Maximizing school-based mental health services

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Commonwealth of Virginia

Behavioral Health Commission

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Purpose

The Commission is established in the legislative branch of state government for the purpose of studying and making recommendations for the improvement of behavioral health services and the behavioral health service system in the Commonwealth to encourage the adoption of policies to increase the quality and availability of and ensure access to the full continuum of high-quality, effective, and efficient behavioral health services for all persons in the Commonwealth. In carrying out its purpose, the Commission shall provide ongoing oversight of behavioral health services and the behavioral health service system in the Commonwealth, including monitoring and evaluation of established programs, services, and delivery and payment structures and implementation of new services and initiatives in the Commonwealth and development of recommendations for improving such programs, services, structures, and implementation.

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1 Overview of school-based mental health services

In the 2022-2024 Appropriation Act, the General Assembly directed the Behavioral Health Commission to study how to maximize school-based mental health services across the Commonwealth (Appendix A). Specifically, the BHC was asked to:

- evaluate the current reach of school-based mental health services and identify strategies to connect mental health clinical interventions to school settings;
- consider opportunities to align Medicaid-funded behavioral health services and school-initiated services newly eligible under the "free care rule;" and
- make recommendations about strategies to implement and expand school-based mental health services.

To complete this study, BHC staff conducted interviews with state agencies responsible for overseeing various components of school-based mental health services, visited schools across Virginia and interviewed school and division staff, reviewed existing literature on school-based mental health planning and delivery models, surveyed school divisions and parents of children in Virginia public schools, and analyzed survey and other data (Appendix B).

Range of school-based mental health services and supports address varying levels of need and acuity

Schools can provide a variety of services and supports for students who experience or are at risk of developing mental health challenges. These services and supports can range from preventative supports provided to all students to intensive interventions that may only be needed by a few students. Specific services and supports are often aggregated into "tiers" that reflect how intensive they are and which population of students typically uses them.

"Mental health services" refer to specialized interventions provided by trained professionals to address the mental health needs of students. They include individual counseling, referrals, crisis intervention, and other interventions offered by providers with certain licenses and qualifications. "Mental health supports" are broader efforts to promote mental well-being in students. They include classroom prevention programs, calming rooms, and school assemblies. These two terms are often used interchangeably. For purposes of this report, the term "services" is used to refer to both services and supports, unless otherwise specified.

Mental health services range from classroom lessons to individual psychotherapy

Virginia schools can provide a diverse array of mental health services and supports to address students' needs. These services range from universal, preventative supports such as Social

and Emotional Learning (SEL) and mental health awareness programming to more intensive services such as individual psychotherapy. Some of the most prevalent mental health services offered in Virginia schools are Social and Emotional Learning (SEL) curricula; professional development for staff; and short-term mental health support provided by a school counselor, school social worker, or school psychologist.

The Virginia Department of Education (VDOE) defines SEL as:

> "The process through which all young people and adults acquire and apply the knowledge, skills, and attitudes to develop healthy identities, manage emotions and achieve personal and collective goals, feel and show empathy for others, establish and maintain supportive relationships, and make responsible and caring decisions."

SEL curricula vary in their strategies and tools, but most center around five core competencies: self-awareness, self-management, social awareness, relationship skills, and decision-making.

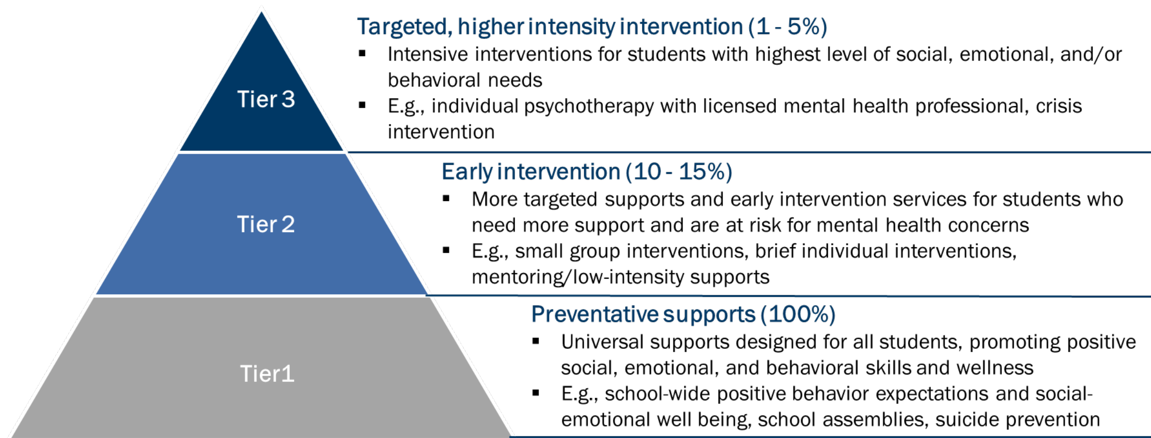
As required by state law, school divisions provide mental health awareness training to teachers and other relevant personnel. Some divisions also provide additional professional development for staff on topics such as Mental Health First Aid. Most divisions also offer short-term mental health supports provided by school mental health professionals, including school counselors or school social workers, or teachers.

Therapeutic Day Treatment (TDT) is another commonly offered program for youth that combines psychological interventions, evaluation, and mental health treatment to students with mental, emotional, or behavioral disorders. While services like individual counseling or group therapy may be provided by either school staff or external providers working inside the school, TDT is almost exclusively offered by external providers.

Services frequently provided as part of a multi-tiered system of supports

Professionals in the field commonly employ the Multi-Tiered System of Supports (MTSS) when discussing school-based mental health. This framework aims to identify and support students' mental health needs through a layered approach consisting of three tiers (Figure 1-1). Tier 1 "services" are generally supports provided by teachers or other school staff, while Tier 3 services are more likely to be interventions offered by licensed mental health professionals. Tier 2 services can be either supports or services provided by school staff or external providers.

Figure 1-1
Multi-Tiered System of Supports (MTSS) framework



Source: BHC staff analysis of MTSS models from DBHDS, National Center for School Mental Health

The MTSS framework is also apparent in the Virginia Tiered System of Supports (VTSS), a program within VDOE that provides support, technical assistance, and coaching to school divisions to help them implement tiered academic and behavioral supports. Although VTSS utilizes the same language of "tiers," its primary areas of focus are academic success and behavior supports rather than mental health. In recent years, some VTSS partner divisions that are supported by a federal mental health grant have added components of mental health into their VTSS plans.

School-based mental health services can be provided by school staff and by community providers

Mental health services and supports in Virginia schools are delivered by a range of professionals, including counselors, social workers, psychologists, and teachers. Many schools also partner with community providers to expand their capacity, particularly for higher-tier services like psychotherapy. These collaborations benefit students and bridge the gap between school and community-based services, allowing for a more comprehensive approach to mental health support in schools.

School staff who provide mental health supports are mostly teachers, counselors, social workers, and psychologists

The school staff most often responsible for providing mental health supports are teachers and school mental health professionals, including school counselors, school social workers, and school psychologists:

- **School counselors** provide instruction, advice, and counseling to students in academics, college and career readiness, and social/emotional development. School

counselors also serve other roles in some schools, such as coordinating 504 plans; however, a 2023 state law requires that they spend at least 80 percent of their time on direct counseling of individual students or student groups.

- **School social workers** are trained mental health professionals who provide students and families with services that include crisis intervention, participation on 504 and special education teams, individual and group counseling, and family education.

- **School psychologists** provide academic, behavioral, and social/emotional support to students through services such as behavioral assessments, evaluations for special education, crisis intervention, and design of school-wide programming.

While all divisions are required by the state to employ school counselors at a rate of 1 counselor for every 325 students, divisions are not required to employ a school social worker or school psychologist. Still, divisions that do not employ a school psychologist will often contract with a psychologist in private practice to evaluate students for special education, as required by federal law.

Classroom teachers also play an important role in the provision of mental health services. Some universal services, like social and emotional learning, are incorporated into classroom lessons or offered as a collaboration between teachers and school mental health professionals. Teachers can also be a part of Tier 2 services, such as a check-in, check-out system for students.

School divisions partner with community providers to supplement the capacity of school staff, especially for higher-tiered mental health services

School staff may not have the time or expertise to handle all student mental health needs, and schools may rely on partnerships with external providers in the community to offer services beyond what school staff can accommodate. Many schools partner with their area Community Services Board or Behavioral Health Authority (CSB), and several divisions have partnerships with private providers in addition to or in lieu of working with CSBs. For example, CSB staff might come into a school once a week to provide individual therapy, and private providers may work with students who require TDT. Community providers can serve students either in schools, or on an outpatient basis in the community.

Community providers working in schools

Community providers may come into schools to offer services to students during school hours. This approach can reduce barriers to access for students who may otherwise have difficulty attending appointments outside of school hours. Community partners tend to provide services such as Mental Health First Aid, screenings, and evaluations. They are also the primary providers of TDT in schools. In some schools, community providers work closely with school mental health staff to collaborate on student needs.

Referrals to external providers in the community

Schools may refer students to services in the community when school is not the proper treatment setting, for example if the school cannot accommodate the level of privacy needed for a service. Referrals may also occur when school staff cannot provide the services needed. In particular, school mental health professionals vary in their levels of professional licensure and experience and may not always be qualified or comfortable providing higher-tiered levels of mental health intervention such as individual psychotherapy. Some school staff and administrators also indicate that it is not the role of the school to provide intensive mental health services to students.

Schools are required to provide mental health services only for certain student populations

Federal law requires that mental health services be provided to students who need them as a component of special education. In contrast, there is no state or federal requirement for other students to receive school-based mental health services. Students with mental health challenges may also qualify for less intensive accommodation strategies through a "504 plan."

Federal law governs mental health services that are a part of IEPs

The Individuals with Disabilities Education Act (IDEA) requires that students with a disability are provided with a "free, appropriate public education" in the least restrictive environment that meets their individual needs. IDEA directs public schools to develop an individualized education program (IEP) for every student with a disability who meets the federal and state requirements for special education. IDEA allows fourteen categories of disability, including "emotional disturbance," which may encompass certain types of mental health diagnoses.

Depending on the needs of students with an IEP, they may receive specially designed instruction, classroom accommodations, and related services such as mobility services or psychological and counseling services. If psychological and counseling services are part of a student's IEP, the school is required to provide them free of charge. (IDEA provides federal funding to help offset some of the costs of accommodating students with disabilities, but state and local funds are often used as a supplement.)

Students may have 504 plans related to mental health

Like IDEA, section 504 of the Rehabilitation Act of 1973 requires school divisions to provide "free, appropriate public education" to all students who may benefit from public education, regardless of disability. Divisions must identify the child's educational needs and satisfy those needs through regular or special education. If a student has a mental health challenge, schools may be required to provide accommodations. Educational plans developed for a student under this Act are called "504 plans" and are treated differently than an IEP. "Disability" under Section 504 is more broadly construed than under IDEA, and 504 plans are often utilized by students who do not qualify for (or do not want) the more intensive special education services provided by IDEA. 504 plans have fewer federal requirements than IEPs and generally focus on classroom accommodations, such as extended test time. Unlike with

an IEP, the federal government does not provide funding to schools to help offset the cost of 504 accommodations.

Few state laws govern school-based mental health services for other students

There are limited laws, requirements, and definitions around school-based mental health services for the general population of students in Virginia. There is no statewide definition of "school-based mental health," leading to potentially conflicting ideas as to what is included in that concept. There are similarly few requirements for schools to provide mental health services. The Code of Virginia contains one provision requiring school boards to provide mental health awareness training to full-time teachers and other relevant personnel and one provision requiring the inclusion of mental health education in 9th and 10th grade health classes.

Beyond those laws, the measure that comes closest to a requirement pertains to staffing ratios within the state educational Standards of Quality (SOQs). The SOQs require that divisions employ specialized support staff at a rate of 3 per 1,000 students. Although the support staff category can include personnel who provides mental health services (e.g., school psychologists and school social workers), it also includes other staff such as school nurses, and a division could comply without hiring any school mental health professionals. There are no specific ratios for school social workers or school psychologists, but the SOQs require that school counselors be staffed at a rate of 1 per 325 students. School counselors can provide mental health services, but they are not required by law to do so.

Virginia Medicaid regulations contain numerous provisions related to mental health services, including services that are provided in schools; however, these regulations only apply to services provided to Medicaid-enrolled students, not to school-based mental health services more generally.

School-based mental health services are funded by a blend of federal, state, and local sources

In Virginia, schools receive funding for mental health services from a combination of federal, state, and local sources. School divisions use money in their base operating budgets to fund mental health services, but many also seek out additional sources of funding. Federal funding, channeled through several federal grants and pandemic relief funds, plays a significant role in supporting these programs. State funding for school mental health flows through the SOQ funding formula for school employees, as well as through a new DBHDS pilot program that supports school partnerships with external community providers. Some local governments also provide supplementary funding for mental health services delivered in schools.

Federal funding accounts for majority of specialized financial support for school-based mental health services

Federal funding, primarily distributed through grants and pandemic relief funds, represents a major source of support for school-based mental health programs in Virginia. Since 2020,

federal pandemic relief funds have played a vital role in school mental health funding, with approximately $123 million spent by divisions on mental health services. These funds are generally set to expire by September 2024.

Federal grants

The federal government—through the U.S. Department of Education, the Substance Abuse and Mental Health Services Administration (SAMHSA), and other agencies—maintains grant programs for school-based mental health. Some divisions apply directly for grants, and the Virginia Department of Education also receives grant funding for programs such as school mental health professional recruitment and retention, which it then distribute to divisions. The size of grant awards varies by division project and funding source.

Pandemic relief funds

Since the Covid-19 pandemic and the passage of the CARES Act in 2020, federal pandemic relief funds have become a significant source of mental health funding for many divisions. All three pandemic relief bills— the Coronavirus Aid, Relief, and Economic Security Act (CARES), the Coronavirus Response and Relief Supplemental Appropriations Act (CRRSA), and the American Rescue Plan Act (ARPA)—contained ESSER funds for school divisions. ESSER funds, which stand for Elementary and Secondary School Emergency Relief funds, are federal grants provided to support K-12 education during the Covid-19 pandemic. These funds aim to help schools address the impact of the pandemic by providing financial resources to improve the health and safety of school environments, bridge learning gaps, and bolster technology infrastructure. ESSER funds have only a few allowable uses, one of which is student mental health supports and services. Many divisions have used ESSER funds to supplement their mental health budgets, hire new staff, and purchase evidence-based programming for students.

According to data from VDOE, between 2020 and 2023, divisions in Virginia spent at least $123 million of pandemic relief funds on mental health services. As funding provisions in the authorizing laws have expired, so have divisions' new funding sources for mental health. ESSER I funds, authorized under the CARES Act, had a deadline of September 30, 2022. ESSER II funds, established under CRRSA, expired September 30, 2023. ESSER III, the most recent and substantial allocation of funds created through ARPA, extends beyond ESSER I and II, with most funds expiring in September 2024.

Federal pandemic relief funds also contributed to school mental health through more indirect channels. For example, the Department of Behavioral Health and Developmental Services (DBHDS) received relief funds through ARPA and the Consolidated Appropriations Act and allocated a portion of that money to supporting school-based mental health through its Office of Child and Family Services. Other state agencies, non-profit organizations, and federal programs may also have used pandemic relief funds to further mental health goals in Virginia schools. However, this information is not tracked centrally or consistently so a comprehensive estimate cannot be provided.

Medicaid reimburses some school-based mental health services

Medicaid funds some school-based mental health services for students covered by Medicaid. Medicaid funding can support school-based mental health services in two different ways: (1) by paying private providers who are enrolled in the Medicaid program for the cost of services they deliver in schools to eligible students; and (2) by reimbursing schools for a portion of the costs they incur to provide school-based mental health services to eligible students. Until September 2023, the scope of services for which schools could be reimbursed was limited.

Direct billing by Medicaid providers

Under the first payment and delivery model, services such as TDT are provided in schools by community or private Medicaid-enrolled providers who bill Virginia Medicaid or its managed care organizations (MCOs) directly for the services provided to students covered by Medicaid.

Cost reimbursement to school divisions

The other pathway for Medicaid reimbursement is a federal pass-through program administered by Virginia's Medicaid agency, the Department of Medical Assistance Services (DMAS). Through this program, participating school divisions are reimbursed through an annual cost-based reimbursement process for a portion of their eligible state and local costs incurred to provide Medicaid school-based health services to Medicaid-enrolled students. These costs include staff salaries and benefits, and payments to contracted providers. Until recently, this federal Medicaid reimbursement process could only provide reimbursement to school divisions for services included in a child's IEP. For a school division to receive Medicaid reimbursement for a clinical mental health service provided to a Medicaid student (e.g., individual therapy provided by a school psychologist), the service had to be included in that student's IEP.

In 2021, the General Assembly directed DMAS to seek approval from the Centers for Medicare and Medicaid Services (CMS) to expand reimbursement opportunities to include Medicaid services outside of the IEP, and for Medicaid-enrolled students without an IEP. This change follows an option available under revised federal guidance issued in 2014 known as the reversal of the "free care rule." In September 2023, CMS approved Virginia's Medicaid state plan amendment retroactive to July 1, 2022, allowing divisions to bill Medicaid for services provided to Medicaid-enrolled students outside of the IEP. The amendment also adds new behavioral health services and provider types for which Virginia school divisions can seek reimbursement. Provider types added include licensed school psychologists and VDOE-licensed school social workers, among others. These recent changes expand opportunities for school divisions to receive additional federal Medicaid reimbursement for mental health services they are already providing to students, as long as the division participates in Medicaid billing.

The cost-based reimbursement program provides Medicaid reimbursement to schools for services they have already provided to students during the year, meaning that upfront investments such as hiring or contracting with increased school mental health personnel to serve more students must be initiated at the state level by VDOE or at the local level by

schools/localities in order to deliver the services later eligible for Medicaid reimbursement. However, funding received through increased reimbursement can subsequently be reinvested by local divisions in initiatives that support student mental health.

Virginia's success in leveraging this opportunity for increased federal funding will depend in part on the quality and scale of support provided to school divisions to enable them to maximize this opportunity. Local school divisions' participation in the school-based Medicaid reimbursement program is voluntary. Participation is a heavy administrative burden, especially for the under-resourced schools that could benefit most from the additional funding. Participation in the Medicaid school-based services program requires school division staff to develop expertise in billing and administering the complex cost-based reimbursement process.

SOQs and new grant program account for majority of state funding for school-based mental health services

Virginia distributes state funds for school mental health through two primary mechanisms: the Standards of Quality (SOQs) and a new pilot program administered by DBHDS. SOQ funding is only for school employees, such as teachers and school counselors, while the pilot program offers funding to support school partnerships with external community providers.

Standards of Quality

The state educational SOQs do not support school-based mental health services directly, but they provide some funding for certain school staff positions that can deliver mental health supports and services. Through the SOQs, the state provides money for a portion of the compensation costs for teachers and school counselors (up to a fixed ratio). The SOQs also fund a portion of the compensation costs for specialized support staff (also at a fixed ratio), which includes school social workers and school psychologists. Divisions can hire additional staff using their local operating budget or other funds if they find that their need for school mental health professionals exceeds the ratios set by the SOQs.

Pilot grant program

Starting in 2022, DBHDS began distributing funds to six divisions through the School-Based Mental Health Integration Pilot ("the pilot program"). DBHDS received $2.5 million in general funds in FY23 to provide technical assistance and grants to school divisions to contract with community mental health providers. DBHDS worked with six school divisions during the 2022-2023 school year: Richmond City, Lunenburg, Mecklenburg, Bristol, Hanover, and Hopewell. The pilot program helped fund the hiring of eleven school-based mental health personnel across four divisions as well as the implementation of other supports, such as calming rooms (see Chapter 3 for more detail on the pilot program). Funding for the pilot program was increased to $7.5 million for FY24 in the budget adopted in 2023.

Local funding for mental health varies significantly among school divisions

Some localities supplement their schools' mental health programs, but the extent of local government support varies significantly based on localities' ability and/or willingness to

contribute additional funding for mental health beyond the standard operating budget. Approximately one in five school divisions receives additional funding from their local government specifically for mental health services, based on a BHC survey of divisions.

Heightened mental health challenges negatively impact Virginia students and the school environment

Increased rates of mental health concerns among students create challenges for both the students themselves and school staff. The prevalence of mental health issues, particularly anxiety and depression, has risen among Virginia students and has been especially exacerbated since the onset of the Covid-19 pandemic. These mental health challenges have also created a more challenging working environment for school staff, which may affect recruitment and retention.

Virginia students are experiencing heightened mental health challenges

Students in Virginia schools are exhibiting a high rate of mental health concerns, which school staff report has been increasing since the onset of the Covid-19 pandemic. Anxiety and depression are both frequent sources of mental distress among students, and anxiety appears to be especially heightened since 2020. Rates of depression and suicidal thoughts are concerningly high, yet they are roughly in line with national averages, suggesting that these trends go beyond Virginia. School-based mental health services are one tool for addressing this need, but attention is needed along the entire continuum of care—such as ensuring adequate access to inpatient beds and to outpatient services for youth—to fully address the worsening mental health challenges of Virginia youth.

Virginia students experience high rates of depression and suicidal thoughts

Recent data from statewide surveys of students reveal alarming rates of depression. The Virginia School Survey of Climate and Working Conditions alternates survey years between middle school and high school, surveying high school students in 2022 and middle school students in 2023. In 2022, 40 percent of high school students in Virginia reported feeling so sad or hopeless almost every day for at least two weeks in a row that they stopped doing their usual activities. Thirteen percent of those students reported that they seriously considered suicide in the preceding 12 month-period. These rates are generally consistent with national experience: in 2021 (the most year for which data is available), 42 percent of high school students in the U.S. felt so sad or hopeless almost every day for at least two weeks in a row that they stopped doing their usual activities, according to the CDC Youth Risk Behavior Survey. Within the preceding 12-month period, 22 percent of those students seriously considered suicide. This national figure is higher than in Virginia (13 percent).

Data from younger students is similarly concerning. In 2023, 34 percent of middle school students in Virginia reported feeling sad or hopeless for two weeks or more, which is only somewhat lower than for high school students (40 percent). Of those middle school students, 11 percent reported seriously considering suicide in the previous 12-month period.

More students are presenting with mental health challenges that tend to be more severe since the COVID-19 pandemic

School staff have noticed an increase in the number of students with mental health challenges and in the severity of those challenges. In a 2022 Joint Legislative Audit and Review Commission (JLARC) survey of school mental health staff, a strong majority of respondents (71 percent) indicated that the number of students with anxiety had “greatly increased” since the pandemic, and almost all (93 percent) reported that the severity of students’ anxiety had increased. The vast majority of respondents also reported increases in the number of students with depression (93 percent) and the severity of students’ depression (88 percent). This trend was echoed in BHC interviews with school and division staff. Mental health staff, administrators, and others frequently remarked on the increase in student mental health needs since the pandemic and pointed to students’ anxiety as being especially pronounced post-pandemic. Youth whose mental health challenges go untreated early in life are at greater risk for academic disruptions and later unemployment, as well as higher-consequence outcomes such as criminal justice involvement and suicide.

Student mental health impacts the working environment of school staff

As students experience more mental health concerns and bring those challenges into the classroom, school staff are affected as well. In interviews with school and division personnel, staff described a more difficult and chaotic working environment than they experienced before the pandemic. Students’ anxiety, emotional disturbances, and lack of emotional regulation skills affect classroom environments, and this can lead to additional challenges for school staff, especially teachers. In their 2023 study of the K-12 teacher pipeline, JLARC found that classroom environments are a major factor impacting teacher recruitment and retention, and 43 percent of the teachers they surveyed cited student anxiety and mental health as one of the most serious problems they faced after the pandemic.

Chapter 1: Overview of school-based mental health services

2 Availability of school-based mental health services

Most students in Virginia have access to some level of mental health services in public schools; however, these are more likely to be low-intensity and preventative than the types of services needed once students develop mental health challenges. Nearly all students have access to Tier 1 supports, but about 45 percent of students who have higher needs are unable to access the level of services they need. The true need for mental health services may be underestimated because most schools do not systematically identify students with mental health needs. Students whose mental health needs go unaddressed are at risk for negative outcomes, such as academic impairment, social challenges, and even suicide.

Most students have access to Tier 1 supports

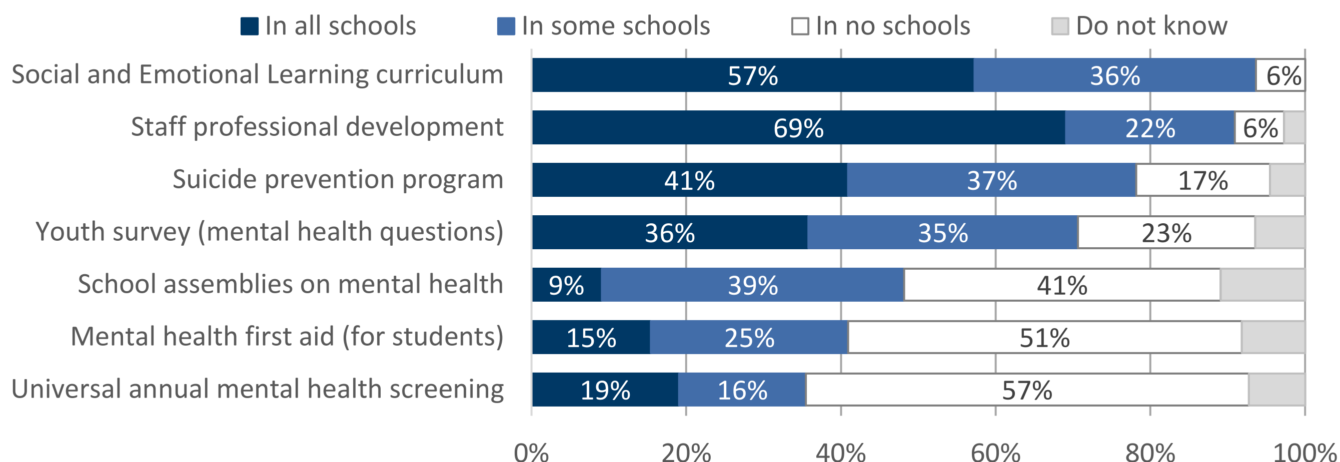
Nearly all Virginia public school students have access to some Tier 1 supports in their schools, although the types of services and the extent to which they are available vary among divisions. During site visits, school staff and administrators in multiple divisions stressed the importance of Tier 1 supports in developing students' skills in areas such as emotional regulation and preventing the onset of serious mental health issues later in childhood.

Over three-quarters (77 percent) of Virginia public school students receive some Tier 1 mental health supports in their school, according to a BHC staff survey of Virginia school divisions. The most common Tier 1 supports provided by divisions include Social and Emotional Learning (SEL) curricula (94 percent of divisions use in at least some schools), professional development for staff on youth mental health (91 percent), and suicide prevention programming (78 percent) (Figure 2-1).

School-based mental health services appear to be least available to students who need the most support

Most divisions offer at least one type of Tier 2 and one type of Tier 3 service in schools. However, many divisions report being unable to meet the demands of students who require these more intensive services. Tier 2 and 3 services, which are targeted interventions and generally require a smaller staff-to-student ratio than Tier 1 supports, can be more costly and resource intensive to provide. However, they are also critical for students who are experiencing moderate to severe mental health challenges, especially in communities that lack robust access to mental health providers outside of school. Youth whose mental health challenges go untreated are at greater risk for academic and social disruptions, later criminal justice involvement, and suicide.

Figure 2-1
Prevalence of Tier 1 supports among school divisions, and use among schools



Source: BHC staff analysis of data from survey of Virginia school divisions conducted in August 2023. 111 out of 131 divisions (85%) completed the survey

Variety of Tier 2 and Tier 3 services offered in Virginia schools

In response to a BHC staff survey, divisions indicated that the most common form of Tier 2 support was short-term mental health support from school staff, which can include school counselors, school social workers, and school psychologists. Ninety-one percent of divisions indicated that short-term mental health support was available in all their schools, and 98 percent said this type of support was available in at least some schools in their division (Figure 2-2). Other common Tier 2 services included check-in/check-out systems (94 percent of divisions report using them in at least some schools) and short-term psychoeducational groups focusing on specific topics (e.g., grief, anger management, mindfulness) (89 percent).

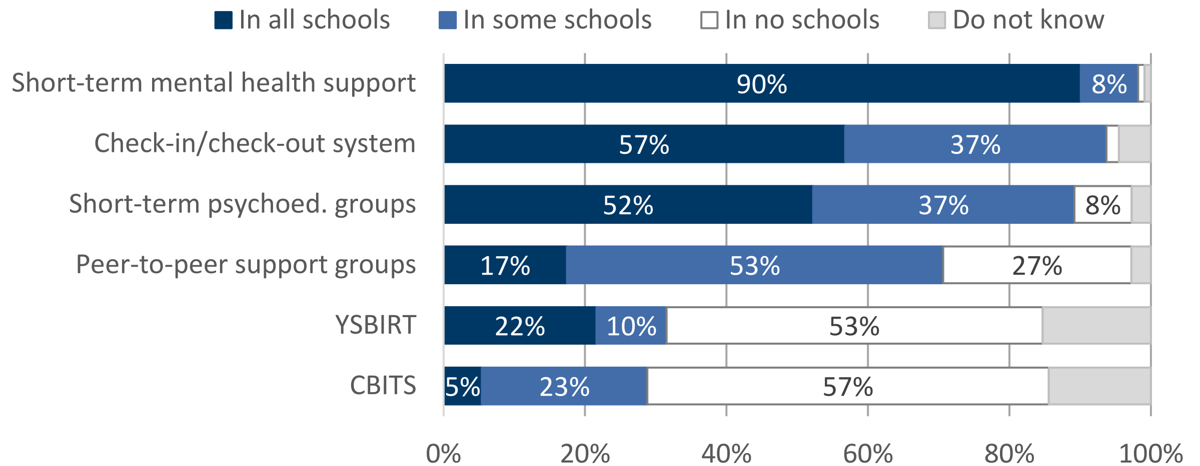
Tier 3 services, which are more intensive services and supports for students with higher acuity of needs, are often delivered by community providers. The Tier 3 services most commonly provided in schools include treatment referrals to community-based providers (99 percent of divisions report offering them in at least some schools), longer-term individual counseling delivered by school support staff (82 percent), and therapy delivered by a community mental health provider in a school setting (78 percent) (Figure 2-3).

About 45 percent of students who need Tier 2 or Tier 3 services or supports do not have access to them in school

Divisions responding to a BHC staff survey indicated that, on average, 55 percent of students who require Tier 2 services and 54 percent of students who require Tier 3 services were able to receive those services at school, leaving approximately 45 percent of students unable to receive the services they need. Students may be unable to receive the services they need in schools because those services are either not offered at all, or they are offered but there is not enough capacity to serve all the students who need them. Divisions' ability to meet the needs

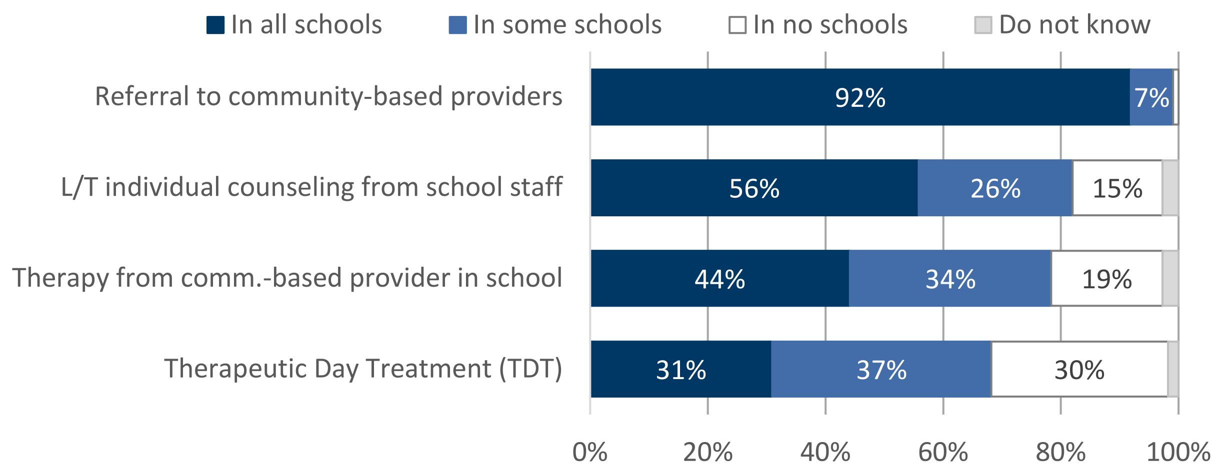
of students vary by region, with Northern Virginia schools able to provide more than 60 percent of students with the Tier 2 and Tier 3 services they need and the Northern Neck divisions able to meet the lowest percentage of student needs (Figure 2-4).

Figure 2-2
Prevalence of Tier 2 services among school divisions, and use among schools



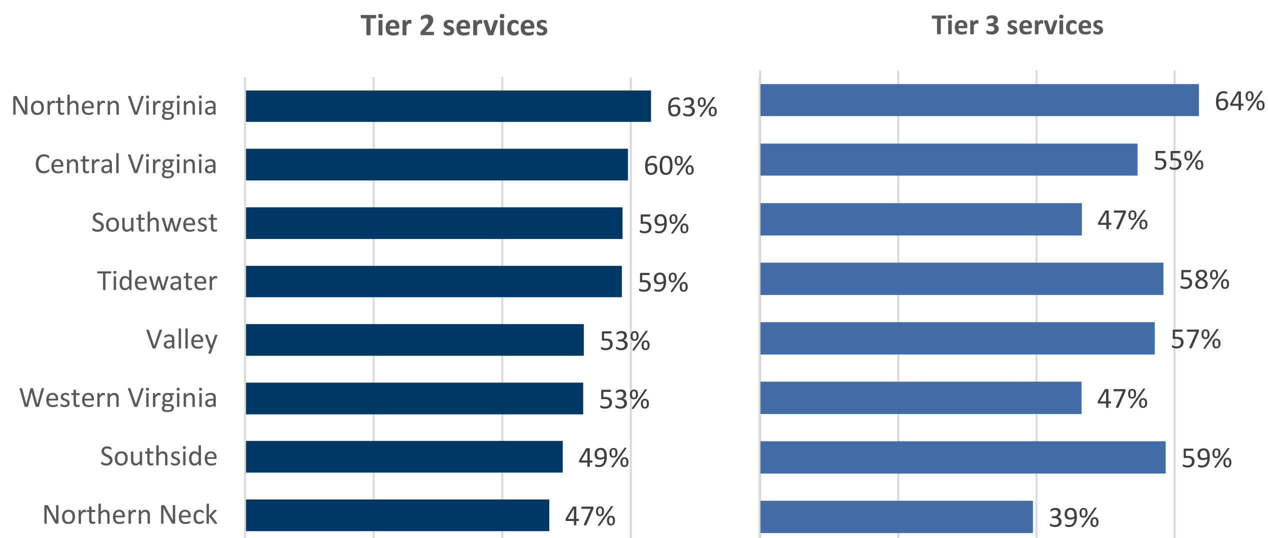
Source: BHC staff analysis of data from survey of Virginia school divisions conducted in August 2023. 111 out of 131 divisions (85%) completed the survey.
Note: YSBIRT= Youth Screening, Brief Intervention and Referral to Treatment; CBITS= Cognitive Behavioral Intervention for Trauma in Schools

Figure 2-3
Prevalence of Tier 3 services among school divisions, and use among schools



Source: BHC staff analysis of data from survey of Virginia school divisions conducted in August 2023. 111 out of 131 divisions (85%) completed the survey.
Note: Divisions also reported use of Behavioral Intervention Plans, which are not considered a mental health service for the purposes f this study

Figure 2-4
Percent of students able to receive needed Tier 2 or Tier 3 services in school, by region



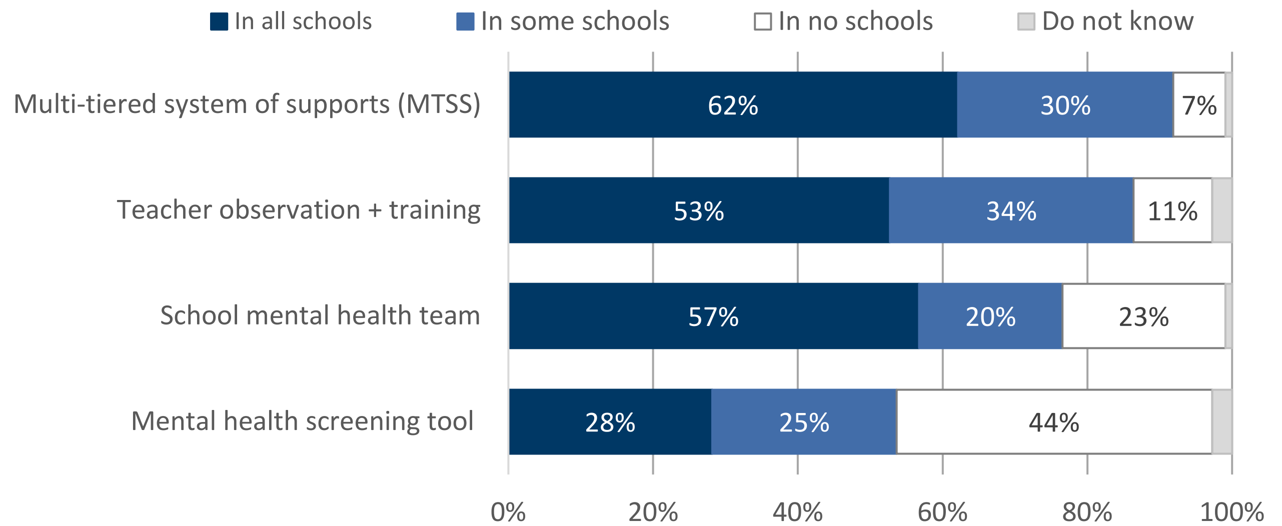
Source: BHC staff analysis of data from survey of Virginia school divisions conducted in August 2023. 111 out of 131 divisions (85%) completed the survey

True need for school-based mental health services likely exceeds the needs identified by schools

Schools in every division that responded to a BHC staff survey use at least one strategy to identify students with mental health needs, but the majority do not rely on comprehensive tools that would enable them to systematically identify all students with mental health needs (Figure 2-5). Only 28 percent of divisions indicated that all schools use a mental health screening tool division wide, while another 25 percent indicated that just some of their schools use such tool. When asked why they did not use a division-wide identification tool, nearly two-thirds of divisions (64 percent) responded that they had limited staff resources to help all the students who would be identified. This further supports that existing services are not sufficient to meet the needs of students who have been identified. Over one-third of divisions also noted that a lack of financial resources and competing priorities for the division were barriers to the implementation of an identification tool.

The majority of school divisions that responded to a BHC survey said that they use staff observation-based identification strategies, such as teacher observation or the tools of the Virginia Tiered System of Supports (VTSS). Strategies that rely on staff observation of students may disproportionately identify students who externalize mental health challenges as academic or behavioral struggles and miss students whose expression is more internalized. As a result, the types and amount of school-based mental health services necessary to meet student needs as well as the true scope of service gaps may be underestimated.

Figure 2-5
Prevalence of processes and tools used to identify students with mental health needs among school divisions, and breadth of use among schools



Source: BHC staff analysis of data from survey of Virginia school divisions conducted in August 2023. 111 out of 131 divisions (85%) completed the survey

Inadequate access to Tier 2 and Tier 3 services are compounded by shortage of providers in the community

Treatment referrals to community-based providers are one of the most commonly available forms of Tier 3 services, but a lack of capacity in external providers appears to be compounding the challenges faced by Virginia youth in accessing mental health services. Approximately 1 in 6 parents whose children needed school-based mental health services during the 2022-2023 school year stated that their child was referred to an outside provider that year, based on a BHC staff survey of Virginia parents with children in public schools. School referrals to outside providers can be made when adequate school-based services are not available or when services are more appropriately delivered in the community, as tends to be the case for higher-intensity services. Many parents whose children had been referred to a community mental health provider were unable to schedule an appointment at all, while several others reported being able to schedule an appointment, but the appointment was more than one month after the referral had been made.

Chapter 2: Availability of school-based mental health services

3 Factors constraining school-based mental health services

Challenges with recruiting staff and constraints on staff time, in addition to funding constraints, have created limitations for schools that wish to provide mental health services to students. The availability of mental health services in Virginia schools relies on schools having adequate funding, personnel, and staff time to implement and maintain those services. Shortages in mental health staff (and their time) prevent schools from serving all students who may benefit from services, and difficulties procuring state and federal funding puts much of the onus of school mental health on localities, who may vary in their willingness and ability to pay for those services. Adjustments to state programs, such as a DBHDS pilot program and a school-based Medicaid service, may ease some of the burden on localities, as would the creation of a new state mechanism to replace some of the mental health funding lost due to the expiration of federal pandemic relief funds.

Insufficient staffing and time constraints have limited schools' ability to provide mental health services

Many schools rely on school-based staff—such as counselors, psychologists, and social workers—to provide mental health services and supervise supports. Shortages of school mental health staff create a barrier to the provision of school-based services. Divisions report challenges in hiring school mental health staff, and staff may be required or incentivized to spend substantial time on non-mental health activities such as 504 coordination for school counselors or IEP evaluations for school psychologists. Recent legislation to limit counselors' time spent on non-counseling activities went into effect this year, and its success so far remains unknown. Constraints on staff time are an important factor in a school's ability to meet student mental health needs. In a 2022 JLARC survey, school mental health staff were asked about the impact potential strategies could have on addressing issues with student mental health. The top answer from respondents was, "more time for staff to provide direct support." This surpassed other answer choices like hiring more counselors and psychologists, additional screening for students, and implementing access to tele-mental health.

Insufficient school mental health staff due to hiring challenges and funding limitations

Nearly half of divisions (49 percent) indicated that they had difficulty filling school psychologist positions, and many also reported challenges hiring school counselors (41 percent) and school social workers (27 percent). School psychologists and school social workers are critical parts of school mental health teams: school social workers who are licensed can provide students with clinical mental health services, such as group therapy; and school psychologists can offer individual and group counseling, as well as assessments and other elements of mental health support. Many school divisions consider additional mental

health staff, such as school counselors, to be a critical need for their school mental health programs.

When asked to identify the barriers that prevented them from providing needed mental health services to students, school divisions' top response (59 percent) was that they "need additional funding to hire one/more school social worker(s) or school psychologist(s)." School-based mental health *services* usually depend on staff availability, although some mental health *supports*, such as calming rooms, may not require trained mental health staff.

The shortage of school-based mental health professionals sits at an intersection of two types of workforce shortages: teachers and behavioral health professionals. Both have been studied extensively over the past year by a variety of state, local, university, and private entities. JLARC published a study of Virginia's K-12 teacher pipeline and offered associated recommendations. Several state and private entities also worked on understanding the sources of Virginia's behavioral health workforce shortages and finding solutions. The Claude Moore Charitable Foundation, in conjunction with DBHDS, published a 2022 report entitled *Strategic Investment Initiatives for Virginia's Public and Private Sector Behavioral Health and Developmental Services Workforce* that offers recommendations such as increasing state funding for psychiatric residencies and encouraging Virginia universities to produce more licensed behavioral health professionals. In 2023, the Foundation partnered with Deloitte to address the health and health sciences workforce issues faced by the Commonwealth and identified a variety of strategic recommendations and supporting priorities to strengthen the recruitment, retention, and experience of health professionals. The Virginia Health Workforce Development Authority also conducted a 2023 health workforce study that examined the issues with the behavioral health workforce and possible solutions. Some of the legislative recommendations in their final report included "loosen[ing] strict behavioral health preceptorship/licensed supervising requirements" to aid behavioral health practitioner recruitment and revisiting documentation requirements to identify areas of redundant and/or unnecessary documentation.

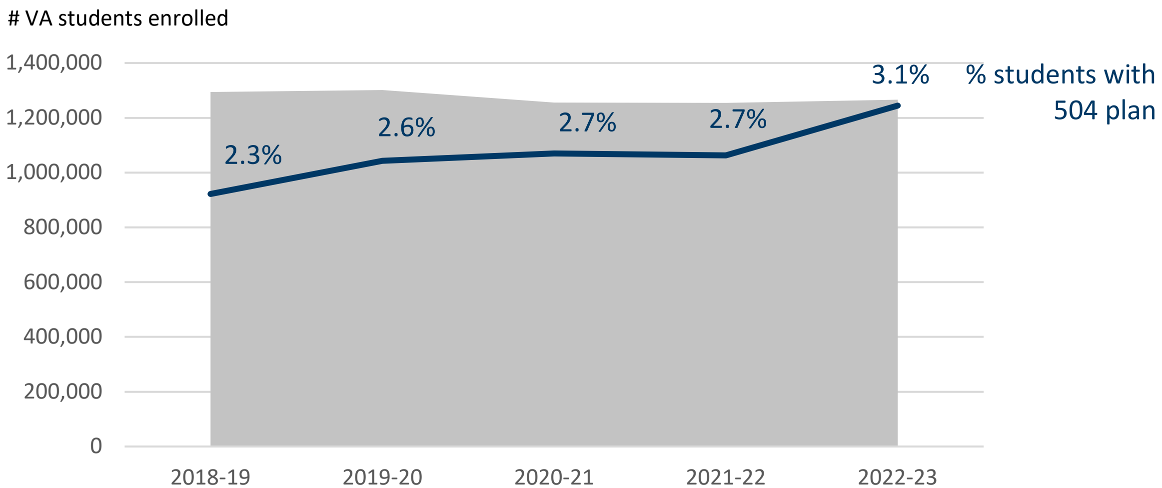
Competing demands on school mental health staff time

Division and school personnel interviewed for this study indicated that school counselors often must take on administrative and other non-counseling tasks, such as 504 coordination and testing, that detract from their ability to provide mental health services. In many schools, especially those in rural areas, school counselors are the primary staff providing mental health services. The 2023 General Assembly passed a law intended to mitigate this issue by requiring school counselors to spend 80 percent of their time on "direct counseling" activities, which includes (among other things) individual and group counseling, crisis counseling, and academic and career counseling.

Despite the new law, some school counselors are not sure whether they will be able to maintain this ratio. A common concern among counselors is that there is no one else to take over their non-direct counseling responsibilities, most notably the coordination of 504 plans and administration of testing. Counselors in smaller divisions with a lighter 504 case load expressed less concern about these duties, but others explained that their responsibilities related to 504 coordination had increased in recent years because the number of students with 504 plans had increased disproportionately. This is supported by statewide data, which

shows that the number of students with 504 plans in Virginia increased by an average of 8 percent annually between the 2018-2019 and the 2022-2023 school year, while total student enrollment fell by an average of 0.5 percent over the same period (Figure 3-1).

Figure 3-1
Trends in number of Virginia student enrolled and % of students with a 504 plan by school year



Source: Staff analysis of data from the Virginia Department of Education

Given the recent implementation of the 80/20 law, it is difficult to discern how well it is working so far. Some divisions use time trackers to measure how counselors are spending their time, but this is not a uniform practice among divisions. To ensure compliance with the new state law and free up staff time for additional mental health services, it may be advisable for all divisions to implement time-tracking software for their school counselors, to the extent practicable.

Funding levels and characteristics have impacted the availability of school-based mental health services

Funding has been a major constraint on the availability of school-based mental health services, according to stakeholders interviewed and surveyed for this study. Direct state appropriations have historically played a limited role in building capacity for school-based mental health services. While Virginia has recently appropriated funding for a pilot program, uncertainty around continued funding has limited how it can be used. The federal government—through mental health grants, pandemic relief funds, and Medicaid—is a major source of funding for school mental health in Virginia. However, changes and limitations to schools' engagement with federal funding can present hurdles for continued or improved access to school based-mental health.

Limited state funding directed specifically to school-based mental health services

Virginia has historically appropriated a limited amount of funding specifically for school-based mental health services. Starting in 2022, DBHDS began awarding $2.5M in grant funds to participants in their School-Based Mental Health Integration Pilot program. This program, along with SOQ funding for some school mental health professionals, is the only direct state allocation for school-based mental health. Through the SOQs, the state funds part of the employment costs of some school counselors, school social workers, and school psychologists, although many divisions employ staff in those roles beyond the state requirements and use other sources of funding to support additional staff members. Divisions may rely on local operating budgets and additional assistance from their localities to supplement mental health services, but localities have different levels of willingness and ability to contribute. This results in disparities in the availability of school-based mental health services among divisions.

There are other means through which state funds can sometimes support school mental health; however, they are indirect and are not specifically appropriated for school-based mental health services. For example, if a community-based provider bills Medicaid for a service rendered to a child in a school setting (such as therapy or TDT), some portion of the provider's reimbursement will be covered from the state share of Medicaid funds. Some Community Services Boards also use their own budgets (which are partially funded by the state) to provide services to children in local schools.

Unreliable funding from Virginia's pilot program

The School-Based Mental Health Integration Pilot ("the pilot program") is the first state-funded program specifically for school-based mental health services. The pilot has provided supplemental mental health funding to several divisions in its first year but has encountered some implementation challenges, according to both program administrators and participants. In particular, the uncertainty around the timing and duration of state support has been a challenge for divisions.

Interviews with some of the divisions that received funding from the pilot program revealed that the late disbursement of the funds combined with uncertain funding for future years created challenges for the divisions' community partners. Without assurance of ongoing funding, CSBs and private providers were often unable to hire new staff to work in schools, which limited the success of the program in some locations.

In a report on the pilot program delivered by DBHDS, reviewers found that four of the six pilot program sites were able to hire additional staff through their community partners with the provided funding. Only two of those four sites were able to hire for the full number of requested staff positions (one of those two sites funded a large portion of its community partnership with pandemic relief funds and was not entirely reliant on the pilot program for program funding). Consistent and ongoing funding could ameliorate some of these issues by giving a longer runway for community partners to plan and hire staff and by assuring new staff that their positions will last for at least a year.

Although the DBHDS report identified recommendations for the future of the program, there has not been a formal evaluation of the program's effectiveness. This is likely due both to the newness of the program and to the lack of performance data collected by DBHDS on the participating sites. Due to time constraints, DBDHS and school divisions had a limited window to initiate and continue school-based mental health services. As a result, the agency was limited in its ability to collect performance data. Going forward, collection of performance measures could allow DBHDS to assess the success of the program at current sites and make determinations about which aspects of the pilot program, if any, should be expanded statewide once the pilot period is over.

To address challenges with funding continuity and ensure that the pilot program is a good use of state funds, the General Assembly could extend the duration of the pilot program by two years.

OPTION 1

The General Assembly may wish to consider including in the Appropriation Act (1) $7.5 million in FY25 and $7.5 million in FY26 to support the School-Based Mental Health Integration Pilot for two additional years, and (2) language directing DBHDS to develop performance measures for participating sites and for the pilot overall, and to report to the Behavioral Health Commission on the selected performance measures by November 1, 2024.

Access to federal grant funding for divisions with fewer resources

Federal mental health grants are the second most common source of funding for schools' mental health programs after federal pandemic relief funds; 28 percent of divisions report using federal grants (such as Project AWARE or grants through Title IV) to fund mental health programs in their schools. However, applying for federal grants can be a complex process that requires specialized skills and knowledge. Interviews with divisions revealed that smaller divisions often do not have a dedicated staff member to write grant proposals. Without available staff to write proposals, smaller or less-resourced divisions may have difficulty accessing the federal grants that could provide additional mental health funding.

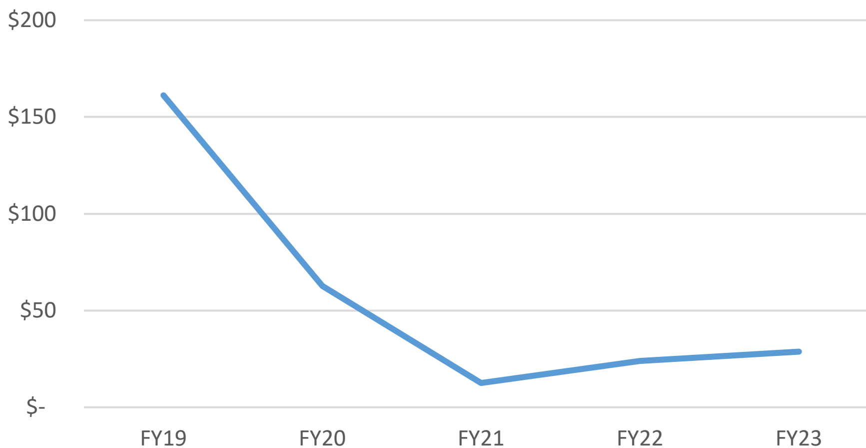
Reduced availability of major Medicaid-funded service

Medicaid-funded TDT services were once a common mental health service available in Virginia schools. TDT was also the primary Medicaid-funded school-based mental health service for students who were not on an IEP. Although a significant number of divisions still rely on TDT for Tier 3 mental health services, expenditures on school-based TDT have decreased precipitously since FY19, reflecting decreases in the number of students receiving these services (Figure 3-2). This has created a gap in the types of Tier 3 services available, and also changed the mix of funding sources supporting school-based mental health services because federal funds pay for at least half of the cost of Medicaid services in Virginia.

TDT services have become less prevalent due to design incompatibility and low reimbursement rates that impacted quality and availability. Between 2017 and 2018, Virginia Medicaid's community mental health services, including TDT, transitioned from the Medicaid

fee-for-service system to managed care organizations (MCOs). Compared to the previous Behavioral Health Services Administrator, MCOs have access to more information about the patients, and they may be better able to determine whether TDT is an appropriate service. Since FY20, far fewer TDT service hours have been authorized than in prior years.

Figure 3-2
Medicaid expenditures on TDT delivered in schools, in $M



Source: BHC staff analysis of DMAS data.
Note: providers have 365 days from the date of service to submit claims. Not all claims for FY23 will be accounted for in this data.

Although the transition to managed care coincided with a large drop in TDT usage, it is not the only factor affecting the declining provision of TDT in schools. In a budget decision package submitted by DMAS in 2022, the issues surrounding TDT were described as follows:

> “This is our only explicitly school-based service for youth in Medicaid and it has a problematic rate and unit structure that has made it impossible for providers to deliver the service. The service was designed before youth with serious emotional problems were mainstreamed out of self-contained classrooms. The service is written as a group-based service but the structure of the school day makes that delivery method nearly impossible and thus providers are having to deliver it as an individual service. This [service] needs to be redesigned into an evidence-based school services with an appropriate rate and rate structure.”

Some schools reported difficulties finding quality TDT providers who administer useful mental health and behavioral supports. Because reimbursement rates for TDT are generally low, TDT is often provided by unlicensed mental health staff such as Qualified Mental Health Professionals (QMHPs) rather than licensed practitioners (such as Licensed Professional Counselors or Licensed Clinical Social Workers). Even when using less costly personnel, some providers do not find TDT to be a financially viable service. In the last five years, several major TDT providers statewide have shut down or stopped providing the service. School closings during the Covid-19 pandemic may also have played a role in TDT providers ceasing to offer the service.

Despite quality concerns and decreasing availability, a strong majority (68 percent) of divisions continue to rely on TDT for Tier 3 services, as shown in the previous section. In 2022, DMAS submitted a decision package requesting funding to hire a contractor to perform (among other things) a review of TDT and to conduct a rate study for Multi-Tiered Systems of Supports in Schools, a “redesign that would permanently replace Therapeutic Day Treatment.” Acknowledging the coming implementation of the free care rule reversal, DMAS said an MTSS rate study would “define a full range of services for schools to reimburse outside the IEP, including prevention, outpatient level early intervention, more intensive behavioral supports, etc.” These rate and redesign studies were not included in the last budget.

DMAS introduced a decision package for the 2024-2026 biennium that would allow for hiring of a contractor to study “Multi-Tiered School Based Behavioral Health Services including redesign of Therapeutic Day Treatment.” A thorough review of TDT would allow the state to determine whether TDT is still a good fit for contemporary classrooms and whether there are other Medicaid mental health services that could be introduced in schools.

RECOMMENDATION 1

The General Assembly may wish to consider including funding in the Appropriation Act for DMAS to commission a review of Multi-Tiered School Based Behavioral Health Services including (1) whether and how to redesign Therapeutic Day Treatment, and (2) the rate structure and amount that should be used to enroll a sufficient number of providers qualified to deliver services identified.

Opportunity for increased federal Medicaid reimbursement

A recent change to Virginia’s Medicaid state plan offers the potential to increase mental health funding for school divisions, but some divisions lack the necessary infrastructure to take full advantage of the change. The state plan amendment newly approved by the Centers for Medicare & Medicaid Services (CMS) allows school divisions to seek Medicaid reimbursement for health services (including mental health) regardless of whether the student has an IEP or whether the service is included in the student’s IEP.

However, in order to take full advantage of this change, divisions will need to be prepared to make the necessary changes to their Medicaid billing and reimbursement processes or to establish a Medicaid billing program if they do not currently engage with Medicaid. Nearly half of divisions (47 percent) report that they are completely prepared or somewhat prepared to take advantage of expanded Medicaid cost-based reimbursement, but 25 percent feel somewhat or completely unprepared. Concerningly, representatives of 17 percent of divisions reported that they were unfamiliar with the change.

For divisions that do not already engage in the Medicaid reimbursement process, it will be more difficult to take advantage of the change. According to DOE data, 18 percent of Virginia school divisions (23 out of 131) do not currently participate in Medicaid billing.

Non-participating divisions tend to be rural with smaller student populations. Southside Virginia had the highest rate of non-participating divisions, while Northern Virginia had the lowest. The majority (70 percent) of non-participating divisions that responded to a survey

said that a top reason for their non-participation was that current staff could not take on additional responsibilities and that they lacked funding to hire more staff who could prioritize the Medicaid billing process.

DOE currently has one staff member who works with divisions on their Medicaid reimbursement processes. The addition of another DOE FTE for school Medicaid could allow the state to provide additional technical support to divisions to leverage opportunities for increased funding created by the new state plan amendment. Funding for the additional position could come from the share of federal Medicaid administrative reimbursement funds that is currently retained by DMAS.

OPTION 2

The General Assembly may wish to consider including provisions in the Appropriation Act (i) directing the Department of Medical Assistance Services and Department of Education to revise their interagency agreement to reduce the percentage of administrative reimbursement pass-through funds retained by DMAS; and (ii) appropriating an equivalent amount of funding to the Department of Education to support one full-time position that would provide Virginia school divisions with additional technical assistance with billing the Medicaid program for school-based services.

4 Funding & guidance for school-based mental health services

Schools will be losing a significant source of funding for mental health services as federal pandemic relief funds expire in 2024, and the state will need to consider whether and to what extent to replace lost funds to avoid a potentially significant decline in access to school-based mental health services at all levels of need. If Virginia opts to direct state funding toward school-based mental health, it will need to (1) articulate a clear vision and purpose for what should be accomplished and (2) develop a plan to ensure that state funds are used efficiently to realize that vision. National and other state models offer guidance for designing school-based mental health programs that can meet students' needs at all levels.

Expiration of federal pandemic relief funds may lead to backsliding across all tiers of school-based services

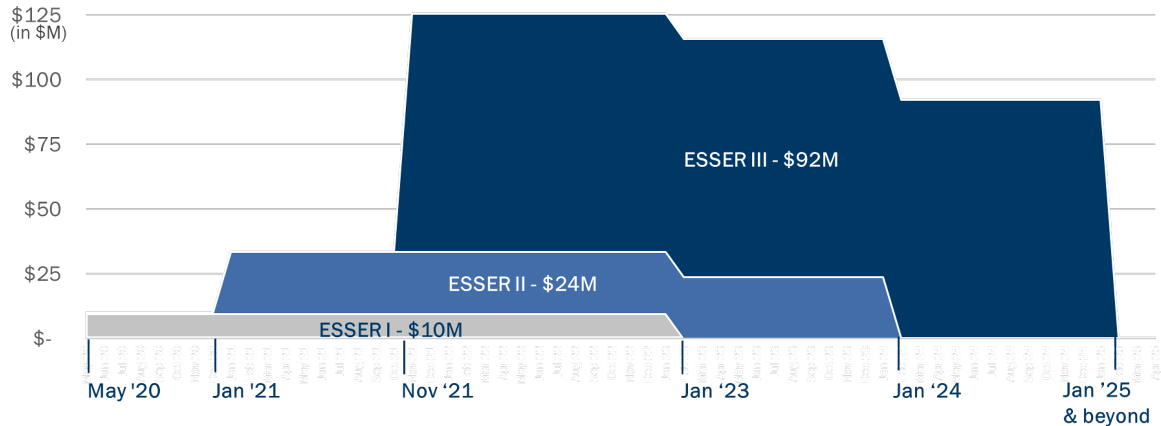
Federal pandemic relief funds have contributed significantly to schools' ability to fund mental health services, but they will be spent entirely by January 2025. Without the injection of new, flexible funding to mitigate the loss of federal dollars, many divisions will likely not be able to maintain the same level of mental health services that they have developed since 2020 as they run out of additional funds to pay new staff salaries or maintain software subscriptions. The expiration of pandemic relief funds may lead to backsliding in service availability across all tiers of service.

The majority (64 percent) of divisions report using federal pandemic relief funds, such as CARES, CRRSA, or ARPA, to fund mental health services. Between 2020 and 2023, Virginia school divisions spent $123 million of federal pandemic relief funds on salaries for mental health staff, community partnerships, evidence-based programming, and other mental health services and supports.

Some funds have already been spent, as required by federal law—CARES in January 2023 and CRRSA in January 2024—and the remaining funds from ARPA will have to be spent by January 2025 (Exhibit 4-1). As pandemic relief funds are depleted entirely, divisions will face a sizeable reduction in their ability to fund existing mental health services that were initiated since the pandemic. In a survey, divisions expressed concern about the expiration of funds, and 40 percent of divisions said that the imminent expiration of federal pandemic relief funds was a major barrier to providing students with access to the mental health services that they need at school. Since pandemic relief funds were flexible and relatively unrestricted, divisions were able to use that money to address mental health goals that they identified as a priority. For example, some divisions used the money to fund contracts with external providers; others purchased tools like Social and Emotional Learning curricula or mental health screening software.

Pandemic relief funds have been used across all tiers of services—often for multiple tiers within the same division. Of those divisions that indicated using pandemic relief funds to pay for mental health services, 76 percent said they use the funds for Tier 1 services; 77 percent said they use the funds for Tier 2 services, and 69 percent said they use the funds for Tier 3 services.

Exhibit 4-1
Pandemic relief funds must be spent by January 2025



Source: BHC staff analysis of information from the U.S. Department of Education and the Virginia Department of Education

Virginia should articulate a clear vision and purpose for school-based mental health services

Although individual school divisions may develop their own long-range planning for school mental health, Virginia does not have a comprehensive vision or set of goals for school mental health programs in the state. Neither federal nor Virginia law requires the provision of mental health services in schools, unless they are part of an IEP or 504 plan, and there is no statutory definition of "school-based mental health" that would offer insight into the vision or goal for these services and their practice. Should Virginia opt to allocate more funding to school-based mental health services, the absence of a clear vision and goals will likely impede the state's ability to strategically direct funds in a way that provides targeted support toward the legislature's desired outcomes. Currently, some state agencies consider the goal of school mental health services to be addressing the effects of mental health challenges on students' ability to learn, behave appropriately in the classroom, and succeed academically; while others understand it to be the healing or improved well-being of the child, regardless of educational benefit.

Alarming trends in anxiety, depression, and suicidal ideation among youth in Virginia and nationally have precipitated the need for action, but it will be important for decision makers to articulate whether the goal of school-based mental health services is to mitigate and reverse these trends or to address mental health needs for academic benefit. This is

consistent with a recommendation from DBHDS in its 2023 report on the School-Based Mental Health Integration Pilot program, which indicated that "the educational system and mental health system should establish shared outcome measures that reflect both the goals of schools as well as mental health outcomes for youth." Whether the goal of school-based services is to support students' overall well-being versus their academic success clearly impacts the types and level of support that must be provided, and the investment required to be successful.

Virginia could create new program to fund and implement effective school-based mental health program

To mitigate the loss of pandemic relief funds and avoid a potentially significant decline in access to school-based mental health services at all levels of need, the General Assembly could consider appropriating state general funds to deliver flexible funding to Virginia public schools. Funds could be used to help schools maintain current capabilities and to expand their mental health programs within a multi-tiered system of supports. As of 2021, at least 37 states appropriated funding specifically for school-based mental health services according to the Education Commission of the States.

To help ensure that state funds achieve intended goals, Virginia could also distribute funding as part of a more comprehensive program. There are some existing models, such as Comprehensive School Mental Health Systems (CSMHS), that could provide a roadmap for Virginia if the state chooses to build a school-based mental health program to achieve its vision for student mental health. CSMHS is a framework designed to wholistically support the mental health of students in educational settings by implementing universal screening, providing an array of MTSS services, and using data to monitor progress and report outcomes. Key elements of comprehensive school mental health systems include resource mapping, targeted prevention and intervention programs, crisis response protocols, mental health training for school and community members, and integration of mental health care delivery within the school setting.

Similarly, West Virginia established a program called "Expanded School Mental Health," through which participating schools can implement a tiered model for comprehensive school mental health using state grant funds. The West Virginia state agencies in charge of education and behavioral health partner with each other and with a local university to help divisions build on their existing mental health infrastructure and utilize tools like universal screening to achieve better outcomes in early identification and intervention.

Other states have also used strategic plans to develop long-term planning and outcome measures to realize their vision for school mental health services. For example, the "State School Mental Health Plan" is a five-year plan that establishes steps for the Texas Education Agency to meet each of its three goals in school-based mental health, including the development and implementation of objective outcome measures.

The departments of Education, Behavioral Health and Developmental Services, and Medical Assistance Services could collaborate and seek the input of division and school personnel, school-based mental health staff, and youth mental health practitioners and experts to:

- develop a proposed vision and goals for the state's school-based mental health program,
- identify outcome measures to determine program success and progress toward program vision,
- adapt the CSMHS model to Virginia,
- create a detailed plan for implementing a CSMHS-like model in the state, and
- propose a funding amount to distribute to divisions for mental health and mechanism to offer flexibility and consistency in this funding over time.

The creation of a new program and funding mechanism will require the dedication of considerable staff time, and it is likely that VDOE, DMAS, and DBHDS will require additional resources, such as additional FTEs, to complete this project.

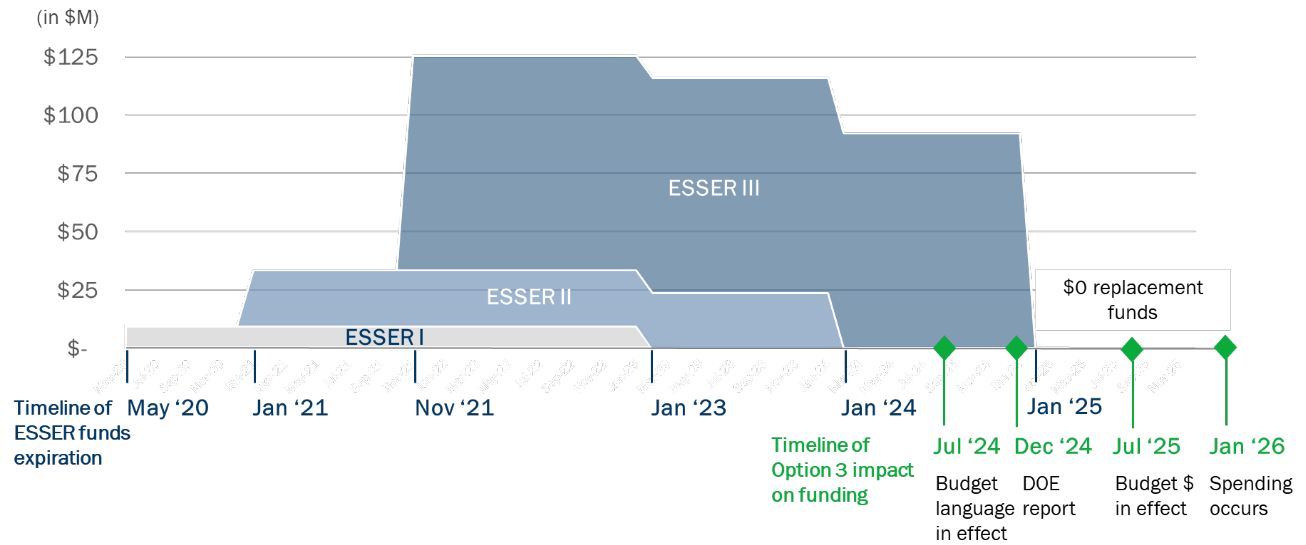
OPTION 3

The General Assembly may wish to consider including language in the Appropriation Act directing the Virginia Department of Education (VDOE) to work collaboratively with the Department of Behavioral Health and Developmental Services and the Department of Medical Assistance Services on a plan for creating a new program to deliver flexible mental health funds to divisions. The program would provide flexible funding to participating divisions for maintaining school-based mental health services and supports as well as technical assistance and evaluation capabilities to build out their mental health programs within a multi-tiered system of supports. The plan should include a proposed vision and goals for Virginia's school-based mental health program and action steps to meet these goals; proposed outcome measures to determine program success; a recommendation on the amount of funding that should be appropriated annually; a proposed funding mechanism to ensure funding flexibility and consistency over time; and a structure for providing technical assistance and evaluation capabilities that will ensure the program is positively impacting the outcomes of students. VDOE should report to the Chairs of the Senate Finance and Appropriations Committee and the House Appropriations Committee as well as to the BHC by December 1, 2024.

The planning and implementation of a new state program will likely take 18 months from the time VDOE is directed to lead the development of a plan until funding has been allocated and is ready to be spent by localities (Exhibit 4-2). The deadline for allocating ESSER funds is September 2024, and the deadline for spending those funds is January 2025. School divisions will therefore lose all federal pandemic funding before a new funding mechanism is available to maintain services. Even if additional funding is expected in the future, a temporary loss in funding will curtail the availability of services for students and may prompt measures with long-term implications, such as laying off school staff, in order to address immediate budget shortfalls. A one-time allocation of temporary flexible funds for divisions to spend on mental health services may help to prevent a large reduction in services prior to the full implementation of a state funding mechanism. This stopgap funding measure will provide temporary assistance to allow divisions to continue their mental health services after the final

expiration of ESSER funds while VDOE plans the implementation of a new, permanent funding mechanism for school-based mental health.

Exhibit 4-2
Pandemic relief funds must be spent by January 2025



Source: BHC staff analysis of information from the U.S. Department of Education and the Virginia Department of Education

OPTION 4

The General Assembly may wish to consider including one-time funding in the Appropriation Act to allow divisions to maintain mental health services in FY 2025 after the final expiration of ESSER funds while VDOE plans the implementation of a new, permanent funding mechanism for school-based mental health available in FY 2026.

Chapter 4: Funding and guidance for school-based mental health services

Recommendations and options: Maximizing school-based mental health services

BHC staff typically offer recommendations or options to address findings identified in its reports. Staff will usually propose options, rather than recommendations, when (i) the action proposed is a policy judgment best made by the General Assembly or other elected officials; (ii) the evidence indicates that addressing a report finding could be beneficial but the impact may not be significant; or (iii) there are multiple ways to address a finding, and there is insufficient evidence to determine the single best way to address the finding.

Recommendations

RECOMMENDATION 1

The General Assembly may wish to consider including funding in the Appropriation Act for DMAS to commission a review of Multi-Tiered School Based Behavioral Health Services including (1) whether and how to redesign Therapeutic Day Treatment, and (2) the rate structure and amount that should be used to enroll a sufficient number of providers qualified to deliver services identified.

Options

OPTION 1

The General Assembly may wish to consider including in the Appropriation Act (1) $7.5 million in FY25 and $7.5 million in FY26 to support the School-Based Mental Health Integration Pilot for two additional years, and (2) language directing DBHDS to develop performance measures for participating sites and for the pilot overall, and to report to the Behavioral Health Commission on the selected performance measures by November 1, 2024.

OPTION 2

The General Assembly may wish to consider including provisions in the Appropriation Act (i) directing the Department of Medical Assistance Services and Department of Education to revise their interagency agreement to reduce the percentage of administrative reimbursement pass-through funds retained by DMAS; and (ii) appropriating an equivalent amount of funding to the Department of Education to support one full-time position that would provide Virginia school divisions with additional technical assistance with billing the Medicaid program for school-based services.

OPTION 3

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Education (DOE) to work collaboratively with the Department of Behavioral Health and Developmental Services and the Department of Medical Assistance Services on a plan for creating a new program to deliver flexible mental health funds to divisions. The program would provide flexible funding to participating divisions for maintaining school-based mental health services and supports as well as technical assistance and evaluation capabilities to build out their mental health programs within a multi-tiered system of supports. The plan should include a proposed vision and goals for Virginia's school-based mental health program and action steps to meet these goals; proposed outcome measures to determine program success; a recommendation on the amount of funding that should be appropriated annually; a proposed funding mechanism to ensure funding flexibility and consistency over time; and a structure for providing technical assistance and evaluation capabilities that will ensure the program is positively impacting the outcomes of students. DOE should report to the Chairs of the Senate Finance and Appropriations Committee and the House Appropriations Committee as well as to the BHC by December 1, 2024.

OPTION 4

The General Assembly may wish to consider including one-time funding in the Appropriation Act for divisions to maintain school-based mental health services in FY 2025, until additional funding is made available through the new state program in FY 2026.

Appendix A: Study mandate

2022-2024 Appropriation Act

§ 1-9. BEHAVIORAL HEALTH COMMISSION

The Behavioral Health Commission shall conduct a study of how to maximize school-based mental health services across the Commonwealth. The Commission shall form a task force of local school administrators, school-based mental health professionals, community-based mental health professionals in public and private settings, teachers, students, and parents as well as relevant stakeholders from the Departments of Medical Assistance Services, Behavioral Health and Developmental Services, and Education to evaluate the current reach of school-based mental health services and to identify strategies to connect mental health clinical interventions (Tier 2 and Tier 3) to school settings. The Commission shall consider opportunities to align Medicaid-funded behavioral health services included in Project BRAVO and school-initiated services that will be newly eligible under the "free care rule" implementation. In addition, the Commission shall provide relevant information related to the role of qualified mental health professionals eligible to provide these services and opportunities to identify where they can be appropriately included and compensated to meet student mental health needs. Other initiatives, such as youth peer support specialists, recovery high schools, and school-based health centers shall be included as well. The Commission shall make recommendations about strategies to implement and expand school-based mental health services by December 1, 2023.

Appendix A: Study mandate

Appendix B: Research activities and methods

Key research activities performed by BHC staff for this study included:

- structured interviews with school staff and school division personnel;
- site visits to schools and divisions;
- convening a workgroup comprised of stakeholders from state agencies, public and private providers, and school staff;
- a survey of school divisions;
- a survey of parents of Virginia public school students;
- review of state and national research;
- reviews of state law and policies relevant to the provision of mental health services in Virginia public schools; and
- data analysis of student enrollment, trends in IEP and 504 participation, and trends in Medicaid TDT services.

Structured interviews

Structured interviews were a key research method for this report. Interviewees were asked about topics such as the state of student mental health, available mental health services and supports, state policy, funding mechanisms for school mental health, and potential ways to expand access to school-based mental health services. Key interviewees included:

- school division superintendents and staff;
- school mental health staff including school counselors, school social workers, and school psychologists;
- school principals;
- staff of DMAS, DBHDS, and DOE;
- subject matter experts in school mental health; and
- stakeholders and industry representatives of CSBs and private providers.

Site visits to schools and divisions

BHC staff conducted in-person site visits to schools and divisions in six localities, which included meetings with school staff and, when possible, students, as well as touring buildings. One additional visit was conducted virtually with division staff. Localities were selected to offer variation in geography, size of student population, population density, Medicaid participation, and participation in the School-Based Mental Health Integration Pilot. The purpose of visits was to learn about services and supports available in schools, hear staff perspectives on student mental health, and talk to school mental health staff. Visits were conducted in the following divisions:

- Botetourt County Public Schools

- Brunswick County Public Schools
- Fairfax County Public Schools
- Grayson County Public Schools (virtual)
- Henrico County Public Schools
- Hopewell Public Schools
- Portsmouth Public Schools

Workgroup

A workgroup was convened to discuss barriers to expanding school mental health services and to work on solutions for overcoming some of those barriers. The workgroup was composed of representatives from DOE, DBHDS, DMAS, CSB staff, private mental health providers, school division leadership, and staff from schools in four divisions in Central Virginia. Multiple attempts were made to include parents, but the invitee selected did not participate. The group met in September 2023 and discussed a variety of topics including funding, school workforce, stigma, and staff training.

Surveys

Two surveys were conducted for this study: (1) a survey of school divisions; and (2) a survey of parents with children in Virginia public schools.

School division survey

BHC staff administered an electronic survey of all Virginia school divisions in August 2023. The purpose of the survey was to collect data on the funding and availability of mental health services from Virginia school divisions. The survey questions asked divisions about the types of mental health services available to students in their division and the extent of their availability; the funding sources used for mental health services; perspectives on barriers to providing services; and the implementation of a new Medicaid rule.

111 of the 131 divisions submitted a completed response, which equates to an 85% response rate. There were slight variations in response rates between VDOE regions, but every region had a response rate greater than 70%.

Parent survey

BHC staff administered an electronic survey of Virginia parents with children in Virginia public schools in September 2023. To be eligible to complete the survey, respondents had to have a child in a Virginia PreK-12 public classroom during the 2022-2023 school year. Parents of multiple children in public schools were asked to consider the experiences of their eldest child. The purpose of the survey was to collect information on the availability of mental health services in schools and satisfaction with those services from parents of children in Virginia PK-12 public schools. The survey questions asked parents about their awareness of mental health services at their child's school, the availability of mental health services in schools and their satisfaction with those services, and the outcomes of referrals to external providers.

The survey was distributed through the Virginia Parent Teacher Association (PTA) to Virginia PTA members statewide. It is not known how many parents received the survey. BHC received 247 completed responses from parents. The greatest share (42 percent) of responses came from parents in Central Virginia, while 35 percent of responses were from Hampton Roads, and 33 percent from other areas of the state.

BHC
Behavioral
Health
Commission