorders. The research related to substance use by adolescent youth is clear. In fact, drug use in adolescents frequently overlaps with other mental health problems. For example, a teen with a substance use disorder is more likely to have a mood, anxiety, learning, or behavioral disorder too (NIDA, 2014). Further, adolescent substance use can impact physical, cognitive, and neurological development, leading to lifelong health and wellness issues.

Research also suggests a strong link between early substance using behaviors and mental health. For example, estimated rates of co-occurring mental illness among adolescents with substance use disorders range from 60 to 75 percent (youth.gov). Among adolescents with no prior substance use, the rates of first-time use of drugs and alcohol in the previous year are higher in those who have had a major depressive episode than in those who did not (SAMHSA, 2010). Without a means to counteract the negative effects of early substance use, these issues can affect youth well into adulthood.

Project AWARE's overarching goals are tied specifically to increasing the mental and behavioral health supports available to youth and families in each of the participating districts. Services aligned with increasing identification and referral of students to Tier 2 (Selective) and Tier 3 (Intensive) services are key components to this project. These supports should be based on the needs identified from these findings, as well as the continual use of data-based decision making to identify those youth most at risk of a mental health crisis.

Community Assets and Resources

Community resources to improve the mental and behavioral health and well-being of people in Yakima County and the Yakima District region include:

- Mental Health Crisis Lines are available for all people in Washington regardless of income or insurance: Washington Recovery Help Line: **1-866-789-1511** (open all day, every day) and Yakima County Line: **1-888-544-9986.**
- Comprehensive Healthcare offers a number of services in Yakima including outpatient therapy for adults and children, substance use disorder treatment services including suboxone, medication management, school-based counseling, and 24-hour crisis intervention services.
- Greater Columbia Behavioral Health delivers behavioral health crisis services 24-hours per day, 7 days a week to all individuals in Yakima and eight other counties, regardless of insurance status, ability to pay, or level of income. The GCBH service line is **(888) 545-3022**.

Protective Factors & Resilience

The research literature is rich with information related to how risk factors can serve as predictors of student problem behaviors. Students with multiple risk factors, or few protective factors, are much more likely than their peers to engage in delinquent behaviors including violence; alcohol, tobacco, or other drug use; and are more likely to drop out of school. Elevated risk factors may be balanced and offset by the presence of protective factors. Protective factors are conditions or attributes in individuals, families, communities, or the larger society that mitigate or eliminate risk in families and communities, thereby increasing the health and well-being of children and families (Hawkins, et 1994; Hawkins, Catalano, Miller, 1992). Moreover, strengths, or protective factors, present in BIPOC communities, such as strong family ties and cultural identity, help to overcome the negative influences risks, challenges, and the effects of trauma.

Resilience, the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress can further counter the impacts of risks (American Psychological Association, 2012). Because Black, Indigenous, and other People of Color (BIPOC) face multigenerational trauma, systemic racism, and cultural barriers, resilience looks different for them as compared to the rest of society. For example, Hispanics/Latinx living in the United States may face stresses due to immigration and acculturation, poor educational opportunities, poverty, discrimination, and inadequate access to health care. Therefore, for BIPOC individuals "being resilient is an act of resistance and survival, while [also celebrating] the joys across and within each community" (Molinar, 2020).

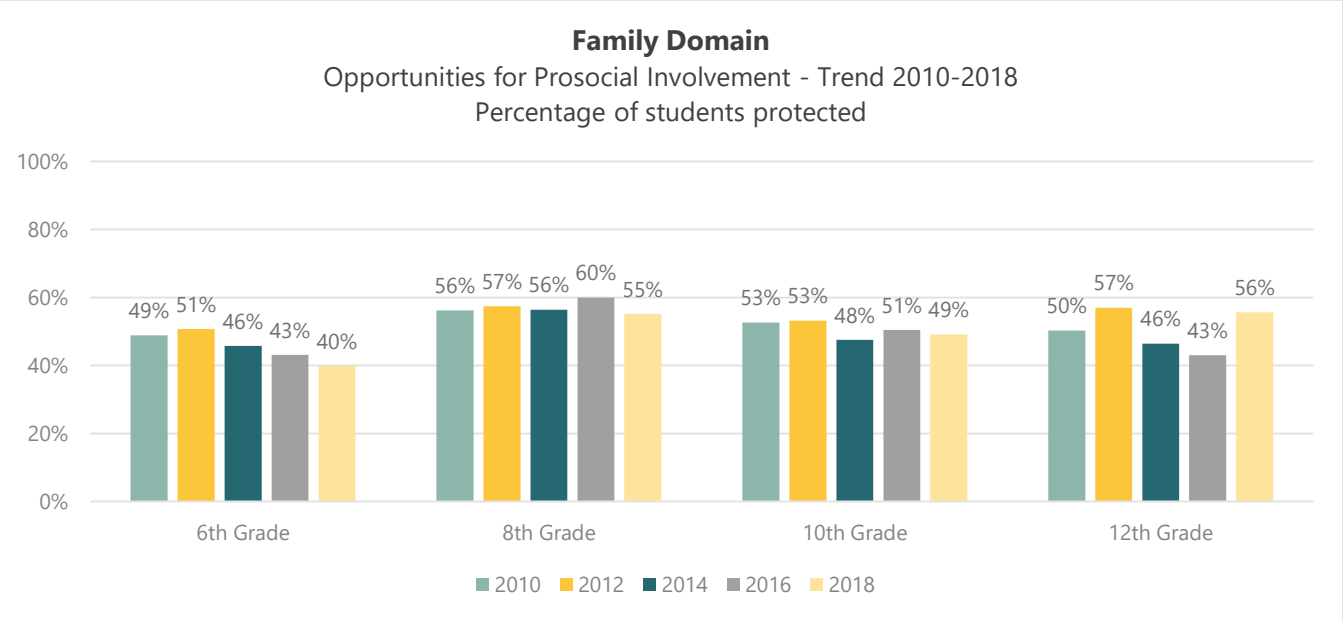
This section of the report highlights identified strengths within the Yakima School District community that mitigate adversities and provide opportunities to thrive. It also includes data about the disproportionate distribution of protective factors and highlights how the conditions for mitigation of risks is dependent upon an individual's race, ethnicity, sex, gender, income, or other characteristics.

Composite Protective Factors

The following information is from the Healthy Youth Survey Risk and Protective Factor Scale results. These composite scales are comprised of multiple survey questions that assess students' views on the presence of protective factors across multiple domains: family, school, peer-individual, and community. For each Protective Factor scale, the percentage of students who are resilient is reported; higher percentages indicate that fewer students are likely to engage in problem behaviors. The following figures show trend results of these composite scales for 8th, 10th, and 12th grade students for the 2010, to 2018 surveys periods.

Family Domain

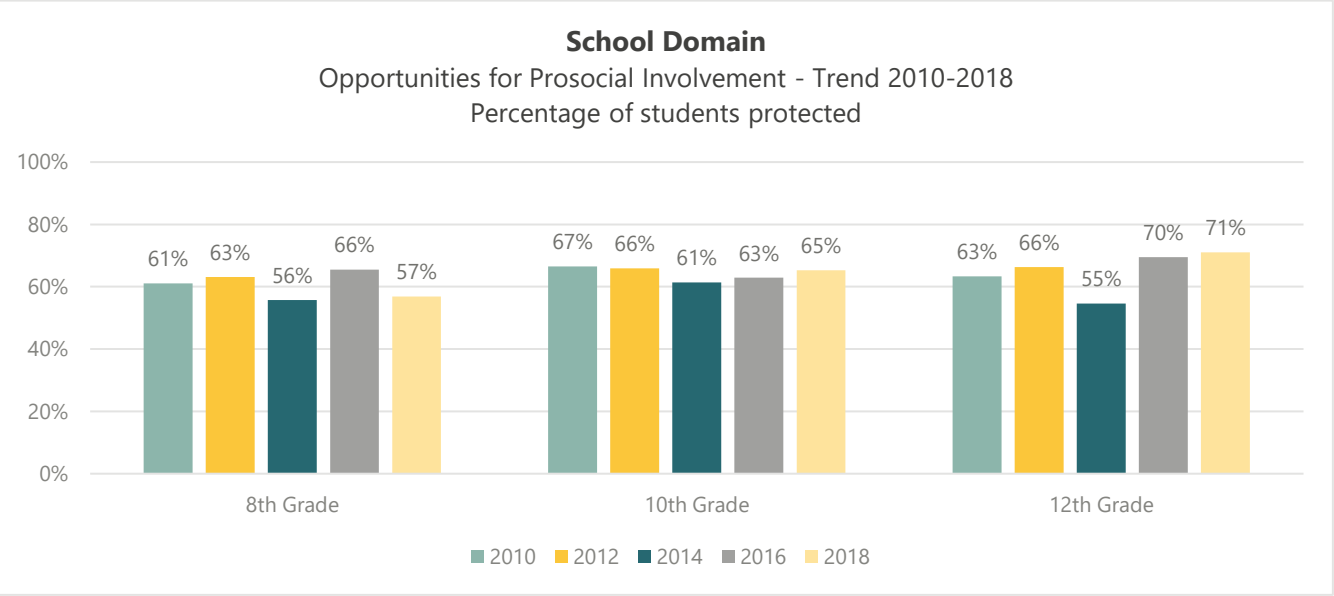
he family protective factor domain assesses students' perception of opportunities and rewards for prosocial involvement and include questions such as "My parents give me lots of chances to do fun things with them", and "If I had a personal problem, I could ask my mom or dad for help."



Source: Healthy Youth Survey (2010-2018) at askhys.net

School Domain

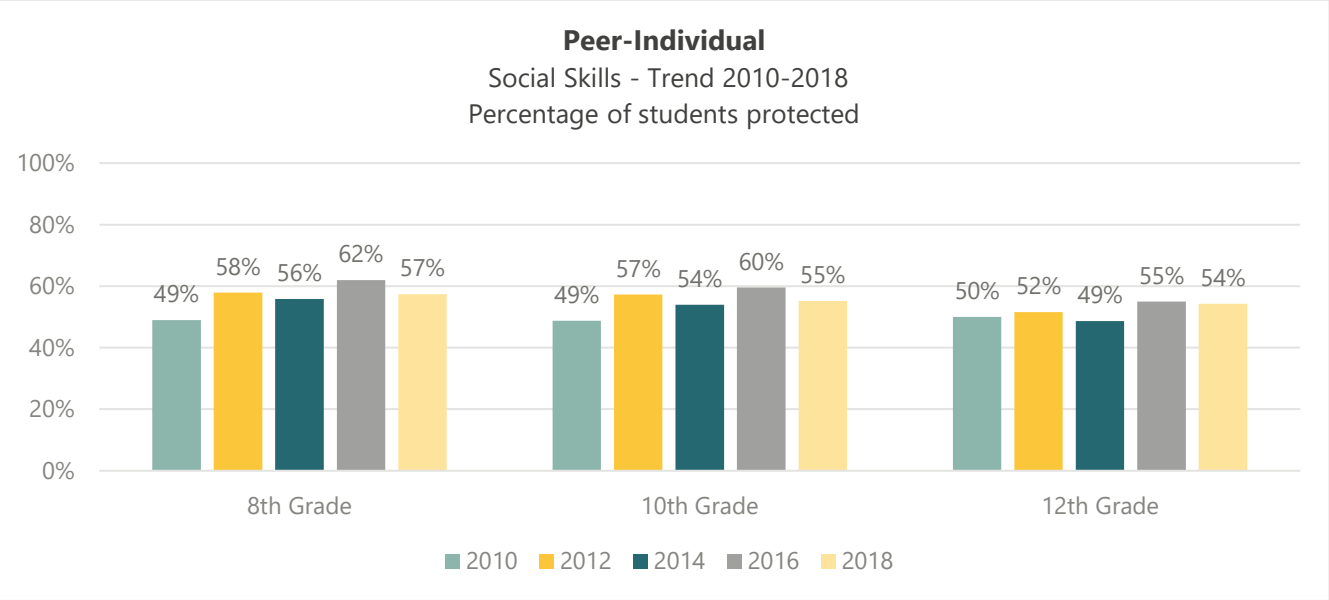
Factors assessed in the school protective factor domain include opportunities for prosocial involvement. Questions include: "There are lots of chances for students in my school to talk with a teacher one-on-one" and, "There are lots of chances for students in my school to get involved in sports, clubs, and other school activities outside of class."



Source: Healthy Youth Survey (2010-2018) at askhys.net

Peer-Individual Domain

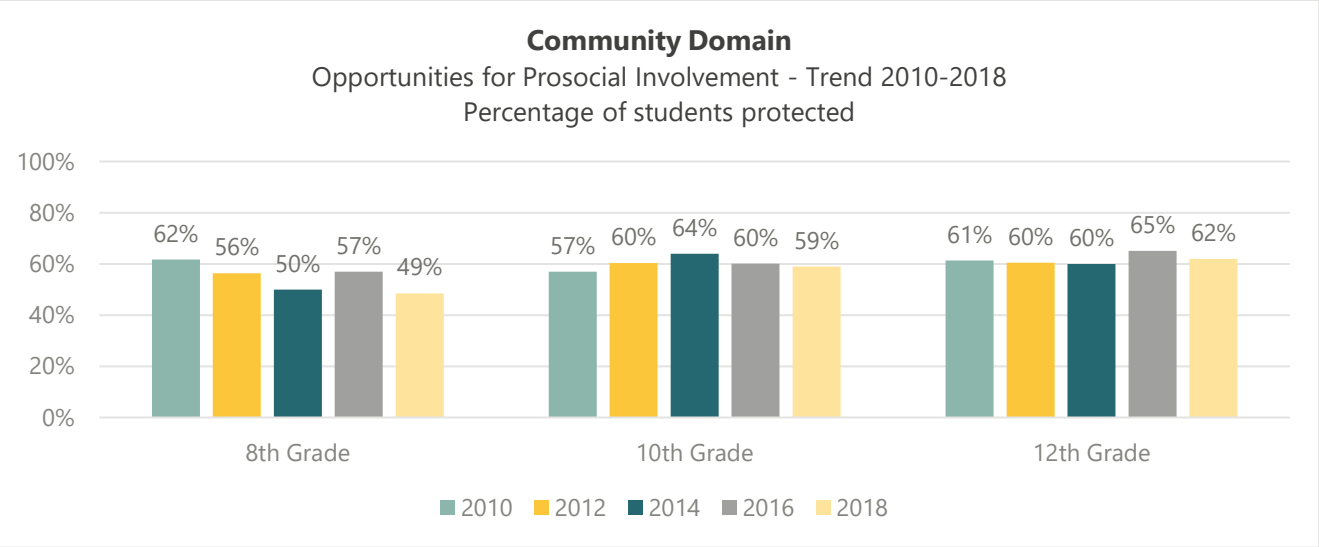
Protective factors assessed here are linked to the presence of social skills. For example, students are asked: "You are at a party at someone's house and one of your friends offers you a drink containing alcohol. What would you say or do?"



Source: Healthy Youth Survey (2010-2018) at askhys.net

Community Domain

Protective factors within the community domain also include opportunities and rewards for prosocial involvement. These include opportunities for youth to engage with pro-social adults (e.g., "There are adults in my neighborhood or community I could talk to about something important.") and pro-social activities such as sports teams, and recreation e.g., Boys and Girls Clubs, YMCA, or other youth-centered clubs.



Source: Healthy Youth Survey (2010-2018) at askhys.net

Findings

In general, these data show that in 2018 most Yakima 8th, 10th, and 12th grade students reported resiliency across multiple domains. These protections were highest, across grade levels and survey years, in the school domain. In fact, students reported multiple opportunities for prosocial involvement including engagement in decision making related to classroom rules and class discussions, high-levels of student-to-teacher interaction, and involvement in school-based clubs, sports, or other extracurricular school activities. However, the perception of protection declined somewhat among 6th graders between 2016 and 2018. At the peer-individual level, the majority of 8th, 10th, and 12th graders acknowledged protective factors specifically related to social skills that reduce their risks for delinquent and substance using behaviors. Although, among 8th and 10th graders, protection declined from 2016 levels.

Perceptions of the presence of family protective factors show variability across grade levels in 2018, with 8th and 10th grade students reporting higher involvement in family-based prosocial opportunities such as decision-making, family outings, and talking to parents about personal problems. The presence of these factors was lower among 12th graders and considerably so for 6th grade youth. In contrast, across grade levels, the majority of youth identified community protective factors, with rates increasing over time. On average over half of these students reported pro-social opportunities in and around their communities, such as access to positive adult role models in their neighborhood as well as recreational activities, and youth-focused service clubs and organizations.

Children's Hope Scale

We end this report on a note of hope. Hope reflects a future orientated mindset and motivational process by which an individual has an expectation toward attaining a desirable goal. Research has linked hope with overall physical, psychological, and social well-being (Hellman, Worley, and Munoz, 2016). Further, if youth do not perceive themselves to have the capacity to pursue their goals, they may

be less likely to make changes in their behaviors, or in the ways that they think and feel about themselves (Jiang, Otis, Weber, and Scott, 2018).

In 2018, a version of the Children's Hope Scale (Snyder et al. 1997) was added to the Healthy Youth Survey. Computed from four questions,[7] the scale is "based on the premise that children are goal directed and that their goal-related thoughts can be understood according to two components (Snyder et al., 1997, p. 400). These are: agency – one's ability to initiate and sustain action towards goals; and pathways – one's capacity to find a means to carry out goals.

Healthy Youth Survey Hope Scale (2018)	8th Grade	10th Grade	12th Grade
No or Very Little Hope	5%	10%	12%
Slightly Hopeful	20%	18%	15%
Moderately Hopeful	28%	21%	26%
Highly Hopeful	47%	51%	48%

Source: Healthy Youth Survey (2018) at askhys.net

The data in the table show responses by grade level. Findings indicate that among Yakima youth, overall, most students (approximately 75%) were at least moderately hopeful for the future, with these rates similar across grade groups. Despite this level of hopefulness, nearly one-in-four youth reported no or very little hope or slightly hopeful.

Summary and Implications

Results indicate that most Yakima 8th, 10th, and 12th grade students reported resiliency across multiple domains in 2018, with these highest, across grade levels and survey years, in the school domain. These findings suggest that students identified opportunities for prosocial involvement in the school setting as well as high-levels of student-to-teacher interaction, and engagement is school-based activities. Other areas of strengths included peer-individual, family, and community protective factors. However, among younger youth, particularly 6th graders, level of family and community protective factors have declined in recent years. Findings also demonstrate that many Yakima youth were at least moderately hopeful about their future, including nearly half or more who were "highly" hopeful.

Protective factors are conditions or attributes in individuals, families, communities, or the larger society that mitigate or eliminate risk in families and communities, thereby increasing the health and well-being of children and families. Elevated risk factors may be balanced and offset by the presence of protective factors. Research has found that students with higher levels of protective factors may be more resilient to the effects of the negative influences of risk factors. Resilience, the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress can counter these impacts.

[7] Questions include: I can think of many ways to get the things in life that are important to me; I am doing just as well as other kids my age; When I have a problem, I can come up with lots of ways to solve it; and, I think the things I have done in the past will help me in the future. Response format is a 6-point Likert scale (1= None of the time, 2= A little of the time, 3= Some of the time, 4 = A lot of the time, 5 = Most of the time, 6 = All of the time).

Strong families and healthy communities are key parts of this process, and together with schools, can help a child transition into adulthood. A large body of research shows that family engagement in schools improves student achievement, reduces absenteeism, and restores parents' confidence in their children's education. Parental involvement also facilitates children's cognitive, social, and emotional functioning and has been linked to increased self- esteem, improved behavior, and more positive attitudes toward school (Christenson & Havsy, 2004; Patrikakou, Weissberg, Redding, & Walberg, 2005).

All assessment participants were asked to name the people, places, and things that make the Yakima School District a safe and healthy community. In other words, to list some of the protective factors that could help to increase the well-being of youth and families. The following are some of the comments from participants.

> *"We have a creative teacher and staff base."*
>
> *"Ours is a well-motivated community."*
>
> *"We are creating a mentor list from community members to work with the kids."*
>
> *"Our support group after school for migrant workers. It's basically like parenting class. It's always a fairly robust group."*
>
> *"I really am a fan of restorative justice and in that program as far as addressing discipline issues and conflict issues and whatnot, it'd be awesome to see if we had like restorative justice specialists in school or somebody who can facilitate that and somebody just take us away from the model of like referrals and suspensions and expulsions and more into kind of like rebuilding the relationships.*
>
> *"I like the way our district is going now. I like the way that we do have a lot of structures and systems in place. I think we're kind of in a period with our administrative teams and with our districts [where] we're really making the push to be equitable, to be healthy, to look at a child as a whole picture rather than as a test score. I mean, there's a lot of that impetus and push out there, and I think the more that that happens, the better off we are."*
>
> *"I believe that the school is moving in the right direction. I believe from what I've seen and from the different committees that I have been blessed to be a part of (…) that there is a positive, healthy movement to support students."*

With the overarching goals of Project AWARE to increase awareness of mental health issues, and to detect, connect and respond to student mental health needs, the Sunnyside School District has the opportunity to not only increase access to behavioral health care for students and families, but also to support systems-level changes to enhance family-school-community partnerships and family engagement. As such, it is imperative that Project AWARE services and supports are designed in a manner that supports and builds upon existing protective factors, across domains, to ensure that youth are ready and able to overcome challenges and are successful academically, personally, and professionally.

References

ACR Business Consulting (2019), Yakima County Homeless Point-in-time Count. Available at: https://yakimacounty.us/DocumentCenter/View/22119/2019-Yakima-County-Point-in-Time-Report?bidId

Administration for Children and Families, U.S. Department of Health & Human Services (2021), Temporary Assistance for Needy Families (TANF). Available at: https://www.acf.hhs.gov/sites/default/files/documents/ofa/fy2020_tanf_caseload_1.pdf

American Psychological Association (2012), Building your resilience. Available at: https://www.apa.org/topics/resilience

Annie E. Casey Foundation. Kids Count Data Book (2014). Retrieved from, http://www.aecf.org/m/resourcedoc/aecf-2014kidscountdatabook-2014.pdf

Astria Health (2018), Community Health Needs Assessment and Improvement Plan. Available at: https://www.astria.health/site/files/file_manager/page/shared/2018-astria-chna-action-plan-final-03012019.pdf

Baquero, B., Gonzalez, C., Ramirez, M., Chavez Santos, E., & Ornelas, I. J. (2020). Understanding and Addressing Latinx COVID-19 Disparities in Washington State. *Health education & behavior : the official publication of the Society for Public Health Education*, *47*(6), 845–849. https://doi.org/10.1177/1090198120963099

Behrens, D., Lear, J.G., & Price, O.A. (2013). Improving access to children's mental health care: Lessons from a study of eleven states. The George Washington University: Washington, D.C. http://www.healthinschools.org/wp-content/uploads/2016/10/March2013-StatePrograms_d5_color_FINAL.pdf

Beteille, T., Kalogrides, D., & Loeb, S. (2011). Stepping Stones: Principal Career Paths and School Outcomes. NBER Working Paper No. w17243.

Bjerragaard and Lizotte (1995). Gun Ownership and Gang Membership. *Journal of Criminal Law and Criminology* Volume: 86 Issue: 1 Dated: (Fall 1995) Pages: 37-58. Office of Justice Programs, U.S. Department of Justice. https://www.ojp.gov/ncjrs/virtual-library/abstracts/gun-ownership-and-gang-membership

Brennan Ramirez LK, B.E., Metzler M., (2008), Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health, Centers for Disease Control and Prevention, Editor. Department of Health and Human Services: Atlanta, GA

Cahill and Hayeslip (2010). Findings From the Evaluation of OJJDP's Gang Reduction Program. Office of Juvenile Justice and Delinquency Prevention. Office of Justice Programs, U.S. Department of Justice https://www.ojp.gov/pdffiles1/ojjdp/230106.pdf

California Health Interview Survey. (2005). Los Angeles, CA: UCLA Center for Health Policy Research, 2007.

Castañeda, H, Holmes, S.M., Madrigal, D.S., DeTrinidad Young, M-E., Beyeler, N., Quesada, J. (2014), Immigration as a Social Determinant of Health. *Annual Review of Public Health,* 36:1, 375-392

Center for Disease Control and Prevention (May 2013), Mental health symptoms in school-aged children in four communities. Available at: https://www.cdc.gov/childrensmentalhealth/features/school-aged-mental-health-in-communities.html

Christenson, S. L., & Havsy, L. H. (2004). Family-school-peer relationships: Significance for social, emotional, and academic learning. In J. E. Zins, R. P. Weissberg, M. C. Wang, & H. J. Walberg (Eds.), *Building academic success on social and emotional learning: What does the research say?* (p. 59–75). Teachers College Press.

Commission on Social Determinants of Health (CSDH), (2008), Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health, World Health Organization: Geneva

Conway, Swendsen, Husky, He, & Merikangas (2016). Association of Lifetime Mental Disorders and Subsequent Alcohol and Illicit Drug Use: Results From the National Comorbidity Survey–Adolescent Supplement: https://www.jaacap.org/article/S0890-8567(16)00070-8/fulltext

Council on Social Work Education *(2016),* Working Definition of Economic Well-Being. Available at: https://www.cswe.org/Centers-Initiatives/Initiatives/Clearinghouse-for-Economic-Well-Being/Working-Definition-of-Economic-Well-Being

Espelage & DeLaRue (2012). School Bullying: Its Nature and Ecology. *International Journal of Adolescent Medicine and Health, 24(1), 3-10.*

Furfaro, Hanna (April 4, 2021). Washington students are facing a mental health crisis. Here's why schools are on the front lines. *The Seattle Times.* Available at: https://www.seattletimes.com/education-lab/washington-students-are-facing-a-mental-health-crisis-heres-why-schools-are-on-the-front-lines/

Gall, G., Pagano, M.E., Desmond, M.S., Perrin, J.M., & Murphy, J.M. (2000). Utility of psychosocial screening at a school-based health center. *The Journal of School Health 70*(7), 292-298.

Great Schools Partnership (2014). The Glossary of Education Reform. Available at: https://www.edglossary.org/

Greenberg, M.T., Brown, J.L., & Avenavoli, R.M. (2016). Teacher stress and health: Effects on teachers, students, and schools. Robert Wood Johnson Foundation. http://www.rwjf.org/en/library/research/2016/07/teacher-stress-and-health.html

Hawkins, J.D., et al. (1992). Risk and protective factor framework: Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin,* 112(1), 64-105.
Healthy Youth Survey, 2010-2018. Retrieved from AskHYS.net

Hellman, C. H. Worley, J. A., & Munoz R. T. (2016) A Primer On Hope As A Theory of Change for Human Service Providers. Available at https://thurstonthrives.org/wp-content/uploads/2016/05/Hope-White-Paper.pdf

Hill, Lui, Hawkins (2001). Early Precursors of Gang Membership: A Study of Seattle Youth. Office of Juvenile Justice and Delinquency Prevention. Office of Justice Programs, U.S. Department of Justice. https://www.ojp.gov/pdffiles1/ojjdp/190106.pdf

Howell, James C. (2013). *Chapter One: Why Is Gang-Membership Prevention Important?* Changing Course: Preventing Gang Membership. National Institute of Justice, National Center for Injury and Prevention Control. https://storage.googleapis.com/edcompass/quantum/materials/1216_Gang-Membership-Updated.pdf#page=9

Jennings, P. A., & Greenberg, M. T. (2009). The prosocial classroom: Teacher social and emotional competence in relation to student and classroom outcomes. *Review of Educational Research, 79*, 491–525.

Jiang, X., Otis, K. L., Weber, M., & Huebner, E. S. (2018). *Hope and adolescent mental health.* In M. W. Gallagher & S. J. Lopez (Eds.), *Oxford library of psychology. The Oxford handbook of hope* (p. 299–312). Oxford University Press.

Kataoka, S.H., Zhang, L., & Wells, K.B. (2002). Unmet need for mental health care among U.S. children: variation by ethnicity and insurance status. *American Journal of Psychiatry, 159*(9), 1548-55.

KIDS COUNT Data Center, A project of the Annie E. Casey Foundation (2021). Available at: datacenter.kidscount.org

Langhout, R., Buckingham, S., Kaur Oberoi, A., Chávez, N.R., Rusch, D., Esposito, F., Suarez-Balcazar, Y. (2018), Statement on the Effects of Deportation and Forced Separation on Immigrants, their Families, and Communities, https://doi.org/10.1002/ajcp.12256

Mental Health America (2021), Youth Data. Available at: https://www.mhanational.org/issues/2021/mental-health-america-youth-data

Migration Policy Institute (MPI) (2020-2021), Analysis of U.S. Census Bureau data from the pooled 2014–18 American Community Survey (ACS) and the 2008 Survey of Income and Program Participation (SIPP). Available at: https://www.migrationpolicy.org/data/unauthorized-immigrant-population/county/53077

Molinar, Gustavo (2020**),** (Re) Defining Resilience: A Perspective Of 'Toughness' In BIPOC Communities. Available at: https://www.mhanational.org/blog/re-defining-resilience-perspective-toughness-bipoc-communities

Montgomery, C., & Rupp, A. A. (2005). A meta-analysis exploring the diverse causes and effects of stress in teachers. *Canadian Journal of Education, 28*, 458–486.

Nader, Kathleen (2012), Violence Prevention and School Climate Reform, National School Climate Center. Available at: https://files.eric.ed.gov/fulltext/ED573695.pdf

National Academies of Sciences, Engineering, and Medicine (2019), Monitoring Educational Equity. Washington, DC: The National Academies Press. https://doi.org/10.17226/25389 .

National Criminal Justice Reference Service, 2013

National Immigration Forum (2018), Fact Sheet: Immigrants and Public Benefits. Available at: https://immigrationforum.org/article/fact-sheet-immigrants-and-public-benefits/

National Network of State Teachers of the Year (2018), Rebuilding the Ladder of Educational Opportunity. Available at: https://files.eric.ed.gov/fulltext/ED595318.pdf

Northwest Harvest (2021), Hunger in Washington. Available at: https://www.livestories.com/statistics/hunger-in-washington/washington/yakima-county-community-snapshot

Organisation for Economic Co-operation and Development (2013), Measuring Well-being and Progress: Well-being Research. Available at: https://www.oecd.org/statistics/measuring-well-being-and-progress.htm

Panchal, N., Kamal, R., Orgera, K., Cox, C., Garfield, R., Hamel, L., Munana, C., & Chidambaram, P. (August 21, 2020). The Implications of COVID-10 for Mental Health and Substance Use. Retrieved from https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

Patrikakou, Eva. (2005). School-family partnerships: Fostering children's school success. Teacher College Press.

Patterson GR, Reid JB, Dishion TJ. *Antisocial Boys.* Castalia; Eugene, OR: 1992. [Google Scholar]

Pearce, Diana M., PhD. (2020), The Self-Sufficiency Standard for Washington State. Available at: http://www.selfsufficiencystandard.org/sites/default/files/selfsuff/docs/WA2020_SSS.pdf

Perou, R., Bitsko, R.H., Blumberg, S.J., et al. (2013) Mental Health Surveillance among Children—United States, 2005-2011. MMWR Surveillance Summaries, 62, 1-3. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/23677130

Pierson, James (2019), Addressing Economic Justice in the Face of Inequality. Available at: https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/economic-justice/addressing-economic-justice-in-the-face-of-inequality/

Resnick et al., 1997 Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health. JAMA. https://www.mdft.org/mdft/media/files/Resnick-et-al-(1997)-Protecting-adolescents-from-harm-National-longitudinal-study-on-adolescent-health-JAMA.pdf

Robert Wood-Johnson Foundation (2021), Healthy Communities. Available: https://www.rwjf.org/en/our-focus-areas/focus-areas/healthy-communities.html

Schroeder, S, 2007, September 20). We Can Do Better – Improving the Health of the American People. The New England Journal of Medicine. 357, 1221-1228

Seattle Children's Hospital, (2019), Community Health Assessment. Available at: https://www.seattlechildrens.org/globalassets/documents/about/community/2019-community-health-assessment-cha.pdf

Simmons, D. N., Brackett, M. A., & Adler, N. (2018). Applying an equity lens to social, emotional, and academic development. Edna Bennett Pierce Prevention Research Center, Penn State University. Retrieved from https://dpi.wi.gov/sites/default/files/imce/sspw/pdf/SEL_-_Equity.pdf

Snyder et al. 1997 (1997). The development and validation of the children's hope scale. Journal of Pediatric Psychology, 22, 399-421.

Spergel, I.A (1995). *The Youth Gang Problem.* New York, NY: Oxford University Press.

Starks, MA Aaron, Sharkova, PhD, Irina V. and Mancuso, PhD David (Jan 2021), Risk and Protection Profile for Substance Abuse Prevention for Sunnyside, Wahluke and Yakima. Community Outcome & Risk Evaluation. Washington State Department of Social & Health Services.

Substance Abuse and Mental Health Services Administration (SAMHSA), Key Substance Use and Mental Health Indicators in the United States: https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR1PDFW090120.pdf

Thornberry, T. P. (1998). *Membership in youth gangs and involvement in serious and violent offending.* In R. Loeber & D. P. Farrington (Eds.), *Serious & violent juvenile offenders: Risk factors and successful interventions* (p. 147–166). Sage Publications, Inc.

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion (2020), Healthy People 2030. Available at: https://health.gov/healthypeople/objectives-and-data/social-determinants-health

United States Census Bureau (2020), 2015-2019 American Community Survey. Available at: https://data.census.gov/cedsci/

United Way Worldwide Annual Report (2011). Retrieved from http://unway.3cdn.net/f58b3b8a9b4f33a573_tvm62lh6v.pdf

University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps (2021), Health Rankings. Available at: https://www.countyhealthrankings.org/explore-health-rankings

Virginia Mason Memorial (2019), Community Health Needs Assessment. Available at: https://www.yakimamemorial.org/pdf/about/community-hna-2019.pdf

Wanapum Heritage Center (2017-21), Our History. About the Wanapum. Available at: https://wanapum.org/about/

Washington Immigrant Solidarity Network, El Centro de la Raza, Northwest Health Law Advocates (2020), Washington State Health Equity for Immigrants Report. With support from the ACLU of Washington. Available at: https://static1.squarespace.com/static/5c9a7904f8135a221909597f/t/60108dca76080474a5e2d6a3/1611697623906/WA+Health+Equity+for+Immigrants_Full+Report_2020.pdf

Washington Office of Superintendent for Public Instruction (2021), 2018-2020 Report Card. Available at: https://washingtonstatereportcard.ospi.k12.wa.us/

Washington State Department of Health (2018), Food Insecurity and Hunger. Available at: https://www.doh.wa.gov/Portals/1/Documents/Pubs/160-015-MCHDataRptFoodInsecHunger.pdf

Washington State Department of Health (2018), Washington State Health Assessment. Available at: https://www.doh.wa.gov/Portals/1/Documents/1000/2018SHA_FullReport.pdf

Washington State Department of Health (2021). COVID-19 Vaccination Coverage by Race and Ethnicity and Age in Washington State. Available at: https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/data-tables/348-791-COVID19VaccinationCoverageRaceEthnicityAgeWAState.pdf

Washington State Department of Health (December 2020), Provider alert regarding increased concern of suicide risk in youth during COVID-19. Available at: https://www.hca.wa.gov/assets/program/covid-19-provider-alert-regarding-suicide-risk-in-youth.pdf

Washington State Employment Security Department (2021), Population Reference Bureau analysis of the U.S. Census Bureau, Household Pulse Survey. Available at: https://esd.wa.gov/labormarketinfo/monthly-employment-report

Washington State Department of Social and Health Services (2021). *Risk and Protection Profile for Substance Abuse Prevention in Washington Communities*. Olympia, WA: Washington State Department of Social and Health Services. Retrieved from: https://www.dshs.wa.gov/ffa/research-and-data-analysis/community-risk-profiles

Washington State Office of Financial Management (2021) 2020 Population Trends. WA State Office of Financial Management, Small Area Estimate Program (SAEP), Estimates of Total Population for School Districts by County Part. Available at: https://www.ofm.wa.gov/sites/default/files/public/dataresearch/pop/april1/ofm_april1_poptrends.pdf

Wehmeyer, M. L., & Field, S. (2007). Instructional and assessment strategies to promote the self-determination of students with disabilities. Thousand Oaks, CA: Corwin. WHO 2016

Yakama Nation (2020), Yakama Nation History. Available at: https://www.yakama.com/about/

youth.GOV (2021). Co-occurring Disorders. Available at: https://youth.gov/youth-topics/youth-mental-health/co-occurring

Appendix A: Healthy Youth Survey Response Rates, 2010-2018

Yakima School District

Grade	2010	2012	2014	2016	2018
6th	82%	84%	88%	86%	82%
8th	74%	80%	71%	76%	74%
10th	67%	49%	65%	70%	71%
12th	79%	51%	48%	58%	62%

The following guidance may be used when reviewing your results. However, if a particular group(s) of students did not complete the survey and therefore did not contribute to your results, there may be limitations to your results even if you have a high participation rate (i.e., if differences exist between students who *did* and who *did not* complete the survey). There may be value in discussing the potential limitations when using the results in this report.

- 70% or greater participation–Results are probably representative of students in this grade.
- 40–69% participation–Results may be representative of students in this grade.
- Less than 40% participation–Results are likely not representative of students in this grade but do reflect students who completed the survey.

Appendix B: Interview and Focus Group Questions

Staff Questions

1. What do you feel are the most pressing mental health issues facing students in your school district/community?
2. Do you consider that these issues are being addressed? If so, how?
3. What are some of the ways that the school is addressing these needs/concerns? What would you like to see more of? <*Probe: Can you provide examples?*>
4. If children in your class/school/district needed mental health support, would you know how to access school-based services?
5. Does the school connect students and families to community-based providers if additional support is needed? <*Probe: Who in the district makes these connections with/for you?*>
6. What are the most significant gaps and barriers in resources, coordination, etc. in this area?
7. Do you consider that teachers and administrators at your school/district receive enough training and are prepared to detect and respond to the students' mental health concerns/issues? <*Probe: Can you provide an example?*>
8. Are there school-based campaigns to reduce stigma and promote awareness of mental health wellness? Do you think these would be well received in the community? <*Probe: Can you explain what those are and how you know about them?*>
9. What are the people, places, and things that make your community healthy, safe, and strong and why are they important? These could include organizations, leaders, coalitions initiatives, policies, or physical/environmental attributes.
10. What ideas do you have for how the school can be more supportive of staff, students, and families with regards to mental health?
11. Is there anything else about mental health in your school or district that you would like to share?

Student Questions

1. What do you feel are the main mental health issues that students in your school face?
2. Have you been encouraged to take care of your mental health from the adults in your family?
3. Were you taught about mental health in school?
4. When you're going through it, do you know of programs or services at your school that can help you? How about in your community?
5. Does your school have spaces/times during the school day for you and your friends to talk about things you're going through?
6. Are there adults at school who talk to you when you are upset about something or have a problem? <*Probe: Who?*> How about in your family? And in your community?
7. What ideas do you have for how the school can be more supportive of your and your friends' mental health?

8. Is there anything else about mental health in your school or district that you would like to share?

Parent Questions - English

2. What do you feel are the most pressing mental health issues facing students in your kid's school and in your community?
3. Do you consider that these issues are being addressed? If so, how?
4. What are some of the ways that the school is addressing these needs/concerns? What would you like to see more of? <*Probe: Can you provide examples?*>
5. Are you aware of any school campaigns to reduce mental health stigma or promote awareness of mental health wellness (adult/child)? Do you think these would be well received in the community? <*Probe: Can you explain what those are and how you know about them?*>
6. Do you consider that school teachers and administrators are prepared to detect and respond to the students' mental health concerns/issues? <*Probe: Can you provide an example?*>
7. What does the district/school do to create a positive and safe environment for your student/family? What could it do better? <*Probe: What does this look like to you? Can you provide an example?*>
8. If your child needed mental health support, would you know how to access services at the school? <*Probe: Have you received information about a referral process or information about services and supports at the school?*> How about in your community?
9. How connected do you feel to the school? Are there opportunities for parents/caregivers to offer feedback on mental health services provided at the school? <*Probe: Can you provide examples?*>
10. What could the school do more of or do differently to better involve parents/caregivers?
11. Do you feel like your family's cultural background is recognized, respected, and valued by the school? If so, how (e.g., language)? If not, how could this be improved? <*Probe: Can you provide examples?*>

Parent Questions - Spanish

1. ¿Cuáles creen que son los principales problemas mentales que enfrentan los estudiantes de la escuela de su hijo o de los jóvenes en su comunidad?
2. ¿Considera que se están abordando estos temas? ¿Si es así, cómo?
3. ¿Cuáles son algunas de las formas específicas en que la escuela está abordando estas necesidades / preocupaciones? ¿Qué más le gustaría que se hiciera? <*Indague: ¿Puede dar un ejemplo?*>
4. Si su hijo necesitara apoyo de salud mental, ¿sabría usted cómo acceder a los servicios en la escuela? <*Indague: ¿Ha recibido información sobre servicios y apoyos en la escuela?*> ¿Y en su comunidad?
5. ¿Considera que los maestros y administradores escolares están preparados para detectar y responder a las inquietudes / problemas de salud mental de los estudiantes? <*Indague: ¿Puede darnos un ejemplo?*>
6. ¿Qué hace el distrito / escuela para crear un ambiente positivo y seguro para su estudiante / familia? ¿Qué podría hacer mejor? <*Indague: ¿Qué le parece esto? ¿Puede darnos un ejemplo?*> ¿Conoce alguna campaña escolar para reducir el estigma de la salud mental o promover la

conciencia sobre el bienestar de la salud mental (adulto / niño)? ¿Cree que serían bien recibidos en la comunidad? <*Indague: ¿Puede explicar qué son y cómo los conoce?*>

7. ¿Hay factores culturales que afecten al estigma en torno a la salud mental? <*Indague: Yo soy latina, y a veces es difícil hablar sobre salud mental con mi familia. ¿Cree que necesitamos más gente Latina como proveedores de salud mental? En otras escuelas hemos visto que incluso cuando tienen servicios o programas de salud mental, los estudiantes o las familias no los utilizan. ¿Tiene la cultura algo que ver con eso?*>
8. ¿Siente que la escuela reconoce, respeta y valora la cultural de su familia? Si es así, ¿cómo? *(por ejemplo, idioma)* Si no es así, ¿cómo podría mejorarse esto? <*Indague: ¿Puede proporcionar ejemplos?*>
9. ¿Qué tan conectado se siente con la escuela? ¿Hay oportunidades para que los padres o adultos responsables de los jóvenes ofrezcan sugerencias sobre los servicios de salud mental que se brindan en la escuela? <*Indague: ¿Puede proporcionar ejemplos?*>
10. ¿Qué más podría hacer la escuela o hacer de manera diferente para involucrar mejor a los padres y adultos responsables de los jóvenes?