# Children's Mental Health Discussion Paper

# October 2021

## School-based Mental Health Services: Navigating the New Normal and Aligning System Goals

*The purpose of this discussion paper is to prompt conversation among stakeholders, legislators, state agencies and advocates to help identify the policy priorities that best address student mental health in the short and long-term.*

*Acknowledgements: Conversations with state agency leaders and other mental health advocates were foundational in helping to grasp these nuanced issues. We are particularly grateful to Nina Marino, Maribel Samire and Alyssa Ward for their contributions.*

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# Setting the Stage: Children's Mental Health Needs

There is no denying that the COVID-19 pandemic has changed the way we think about mental health as a society. The collective trauma of the pandemic normalized conversations about social-emotional health and has led to such innovations as "Wellness Wednesdays" and other universal social-emotional supports in school. The individual traumas of grief and isolation during the pandemic have produced additional anxiety, depression and behavioral concerns for some students.

**Students**: Before the pandemic, mental health concerns among high school students were increasing. The 2019 Virginia Youth Survey reported that one in three high-school students felt sad or hopeless every day for two weeks or more. The rate of students feeling hopeless in Virginia increased seven percentage points from 2011 to 2019. Girls were more likely to report mental health concerns with 41.7% feeling sad or hopeless compared to 24% of boys.

According to a May 2021 research brief from KFF, more than 25% of high school students nationally reported worsened emotional and cognitive health; and more than 20% of parents with children ages 5-12 reported their children experienced worsened mental or emotional health.

**LGBTQ+ Children and Youth**: The same May 2021 KFF research brief reported an overwhelming majority of LGBTQ+ students reported mental health concerns, including symptoms of anxiety (73%) and depression (67%) and serious thoughts of suicide (48%) during the pandemic. LGBTQ+ students were also more likely to experience mental health needs prior to the pandemic. In 2019, 66% of lesbian, gay, and bisexual high schools students in Virginia reported persistent feelings of sadness and hopelessness compared to 37% of all high school students.

**Black, Latino & Multi-Race Children & Youth**: Systemic racism in our country shows up when systems produce harmful impacts to one group over another. As an example, school discipline policies have produced disproportionate suspension and expulsion rates among Black children. The role of systemic racism in producing trauma, and in creating obstacles within systems, such as our education and mental health services, is critical to address in the proposals to improve our mental health system. As a growing number of children in Virginia represent historically disadvantaged communities, designing services intentionally to meet the needs of Black, Latino and multi-racial children is necessary.

Research from the CDC shows at the national level prior to the pandemic, non-Hispanic white children were more than twice as likely (17.7 %) to participate in mental health

treatment compared to Black children (8.7 %). Hispanic children had similar rates compared to Black children at 9.2 %. Systemic barriers such as eligibility criteria for health insurance and accessibility of services contribute to lower participation among Black and Latino children. A history of racism and disinvestment in communities of color have made mental health services less accessible for children of color by geography, cultural fit and language.

**Young Children**: Forty-seven percent of parents with children who are not yet school-age reported they are more worried about their children's social development than they were before the pandemic. Mental health interventions for preschool age children require treatment services for both the child and the parent together.

**Schools:** Throughout the pandemic additional federal resources have been allocated to schools and the Department of Education (VDOE). These resources have enabled COVID safety protocols to be put in place. Many schools have also used additional resources to invest in social-emotional and mental health screening practices and training. Over the same time, legislation went into effect increasing state funding for school counselors and student support personnel. In the 2021-2022 school year VDOE will begin tracking how these positions are being filled.

While flexible resources have been allocated and additional positions created, the practices in schools remain largely unknown by state agencies and lack consistency. School divisions have made individual decisions based on their local context. These new efforts likely include promising practices that could be shared across divisions or statewide. However the intersection of school practices and mental health services is complicated and fragmented. Local innovation and flexibility provides opportunity for local divisions to go beyond the frameworks and resources provided by the state. And fragmentation within state government between school and mental health systems creates complications for VDOE to administer and support school-based services.

VDOE's support of mental health initiatives is complicated by lack of consistent state resources within the agency to support mental health initiatives— agency staff to support state initiatives are grant funded and limited in their scope of work and initiatives are funded and supported across multiple agencies (DCJS and VDOE) complicating the ability to track outcomes and provide resources, implementation guidance and professional development. A lack of dedicated state funded resources for mental health initiatives at VDOE hampers the ability for the agency to define needs and best practices across the local divisions and to help local divisions implement state-supported initiatives such as Multi-Tiered Support Services (MTSS) or other best practices that require training across systems and to fidelity.

**Mental Health Public and Private Providers:** As the pandemic drags on, we are experiencing severe challenges in attracting and retaining mental health professionals to work at any point in the mental health system. Prior to the pandemic, only five counties in Virginia had enough child psychiatrists to meet the demand. Inadequate compensation and fatigue are creating workforce shortages in hospitals and public mental health agencies. A lack of mental health professionals that meet criteria for licensure and reimbursement means that children with more severe needs may not be able to get their needs meet outside of schools. We have heard anecdotal reports of months long waitlists to receive mental health clinical services over the summer months.

The publicly funded mental health services offered by Community Services Boards (CSBs) remain the safety net for publicly available mental health and crisis response services. Services offered by CSBs should be accessible to all children. However, fully funding the comprehensive services (STEP-VA) offered by CSBs has been delayed. Often services dedicated to children are considered "Part 2" of any new implementation plan, such as alternative transportation or crisis response services, and send a message that children's services are less of a priority.

**Federal/State Policy Response and Medicaid:** As the demands of the mental health system continue to compound, federal and state resources have been applied as band-aids to keep these systems from collapsing and to help them look to the future. Although state legislators authorized additional federal flexible funds to the mental health system during the summer 2021 Special Session they recognized it as a "down payment" and far short of the full cost for a comprehensive system.

As Medicaid is one of the largest payors in the mental health system, changes to Medicaid policy impact access to services for economically disadvantaged children. Over the course of the pandemic, Medicaid enrollment for children has steadily increased to more than 790,000 children, or just over 1 in 3 children now insured by Medicaid/FAMIS. While the state has authorized increases for Medicaid reimbursement rates for behavioral health services, these increases are not permanent and are not indexed to inflation or the cost of living. The start point for Medicaid reimbursement rates is often far below private pay and market rates, and in some cases below Medicaid rates in other states, for example residential treatment.

Over the last several years, Virginia has undergone system transformations in Medicaid-funded behavioral health services; from the shifts from a carve-out service and then back into the base plans creating confusion as to how services are covered by Managed Care Organizations (MCOs). Over the last four years the design of additional behavioral health services through Project BRAVO (Behavioral Health Redesign for Access, Values and Outcomes) has opened doors to revisit the type of behavioral health services offered and how they are delivered and reimbursed by Medicaid. While DMAS has developed a large-scale vision of the services needed to build out a robust,

trauma-informed, evidence-based and person-centered system of care, the current funding for these efforts has been focused on addressing hospitalization and crisis response and has not included enhancement of school-based services.

Within the next year, the state will seek approval for "free care", a portion of school-initiated health and mental health services to be reimbursed by Medicaid, bringing a potential dollar for dollar match for some Medicaid funded services from the federal government directly to local school divisions.

**Working Across Silos:** Each of the systems referenced above-- schools, CSBs, private providers, the state Medicaid agency, and MCOs—includes its own rules, policies and challenges. Working across the continuum of mental health services is complicated in the adult system, but student mental health adds the additional layers of collaborating with child care and schools and facilitating parental consent. These systems operate in different secretariats and with different rules about who can provide services to children based on the setting.

**Focus on The Students:** To provide the optimal services to children we need to shift our thinking to focus on the children, not the systems where services are delivered or how they are paid for. It is our job at Voices to bring the discussion to focus on the children and where they could identify mental health concerns, where they seek help and then shift our focus on the systems they can plug in to. We encourage everyone trying to improve polices and services for children in the mental health system to begin with the perspective of the child.

# Considerations to Improve Policy and Practice:

## 1. Identifying student mental health needs

While identifying student mental health needs is important, we knew that before the pandemic 22% of children in Virginia had a diagnosed emotional, behavioral or mental health need. Any identification process should take into consideration how that screening will lead to appropriate service delivery.

- **Assuming universal need**: With the collective trauma and isolation of the pandemic we are safe to assume that there is a universal need for some social-emotional and mental health support for students. Therefore rather than focus on screening tools and process to determine the scope and scale of students needing support, screening tools should focus on efforts to normalize mental health concerns and to identify the severity of any mental health need.

If widespread screening is going to be adopted, then systems should consider developmentally appropriate screening tools that can identify the needs for further age-appropriate intervention.

- **Screening in schools and early care settings:** Careful consideration of how screening takes place and who conducts screening will be critical for success. Starting with an end goal in mind will be essential to design the appropriate process. For example, before beginning universal screening efforts decide how students needing additional services will be served and data measurement purposes.

- **Health care partners**: Innovative partnerships such as the Virginia Mental Health Access Program (VMAP) have better equipped pediatrician and family medicine providers to screen and manage children's mental health concerns. This remains and critical component of the system as more children participate in virtual school settings or experience school closure due to COVID. Continuing to scale-up the training, supports and services offered in health care settings will help ensure children do not fall through the cracks.

**Discussion prompts for policymakers:**

- *If universal screening methods are proposed, how are they tied to accessing services?*
- *What screening tools can be used to normalize mental health needs?*
- *Which tools are developmentally- appropriate, culturally-appropriate and reliable to detect the severity of needs?*
- *Which tools are appropriate by setting and can be used by parents and non-clinical staff; and if using these tools, how can they be reimbursed?*
- *Which tools are billable to Medicaid and what processes can be in place for seeking reimbursement?*

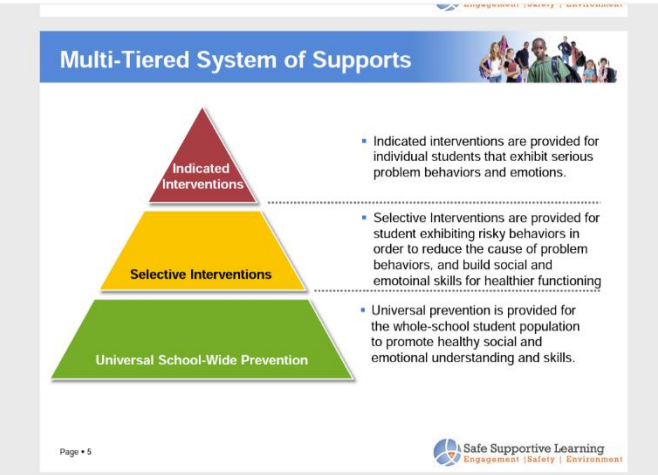
# 2. Schools are managing to provide universal supports (Tier 1) but need more resources to address more severe Tier 2 & Tier 3 needs

With additional flexible funding allocated to local school divisions many are opting to spend new resources on student health and wellness, including mental health programming. In addition, positive behavior interventions and supports-- trauma-informed, trauma-sensitive and restorative justice practices-- were increasing in implementation before the pandemic began. And VDOE was offering several resources

to schools to guide there social-emotional support including the Virginia Tiered System of Support (VTSS) and newly approved SOLs for social-emotional learning.

- **Universal approaches in school-settings are becoming stronger**: With the additional support for universal and tier one supports offered by VDOE and additional positions such as school counselors, schools feel like they are better equipped to provide universal supports. With the overall focus on wellness and social-emotional health by schools, including the adoption of the social-emotional SOLs, the continuum of student mental health services is bolstered by the enhancement of universal support offered by schools.

- **School divisions and schools are testing innovative approaches, packages, and curriculum:** We have heard that schools are adopting new mental health support packages and curriculums with their additional recovery funds such as Harmony and RethinkEd. Some of these new approaches are likely to be well-liked and embraced by staff and students, while others may experience resistance to change. Intra-district learnings of new approaches should be encouraged through facilitated support at VDOE. In offering guidance, VDOE staff should offer guidance that builds on local approaches and provides the flexibility they need. VDOE should have the staff resources to support intra-department connections and opportunities to share best practices with other school divisions and leadership from schools, local government and state agencies.




- **Tier 2 & Tier 3 services in school are weaker**: While universal services are strong, school leaders express more challenges with trying to offer Tier 2 & Tier 3 services to students with greater needs. While these students may sometimes be better served in community-based or clinical settings, particularly in Tier 3, there is a wide variety of Tier 2 supports that are well-suited for school-based environments

such as brief interventions, group interventions, peer-led interventions and case management services.
The challenges to offer Tier 2 services include appropriately trained staff to support group interventions and to work with parents and students.

In addition, the Tier 2 and Tier 3 services are more likely to potentially meet the criteria as a Medicaid-funded service. As DMAS continues to revise program standards and manuals in behavioral health services these types of school-based services should be billed to Medicaid. DOE will need staff dedicated to collaborating with DMAS, schools and community-based providers to best define those services and to determine how Medicaid or private insurance can be used to support these school-initiated interventions.

  - **Special note of Consideration:** Helping to support children with more severe behavioral health diagnosis will require further exploration of the services provided in school for Tier 2 & Tier 3 and Medicaid-funded services. To fully examine Medicaid-funded services for Tier 2 & Tier 3 supports VDOE, DMAS, DBHDS, local school divisions, CSBs and private providers should identify a range of interventions to serve students in Tier 2 & Tier 3 and recommend which ones can be reimbursed by Medicaid.

- **Child care and preschool largely considered a separate system from K-12 when it comes to social emotional supports:** Due to the uniqueness of the developmental needs of young children, the public-private partnership in child care settings and the best practice needs to involve both the parent and children in mental health or behavioral interventions, early childhood consultation models are being developed separately from the tiered support systems in schools. As these systems develop it will be useful to identify the points at which they should be connected and how funding resources can be used to build the early childhood system and the K-12 system.

**Discussion prompts for policymakers:**

- *How can VDOE and other state agency partners be best equipped to support student needs following the framework of a tiered system of supports?*
- *Do students, specialized support staff and clinical practitioners find natural connections between interventions and needs at the different tiers?*
- *Do any schools feel like they are adequately meeting needs at Tier 2 & Tier 3, and if so what are these approaches?*
- *How are schools currently funding Tier 2 & Tier 3 supports?*
- *Where does Therapeutic Day Treatment fit in the discussion of tiered supports and how might those private providers adapt to better meet student needs?*

# 3. **It matters to students what mental health support looks like, feels like and who delivers it**

Because children, youth and young adults spend so much time in school and connected to school, students often report that their relationships to teachers and school staff are their first connections to finding mental health supports. The ability to connect, spend much of the day in the same spaces and convenience on seeing each other day-in and day-out helps to build trusted relationships.

Beyond the convenience factor, students also want to connect with treatment providers that understands their background and experience. They want racially diverse, gender diverse and LGBTQ+ friendly connections. They would appreciate diverse delivery methods that include peer or group connections and restorative practices. Virginia should explore models that expand and fund youth peer support groups, such as Youth MOVE, and whole body wellness efforts.

To encourage the diversity of experiences and services offered in school-based settings, schools should be encouraged to partner with community-based private and public mental health programs to expand their service delivery and compliment universal approaches with tiered support that can be provided by specialized support staff. Community partners could bill Medicaid for services; clear processes to help community providers bill Medicaid with appropriate billing codes will ensure services are funded.

There is an enormous potential normalize health and mental health services in school settings and to support whole child wellness. School-based health centers and integrated wellness models should be encouraged and incentivized to connect the health and wellness to optimal learning environments. The ideal setting of a new normal recognizing that everyone has some mental health needs will be school environments attuned to addressing mental health needs, and when mental health professionals in connected to schools are diverse in background and perspectives and well suited to make positive connections.

**Discussion Prompts for Policymakers**:

- *Where can young people lead in the discussions to shape and define mental health services?*
- *How can peer-led interventions and culturally appropriate services be better supported in schools or connected to schools?*
- *How can schools and community partners learn from each other in adopting integrated care and trauma-informed appraoches?*
- *COVID-19 has prompted better collaboration between health providers and education systems. How can this foundation be built on to support mental health services and school-based health centers?*

**A note on the "free care rule"**

In the 2021 General Assembly Session SB1307 (Dunnavant) passed requiring Virginia to submit a state plan amendment to the Centers for Medicare and Medicaid to begin implementation of "free care". This change enables local school divisions to bill Medicaid for health and mental health services initiated by the school. Any student can receive services billed to Medicaid or school-wide interventions can be supported. The reimbursement process requires record keeping on Medicaid eligible students and identifying the eligible services provided to bill Medicaid. When local school divisions can begin billing for services the school division would receive the federal Medicaid matching funds (a dollar-for-dollar match) for the service delivered.

These funds flow outside state coffers directly to school divisions. The divisions will need training and additional capacity to complete the record keeping and billing process. Either VDOE or DMAS must identify additional training support for school administrators and record keepers. The state is seeking a broad set of services under the state plan in line with EPSDT but it is possible that not every health mental health service delivered in schools will be eligible. As a model state, Michigan has promoted Medicaid reimbursement in schools since 2019.

# 4. Licensure of professionals serving children

As we face a shortage in the mental health workforce it is time to address gaps and weaknesses in the licensing and credentialing systems for mental health professionals in community-based and school settings. As many partners have pointed out, there are several disconnects in process to become an "approved" mental health professional in different settings or by payor. As the state needs to address workforce shortages and ramp up the scale of mental health professionals, it is time to re-examine who is "allowed" to provide mental health support and how we can reduce as many barriers as possible.

Qualified Mental Health Professionals (QMHPs) often serve in a variety of roles. This position can fill in the gaps but also is at-risk of being less meaningful or impactful without a specific role, value or expertise to play in the mental health field. This level of unlicensed professional is needed when barriers to licensure are significant and can be a tool to diversify the field. The role of QMHPs and the role of the licensed professionals who provide their oversight should be better defined by settings and incorporated into payment structures.

Barriers that exist in terms of licensure include:

- The licensure process for school-based professionals that is in addition to community licensure and not aligned with transferrable licensure from other states.

- Expensive and time-consuming processes for becoming a licensed mental health professional.
- A lack of career pathways and stackable credentials to support mental health professionals wishing to level up from QMHP to licensed.
- Experiential learning and contact hours that are based on time frame and not aligned with achieving specific credentials or incentives for achieving additional expertise. Lack of useful mentorship and feedback opportunities between the licensed professionals and QMHPs.
- Lack of incentive for professionals to bill for oversight of QMHPs and lack of meaningful training and feedback opportunities to build towards licensure.

**Discussion prompts for policymakers:**

- As multiple legislative proposals will likely be in play to address licensure and workforce barriers what criteria will be used to examine proposals?
- To meet children's needs proposals that encourage a diverse and reflective workforce, proposals that allow flexibility to the setting providing care, and proposals that provide pathways to competency in developmentally appropriate services would be beneficial?
- Beyond outlining new pathways to licensure and school-endorsement, how are mental health professionals supported in gaining skills and competencies?

# Immediate Next Steps for Policy Makers:

1. **Address workforce shortages** by reducing as barriers to licensure, improving pay equity and investing in a workforce pipeline. Examine how policy proposals can recruit a language diverse, racially diverse and culturally responsive workforce.
2. **Pilot and evaluate new initiatives to provide more tier 2 & tier 3 services in schools** such as regional consultants to help advise on practice and programming and on-going training and coaching to implement evidence-based approaches.
3. **Provide training and technical for local school divisions to bill Medicaid under free care and to implement school-initiated health and mental health services.** Additional staff positions can be created at VDOE or contracts can be awarded to TA providers to assist local school divisions.
4. **Facilitate connections across silos** by supporting children's mental health efforts as a focus of an on-going children's cabinet and other local cross-sector networks, such as community resilience networks.
5. **Allow stakeholders, including students themselves, to help identify and define the school-based services.** DMAS, DOE and DBHDS should convene a workgroup of stakeholders, parents and students to advise on the scope of services that should be provided in school-settings and what changes to Medicaid or state funding resources can support those services.