Meeting Summary

Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century

Work Group 2: Criminal Justice Diversion

September 23, 2019, at 10:00 a.m.

Pocahontas Building, Senate Committee Room A

http://dls.virginia.gov/interim_studies_MHS.html

Work Group 2: Criminal Justice Diversion (the Work Group) of the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century (the Joint Subcommittee) met in Richmond with Delegate Robert B. Bell, chair, presiding.[1] The meeting began with introductions and opening remarks followed by presentations and discussion. Materials presented at the meeting are accessible through the *Joint Subcommittee's website*.

Presentation: Virginia Mental Health Access Program

Nina Marino, MSW, LCSW, Director, Office of Child and Family Services, Department of Behavioral Health and Developmental Services

Sandy Chung, M.D., Virginia Mental Health Access Program, Medical Director

Ms. Marino and Dr. Chung presented to the members on the plans for the Virginia Mental Health Access Program (VMAP). Virginia's ranking for mental health care for children under 18 years of age has improved to twenty-third in the country overall, but pediatricians still report lacking mental and behavioral health knowledge and skills. Virginia is also struggling with a mental health workforce shortage. Ms. Marino reported that there are only two counties in Virginia (Rappahannock and Albemarle) that currently have sufficient numbers of child and adolescent psychiatrists, and several counties have none.

The presenters explained that VMAP is a pediatric-driven training, consultation, and referral model designed to increase capacity for primary care providers (PCPs) who provide health care for children and adolescents to treat and respond to common mental health conditions like anxiety, depression, and attention deficit hyperactivity disorder (ADHD). VMAP enhances screening, integrates behavioral health into primary care settings, and has four key objectives: education for PCPs, PCP telephonic/video consults with regional VMAP teams, telehealth visits, and care navigation. The presenters noted that Virginia's need for VMAP is evidenced by responses on a survey from providers who are enrolled in VMAP indicating that they do not feel there is adequate access to child psychiatry and other child mental health services, they are not able to meet the needs of children with mental health problems with existing resources, and they are not able to receive a psychiatric consultation in a timely manner when needed.

When VMAP is fully funded, DBHDS envisions having five regional hubs; each would be responsible for providing services for its own region. Each regional hub would have psychiatrists, other mental health providers, and a navigator. Currently, there is a psychiatric line open, but it is serving the entire state. This is manageable for the time being as the program rolls

[1] **Members Present:** Delegate Robert B. Bell, III, chair, Senator R. Creigh Deeds, Delegate Patrick A. Hope, Delegate Vivian E. Watts

Members Absent: Senator John A. Cosgrove, Senator Janet D. Howell, Delegate Margaret B. Ransone

out, but as VMAP expands, it will need more resources. Members asked about how the program works in practice and how many psychiatrists will be needed to cover the different regions. Presenters indicated that one child psychiatrist can cover 250 PCPs. Ms. Marino spoke about similar programs that exist in other states. Massachusetts has the Massachusetts Child Psychiatry Access Program (MCPAP) and now has over 95 percent of its pediatric PCPs enrolled. Between Fiscal Year 2016 and Fiscal Year 2018, 80 percent of well child visits included a standardized behavioral health screening.

Ms. Marino explained the existing funding for VMAP and stated that the Governor's budget included $1.23 million for fiscal year 2019-2020 allocated to DBHDS for the VMAP initiative, and DBHDS received the Health Resources and Services Administration (HRSA) grant, which includes $445,000 per year for five years. VMAP also has $189,818 in in-kind support.

Members inquired about whether VMAP might also be available in schools for school counselors, school nurses, etc. The presenters explained that, currently, the program is meant for pediatricians and other PCPs, which is the model that most other states are following. Dr. Chung noted that children must see pediatricians and physicians for school-based physicals, and those providers have access to VMAP when they see students. Massachusetts has expanded its program so that it is available to OBGYNs to help mothers and expectant mothers, so the model could be used for a broader audience. The presenters also explained that although VMAP is not available to school counselors and other such providers, if a school has a medical provider on site, then that provider would be able to use VMAP. Additionally, if school nurses have prescribing authority or a physician overseeing them, then VMAP may be available as a resource for them.

The VMAP pilot program began on August 5, 2019, and consultation services are currently being provided. As of September 12, 138 PCPs were enrolled in VMAP and there were 15 calls received in the first month. So far, they have been able to meet the goal of PCPs receiving a call back within 30 minutes, but as the program continues to expand and more PCPs enroll, they will need more resources to continue to meet this goal. The state general funds are being used to incrementally build VMAP infrastructure, grow the regional hubs, and hire people to handle the call center. Additionally, to achieve VMAP's objective of providing training and education for PCPs, 174 providers in the state have participated in Resource for Advancing Children's Health (REACH) trainings, and 24 providers have trained through Project Echo to date. In addition, using quality improvement projects to encourage screening and early identification of mental health conditions led to 80 to 90 percent more mental health screenings, with more than 5,000 children screened.

Presentation: A School Nurse's View: Mental Health and Nursing Scope of Practice

Debra Ruppert, R.N., Independence Nontraditional School, Prince William County Schools

Ms. Ruppert presented to the members on the role school nurses play in identifying and addressing mental health issues seen in children. Ms. Ruppert has been a school nurse for 42 years and for the last 19 has been working in Prince William County. She serves a K-12 nontraditional school. She highlighted the National Association of School Nurses' (NASN) statement that school nurses serve an important role in promoting positive behavioral health outcomes in students, which also encompasses mental health. School nurses collaborate with school personnel, community health care professionals, students, and families in the identification, intervention, and referral of children in need of behavioral health services and are

often uniquely qualified to identify such students because of their regular access to them, she said. Ms. Ruppert talked about how signs and symptoms of social, emotional, and behavioral health often show themselves in school settings.

Ms. Ruppert noted that part of supporting children who have social, emotional, and mental health needs includes ensuring safety in the building for the students and staff, which requires collaboration with building security and local police departments. In her practice, she works with counselors, social workers, school psychologists, administrators, and security specialists. She stressed the importance of real-time information sharing between all of these groups. There was discussion about restrictions and concerns with respect to the Health Insurance Portability and Accountability Act (HIPPA) and the Family Educational Rights and Privacy Act (FERPA), but the reality, she said, is that it is important to quickly communicate with families in order to let them know the signs of a potential issue that could be addressed by community care providers.

Ms. Ruppert explained that when students and families in her service area are referred to outside community providers, 60 percent are referred to community services boards (CSBs). Those who have private insurers often reach out to private providers. Many students do not have PCPs and, therefore, school nurses and other personnel rely heavily on emergency rooms and CSBs when handling mental health-related issues. Ms. Ruppert stated that schools can move quickly in seeking care for students in emergency situations, but there are many difficulties with follow-up and ongoing treatment. Continuity of care is important in order for students to see improvement, but achieving such continuity can be difficult. Citing as an example the way that schools have addressed the needs of students with chronic illnesses such as diabetes, Ms. Ruppert said schools need health treatment plans endorsed by families and physicians to address mental health.

Members asked about whether interactions with CSBs or emergency rooms require parental notification first and, if so, whether that presented a barrier for children who might be attempting to hide certain issues from their family. If students are under the age of 18 and not emancipated, parental notification is required. This sometimes can be a barrier and, when possible, reaching out to families to try to educate, provide resources, and help them move forward with arranging treatment and care is helpful, she said.

Ms. Ruppert explained that the goal for her own clinic is to provide 360 degrees of care, which involves making sure every member of the team is aware of the events of the day. Team meetings are important and include real-time information sharing, the inclusion of school resource officers, practice and discussion of 911 protocols, and staff education on working with students living with mental illness. She added that it is important that emergency plans are seamless and respectful of the student's needs. Ms. Ruppert also discussed that when a student is being referred out for emergency care, it is essential to remember that this is only a snapshot of that student's situation, and she stressed the importance of trying to provide as much background information about that student as possible.

Presentation: School Counselors: Role in Student Mental Health Access

Dr. Denise McKaig-Phillips, Mr. Matt Sheneker, and Ms. Brett Welch

Dr. McKaig-Phillips, Mr. Sheneker, and Ms. Welch spoke to the members about the role of school counselors in student mental health access. Dr. McKaig-Phillips reported that, every year, 14 to 20 percent of youth are diagnosed with mental, emotional, or behavioral health disorders and only 45 percent of youth with a diagnosis receive treatment. Further, only 24 percent of

those individuals receive care in the school system. She explained that a school counselor's training includes mandatory mental health training in recognition of mental health disorders and behavioral distress, and she stated that school counselors are trained to provide social-emotional learning, prevention programs, mental and behavioral support, and crisis response in the school setting, in addition to providing academic and career development services.

Mr. Sheneker discussed the evidence-based, multi-tiered system of support that is the framework used by many schools in Virginia for school counselors to provide support and intervention in order to meet the academic, emotional, and social needs of students:

- Tier I of this system represents the core supports that are implemented throughout the school for all students. The expectation is that these programs will meet the needs of 80 percent of students and may include classroom counseling instruction designed to target social-emotional learning, academic support, and college/career exploration.
- Tier II represents the targeted supports that are expected to meet the needs of 15 percent of students and includes remediation and specialized and targeted supports in small groups or one-on-one meetings.
- Tier III includes the more intensive supports and is meant to reach the remaining five percent of students who have high needs. These services may include individual brief counseling support sessions.

Mr. Sheneker also noted that students are referred to school counselors through parent referrals, teacher referrals, Virginia Tiered Systems of Support (VTSS) referrals, and sometimes by older students through self or peer referrals. Mr. Sheneker stated that school counselors also conduct suicide assessments, provide crisis intervention, and give referrals to and collaborate with outside mental health providers to support students in the school setting. It is important to note, he said, that school counselors do not provide therapy or follow treatment plans for students with diagnosed or undiagnosed mental health disorders. This is sometimes a challenge because in many cases students cannot get in to receive services quickly. The availability of mental health services and insurance are both barriers for students.

Ms. Welch spoke about some of the school counselors' recommendations, such as universal mental health screening, which would include a quick screening conducted with every student. Parents would have the opportunity to opt out of the screening. Three counties have piloted a universal mental health screening program and have had positive results. Members inquired about how long such screenings would take. While it would depend on the tool used, the presenters said, the longer screenings could take up to 30 minutes. They also recommended lowering the student-to-counselor ratio to 1:250 and requiring that school counselors be left out of the master schedule rotation as a resource class. School counselors currently may still be included in the "master schedule" in some schools, which means school counseling is one of the weekly class blocks for students. While this can provide a good opportunity for Tier I intervention, it also means school counselors do not have the time or ability to work with students who may need more in-depth interventions.

The presenters also responded to members' inquiries about the recent changes to the way students are reviewed and referred to therapeutic day treatment and whether they have felt the effects. They also noted that while the passage of HB 1729 (Landes, 2019) was a good start, there have been some negative consequences. For example, some schools are now including

school counselors on the master schedule when they had not done so previously in order to count this scheduled time toward the 80 percent of counseling time. They also spoke to members about the difficulties of balancing working with higher-need students while continuing to support to all students. Members inquired about how school counselors respond to students who exceed their ability to intervene, and the counselors explained that they make a referral to an outside mental health provider, but they cannot mandate the process and it is up to families to follow through. The presenters spoke of a need for more of a continuum of services inside schools.

Presentation: School Psychologists: Addressing Mental Health in the Schools

Patricia Onorato, Ph.D., NCSP, Leigh Gahr, Ed.S., NCSP, and Laura Early, Ed.S., NCSP

Dr. Onorato, Ms. Gahr, and Ms. Early spoke to the members about the role of school psychologists in addressing mental health in schools. All of the presenters work in Chesterfield County. The current model for school psychological services proposed by the National Association of School Psychologists aims to provide the most cost-effective use of school psychologists' time that is also proactive. The model delineates the services that can be expected from school psychologists across 10 domains of practice. In order for the model to be implemented effectively, the recommended ratio is one school psychologist for every 500 to 700 students.

The presenters gave the members an overview of each of the 10 domains of practice included in the model, including domain four, which involves interventions and mental health services to develop social and life skills. School psychologists have knowledge of child development and understand the biological, cultural, developmental, and social influences on behavior and mental health, they said. School psychologists can conduct therapy in schools, but since their services are school-based, the treatment is focused on what will enhance a student's learning. They work very closely with nurses, social workers, and counselors. They also conduct group and individual counseling, provide trauma-informed care, serve as resources for parents and educators about mental health, engage in restorative practices, have direct communication with outside mental health providers such as pediatricians and psychiatrists, and provide behavioral and social-emotional support. Some of school psychologists' current practices include a Signs of Suicide prevention program, crisis intervention for students and staff, threat assessments, support for parents as they navigate community services, and development of reentry plans to help students transition back to school after a crisis. When mental health issues go beyond school-based services, school psychologists may be there to conduct threat assessments, connect families to outside service providers to help them navigate that process, develop partnerships for direct admissions to particular hospitals, and help create reentry plans for students, they said.

The presenters spoke of some of the challenges school psychologists face. While the recommended ratio is one school psychologist for every 500 to 700 students, many Virginia school ratios are closer to one school psychologist for every 2,000 students. There is a national shortage of psychologists and the salary is low in comparison to other professions that require graduate degrees. Because of these obstacles, school psychologists are currently forced to focus on crises rather than on preventative and proactive services.

Members inquired about the proper alignment between school counselors and school psychologists, and the presenters noted that it is definitely a partnership. The presenters noted that school counselors have access to all students, and their skillsets may be better honed to the Tier I and Tier II services mentioned in the previous presentation, but school psychologists can

serve as the next step and hone in on those Tier III supports. School psychologists also serve as helpful liaisons to families because they have a medical background and they often speak the language of the medical model.

For more information, see the *Joint Subcommittee's website* or contact the Division of Legislative Services staff:

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