CHILDREN'S
MENTAL HEALTH
CARE ACCESS
ISSUES IN VIRGINIA

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DISCLAIMER

The author conducted this study as part of the program of professional education at the Frank Batten School of Leadership and Public Policy, University of Virginia. This paper is submitted in partial fulfillment of the course requirements for the Master of Public Policy degree. The judgments and conclusions are solely those of the author, and are not necessarily endorsed by the Batten School, by the University of Virginia, or by any other agency.

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Leadership and Public Policy



GLOSSARY

ADD – Attention Deficit Disorder

ADHD – Attention Deficit Hyperactivity Disorder

CMS – Center for Medicare and Medicaid Services

DMAS – Department of Medical Assistance Services

FAMIS - Family Access to Medical Insurance Security

IEP – Individualized Education Plan

LEA – Local Education Agency

MHPSA – Mental Health Provider Shortage Area

ODD – Oppositional Defiant Disorder

VA-SLRP – Virginia State Loan Repayment Program

VDH – Virginia Department of Health

VDOE – Virginia Department of Education

EXECUTIVE SUMMARY

Nearly 1 in every 4 children in Virginia suffer from some mental or behavioral health disorder, but only 20% receive the services or treatment they need (Voices for Virginia's Children, 2020). Deaths due to suicide have increased by 25% in the past decade, with about 22% of middle school students seriously considering suicide in 2017 (NAMI Virginia, 2020). Mental health access and outcomes are disparate between children of different races as well as children in different geographic locations. This is due to different factors, one of which is the lack of culturally-competent and available providers.

Additionally, the current public health crisis has greatly increased the trauma burden among Virginia's youth, signaling an increase in the demand for mental health services in the coming years. Many of the children that do access services do so within the school system. Many children were at home over the past year, and therefore were unable to receive mental health services through school. Even when students return to school, there will not be enough supply of mental health care providers to meet the expected demand.

While there are many ways to increase access to mental health care for children in the Commonwealth, we choose to look at four evidence-based methods that focus on increasing provider supply and creating a more equitable system. The four we look at are: 1) increasing funding for hiring more school counselors, 2) creating guidance to ensure an equitable implementation of recently-passed, expanded Medicaid funding in the school system, 3) implementation of a grant system to incentivize the building of new school-based health centers, and 4) increasing funding for student loan repayment programs for mental health providers. We analyzed each of the options with four criteria: 1)effectiveness, 2) race-based equity, 3) geographic-based equity and 4) cost.

Even though funding can be used in many ways, this report recommends a combination of alternatives to best meet the short and long-term needs of children. Specifically, we call for our client, Voices for Virginia's Children, to pull together a diverse group of stakeholders and create guidance that will help the state implement the expanded Medicaid funding. Additionally, we recommend that they advocate for a new grant-based pool of money that can be used by health care organizations to implement new school-based health centers. We believe this helps shape the system in both the short and long-term so that children of all races, ethnicities and geographic regions can better access mental health care.

CLIENT PROFILE

Our client for this analysis is Voice's for Virginia's Children. They are a 501©3 non-profit operating out of Henrico, VA. Their mission is to champion public policies that improve the lives of Virginia's children. They primarily operate through state-focused legislative policy analysis and lobbying. They employ four full-time policy analysts, each of whom focus on a different area of children's well-being, including early care and education, foster care and adoption, health & wellness, mental health, and family economic security. Additionally, Voices employs an advocacy and engagement manager, who focuses on the trauma-informed care network as well as racial justice, and a research director, who operate the Virginia Kids-Count Data Center. The research director, as well as the rest of the staff, was heavily involved in outreach efforts regarding the 2020 census. More information about Voices can be found on their website at https://vakids.org. Our contact for this project was Emily Griffey, Chief Policy Officer, and she can be reached at emily@vakids.org.

BACKGROUND

INTRODUCTION

It is estimated that there are approximately 1.87 million children ages 0-18 living in the Commonwealth of Virginia in 2019, a group that accounts for roughly 22% of the population (KIDS COUNT Data Center, 2021). During this time, there were approximately 400,000 children ages 3-17 that had been diagnosed with a behavioral, emotional or developmental condition (KIDS COUNT Data Center, 2020b)¹. This represents approximately 26% of all children in this population. For comparison, the national prevalence of mental health disorders in children in 2016 was 16.5% (Whitney & Peterson, 2019). These diagnoses included disorders such as ADD, ADHD, ODD, anxiety, depression and others (CDC, 2013). About a third of these children suffered from a serious mental illness, marked as a disorder that causes substantially lowered quality of life or functional impairment (Voices for Virginia's Children, 2020; National Institute of Mental Health, 2021).

RACIAL DISPARITIES

Nationally, children of color are just as likely to suffer from mental illness as white children (Voices for Virginia's Children, 2021). However, white children are twice as likely to receive treatment than their peers. About 18% of white children received treatment for a mental health disorder compared to about 9% of both Black and Hispanic children (Zablotsky & Terlizzi, 2020). Similar disparities are seen when looking at differences in therapy access and medication usage – about 11.5% of white children took medication for a mental health condition, whereas about 4.5% of Hispanic children and 5.5% of Black children took medication². These disparities persist even when accounting for income (Substance Abuse and Mental Health Services Administration, 2015). Children with mental illnesses that go untreated are more likely to have poor school performance, decreased likelihood of high school graduation, and are even more likely to be unemployed later in life (Fergusson & Woodward, 2002; Asarnow et al., 2005). Untreated mental illness not only has major individual implications, but also costly societal ones.

¹ This data represents children aged 3-17 who was diagnosed with autism, developmental delays, depression, anxiety, ADD/ADHD or behavioral issues.

² Unfortunately, this type of data is not available at the state level. VDH provides little data about mental health status, and does not disaggregate the data by race and ethnicity. Therefore, we will be using the national data as a proxy for mental health disparities in Virginia.

GEOGRAPHIC DISPARITIES

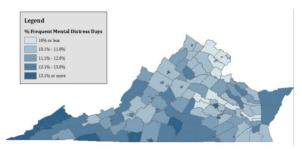


Figure 1. Percentage of the population within Virginia localities that experience 14 or more mental distress days per month. Darker colors represent a locality with a higher prevalence of mental distress (County Health Rankings, 2019).

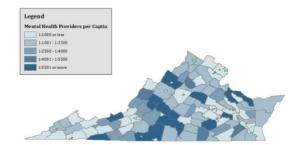


Figure 2. Ratio of mental health providers per capita. Darker colors correlate to less mental health providers accessible to those in the locality.

While there is little data on racial and ethnic disparities in mental health treatment in the Commonwealth, there is ample data showing the geographic disparities that exist. Particularly, communities in Southside and Southwest have a higher prevalence of mental health illness. Figure 1 (above, left) shows the percentage of the population that experiences frequent mental distress days, measured as 14 or more days of mental distress per month. The localities with the highest prevalence are concentrated within Southwest and Southside. The locality with the highest prevalence is Emporia City, with 15.62% of adults experienced 14 or more days of mental distress per month, whereas the locality with the lowest prevalence is Loudon County in Northern Virginia (8.68%). Unfortunately, these localities are also likely to have less access to mental health providers. Figure 2 (above, right) shows the ratio of mental health providers per capita in localities across the Commonwealth. The darker colors in Southside and Southwest Virginia correlate to a higher provider-to-population ratio. These estimates are for child and adult mental health providers, but many of these same counties have zero child psychologists or psychiatrists (CDC, 2015). This means that if children in these counties need to see a mental health worker in person, they have to travel out of the county.

COMPLICATING FACTOR: TRAUMA FROM COVID-19

While there is a growing body of research on trauma and its effects, the current crisis we are experiencing is novel and the long-term consequences are largely unknown. What we do know is that children who have experienced disruptions in their schedule are experiencing trauma. For many children, trauma can turn into post-traumatic stress disorder among other mental disorders (Wagner, 2016). These mental health issues are also positively correlated to an increased risk for suicide. In 2019, there were 13.8 suicides per 100,000 youth in Virginia, a rate that has been increasing in recent years (United Health Foundation, 2019). Since this trend is increasing, we can expect the 2020 rate to increase as well. If the trauma caused by the pandemic and other factors over the past several months goes unchecked, Virginia could see a larger-than-normal increase in the youth suicide rate.

Other children with high levels of trauma can also see an increase in physical health problems. For many children, trauma manifests in physical ways, causing both temporary and life-long disabilities. Higher amounts of trauma have been shown to correlate with an increased risk in developing diabetes, coronary heart disease and stroke (Gilbert et al., 2015). Not only are these diseases, chronic, lifelong conditions, but they are also costly. Treatment of chronic illness almost always means visits with

specialists and procedures, both of which come with high medical bills. If these medical bills go unpaid, individuals will be forced to declare bankruptcy. More than two thirds of Americans who filed for bankruptcy cited medical bills or other illness-related issues was the main reason for their decision (Konish, 2019). Even if increased trauma does not trigger chronic illness in an individual, they will most likely need some sort of therapy or mental health services, which can be costly as well, especially for uninsured individuals.

Children who are exposed to trauma at a young age are also more likely to have behavioral issues, particularly in school. These behavioral issues are highly correlated with poorer school performance and chronic absenteeism (Frieze, 2015). These children are also less likely to obtain a high school diploma, which means they have less opportunities for high-paying jobs. American adults with a high school diploma make \$1,600 more per month than GED earners, on average (Ewert, 2012). This shows that it is absolutely critical to not only address childhood trauma, but address it when it happens. The sooner a child is given coping methods and mechanisms, the sooner they are able to adapt and overcome their trauma, lessening its life-long effects.

SCHOOL-BASED HEALTH CARE IN VIRGINIA

Among the 20% of children who receive mental health services, 80% are served within the school setting (Commission on Youth, 2013). There are many reasons for this, but one of the main reasons is convenience. 86% of Virginia children attend public school, and the data shows that these children are more likely to receive mental and behavioral health services in school than in the community setting (Commission on Youth, 2013). Studies have estimated that students with access to mental health services in schools are nearly 20 times more likely to access them than those with services in the community, but not based in the school (Guo et al., 2008).

While school-based services are more convenient, there are issues with both the consistency of services offered and the availability of providers. In Virginia, DMAS provides guidelines about what they will and will not reimburse for within school-based service delivery models. Many forms of mental health care are available for reimbursement, including general mental health counseling, crisis intervention, therapeutic day treatment and case management. These services vary depending on the child's need, and can range from simple to intricate interventions, many of which are funded through a combination of Medicaid and FAMIS reimbursement. Children in the Commonwealth are unique in that they are able to receive subsidized health services, including school-based mental health services, as long as their family is within 200% of the Federal Poverty Line (FPL). It is estimated that 1 in 3 children across the state fall within this category and could access these services, should the need arise. That being said, these services are severely underfunded and understaffed in many localities, specifically rural locales. Additionally, there are not enough providers in well-funded locales that are able to provide culturally competent care to minority populations.

PROBLEM STATEMENT

In 2019, approximately 130,000 of Virginia's children suffered from a serious mental illness, but only 20% received the help they needed (Voices for Virginia's Children, 2020). Due to the challenges children faced during the Covid-19 pandemic, experts are expecting a significant increase in need for mental health services across the Commonwealth (Mental Health America, 2021). Early studies also show that the mental health effects of the pandemic are disproportionately impacting people of color

(Grooms, Ortega, Rubalcaba and Vargas, 2020). If left unaddressed, the future demand will far exceed the current capacity of the already fragmented and burdened mental health care system offered by the state.

EVIDENCE ON POSSIBLE SOLUTIONS

SCHOOL COUNSELORS

School counselors, sometimes called guidance counselors, have a variety of tasks that fall under the umbrella of their work. Specifically, they help students learn how to thrive in school, choose a college or career path, and flag potential worrisome behaviors. These individuals often play a role in schoolwide social/emotional planning and also serve as a resource hub (King-White, 2019). While they do not participate in the direct service provision of mental health care, they play an important role in the school ecosystem. One of the ways that school counselors can assist in the social-emotional learning and ultimately the mental health of students is through multi-tiered systems of support. Virginia schools implement this through the Virginia Tiered Systems of Support (VTSS), where there are three tiers of evidence-based programming and support is provided to students through the school system (Virginia Department of Education, 2020). Tier one provides support for all students, and these programs help improve school climate and culture. Tiers two and three provide services directly to specific groups and individuals. School counselors might play a role in referring those children, but do not directly provide services in tiers two and three. Even so, school counselors are intended to help with general mental and social health outcomes (King-White, 2019). They are some of the main providers of these supports, giving them important roles in the students' lives (Sink, 2016). One of the most effective ways that school counselors work is through care coordination and referrals. Often, school counselors are the first point of contact for a student that is struggling, where the counselor can refer to mental health or other providers for services (King-White, 2019). There are several studies that show there to be lasting impacts on a student beyond mental health, such as improved academics and social interactions (Boudreau, n.d.; Collins, 2014).

Counselors with a higher student population to look after simply have less time to spend with each student, causing some students to fall through the cracks and potentially not receive the resources they need. Schools that have a high ratio of school counselors to students often have worse graduation rates and see more disciplinary issues than schools with lower ratios (Gagnon & Mattingly, 2016; Reback, 2010). Additionally, students at these schools are significantly less likely to be involved in a weapons-related incident (Reback, 2010). One Alabama study showed that for each additional, state-subsidized counselor placed in a school, students there were 25% less suspensions (Reback, 2010). Less is known about the direct mental health effects of school counselors, but the measures described above can act as a proxy for effectiveness. When school counselors have more students, they have less time to spend referring students to mental health professionals, or teaching social-emotional lessons.

FUNDING FOR SCHOOL-BASED MENTAL HEALTHCARE OUTSIDE OF AN INDIVIDUALIZED EDUCATION PLAN (IEP)

In 2014, the federal Center for Medicare and Medicaid Services (CMS) issued guidance that allowed for an expanded use of Medicaid dollars for school-based health care, among other uses. With this, states were able to bill Medicaid for either fee-for-service or cost-based reimbursement for health services delivered in schools – with or without an Individualized Education Plan (IEP) (Healthy

Schools Campaign, 2019). However, many states, including Virginia, had laws that prevented schools from billing Medicaid for services provided outside of an IEP³. This, combined with other political and regulatory issues, caused a slow uptake to change. By the end of 2019, only ten states had expanded school-based access to care through this new guidance. However, this prompted the Virginia general assembly to call for DMAS to study the best route for Virginia to take if they were to expand Medicaid in this way. The report was published during December of 2020, and a bill was passed during the 2021 Special Session I to this effect. This new law will allow for schools to bill DMAS for reimbursement of mental health care services provided, even if the child does not have an IEP. Additionally, the state is adopting a cost-based reimbursement model, which will eventually allow for more reimbursement dollars, but also a higher administrative burden for schools (some of which will be reimbursable by Medicaid).

While this new law paves the way for increased access to services within the school system, there are barriers to implementation that must be addressed by the state in order for an equitable roll out of this new program. Firstly, school systems that already do not have enough providers, as discussed above, will not have the staff to support additional services delivered through the schools. Additionally, physical space can be an issue with schools that are at capacity or overcrowded. Finally, this expansion should directly target health inequities by increased access to health services in schools with a high Medicaid-enrolled population; however, it still does not address access to uninsured or underinsured children (Healthy Schools Campaign, 2019). School systems that have implemented expanded Medicaid reimbursement have employed several tactics that lead to an easier implementation and a reduced rate of errors. These include activities such as collecting data, collaborating between different state agencies, and aligning priorities at a state level (Center for Children and Families, 2020).

SCHOOL-BASED HEALTH CENTERS

School-based health centers have been utilized across the country to provide medical, dental and vision services to students and their families. Additionally, many of these centers have provided mental and behavioral health services. This system allows for drastically improved physical and mental health outcomes, especially in rural and/or low-income communities. Specifically, SBHCs are able to provide a variety of mental health services that range from general counseling to crisis intervention to all students and their families, regardless of their insurance status or their ability to pay (Ventimiglia, 2007). Additionally, services are often free for students and their families, and are either free or heavily discounted for community members. Depending on the state and the specific health care center, anyone in the community can access services. These services are different from the ones that some schools already provide. This model provides for greater community access, less cost burden on families and a dedicated group of providers to work within the school setting (Healthy Schools Campaign, 2019). This allows for an increased coordination between families, teachers, school administrators, health care providers and the students. Ultimately, this solves many of the provider-shortage and care provision disparity issues.

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³ These laws were passed to codify federal regulations that mainly impacted state policy. From our research, we cannot ascertain if there were any additional motives for these laws, and therefore, we unsurprised when there was bipartisan support to overturn the law.

PIPELINE PROGRAMS

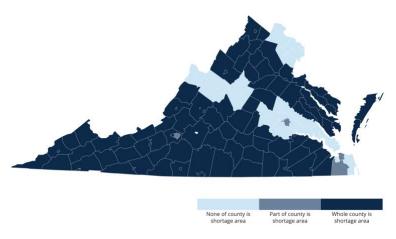


Figure 3. Mental Health Provider Shortage Area Designation, by locality. Source: RHI Hub, 2021.

One of the main issues of the Virginia mental health system is the lack of providers. The large majority of localities in the Commonwealth are considered to be Mental Health Care Provider Shortage Areas, meaning that the demand for mental health providers is much higher than the current level of supply, to a critical point (Figure 3). One of the best ways to rectify this in the long term is to support and fund pipeline programs that incentive providers moving and working to

underserved areas. These programs have been proven to be incredibly effective, not only at increasing supply, but also increasing the diversity of providers, an important aspect of culturally-competent care. Almost all federally-funded pipeline programs have been studied and researchers found that all but one have increased the participation by non-white students (U.S. Department of Health, 2009). Additionally, pipeline programs have been shown to drastically increase the number of community mental health workers, a subset of the mental health workforce that has typically seen higher turnover rates due to burnout (O'Donnell et al., 2019). Between the increase in these community health workers, and the increase in access to school funding for non-white students, pipeline programs remain a viable option for the Commonwealth.

EVALUATIVE CRITERIA

When analyzing the potential solutions to this problem, we wanted to include criteria that would address some of the most pressing disparities discussed above. Specifically, we wanted to look at both race-based and geographic-based equity as they pertain to children's mental health. We also wanted to look at effectiveness, as that is critically important for any data-based policy recommendation. Finally, we wanted to include measures of cost, as any legislation or new program could reach opposition if the cost is too high. The criteria are weighted as follows: effectiveness - 35%, race-based equity -20%, geographic-based equity – 20% and cost 15%. The rationale is that if the policy is not effective, we do not want to advocate for the Commonwealth to put resources into it, and therefore it has the most weight. Both of the equity measures are equally important, as race-based and geographic-based inequities in mental health care run deep in Virginia. We also wanted to highlight the fact that some racial-inequities are compounded by a geographic lack of resources, and we believe there are many ways to tackle this issue. Finally, the cost criterion was given the lowest weight. While it is important to measure and quantify the cost of a proposed policy, recent legislatures have given financial priority to mental health programs due to the gravity of the issue. Therefore, we believe that through extensive analysis and a strong advocacy plan, even a higher-cost program could pass through the legislature successfully.

EFFECTIVENESS (35%)

This criterion looks at the available evidence for each program or alternative and ranks each policy option based on their anticipated evidence-based impact. This will give policies as high, moderate or low designation based on the percentage change of students expected to receive access to mental health services, specifically general mental health counseling. To do this, we will look at data from other states that implemented similar programs and extrapolate to Virginia. We also look at proxy measures when specific programs or alternatives have not been researched formally. Below are the descriptions of the designations:

- *High 3:* A policy option will be ranked as high and given a score of 3 if it is shown to increase access to mental health services by 26% or more⁴.
- *Moderate 2:* A policy option will be ranked as moderate and given a score of 2 if it is shown to increase access to mental health services by 11-25%.
- Low 1: A policy option will be ranked as moderate and given a score of 2 if it is shown to increase access to mental health services by 0-10%.

RACE-BASED EQUITY (20%)

This criterion would look at each policy through the lens of how it would work to address race-related disparities in mental health care and access. Equity on the basis of race in healthcare is not new, but mental health disparities are generally left out of the conversation. Thus, it is important to make sure the recommended policy option is equitable and works to address these disparities. This criterion will

⁴ The cutoff for the "high" designation is 26%, because we believe that increasing access by this much shows that the policy works, and will significantly increase access to children in Virginia who were unable to access mental health care before.

be measured on a scale of high, moderate and low based on how much each alternative is expected to reduce the gap in mental health access by race.

- *High 3*: A policy option with this designation would be the most equitable, reducing the gap in access by 26% or more.
- *Moderate 2*: A policy option with this designation would have indirect equitable effects, where there would be a positive effect on addressing race-related disparities, but not due to any direct work done by the alternative. This designation would be used if an alternative is projected to reduce the gap in access by 11-25%.
- Low 1: A policy option with this designation would be the least equitable, meaning there are little to no effects on race-related disparities at all. This designation would be used if an alternative is projected to reduce the gap in access by 0-10%.

GEOGRAPHIC-BASED EQUITY (20%)

This criterion would look at each policy through the lens of how it would work to address geography-related disparities in mental health care and access. Geography-related disparities include factors such as fewer resources and poor outcomes. This criterion would be measured on a scale of high, moderate and low. Below is a breakdown of what each of these labels mean.

- High 3: A policy option with this designation would be the most equitable, working to directly address geography-related disparities in care and access and reducing the gap in access by 26% or more.
- *Moderate 2*: A policy option with this designation would have indirect equitable effects, where there would be a positive effect on addressing geography-related disparities, but not due to any direct work done by the alternative. This designation would be used if an alternative is projected to reduce the gap in access by 11-25%.
- Low 1: A policy option with this designation would be the least equitable, meaning there are little to no effects on geography-related disparities at all. This designation would be used if an alternative is projected to reduce the gap in access by 0-10%.

COST (15%)

Cost is crucial, as almost all alternatives we are looking at require funding from the general assembly. Legislators have shown that they are willing to fund mental health initiatives, but only up to a certain point. Therefore, looking at the cost of each alternative will prove to be important for both the final policy analysis and my client's advocacy efforts. This criterion will be measured by looking at what different programs have been funded in Virginia historically. If it is a new program, then I will look to see how other states have funded it, and translate that cost to Virginia based on size and funding of the state in question. I will also look at both direct and indirect costs of each program, and how much it would ultimately cost the state. The programs will be ranked from highest cost (1) to lowest cost (4) in the outcomes matrix.

POLICY ANALYSIS

OPTION #1: INCREASE THE NUMBER OF SCHOOL COUNSELORS IN VIRGINIA SCHOOLS

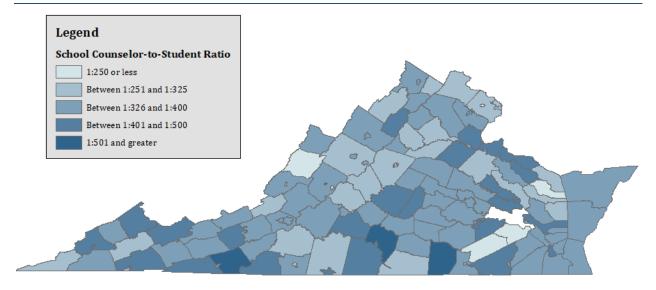


Figure 4. Current (2019) school counselor-to-student ratios in Virginia, by locality. Map made in ArcGIS ArcMap; Data from VDOE.

In 2019, the average Virginia school had one school counselor for every 346 students (Shanhotlz, 2020). The American School Counselor Association recommends that schools have no more than 250 students for each counselor (American School Counselor Association, 2019). Only five LEAs meet this threshold at the start of the 2019 school year: Surry County, Buena Vista City, Sussex County, Lancaster County and Bath County. The LEA with the highest counselor to student ratio was Charles City County, where there was one counselor working to cover all 620 students enrolled in that system.

During the 2019 Virginia General Assembly session, legislators passed a bill that would bring the mandated ratios from 1:500 in public schools to 1:350, a step toward the recommended goal. However, the funding attached to this bill did not pass in its entirety and ultimately revised the goal of the bill from 1:350 to 1:460 (SB1406, 2019). During the 2020 general assembly session, legislators further decreased the ratio to 1:325, and the current Code of Virginia states that each school board "shall employ one full-time equivalent school counselor position per 325 students in grades kindergarten through 12." (Standard 2. Instructional, Administrative, and Support Personnel., 2021). This policy option proposes additional legislation, introduced during the 2022 general assembly session, that would mandate a 1:250 school counselor-to-student ratio at the school district level. In order for every school district to hire enough counselors to be below the minimum 1:250 ratio, an additional 1,528 licensed school counselors need to be hired. Some school districts only need to hire one additional (or no additional counselors), but other school systems need over 100 new hires to meet the demand of their large populations. There are currently 3,727 counselors working in public schools in the Commonwealth; if this proposal was accepted, there would be a total of 5,255 licensed school counselors working in the Virginia K-12 system.

EFFECTIVENESS

While school counselors do not provide direct services, they do help to elevate the whole school's mental health through population-level supports. They also have been shown to have impacts on school attendance, the number of suspensions, and the likelihood of college attendance. There are no direct effects documented in the literature of the effectiveness of school counselors on mental health. However, there are studies that show the effect of an increase in school counselors on non-cognitive effects in students. These non-cognitive skills can include improving overall school climate or indirect mental health skills taught directly to groups of students. Importantly, these skills help to reduce suicide and suicide attempts in the school-age population (Virginia Board of Education, 2020). For non-cognitive skills, an increase in 1 school counselor has a 2.049%-point change in developing these skills in students (Mulhern, 2019). This positive change in coping skills could lower the suicide rate, which is currently at 11.6 per 100,000 Virginia teens annually (CDC WONDER, 2020). Additionally, school counselors have a positive impact on school attendance, which in turn positively impacts lifelong health outcomes. A school with a 1:250 counselor-to-student ratio saw a 0.3% increase, meaning a school with 1,000 students saw 3 additional students make it to school each day that otherwise would not have (American School Counselor Association, 2019). However, given the criteria and the lack of documented impact of school counselors on direct mental health effects, we are rating this as "low" on the effectiveness scale.

RACE-BASED EQUITY

Since every student theoretically receives these same supports, this is important for race-based equity. Tier one programs like Positive Behavioral Interventions and Supports (PBIS) have been shown to help reduce the achievement gap between students of different racial backgrounds (Davis et al., 2013). Additionally, since many of these programs focus on mental wellness and social-emotional learning, students who would not otherwise receive these supports might be more greatly impacted. Increasing access to school counselors is also shown to increase high school completion rate, which advances health equity (Hahn et al., 2015). Another proxy for the disparities seen in mental health is the disparities seen in disciplinary action between minority and non-minority students. Many studies show that an increase in school counselors within a school directly reduces disparities in discipline (Carrell & Carrell, 2006; Barnum, 2016). This leads to less arrests and fewer days of missed school, both of which can negatively impact mental health.

While there are no known studies that look at the change in disparities in mental health outcomes for minority vs. non-minority youth as it pertains to access to school counselors, the proxies mentioned above give a good picture of the change this alternative could have. For these reasons, we are able to rank this alternative as a "moderate" in terms of its impact on race-based equity. We did not feel that there was enough evidence to label the alternative as "high" but more evidence than another option that would be labeled "low."

GEOGRAPHIC-BASED EQUITY

In terms of geographic-based equity, schools in Southwest and Southside Virginia are more likely to have high student-to-counselor ratios (Figure 4). Since this alternative would bring all localities within Virginia to the recommended ratio of 1:250, these disparities would diminish. It is important to note that the bill that would need to be passed would require each locality to meet the 1:250 mark, not just the state overall. In essence, the localities that have the most need would receive the funding to hire additional counselors. However, some localities will continue to have a lower ratio, even lower than 1:250, perpetuating some of the geographic inequities. That said, there would be an 85% to 95%

reduction in geographic inequities for provision of mental health services by school counselors. Because of this, we scored this alternative as "high" in regards to geographic-based equity.

COST

In fall of 2019, there were 1,298,083 full time students enrolled in Virginia public schools (Virginia Dept. of Education, 2019). In accordance with the passage of SB880 during the 2020 general assembly session, the state is currently funded to hire enough school counselors such that the ratio is 1:325 (School Counselors; Minimum Staffing Ratio, Effective Clause, 2020). This would require the state to employ 3,851 counselors to meet the ratio threshold. This alternative would require an additional pot of funding to further decrease the ratio to 1:250 at the district level. This would require an additional 1,409 counselors to be hired for a total of 5,260 counselors employed to work in local schools. The average salary for a school counselor during the 2019-2020 school year was \$57,252, and administrative costs and fringe benefits add roughly 25% to the cost, creating a cost-per-counselor of about \$71,565 (Lane, 2020). For an additional 1,409 school counselors, this option would cost \$100,835,085 total. The state share of this cost would be \$80.67 million, leaving about \$20.17 million for the localities to fund (School Counselors; Minimum Staffing Ratio, Effective Clause - Fiscal Impact Statement, 2020). For the purposes of this analysis, we will only be looking at the cost to the state. Therefore, the final cost of this alternative is an \$80,668,068 increase in the annual budget. Compared to the other alternatives, this policy option ranks in 1st as it is the policy option with the highest cost to the state.

OPTION #2: IMPLEMENTATION GUIDANCE FOR EXPANDED MEDICAID REIMBURSEMENT IN SCHOOLS

During the 2020 Regular General Assembly session, legislators included language in the budget that directed DMAS to study the impact of allowing Medicaid-enrolled children to receive additional mental health programming in school (Kimsey, 2020). Traditionally, these supports are only provided through an IEP, which can prove to be a burden on some families. DMAS reported their recommendations at the end of 2020, which showed support for a cost-based reimbursement system. During the 2021 general assembly session, legislators passed a bill allowing for Medicaid reimbursement for mental health services provided outside of an IEP (SB 1307, 2021). The bill was signed into law by Governor Northam on March 18, 2021.

While the passage of this bill is celebrated by children's mental health advocates across the spectrum, the burden is now placed on the local school districts to learn how to best take advantage of this increased funding pool. This alternative would prompt Voices for Virginia's Children as the advocacy agency to create guidance for state agencies about the best practices for equitable implementation. Potential barriers on the Local Education Agency (LEA) side include a lack of knowledge about the program and a lack of mental health providers ready to work within the school system. Additionally, the state does not know much about the experience or outcomes of children of color as it pertains to mental healthcare and access. The guidance must include ways to better track the demographics and needs of students as they receive services. Certain school districts, such as Charlottesville City Public Schools, already provide a similar service for their students, showing a path to implementation that could work in other parts of the Commonwealth. Through creating this guidance, Voices would listen to relevant stakeholders including staff from DMAS, VDOE, local school administrators, mental health providers and families who would be the consumers of this new service. Special attention would

be given to ensure geographic and racial representation to allow for the most equitable guidance possible.

EFFECTIVENESS5

In 2018, about 13% of school-aged children were receiving services outlined in an IEP, which leaves nearly half of the children with diagnosed behavioral or mental health disorders not receiving care through school (U.S. Census Bureau, 2020). Creating guidance will take some of the administrative burden off DMAS and VDOE, which will help expand services for the other half of children that are in need of services. Students are nearly 20 times more likely to access services when they are provided within the school system (Guo et al., 2008). Early reports looking at other states' implementation of this program show that it is positively impacting the number of students who are able to receive mental health care. Results from Colorado show that school psychologists spent 6% of their time on students that otherwise would not receive any care in school (Healthy Students, Promising Futures Learning Collaborative, 2019). Furthermore, school nurses spent about 18% of their time providing newly-covered services to students outside an IEP (Healthy Students, Promising Futures Learning Collaborative, 2019). Therefore, we estimate the increase in service to be between the 6% and 18% figure. As such, we designate this policy option as moderately effective in terms of increasing access to care.

RACE-BASED EQUITY

Since this policy option only targets Medicaid-enrolled children, students of color will be more likely to be helped through this new law. In 2019, 17% of white children were on Virginia-state insurance, such as Medicaid or FAMIS, and 77% of all white children were covered on private insurance (KIDS COUNT Data Center, 2020a). Only 3% of white children were uninsured during this time period. In a stark comparison, 42% of Black children were covered by public insurance, while 49% of Black children were covered by private insurance. About 5% of Black children were uninsured. This trend follows, albeit at a lower rate, for Hispanic students. During 2019, 36% of Hispanic students covered by public insurance, 49% had private insurance and a staggering 11% were uninsured (KIDS COUNT Data Center, 2020a). Compounding this issue, children of color are less likely than their white peers to receive special education services through an IEP when compared to children of a similar family and health status (Barshay, 2019).

One of the major pieces of this alternative is listening to stakeholders with diverse voices. It is crucial that individuals of all races and ethnicities are heard so that any recommendations are appropriate for all children, especially those of color. Specifically, it is important that the guidance for the schools addresses race in the screening process, especially given the disparate outcomes in regards to school discipline (Barshay, 2019). If implemented well, this law should help reduce the racial disparities in access to care as more children of color will be eligible for services through this program. As such, we

⁵ While this policy option advocates for the creation of a task force to create implementation guidance for VDOE and DMAS, the analysis will focus on the effectiveness and cost of the law itself. This will help for a more even analysis of policy options against one another, and will help Voices determine where they should focus their time in the coming months on this issue. Regardless of the outcome of this analysis, we will be recommending that Voices advocate for one of the four options, and thus it is important to know the effectiveness, race-based equity, geographic-based equity and cost of this option as well.

anticipate a "moderate" decrease in the racial disparity gap, similar to the 18% figure we found when analyzing the effectiveness criteria.

GEOGRAPHIC-BASED EQUITY

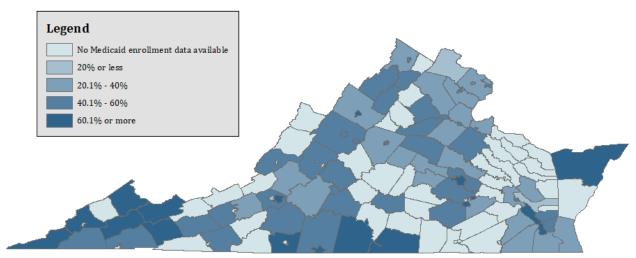


Figure 5. Percentage of children enrolled in Medicaid or CHIP, by locality, on January 1, 2021. Sources: DMAS, 2021 and KIDS COUNT Data Center, 2021.

Geographically, the proportion of children enrolled in Medicaid, FAMIS, CHIP or another income-based public insurance program is concentrated in Southwest and Southside Virginia. Based on discussions above, we know that children in these areas are also more likely to have worse mental health outcomes and a reduced number of mental health providers per capita. Much like the discussion about race-based equity, this policy will also more greatly impact geographic locations with worse outcomes based on the Medicaid data. Again, similarly to race-based equity, the staff at Voices will listen to stakeholders from all geographic regions of Virginia. This will allow for the state to create guidance that will work in all locales. We anticipate that geographic disparities will be reduced similar to the 18% seen in the general effectiveness analysis. Therefore, this policy option is designated as "moderate."

COST

There is no cost to the state for this option. As such, this policy option ranks 4th since it has the lowest cost to the state between all options.

OPTION #3: FUNDING FOR SCHOOL-BASED HEALTH CENTERS

While other states, such as West Virginia, have heavily leaned on SBHCs to provide care, Virginia only has a few across the Commonwealth. For perspective, West Virginia had 161 centers in 2017, whereas Virginia had seven (School-Based Health Alliance, 2018). In January 2019, the Virginia legislature created a Joint Task Force on School-Based Health Centers that was housed in the Children's Cabinet (SB 1195, 2019). The task force provided recommendations to the legislature in December of 2019, where they showed the benefits of SBHCs and gave solutions to administrative issues (Children's Cabinet, 2019). Despite the positive report, there was no legislation in the 2020 or 2021 general assemblies that focused on increasing funding for or pursuing further implementation of SBHCs.

This policy option would prompt the state to create a program within VDH that provides guidance and grants. Specifically, this program would provide two \$2.5 million grants annually to qualified health care organizations in order to cover implementation costs. The money could be used to fund providers, construction, equipment, or any expense incurred by the implementation of the center. Priority will be given to health providers who intend to use the funds to implement a SBHC in a high-need area. Additionally, this program will be funded with an additional \$200,000 to cover the salary of one staff person and a small marketing budget. This person will oversee the grantees and market the program, with the goal of attracting two successful grantees per year. Ideally, this program will run until all localities have at least one SBHC. The burden would be on the health care agency to find a LEA willing to partner with them. The LEA would be responsible for providing the space and the maintenance of the space that the health care provider would work out of. DMAS would provide billing assistance to grantees as they implement new programs. After the implementation period, all future billing and funding would be the responsibility of the health care partner.

EFFECTIVENESS

SBHCs have been shown to be effective in many facets of both physical and mental health. These effects hold even when looking at students that access services in an SBHC versus a community health center. Specifically, screenings and counseling services for depression and anxiety increased nearly 70 percentage-points when students had access to SBHC services vs. traditional community-based care (Knopf et al., 2016). Positive effects were also seen for screening/counseling as it pertains to emotional health (45%-points) and feelings of hopelessness (10%-points) (Knopf et al., 2016). Studies have also shown that students with access to a SBHC are nearly 20 times more likely to utilize mental health services compared to students who only have access to community-based services (Guo et al., 2008). This same study showed that SBHC-users utilized less emergency department services compared to other students in the district that did not have access to an SBHC. Beyond the number of services utilized, SBHCs have been linked to a modest but direct increase in pediatric health-related quality of life (Guo et al., 2008). Additionally, students in both middle school and high school reported an increase in self-reported mental health (Knopf et al., 2016). Because of these direct, strong, positive effects on mental health outcomes for children, we have given this alternative a "high" designation as it pertains to effectiveness.

RACE-BASED EQUITY

One of the most effective pieces of the SBHC intervention is that all students and their families are able to access services for free. In some models, the greater community can also come and receive physical, dental and mental health care. Because of this, the potential impacts on race-related health disparities are great. Medical providers that apply for SBHC funding generally focus on providing care to underinsured and/or minority communities (School-Based Health Alliance, 2011). As such, increasing the access and funding available for SBHCs will generally increase health access in these communities. SBHCs also address transportation issues, which can be a major obstacle in a child (or caregiver) receiving necessary mental health care ("Understanding Barriers to Minority Mental Health Care - Nursing@USC," 2018).

While there is no known literature that directly shows the effects of SBHCs on race-related mental health disparities, there are studies that look at other measures of health disparities, such as poor asthma outcomes. Black children are more likely to have poorly controlled asthma, leading to more emergency department visits and hospital stays (Guilbert et al., 2019). Multiple studies have shown

that SBHCs significantly reduce asthma-related emergency department visits and hospitalizations, by about 70% (Knopf et al., 2016). While this is not a direct measure, it is a proxy that can give some insight on the mental health outcomes of minority populations as well. Another proxy we can look at is teenage pregnancy. Hispanic and non-Hispanic black teens are disproportionately more likely to get pregnant than their white peers (CDC Features - Teen Birth Rates Drop, But Disparities Persist, 2019; Wiltz, 2015). SBHCs are incredibly effective in reducing many outcomes in regards to this, such as teen pregnancy, where schools that implemented school-based health centers were able to see an average 40% reduction (Knopf et al., 2016). Because of these proxies and the other positive effects discussed above, we have given this alternative a designation of "high" as it pertains to reducing the gap in race-related mental health disparities.

GEOGRAPHIC-BASED EQUITY

SBHCs are found in urban, suburban and rural localities across the country and state. When implemented in both rural and urban locales, SBHCs have been shown to reduce gaps in access to healthcare. One study found that the proportion of rural students accessing mental health services increased nearly 6 percentage-points (20% change) after SBHCs were implemented in their school districts. Similarly, the study found that the proportion of urban students accessing mental health care increased about 5 percentage-points (18% change) (Guo et al., 2008).

In Virginia, they are found in areas such as Richmond City, Nelson County and locations in far Southwest Virginia. The most underserved areas as it pertains to mental health care is Southwest and Southside Virginia, where there are not nearly enough providers to cover the need. This alternative would prioritize funding for SBHCs who would move into these designated shortage areas. Because of this, there is an expected drastic decrease in geographic disparities of at least 18%, meaning that this alternative is designated as "moderate" as it pertains to geographic-based equity.

COST

There are many analyses available that look at the costs and benefits of school-based health care centers. From a societal perspective, the main benefits of SBHCs are both pregnancy prevention and general productivity from both a physical and mental health perspective. The societal benefit per SBHC user ranges from about \$500 to nearly \$2,000 depending on the services available. Additionally, there are net savings of about \$300 per user from a payer perspective, showing that some of the money that comes into the SBHC could be monies saved in Medicaid payments. One study found that Medicaid reimbursements for mental health care for a student in a SBHC-school were significantly lower than a student without access to a SBHC. An average annual reimbursement for a non-SBHC child is about \$1,500, whereas the average annual reimbursement for a student with access to an SBHC is about \$715. Additionally, the average Medicaid reimbursement for students who utilize a SBHC they have access to is about \$440, even lower than students in the other two categories (Guo et al., 2008).

The cost to the state for this policy option would be \$5.2 million annually, which would include a full-time staff person to work with grantees, market the program, and keep track of evaluation. The additional \$200,000 above the \$5 million grant-award funds would include a full-time staff person's salary, benefits, marketing budget, equipment/office materials, and travel-based reimbursement for visiting potential sites. Compared to the other alternatives, this policy options ranks in 2nd as it is the policy option with the second-highest cost to the state.

OPTION #4: INCREASE FUNDING FOR THE BEHAVIORAL HEALTH LOAN REPAYMENT PROGRAM

Prior to 2021, the Commonwealth's student loan repayment program existed as the Virginia State Loan Repayment Program, or VA-SLRP. Essentially, it allows for up to 25% of a health care workers student loan to be paid by the state for each year of service to the Commonwealth. With a few exceptions, health care workers can be student-debt free after working for a public entity for 4 years. However, this program requires communities that receive the workers to provide a 50% match, making already low-resource communities unable to take advantage of this program. During the 2021 General Assembly special session I, funding was allocated in the enrolled budget for a revamp of the Behavioral Health Loan Repayment Program. This program, specifically for mental health providers, provides up to \$30,000 in loan repayments per year of service to the Commonwealth, with a maximum of four years. Importantly, it does not require a community match, which allows low-resource localities to take advantage of this program. Graduating providers must commit to at least two years of service, and preference will be given to those who are practicing in a Healthcare Provider Shortage Area. This program is funded at \$885,000 for FY2022 and \$3,120,000 for FY2023 (2021 Special Session I Budget Bill, 2021). As the program is currently written, this will allow for a maximum award of \$30,000 for tier one professionals (child and adolescent psychiatrists, psychiatric nurse practitioners, and psychiatrists) and a maximum award of \$20,000 annually for tier two professionals (licensed clinical psychologists, licensed clinical social workers, and licensed professional counselors) (Item 295 #1c -Behavioral Health Loan Repayment Program - Budget Amendment, 2020). This would provide 29 scholarships for tier one professionals in year one and 104 in year two.

To remove all Mental Health Provider Shortage Area designations, the state needs to hire 56 workers, mostly tier one professionals, in localities across the Commonwealth, but we do not anticipate that all scholarships given will go to providers that are working in these exact areas, as that is not a program requirement. Additionally, adding just 56 workers in these areas will allow for the minimum standard of care, but not beyond that. Because of this, we propose that the funding for the BHLRP be increased to \$4.98 million for year two. This would allow for 166 providers to receive loan repayments annually, all while working in state-sponsored health care facilities.

EFFECTIVENESS

While some of the details in the BHLRP package are new, programs like these are not new to the Commonwealth. Another pipeline program, the Virginia State Loan Repayment Program, operates similarly for physicians, nurses and other health providers (Joint Commission on Health Care, 2010). This program was analyzed in 2008 and found that 40% of physicians completed the maximum four years of service (Bowman, 2008). Of those, 58% (or 23% of the total population) served in HPSA or HPSA-adjacent areas. This shows that the program was about 23% effective in increasing access to low-access areas, and bringing more care to underserved areas with them. We believe that these numbers will improve with more targeted funding requirements, but we are unsure by how much it

⁶ Note: We reached out to the director of the State Loan Repayment Programs, where the BHLRP will most likely be housed, and we did not hear back. Any comments about which localities receive the most providers in the program is purely speculative. Additionally, this program has not yet been implemented, so data on the inaugural cohort is unknown at this time.

will increase. Given the definition of our criteria, we can designate this policy option as "moderately" effective in increasing care in the Commonwealth.

RACE-BASED EQUITY

Traditionally, health care provider pipeline programs work to get more diverse providers into the workforce (Smith et al., 2009). In 2016, 64% of Virginia's population was white, but 86% of licensed clinical psychologists were white (Office of Health Equity, 2016). Comparatively, 19% of Virginia's population was black, but only 5% of all licensed clinical psychologists were black. Additionally, 8% of Virginia's population was Hispanic, but only 3% of all licensed clinical psychologists in 2016 were Hispanic. It is known that diversity in the provider pool helps improve health care through an increased focus on culturally competent care (Alegría et al., 2008). This is important in both children wanting to access mental health services, but also parents feeling comfortable enough to take them to see a provider. Overall, culturally competent care positively impacts mental health (Alegría et al., 2008). Even so, this program does not directly address adding diversity to the mental health provider pool, and instead focuses on geographic equity. Because of this, we designated this program as "low," as we anticipate this will not measurably reduce the race-related disparities between white children and children of color.

GEOGRAPHIC-BASED EQUITY

The revamped pipeline program will prioritize behavioral health workers that choose low-resource areas. This type of program was cited as one of the most critical recruitment tools for rural areas across the country (Center for Health Research and Transformation, 2020). If this program was funded appropriately, it would be crucial in working to eliminate mental health provider shortages, and even help some areas perform better than the minimum. Studies have shown that pipeline programs, such as the National Health Service Corps, saw 87% of providers practicing in underserved areas at the time of program completion (NCSL, 2017). 55% of all participants were still working in underserved areas ten years post-completion of the program. Other studies show that for every 4 participants that went through the Rural Health Scholars program in Alabama, 1 will remain in underserved counties to practice medicine (Wheat & Leeper, 2020). This is a 25% retention rate. Currently, Virginia needs a minimum of 56 workers in specific areas of the Commonwealth in order to eliminate all Mental Health Provider Shortage designations. This proposal will allow for scholarships for nearly three times as many workers as are needed. Using the conservative 25% retention rate from the studies mentioned above, the gap in needed care providers would be reduced by 73%. Therefore, we designate this policy option as "highly" effective in reducing geographic-related disparities.

COST

The current allocated amount for this program is \$885,000 in year one of the program, and \$3,120,000 in year two. This policy option proposes an increase of \$0 in year one, and \$1,860,000 in year two. Since the program is overseen by a volunteer board of stakeholders, there will not be any operating costs associated with the program. We recommend an analysis of the program at year two to determine the gaps and needed funding moving forward. Compared to the other alternatives, this policy options ranks in 3rd as it is the policy option with the second-lowest cost to the state.

OUTCOMES MATRIX

	Effectiveness of the Policy (35%)	Race-Based Equity (20%)	Geographic- Based Equity (20%)	Cost to the Commonwealth (15%)	Total Score
Decrease School Counselor-to- Student Ratio	Low - 1 0.35	Moderate - 2 0.40	High - 3 0.60	\$80.67 million Rank: 1 0.15	1.50
Implementation Guidance for Medicaid Cost- Based Reimbursement	Moderate - 2 0.70	Moderate – 2 0.40	Moderate - 2 0.40	\$0 Rank: 4 0.60	2.10
Funding Plan for SBHCs	High – 3 1.05	High – 3 0.60	Moderate – 2 0.40	\$5.2 million annually Rank: 2 0.30	2.35
Increase Funding for BHLRP	Moderate - 2 0.70	Low – 1 0.20	High - 3 0.60	\$400,000 annually Rank: 3 0.45	1.95

For the effectiveness, race-based equity and geographic-based equity, the descriptors of high, moderate and low were translated into scores of 3, 2 and 1 respectively to make for easier weighting. The policy options were also ranked from highest cost (1) to lowest cost (4) in order to make for easier incorporation of the cost criterion. The total values represent the final weighted totals for each policy option.

RECOMMENDATION + IMPLEMENTATION

Based on the analysis above, the best choice for Voices for Virginia's Children is to lobby for a grant-funding program that would minimize the start-up costs of SBHCs. It is highly effective in general, and works to eliminate both racial and geographic disparities in mental health access to care. Furthermore, it is moderately expensive, but the cost is not expected to garner pushback due to the increased emphasis on mental health care seen in general assembly in the past few sessions. The one wild card is that there will be a new governor and legislators elected before the start of the next general assembly session, which can shift the balance in political feasibility.

However, due to the nature of the crisis, our full recommendation is two-fold. We recognize that students need help now, and a SBHC grant program will not be implemented or functional for a year or two. In light of this, we recommend that Voices for Virginia's Children immediately meet with stakeholders to create guidance regarding the implementation of cost-based Medicaid reimbursement for mental health services at the school-level. The immediate next steps would be for Voices to identify and reach out to potential stakeholders. Here are some people they could reach out to:

- Individual from DMAS, preferably from the Behavioral Health Services or Policy Planning team
- Amy Edwards, Medicaid Specialist at VDOE
- Jenne Nurse, Equity Coordinator at VDOE
- Kathy Harkey, Executive Director of NAMI Virginia
- Bruce Cruser, Executive Director at Mental Health America (Virginia Chapter)
- Margaret Huang, President and CEO of Southern Poverty Law Center
- Other important groups to pull from:
- School administrators from Nova, SW, Southside, Valley, Central & Beach
- School counselor
- School nurse
- Teacher
- Service provider
- Parent/family that utilizes care

By the end of July, Voices will have a comprehensive document for DMAS and VDOE that they can present. This report could include items such as potential referral systems, case studies detailing different "tricky" scenarios, billing guidance, and more. This should allow for a more comprehensive approach to the Medicaid funding, and could help the stakeholder determine priorities for the coming school year as this is introduced.

After this, the staff at Voices can start advocating for the school-based health center program. Ideally, Voices will be able to find a patron for this bill during the 2022 general assembly session. The patron would need to bring forth a bill that would provide for the grant program to begin starting on July 1, 2022. This bill will need a budget amendment attached, since it is requiring a \$5.2 million allocation in funds. This amount of money could be a point of contention in the finance committees, but if the bill is well-advocated, it is expected to pass. There have been similar mental health investments that passed

through the legislature in recent years, with larger pots of funding attached. Additionally, finding a willing patron could be tough, since it is an election year, and there could be turnover in the legislators. We think the best legislators to advocate for this would be a combination of Senator Creigh Deeds (D-25), Senator Siobhan Dunnavant (R-12), or Delegate Patrick Hope (D-47). All of these legislators have a record of sponsoring bills that champion mental health, especially children's mental health. Notably, Senator Dunnavant was the chief patron of the bill that allowed for Medicaid funding to be used for children without an IEP. We believe that a combination of these legislators could help champion this bill.

CONCLUSION

Access to mental health care in the Commonwealth is crucial as Virginia moves out of the Covid-19 crisis and resumes some form of normal life. Children have been bore a large trauma burden as their daily life and routine has been upended. In the coming months, there will be an increased need for mental health services, even though the current system was only meeting about 20% of the previous need. While all four policy options presented in this analysis were evidence-based and feasible, we believe the best course of action is a two-pronged approach that focuses on both short-term and long-term needs. Firstly, Voices should create guidance that focuses on the equitable roll out of the newly expanded Medicaid reimbursement for mental health services in schools. Secondly, we believe Voices should advocate for an increased emphasis on increasing the number of school-based health centers in regions throughout the Commonwealth. Our hope is that these are two small steps that bring together all the health-focused and child-focused stakeholders to start toward a more complete and holistic mental health care system.

REFERENCES

- 2021 Special Session I Budget Bill, (2021). Retrieved from https://budget.lis.virginia.gov/get/budget/4399/HB1800/
- Alegría, M., Polo, A., Gao, S., Santana, L., Rothstein, D., Jimenez, A., Hunter, M. L., Mendieta, F., Oddo, V., & Normand, S.-L. (2008). Evaluation of a Patient Activation and Empowerment Intervention in Mental Health Care. *Medical Care*, 46(3), 247–256. https://doi.org/10.1097/MLR.0b013e318158af52
- American School Counselor Association. (2019). Measuring the Impact of School Counselor Ratios on Student

 Outcomes. https://www.schoolcounselor.org/getmedia/5157ef82-d2e8-4b4d-8659-a957f14b7875/Ratios-Student-Outcomes-Research-Report.pdf
- Asarnow, J. R., Jaycox, L. H., Duan, N., LaBorde, A. P., Rea, M. M., Tang, L., Anderson, M., Murray, P., Landon, C., Tang, B., Huizar, D. P., & Wells, K. B. (2005). Depression and role impairment among adolescents in primary care clinics. *Journal of Adolescent Health*, *37*(6), 477–483. https://doi.org/10.1016/j.jadohealth.2004.11.123
- Barnum, M. (2016). Exclusive—Data Shows 3 of the 5 Biggest School Districts Hire More Security Officers Than Counselors. https://www.the74million.org/article/exclusive-data-shows-3-of-the-5-biggest-school-districts-hire-more-security-officers-than-counselors/
- Barshay, J. (2019, August 19). New studies challenge the claim that black students are sent to special ed too much. *The Hechinger Report*. https://hechingerreport.org/new-studies-challenge-the-claim-that-black-students-are-sent-to-special-ed-too-much/
- Boudreau, E. (n.d.). Investing In Counselors Isn't Only About Mental Health, It's Good For Academics

 Too. *KQED*. https://www.kqed.org/mindshift/55382/investing-in-counselors-isnt-only-about-mental-health-its-good-for-academics-too
 - Children's Mental Health Care Access Issues in Virginia

- Bowman, S. (2008). *Analysis of Health Workforce Pipelines* (p. 17). Retrieved from http://services.dlas.virginia.gov/user_db/frmjchc.aspx?viewid=529
- Carrell, S. E., & Carrell, S. A. (2006). Do Lower Student to Counselor Ratios Reduce School Disciplinary Problems? *Contributions in Economic Analysis & Policy*, 5(1). https://doi.org/10.2202/1538-0645.1463
- CDC. (2013). Mental Health Surveillance Among Children—United States, 2005–2011. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm
- CDC. (2015). Behavioral health services in Virginia by county. Retrieved from https://www.cdc.gov/childrensmentalhealth/stateprofiles-providers/virginia/index.html
- CDC Features—Teen Birth Rates Drop, But Disparities Persist. (2019, October 15). Retrieved from http://www.cdc.gov/Features/dsteenpregnancy/
- CDC WONDER. (2020). Teen Suicide Rate. Retrieved from

 https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/child_mortality_a/state/VA
- Center for Children and Families. (2020). New Brief Unpacks How States Can Leverage Medicaid Funds to Expand School-Based Health [Georgetown University Health Policy Institute]. Retrieved from https://ccf.georgetown.edu/2020/02/14/new-brief-unpacks-how-states-can-leverage-medicaid-funds-to-expand-school-based-health/
- Center for Health Research and Transformation. (2020). The Behavioral Health Workforce in Rural America:

 Developing a National Recruitment Strategy. School of Public Health.

 https://www.behavioralhealthworkforce.org/wp-content/uploads/2020/02/Recruitment-and-

Retention-of-BH-Providers-Full-Report-2.2020.pdf

- Children's Cabinet. (2019). Children's Cabinet 2019 Report.

 https://www.governor.virginia.gov/media/governorvirginiagov/governor-of-virginia/childrens-cabinet/Connor-Edits_Dec-2-Slideshow.pdf
- Collins, T. P. (2014). Addressing Mental Health Needs in Our Schools: Supporting the Role of School Counselors. *Professional Counselor*, 4(5), 413–416.
- Commission on Youth. (2013). School-Based Mental Health Services. Retrieved from http://vcov.virginia.gov/pdf/documents/collection/SchoolBased_MH_Services0513.pdf
- County Health Rankings. (2019). Virginia Ranking Data.

 https://www.countyhealthrankings.org/app/virginia/2021/downloads
- Davis, P., Davis, M., & Mobley, J. (2013). The School Counselor's Role in Addressing the Advanced Placement Equity and Excellence Gap for African-American Students. *Professional School Counseling*, 17(1), 32–39. https://doi.org/10.1177/2156759X0001700104
- DMAS. (2021). Medicaid/FAMIS Enrollment Dashboard.

 https://www.dmas.virginia.gov/#/enrollmentdashboard
- Ewert, S. (2012, February 27). GED Recipients Have Lower Earnings, are Less Likely to Enter College

 [Government]. The United States Census Bureau.

 https://www.census.gov/newsroom/blogs/random-samplings/2012/02/ged-recipients-have-lower-earnings-are-less-likely-to-enter-college.html
- Fergusson, D. M., & Woodward, L. J. (2002). Mental Health, Educational, and Social Role Outcomes of Adolescents With Depression. *Archives of General Psychiatry*, 59(3), 225. https://doi.org/10.1001/archpsyc.59.3.225

- Frieze, S. (2015). How Trauma Affects Student Learning and Behaviour. *Boston University Journal of Graduate Studies in Education*, 7(2). https://files.eric.ed.gov/fulltext/EJ1230675.pdf
- Gagnon, D., & Mattingly, M. (2016). *Most U.S. School Districts Have Low Access to School Counselors* (National Issue Brief #108). Carsey Research.

 https://scholars.unh.edu/cgi/viewcontent.cgi?article=1285&context=carsey
- Gilbert, L. K., Breiding, M. J., Merrick, M. T., Thompson, W. W., Ford, D. C., Dhingra, S. S., & Parks, S. E. (2015). Childhood Adversity and Adult Chronic Disease. *American Journal of Preventive Medicine*, 48(3), 345–349. https://doi.org/10.1016/j.amepre.2014.09.006
- Grooms, J., Ortega, A., & Rubalcaba, J. A.-A. (2020). Racial and Ethnic Disparities: Essential Workers, Mental Health, and the Coronavirus Pandemic. 21.
- Guilbert, T., Zeiger, R., Haselkorn, T., Iqbal, A., Alvarez, C., Mink, D., Chipps, B., & Szefler, S. (2019).

 Racial Disparities in Asthma-Related Health Outcomes in Children with Severe/Difficult-to-Treat

 Asthma. *The Journal of Allergy and Clinical Immunology: In Practice*, 7(2), 568–577.

 https://doi.org/10.1016/j.jaip.2018.07.050
- Guo, J., Wade, T., & Keller, K. (2008). Impact of School-Based Health Centers on Students with Mental Health Problems. *Public Health Reports*, 123(6), 768–780.

 https://doi.org/10.1177/003335490812300613
- Hahn, R., Knopf, J., Wilson, S., Truman, B., Milstein, B., Johnson, R., Fielding, J., Muntaner, C., Jones,
 C., Fullilove, M., Moss, R., Ueffing, E., & Hunt, P. (2015). Programs to Increase High School
 Completion: A Community Guide Systematic Health Equity Review. *American Journal of Preventive Medicine*, 48(5), 599–608. https://doi.org/10.1016/j.amepre.2014.12.005

- Healthy Schools Campaign. (2019). A Guide to Expanding Medicaid-Funded School Health Services.

 https://healthyschoolscampaign.org/dev/wp-content/uploads/2019/12/A-Guide-to-Expanding-Medicaid-Funded-School-Health-Services-1-22-20.pdf
- Healthy Students, Promising Futures Learning Collaborative. (2019). Understanding the Financial Impact of

 Expanding Medicaid Funded School Health Services in Colorado. Retrieved from

 https://healthystudentspromisingfutures.org/dev/wp-content/uploads/2020/09/CO-RMTS-Case-Study-HSPF.pdf
- Item 295 #1c—Behavioral Health Loan Repayment Program—Budget Amendment, HB30, Virginia General Assembly, 2020 Regular Session (2020). Retrieved from https://budget.lis.virginia.gov/amendment/2020/1/HB30/Introduced/CR/295/1c/
- Joint Commission on Health Care. (2010). Final Report: Analysis of Virginia's Health Workforce Pipelines (No. 90). Retrieved from https://rga.lis.virginia.gov/Published/2010/RD90/PDF
- KIDS COUNT Data Center. (2020a). Children who have health insurance by health insurance type and by race and ethnicity. https://datacenter.kidscount.org/data/tables/10382-children-who-have-health-insurance-by-health-insurance-type-and-by-race-and-ethnicity?loc=48&loct=2
- KIDS COUNT Data Center. (2020b). Children who have one or more emotional, behavioral, or developmental conditions. Retrieved from https://datacenter.kidscount.org/data/tables/10668-children-who-have-one-or-more-emotional-behavioral-or-developmental-conditions?loc=48&loct=2
- KIDS COUNT Data Center. (2021). *Total Child Population: After 2011*. Retrieved from https://datacenter.kidscount.org/data/tables/9191-total-child-population-after-2011?loc=48&loct=2

- Kimsey, K. (2020). Medicaid Reimbursement of School Health Services Outside of a Student's Individualized Education

 Plan. https://rga.lis.virginia.gov/Published/2020/RD688/PDF
- King-White, D. L. (2019). The Role of School Counselors in Supporting Mental Health Models in Schools. *Journal of School Counseling*, 17(4). https://eric.ed.gov/?id=EJ1210764
- Knopf, J., Finnie, R., Peng, Y., Hahn, R., Truman, B., Vernon-Smiley, M., Johnson, V., Johnson, R., Fielding, J., Muntaner, C., Hunt, P., Phyllis Jones, C., & Fullilove, M. (2016). School-Based Health Centers to Advance Health Equity. *American Journal of Preventive Medicine*, 51(1), 114–126. https://doi.org/10.1016/j.amepre.2016.01.009
- Konish, L. (2019, February 11). This is the real reason most Americans file for bankruptcy. CNBC. https://www.cnbc.com/2019/02/11/this-is-the-real-reason-most-americans-file-for-bankruptcy.html
- Lane, J. (2020). 2019-2020 Teacher Salary Survey. Retrieved from https://rga.lis.virginia.gov/Published/2020/RD40/PDF
- Mental Health America. (2020). 2020 Mental Health in America—Youth Data. Mental Health America. https://www.mhanational.org/issues/2020/mental-health-america-youth-data
- Mulhern, C. (2019). Beyond Teachers: Estimating Individual Guidance Counselors' Effects on Educational Attainment. *Center for Education Policy Research*.

 https://cepr.harvard.edu/files/cepr/files/counselors-mulhern.pdf
- NAMI Virginia. (2020). Data on Mental Health. NAMI Virginia. https://namivirginia.org/data-on-mental-health/

- National Institute of Mental Health. (2021, January). *Mental Illness*. Retrieved from https://www.nimh.nih.gov/health/statistics/mental-illness.shtml
- NCSL. (2017). Improving Access to Care in Rural and Underserved Communities: State Workforce Strategies (Health). https://www.ncsl.org/documents/health/WorkforceStrategies2017.pdf
- O'Donnell, H., Davis, K., & Mestan, S. (2019). Building The Community-Based Mental Health
 Workforce To Expand Access To Treatment. *Health Affairs*.

 https://www.healthaffairs.org/do/10.1377/hblog20191022.281887/full/
- Office of Health Equity. (2016). Behavioral Health Loan Repayment Program Plan. Retrieved from https://rga.lis.virginia.gov/Published/2016/RD412/PDF
- Reback, R. (2010). Noninstructional Spending Improves Noncognitive Outcomes: Discontinuity

 Evidence from a Unique Elementary School Counselor Financing System. *Education Finance and*Policy, 5(2), 105–137. https://doi.org/10.1162/edfp.2010.5.2.5201
- SB1307. (2021). Virginia General Assembly, 2021 Special Session I (2021). Retrieved from https://lis.virginia.gov/cgi-bin/legp604.exe?212+sum+SB1307
- School-Based Health Alliance. (2011). 2010-2011 Census Report of School-Based Health Centers. Retrieved from https://www.sbh4all.org/wp-content/uploads/2015/02/CensusReport 2010-11CensusReport 7.13.pdf
- School-Based Health Alliance. (2018). 2016-17 National School-Based Health Care Census Chart Pack.

 Retrieved from https://www.sbh4all.org/wp-content/uploads/2019/07/2016-17-Census-Chart-Pack.pdf

- School boards; staffing ratios; guidance counselors., SB 1406, General Assembly of Virginia, 2019

 Legislative Session (2019). https://lis.virginia.gov/cgi-bin/legp604.exe?191+ful+CHAP0796+pdf
- School counselors; minimum staffing ratio, effective clause—Fiscal Impact Statement, SB880, Virginia General Assembly, 2020 Regular Session, § 22.1-253.13:2 (2020). https://lis.virginia.gov/cgibin/legp604.exe?201+oth+SB880FER122+PDF
- School counselors; minimum staffing ratio, effective clause., SB880, Virginia General Assembly, 2020

 Regular Session, § 22.1-253.13:2 (2020). https://lis.virginia.gov/cgi-bin/legp604.exe?ses=201&typ=bil&val=SB880
- Secretary of Health and Human Resources and the Secretary of Education to establish a school-based health centers joint task force; report., SB 1195, General Assembly of Virginia, 2019 Legistlative Session (2019). https://lis.virginia.gov/cgi-bin/legp604.exe?191+ful+SB1195S1
- Shanholtz, S. (2020, August 12). School counselors provide critical service in K-12 schools. *StatChat*. http://statchatva.org/2020/08/12/school-counselors-provide-critical-service-in-k-12-schools/
- Sink, C. A. (2016). Incorporating a Multi-Tiered System of Supports into School Counselor Preparation.

 Professional Counselor, 6(3), 203–219.
- Smith, S. G., Nsiah-Kumi, P. A., Jones, P. R., & Pamies, R. J. (2009a). Pipeline Programs in the Health Professions, Part 1: Preserving Diversity and Reducing Health Disparities. *Journal of the National Medical Association*, 101(9), 836–851. https://doi.org/10.1016/S0027-9684(15)31030-0
- Standard 2. Instructional, administrative, and support personnel., § 22.1-253.13:2. (2021). Retrieved from http://law.lis.virginia.gov/vacode/22.1-253.13:2/

- Substance Abuse and Mental Health Services Administration. (2015). Racial/Ethnic Differences in Mental

 Health Service Use among Adults. HHS Publication No. SMA-15-4906. Rockville, MD: Substance

 Abuse and Mental Health Services Administration. Retrieved from

 https://www.samhsa.gov/data/sites/default/files/MHServicesUseAmongAdults/MHServicesUseAmongAdults.pdf
- U.S. Department of Health. (2009). Pipeline Programs to Improve Racial and Ethnic Diversity in the Health Professions. Retrieved from https://www.aapcho.org/wp/wp-content/uploads/2012/11/PipelineToImproveDiversityInHealthProfessions.pdf.
- Understanding Barriers to Minority Mental Health Care—Nursing@USC. (2018, May 10). *USC-MSN*.

 Retrieved from https://nursing.usc.edu/blog/discrimination-bad-health-minority-mental-healthcare/.
- United Health Foundation. (2019). Explore Suicide in Virginia | 2019 Annual Report. America's Health Rankings. https://www.americashealthrankings.org/explore/annual/measure/Suicide/state/VA
- Ventimiglia, V. (2007). School Mental Health: Role of the Substance Abuse and Mental Health Services

 Administration and Factors Affecting Service Provision (GAO-08-19R). GAO. Retrieved from https://www.gao.gov/assets/a95202.html.
- Virginia Board of Education. (2020). Suicide Prevention Guidelines for Virginia Public Schools. Retrieved from https://www.doe.virginia.gov/support/prevention/suicide/suicide-prevention-guidebook.pdf
- Virginia Department of Education. (2020). VTSS RIC Virginia Commonwealth University. Virginia Tiered Systems of Supports. Retrieved from https://vtss-ric.vcu.edu/?loxi-pathname=%2Flist%2Ffuture%2F1

- Voices for Virginia's Children. (2020). *Mental Health*. Voices for Virginia's Children. Retrieved from https://vakids.org/our-work/mental-health
- Voices for Virginia's Children. (2021). Mental Health Equity Impact Statement. Retrieved from https://vakids.org/take-action/2021-legislative-agenda/mental-health/mental-health-equity-impact-statement
- Wagner, K. (2016). Effects of Childhood Trauma on Depression and Suicidality in Adulthood. Psychiatric Times.

 Retrieved from https://www.psychiatrictimes.com/view/effects-childhood-trauma-depression-and-suicidality-adulthood
- Wheat, J. R., & Leeper, J. D. (2020). Pipeline Programs Can Support Reforms in Medical Education: A Cohort Study of Alabama's Rural Health Leaders Pipeline to Engage Community Leaders. *The Journal of Rural Health*, jrh.12531. Retrieved from https://doi.org/10.1111/jrh.12531
- Whitney, D. G., & Peterson, M. D. (2019). US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children. *JAMA Pediatrics*, 173(4), 389.

 Retrieved from https://doi.org/10.1001/jamapediatrics.2018.5399
- Wiltz, T. (2015). Racial and Ethnic Disparities Persist in Teen Pregnancy Rates. Retrieved from http://bit.ly/1wF4YGd.
- Zablotsky, B., & Terlizzi, E. P. (2020). Mental health treatment among children aged 5–17 years: United States, 2019. (NCHS Data Brief, no 381). Retrieved from https://www.cdc.gov/nchs/products/databriefs/db381.htm