

**REPORT OF THE VIRGINIA DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL
SERVICES**

**Final Report on Mental Health
Screening in Public Elementary
Schools (HJR 586, 2015)**

**TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA**



HOUSE DOCUMENT NO. 9

**COMMONWEALTH OF VIRGINIA
RICHMOND
2016**



COMMONWEALTH of VIRGINIA

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

JACK BARBER, M.D.
INTERIM COMMISSIONER

November 21, 2016

To: The Honorable Terence R. McAuliffe
and
Members, Virginia General Assembly

In accordance with *House Joint Resolution No. 586* of the *2015 General Assembly Session*, I am pleased to provide you with the *Mental Health Screening in Public Elementary Schools Final Report*. HJR 586 required the Department of Behavioral Health and Developmental Services to “study the benefits of offering voluntary mental health screenings to students in public elementary schools”.

Please find enclosed the report in accordance with HJR 586. Staff at the department are available should you wish to discuss this request.

Sincerely,

A handwritten signature in blue ink that reads "Jack Barber, M.D." in a cursive style.

Jack Barber, M.D.

Enc.

Cc: William A. Hazel, Jr., M.D.
Joe Flores
The Honorable Joseph R. Yost



Virginia Department of
Behavioral Health &
Developmental Services

Mental Health Screening in Public Elementary Schools Final Report

(House Joint Resolution 586)

November 30, 2016

DBHDS Vision: A Life of Possibilities for All Virginians

Mental Health Screening in Public Elementary Schools Final Report

Preface

House Joint Resolution 586 of the 2014 General Assembly requires the Department (DBHDS) to submit a report to the Governor and General Assembly.

WHEREAS, public school students in the Commonwealth are required to be tested and screened for various impairments, including vision impairments, hearing impairments, and scoliosis; and

WHEREAS, public school students in the Commonwealth are not routinely screened for mental illness; and

WHEREAS, an accurate picture of student mental health and early diagnosis of mental illness in students are crucial to ensuring the social and academic development of students in the public schools of the Commonwealth; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, that the Department of Behavioral Health and Developmental Services be requested to study the benefits of offering voluntary mental health screenings to students in public elementary schools.

In conducting its study, the Department of Behavioral Health and Developmental Services shall convene a workgroup of experts. The workgroup shall develop a feasible study plan and implementation timeline. The workgroup shall (i) review existing research on screening of elementary school children and whether there is an ideal year to administer such screenings, (ii) review available screening instruments that may be appropriate for elementary school children, (iii) recommend methods of notifying parents of the availability of screening and recommend procedures for seeking parental consent, and (iv) consider what in-school and other services may be available for children whose screening indicates a need for follow-up.

Technical assistance shall be provided to the Department of Behavioral Health and Developmental Services by the Department of Education. All agencies of the Commonwealth shall provide assistance to the Department of Behavioral Health and Developmental Services for this study, upon request.

The Department of Behavioral Health and Developmental Services shall complete its meetings for the first year and submit a preliminary report by November 30, 2015. For the second year, the Department of Behavioral Health and Developmental Services shall submit its final report to the Governor and the General Assembly, including findings and recommendations for publication as a House or Senate document by November 30, 2016. The executive summaries and reports shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports no later than the first day of the next Regular Session of the General Assembly and shall be posted on the General Assembly's website.

Mental Health Screening in Public Elementary Schools Final Report

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Executive Summary

The 2015 General Assembly charged the Department of Behavioral Health and Developmental Services (DBHDS) with studying the benefits of offering voluntary mental health screening to students in public elementary schools. DBHDS developed a two-year study plan and implementation timeline that focused on the following areas:

- Review existing research on screening of elementary school children and whether there is an ideal year to administer such screenings;
- Review available screening instruments that may be appropriate for elementary school children;
- Recommend methods of notifying parents of the availability of screening and recommend procedures for seeking parental consent; and
- Consider what in-school and other services may be available for children whose screening indicates a need for follow-up.

During the first year of study, DBHDS reviewed and researched background information and convened a workgroup of experts to advise on mental health screening in elementary schools. Topics of consideration for the expert panels included themes on current practice and ideal best practices. The work of these panels was expanded when the workgroup met during the second year of the study to develop a screening process.

The workgroup identified the *Strengths and Difficulties Questionnaire* as an initial screening instrument and *The Behavioral and Emotional Screening System* as a secondary screening instrument to administer to second graders. Additionally, during the second year of study, a process was developed to administer a screening tool, ensure parental notification about the screening process, and identify follow up services.

The workgroup strongly supports the concept that early intervention with the appropriate infrastructure can reduce future more serious emotional disturbances for many children. To that end, the workgroup made the following recommendations:

- Provide funding to the Department of Education for three pilots to be implemented in Virginia schools, including:
 - Placing and funding a Screening Coordinator in each pilot school;
 - Making available and funding a contracted Qualified Mental Health Professional (QMHP) in each pilot school; and
 - Decreasing the current ratio of school counselors to students and include school psychological, school social work, and school nursing services at each pilot school.
- Provide funding for general mental health education for all school employees.

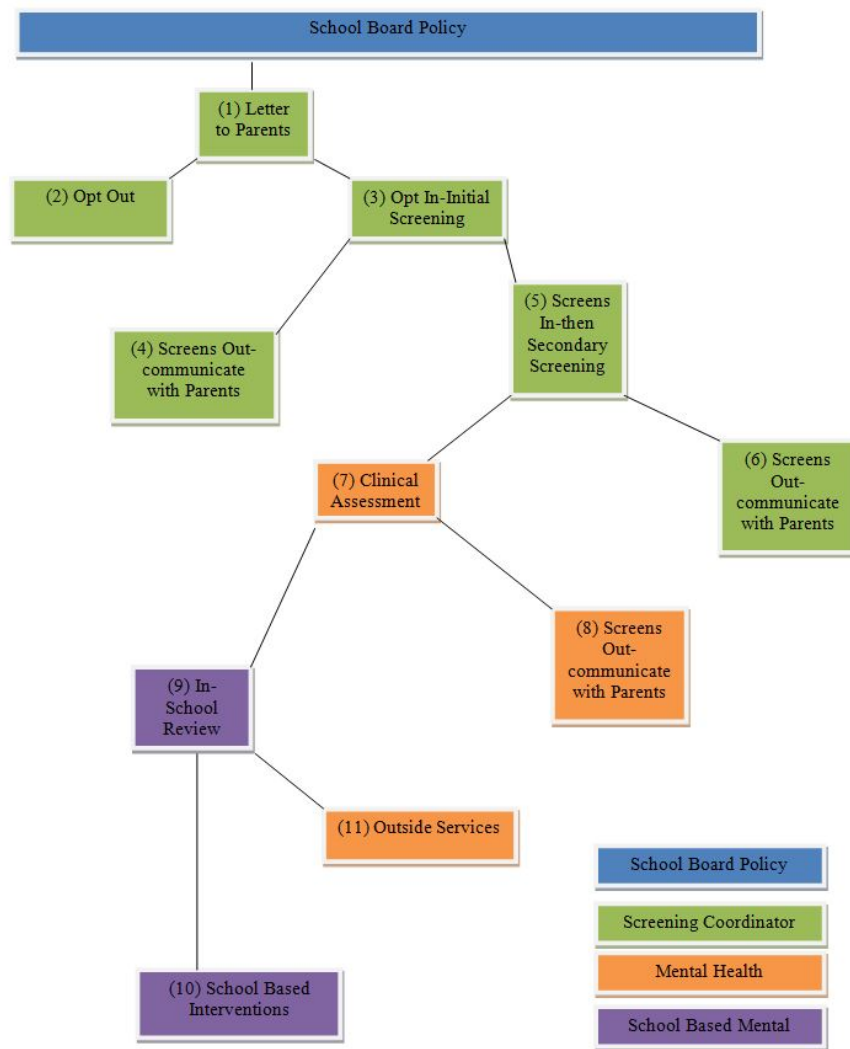
Study Process

In addition to reviewing literature about mental health screening in schools, DBHDS, along with the Department of Education (DOE), convened three expert input panels in the first year of the study (Appendix B). The panel’s tasks included identifying current practice surrounding student mental health and learning from those that are working in the field about the pros and cons of mental health screening in elementary schools. The first year study process is detailed in the HJ 586 interim report and can be found at the following link:

[http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD152015/\\$file/HD15.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD152015/$file/HD15.pdf) .

The second year of the study focused on considering how the process would be carried out if mental health screening were implemented in elementary schools (Appendix D). The workgroup created a mental health screening process flowchart (see Figure One) as a visual description to explain how the process should be implemented.

Figure One: Mental Health Screening in Public Elementary Schools Process Flow Chart



Detailed descriptions of each of the steps within the process flow chart are found in Figure Two below.

Figure Two: Mental Health Screening in Public Elementary Schools Process Flow Chart Detail

School Board Policy	
(1) Letter to Parents	<ul style="list-style-type: none"> • School boards would have discretion on how and when to send the letter • Letters will include: purpose of the initiative, the screening process, the screening tool to be used, and possible next steps • Screening coordinator answers any questions a parent may have
(2) Opt Out	<ul style="list-style-type: none"> • Parent chooses to opt out or opt in and returns letter • Screening coordinator keeps track of who opts out
(3) Opt-In Initial Screening	<ul style="list-style-type: none"> • Screen all 2nd graders, whose parents opt in • Screening coordinator maintains a list of students to be screened • Screening coordinator conducts and interprets initial screening
(4) Screens Out-Communicate with Parents	<ul style="list-style-type: none"> • Screening coordinator communicates with parents if child screens out and is available to answer any questions
(5) Screens In/Secondary Screening	<ul style="list-style-type: none"> • For those children that meet the screening threshold for follow up, the screening coordinator communicates with parents • Parent opts in or opts out • Screening coordinator conducts a secondary screening after parent opts in
(6) Screens Out- Communicate with Parents	<ul style="list-style-type: none"> • Screening coordinator communicates with parents if child screens out and is available to answer any questions
(7) Clinical Assessment	<ul style="list-style-type: none"> • Screening coordinator communicates with parents and parents are given the option to opt in or opt out • Those children that screen at risk on a secondary screening and opt in are referred to Qualified Mental Health Professional for a Clinical Assessment
(8) Screens Out- Communicate with Parents	<ul style="list-style-type: none"> • Qualified Mental Health Professional communicates with parent if it is determined during the clinical assessment that no further services are needed
(9) In School Review Team	<ul style="list-style-type: none"> • An in school review team will meet when a child has been determined as needing additional support after the clinical assessment • The in school review team will review the child’s records to determine if there are any school-based interventions that are appropriate or referrals to outside services should be made
(10) School Based Interventions	<ul style="list-style-type: none"> • The in-school review team will determine which school based interventions are appropriate • The screening coordinator will make a record of which interventions are identified
(11) Outside Services	<ul style="list-style-type: none"> • If the school based review team, along with the clinical assessment determines that outside services are needed, the child will be referred for those services • The outside service provider may provide the service at the school

The workgroup’s efforts also included identifying those personnel that would need to be available and the process by which a student would be screened. Additionally, the workgroup, along with a smaller task group, identified a screening tool and the ideal year for screening.

The study process also included coordinating with existing efforts that are aligned with this study of mental health screening in public elementary schools. Those two initiatives, both led by DOE, are:

- Project AWARE – Designed to provide an integrated and comprehensive continuum of services to address mental health needs of children and youth; and
- School Climate Transformation – Focuses on expanding and enhancing the implementation of Positive Behavioral Intervention Supports (PBIS) within the Virginia Tiered Systems of Supports (VTSS) in Virginia school divisions. PBIS is an evidence-based, multi-tiered behavior framework for improving behavioral outcomes and learning conditions for all students.

Information on these initiatives can be found in Appendix E. DBHDS has worked closely with DOE so that this study will complement the work that is currently underway.

Review of Research on Screening of Elementary School Children and Review of Existing Research

DBHDS reviewed numerous research studies, journals, and articles about mental health screening for elementary school children (Appendix F). Additionally, during the first year of the study, DBHDS convened three expert input panels to garner information on current practice, screening tools, and best practice. Based on this review and the work of the expert input panels, there does not appear to be consensus about which screening instrument to use or when to use it. There are many screening instruments available for school aged children starting in preschool through high school. Screening instruments vary depending upon the purpose of the screening. For example, some screening instruments are used for very specific disorders while others are used to screen for more general mental health concerns.

During the second year of the study, the workgroup and smaller task group reviewed and commented on instruments that screen for general mental health concerns. In order to narrow the numerous mental health screening tools that are available, a select group of instruments were chosen for an in depth review. The workgroup was broken into a smaller task group including additional subject matter experts that were invited to review the selected screening tools as well as suggest additional screening tools. The screening tools that were chosen to be reviewed either appeared on the websites for the Orange County Department of Education, Center of Healthy Kids and Schoolsⁱ, or the Massachusetts Health and Human Services approved screening tools listⁱⁱ. (Please note citations are found in Appendix F at the end of this report.)

The workgroup believes it is important for school personnel to have a good understanding of the mental health needs of students before implementing a screening process. It was recommended to offer an early childhood mental health training to all school employees.

A small number of additional screening tools were identified by the task group. Those screening instruments were also reviewed by the workgroup and ultimately an initial and secondary screening tool were selected to be administered in second grade. Since some children may not

have been enrolled in full day kindergarten, second grade was chosen as the screening year. This would allow for children to have completed one year of full day classroom experience in the first grade.

The workgroup deemed that it was important to not only choose an initial screening tool but to choose a secondary screening tool for those that had a positive initial screen. The initial screen selected was the Strengths and Difficulties Questionnaire (SDQ). The work group recommended that a positive result on an initial mental health screening should warrant a secondary screening. The Behavioral and Emotional Screening System (BASC-3 BESS) was selected for the secondary tool. This protocol of completing the initial and secondary screening tools follows the recommendation made by U.S. Prevention Task Force (USPSTF) for assessing depression in children and adolescentsⁱⁱⁱ.

The U.S. Preventive Services Task Force (USPSTF) found that:

“A positive result on an initial screening test does not necessarily indicate the need for treatment. Screening is usually done in 2 phases: The initial screening is followed by a second phase in which skilled clinicians take into account contextual factors surrounding the patient’s current situation, through either additional probing or a formal diagnostic interview...A negative result on a screening test, however does not always preclude referral when clinical judgment or parental concerns suggest it is warranted...The USPSTF recommends that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up...Finally, inadequate support and follow-up may result in treatment failures or harms, as indicated by the FDA boxed warning. ‘Adequate systems in place’ refers to having systems and clinical staff to ensure that patients are screened and, if they screen positive, are appropriately diagnosed and treated with evidence-based care or referred to a setting that can provide the necessary care.”

The workgroup’s mental health screening in elementary schools process flow chart is similar to the process described above. Additionally, the workgroup thought it imperative that infrastructure and funding were in place to provide services when the screening process indicated that further supports were needed.

Methods of Notifying Parents and Procedures for Seeking Parental Consent

Similar to other school-based screening initiatives, the workgroup recommended that mental health screening be governed by local school board policy. The Virginia School Health Guidelines Manual^{iv}, published by the Virginia Department of Health in partnership with DOE, offers information on procedures for health screenings in schools. This document contains recommended procedures for the statewide implementation of mental health screening.

The workgroup recommends that the mental health screening process be piloted prior to statewide implementation. One of the intended outcomes of this pilot includes the development of a model school board policy related to the screening as well as further refinement of the

procedures recommended by the workgroup. During the pilot period, parental consent will be sought using an opt-in method as per DOE's recommendation. This would require parents to actively consent to the pilot and screening by signing and returning a parent information letter to the screening coordinator. The parent information letter would provide information about the screening, including the purpose, process, timelines, and how the information would be maintained or shared.

For statewide implementation, the parent information letter could potentially be sent home with an opt-out provision for parents. By not opting out, a parent would be consenting to the screening. Parents who do not consent to have their child participate in the screening (i.e. opt-out) would need to sign and return the parent information letter to the coordinator. Research suggests that an opt-out method is likely to yield a greater number of children going through the screening process.

The workgroup believes that communication with parents is important at each step in the process. The mental health screening in elementary schools process flow chart indicates where parents should receive additional communication at each step of the process. It should be noted that parents will have the right to opt out at any step of the process. By hiring a screening coordinator, schools would have a dedicated position to help answer any questions and guide parents through screening process.

In-School and Other Services That May Be Needed by Children Who Are Screened

In-school services

Schools currently provide limited behavioral health services in order to meet students' educational needs. Services vary among school divisions based on needs and funding. The Commonwealth of Virginia requires the Board of Education to prescribe standards of quality for the public schools in Virginia, subject to revision only by the General Assembly. These standards, found in the Code of Virginia at §§ 22.1-253.13:1 through 22.1-253.13:10, are known as the Standards of Quality (SOQ) and encompass the requirements that must be met by all Virginia public schools and school divisions. The SOQ currently lists school counselors as required personnel and establishes a ratio of one counselor to every 500 elementary school students.

The SOQ does not name school psychologists, school social workers, or school nurses as required personnel and thus does not offer minimum staffing requirements. Consequently, current ratios vary widely by locality. Some school divisions may not have any school psychologists or school social workers on staff.

The workgroup determined that it was a high priority to ensure that the appropriate staffing levels and resources are available in the schools to address student needs identified through a positive screening as it relates to students ability to learn and benefit from the educational

environment. To do this, additional funding would be necessary to increase the current levels of Specialized Instructional Support Personnel (SISP).

The National Alliance of Instructional Support Personnel provides examples, including those below, of services that are provided by specialized instructional support personnel that support student mental health^v.

- Psychological services,
- School counselor services,
- School nurse services, and
- School social worker services.

Outside-of-school services

304. M, A Plan for Community Based Children's Behavioral Health Services in Virginia^{vi}, includes a comprehensive service array that ideally should be available for all children no matter which community they live in or their ability to pay. These services listed below, in addition to tailored community services based on individual need, may be beneficial for children who screen as needing additional services. By offering these services from an outside mental health professional in the school building either during or after school, barriers to treatment may be overcome.

Examples of outside-of-school services that could be provided by a contractual mental health professional:

- School based 1:1 therapy – Mental health counseling or psychotherapy that occurs between youth and therapist in the school setting.
- School based 1:1 behavioral specialists – Specialists use behavioral therapy techniques in the school setting to modify maladaptive behavior.
- School based therapeutic day treatment (mainstream) – A combination of psychotherapeutic interventions combined with medication education and mental health treatment offered in the school setting. If mainstreamed the interventions occur in a setting where the children are in a regular education classroom with same age peers
- School based therapeutic day treatment (self-contained) – A combination of psychotherapeutic interventions combined with medication education and mental health treatment offered in the school setting. Self-contained interventions occur in a setting where the child is removed from the general school population for all academic subjects to working a small controlled setting with a special education teacher.
- School based after school therapeutic day treatment – A combination of psychotherapeutic interventions combined with medication education and mental health treatment offered in the school setting during after school hours.
- Summer programs for special education/behavioral challenges – Summer programs that offer educational, recreational, and therapeutic activities for children and adolescents with special education and behavioral challenges.

The workgroup considered many factors when attempting to estimate which in school and out of school services are needed, including current service levels, current needs and gaps, and

projected increased needs based on a positive screening. As described in the section below, the workgroup determined that it is necessary to pilot this initiative to obtain a valid representation of needed statewide levels of services.

Study Recommendations and Cost Estimates

The research, review, and expert input of the workgroup members were extremely beneficial in studying the benefits of screening elementary school children for mental health problems. Through this study, the workgroup was able to identify appropriate screening instruments and to map out a process for how the screening might best be implemented in schools.

There were a number of questions, however, about certain steps in the process and how best to implement them. While the workgroup had ideas based on their experience, they strongly believed the ideas need to be tested in a school setting. As such, the workgroup was reluctant to recommend immediate statewide implementation of mental health screening in schools. As described below, the recommendation is to pilot the screening process as described in the flow chart on pages 3 and 4 for three years in three diverse elementary schools. The results of the pilots would inform future implementation.

The workgroup recommended that the pilot be implemented over a three year time period to allow sufficient time to gather information about infrastructure building and planning needs, screening implementation needs, and follow up supports needs. In order for the pilots to be successful, a year to build the infrastructure to support the screening process is important. During the first year of funding, the pilots will begin to train school personnel in early childhood mental health, develop and refine policies and procedures for each specific pilot, and begin the process of hiring or reassigning staff. It is estimated that the process of hiring or reassigning staff will take five months after funding has been awarded. Screening would start in the second year and continue during the third year. Training in early childhood mental health would also continue during the second and third year. At the end of the second year and during the third year, DOE, with the input of the pilot schools, would prepare a report that outlines the pilot's successes and challenges. This report would be used to make a determination whether to continue the screening, make adjustments in the process, add additional pilots, or implement the screening process statewide.

Study Recommendations

The workgroup offers the following recommendations along with cost estimates for the General Assembly to consider.

- 1. After careful consideration of the benefits and challenges of implementing mental health screening in schools, the workgroup recommends that the General Assembly provide funding to the (DOE) for three pilots to be implemented in Virginia schools. The pilot schools would be selected by DOE.** DOE would implement the screening and follow-up services as described in the mental health screening process flow chart as a three year pilot. Next steps and future implementation in elementary schools would be based on the experience of the pilots. Each pilot would have the following essential components:

- **A Screening Coordinator in each pilot school and funding to support this position.** A Screening Coordinator hired by the school division would be responsible for all of the administrative and reporting tasks. The screening coordinator would also be the point of contact for both school personnel and parents to answer any questions and to help guide a family through the process.
 - **A contracted Qualified Mental Health Professional (QMHP) available in each pilot school and funding to support this position.** A qualified mental health professional (QMHP) hired through a contract with a CSB or private provider would provide follow up clinical assessments and needed mental health services to children that screen as at-risk and need services in addition to those that can be provided by the school system. These services could be provided in or out of the school building.
 - **Decrease the current ratios of school counselors to students and include school psychological, school social work, school nursing services at each pilot school to more closely align to national recommended ratios.** Adequate specialized instructional support personnel (SISP) to student ratios are necessary to ensure the validity and reliability of the screening process as well as the access to necessary school-based interventions. By using a screening tool to identify children that may need early intervention, it is important to increase the number of personnel that is currently available to provide services. These professionals would be responsible for conducting screening, serve on the in-school review team, and be responsible for providing necessary interventions to address identified mental health needs that are impacting the children within the educational environment. In addition, these professionals, as members of the in-school review team, would assist the team in determining whether there is a suspicion of a disability and whether a referral to special education evaluation is needed.
 - The recommended staffing levels for SISP to student ratios by professional organizations are listed below:
 - **School Social Work 1:250**, as recommended by the National Association of School Social Work (NASSW)^{vii}
 - **School Psychology 1:500-700** (based on a comprehensive model of service), as recommended by the National Association of School Psychologists.^{viii}
 - **School Counselors 1:250** as recommended by the American School Counselor Association (ASCA)^{ix}
- 2. Provide funding for general mental health education for all school employees.** Before a screening process is implemented, it is important for school personnel to have a good understanding of the mental health needs of students. It is recommended that early childhood mental health training is offered to all school employees. Teacher participation in early childhood mental health training is affected by the lack of funds available to support substitute teaching hours. Additional funding specifically designated for this

purpose would allow teachers to access this training. The training should cover a range of common disorders and potential crises. Training participants should be able to:

- Recognize the potential risk factors and warning signs of a variety of mental health challenges common among young children, including depression, anxiety, psychosis, Attention Deficit Hyperactivity Disorder, and disruptive behavioral disorders.
- Have a plan to help a young person in crisis connect with appropriate professional assistance.
- Interpret the prevalence of various mental health disorders in youth within the U.S. and the need for reduced negative attitudes in their communities.
- Apply knowledge of the appropriate professional, peer, social, and self-help resources available to help a young person with a mental health problem assess their own views and feelings about youth mental health problems and disorders.

Summary of Cost Estimates to Support the Recommendations

The following are cost estimates for the DOE to implement mental health screening in elementary schools. DOE annually collects statistics on the number of students enrolled in public school on September 30. This report is known as the Fall Membership report. For the 2015-2016 school year, there were 98,693 registered second graders in Virginia; enrollment ranges from a low of three students to a high of 303 students^x. Cost estimates for this report were based on 100 students per pilot program. The screening coordinator caseload is estimated to be 100 students per pilot. The caseload for both the school mental health professional and the contracted mental health professional is estimated to range between 20-30 students per pilot. Ultimately, caseloads totals will be dependent on the selected pilot schools. The DOE would allocate this funding to schools for pilot projects. Based on the experience of pilots, additional schools, or statewide implementation could occur in successive fiscal years.

Cost Estimates to Support the Recommendations

Service	Description of Service	Cost Methodology	Year 1	Year 2	Year 3
<i>Mental Health Screening in Schools</i>					
Early Childhood Mental Health Training	Early childhood mental health training designed to give educators key skills to help a child who is developing a mental health problem or experiencing a mental health crisis. The training should cover a range of common disorders and potential crises.	Teacher substitutes for all teachers in each school (average 20 per school) at an estimated \$125 daily rate \$2,500.00 per school	\$2,500	\$2,500	\$2,500
Initial Screening Instrument	Strengths and Difficulties Questionnaire (SDQ).	Printing the screening instrument at an estimated \$0.08 per page for 100 students per pilot Printing for the scoring instrument at an estimated \$0.08 per page for 100 students per pilot		\$16	\$16
Secondary Screening Instrument	Behavioral and Emotional Screening System (BASC/BESS).	<ul style="list-style-type: none"> BASC-3 Q-global Comprehensive Kit at an estimated \$353 per pilot Paper screening instruments for 80 students per pilot at an estimated \$348 per pilot One year subscription of on line scoring at an estimated \$60 per pilot http://www.pearsonclinical.com/ 		\$761	\$761
School Based Mental Health Professionals	An in school review team that would review a child's records and determine if there are appropriate school based interventions or if the child would need additional services from the mental health professional.	<ul style="list-style-type: none"> Pilots to utilize existing resources and equivalent of 1.0 SISP FTE to be locally allocated at an estimated \$85,000 per school. Pilot study would include documentation and analysis of school based services utilization to determine service needs, gaps, and provide statewide implementation cost estimate by specific SISP role. 	\$49,583	\$85,000	\$85,000
Screening Coordinator	Provides administrative and technical support. This individual would be the point person for parents about the screening and the liaison between the school, providers and families.	1.0 FTE at an estimated \$70,000	\$40,833	\$70,000	\$70,000
Mental Health Professional-Contractual	Provides additional support that may be needed to children that screen at risk. This individual would not be an employee of the school but would be hired to provide in or out of school services to children.	1.0 FTE at an estimated \$90,000	\$52,500	\$90,000	\$90,000
Total per pilot school			\$145,417	\$248,277	\$248,277
TOTAL FOR THREE PILOT SCHOOLS			\$436,250	\$744,831	\$744,831

Conclusion

The workgroup strongly supports the idea that early intervention can reduce more serious emotional disturbances for many children in the future. Schools have the opportunity to identify children early and provide mental health services and supports in a familiar setting with parent involvement.

Detailed discussion of the process of how mental health screening would be conducted in elementary schools often uncovered implementation questions, which could not all be answered by the workgroup. This led to the recommendation to pilot the proposed screening process in several schools. The pilot programs would test the ideas developed by the workgroup and determine their practical implementation. All components of the screening process would need to be tested by the pilots to determine any adjustments or improvements that would need to be made for statewide implementation. As described in the study recommendations, in order to implement mental health screening in elementary schools, the infrastructure must be in place to provide the necessary supports to students identified through the screening, both in school as well as outside of school. If the infrastructure is not in place, the success of the screening and children identified as needing further support will be compromised.

Appendices

Appendix A House Joint Resolution 586 Workgroup Members

School Personnel Expert Panel		
Name	Title	Agency
Rebecca Cooper	School Nurse	Shenandoah County Public Schools
Erika Daniel	School Psychologist	Newport News Public Schools
Dr. Tynisa Giles	School Social Worker	Sussex County Public Schools
Stephanie Bourgeois	Sr. Director, Student Services	Williamsburg-James City County Public Schools
Dr. Marlene Scott	Administrator	Chesterfield County Public Schools
Stephanie Perkins	Special Education Teacher	Alexandria City Public Schools
Behavioral Health Service Provider Expert Panel		
Paulette Skapars	Director, Children's Mental Health Services	Richmond Behavioral Health Authority
Christopher Taylor	Crisis and Family Assistant Director	New River Valley Community Services Board
Nicole Jackson	Therapeutic Day Treatment Program Manager	Hampton Newport News Community Services Board
Ryan Dudley	Clinical Services Administrator	Hampton Newport News Community Services Board
Ross Moore	Senior Clinician	Youth-Challenged Advised and Positively Promoted
Kristen Ault	Director of Regional Programs	Youth-Challenged Advised and Positively Promoted
Dr. Valerie Bowan	Pediatrician	American Academy of Pediatrics, Virginia Chapter
Professional, Advocacy and Parent Organizations Expert Panel		
Karen Carlson, M.Ed	VASC President	Virginia Alliance for School Counseling
Rosemary Sullivan	Executive Director	Virginia Association of Community Services Boards
Hillary Press	President	Virginia Counselors Association
Troilen G. Seward	Legislative Advocate	Virginia Academy of School Psychologists
Susan Daly	President	Virginia Assn of Visiting Teachers/School Social Workers
Diana Donnelly	Parent	Virginia Family Network
Ashley Everette	Policy Analyst	Voices for Virginia's Children
State Staff		
Janet Lung, LCSW	Director, Office of Child and Family Services	Department of Behavioral Health and Developmental Services
Katharine Hunter, MSW	Program Specialist	Department of Behavioral Health and Developmental Services
Maribel Samire, Ed. S.	School Psychology Specialist	Department of Education
Joseph Wharff	School Counseling Specialist	Department of Education

Appendix B Discussion Questions For the Workgroup

1. How do you currently identify students who need mental health supports? Does this work well? Why/why not?
2. What school-based mental health services/supports are available in your school division?
3. What out-of-school mental health services are available in your community?
4. Are you aware of any mental health screening tools or methods that are being used in a Virginia school division? If so, please describe.
5. What are the advantages of implementing mental health screenings in schools?
6. What are the disadvantages of and/or barriers to implementing mental health screening in schools?
7. If mental health screenings were to be implemented in schools, what should be considered when developing procedures?
8. Are there other comments? Are there things we haven't asked about that you want to discuss?

Appendix C Study Plan

Deliverables:

- Recommended screening instrument
- Screening schedule
- Sample parental notification
- Guidance document on how to conduct a screening (including questions/answers for parents and procedures for follow-ups)
- Guidance document on maintaining confidentiality
- Budget

Month	Task Group	DBHDS/DOE
December 2015		<ul style="list-style-type: none"> • Review interim report and study plan for year two with year one workgroup • Collect screening instruments • Draft screening schedule
January 2016	<ul style="list-style-type: none"> • Select screening instrument • Select screening schedule • Choose screening instrument by February 28, 2016 	<ul style="list-style-type: none"> • Draft personnel that will be needed to conduct screening and analyze results. • Draft parental notification • Draft school procedures for responding to parent’s questions/concerns and instructions for conducting screenings
February 2016	<ul style="list-style-type: none"> • Identify what personnel will be needed to conduct screening and analyze the results of children whose parents elect to participate. • Complete by March 31, 2016 • Parental notification form for voluntary screening • Develop school procedures for responding to parent’s questions/concerns and instructions for conducting screenings • Complete by April 30, 2016 	<ul style="list-style-type: none"> • Review cost, including analyzing results • Draft procedures for maintain confidentiality or records and assuring HIPAA or FERPA compliance
March 2016	<ul style="list-style-type: none"> • Develop procedures for maintaining confidentiality of records and assuring HIPAA or FERPA compliance • Complete by April 30, 2016 	<ul style="list-style-type: none"> • Draft procedures for follow up for children that fall within the at-risk range: additional school based services, referral for evaluation, diagnosis and treatment outside of the school
April 2016	<ul style="list-style-type: none"> • Procedures for follow up for those children that fall within the at-risk range: additional school based services, referral for evaluation, diagnosis and treatment outside of the school. • Complete by May 30, 2016 	
May 2016		<ul style="list-style-type: none"> • Calculate budget requests • Complete by June 30, 2016
June 2016		<ul style="list-style-type: none"> • Present work generated by the task groups to the full workgroup

Appendix D Project Aware and School Climate Transformation

Project AWARE (Advancing Wellness and Resilience in Education)

Project AWARE is a grant to the state of Virginia from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) and the U.S. Department of Health and Human Services (HHS). The purpose of the Virginia Project AWARE is to provide an integrated and comprehensive continuum of services to address mental health needs of children and youth. This includes a cohesive, cross-agency vision and systems approach for addressing policy development, funding, data collection, and workforce development to improve coordination of state and local resources. The goals of Project AWARE are:

- Develop a multi-tiered model that integrates a comprehensive systems approach for addressing the mental health needs of school-aged (K-12) youth that can be piloted within three selected county public school divisions (Fairfax, Montgomery, and Pulaski).
- Integrate a multi-tiered systems framework for the delivery of mental health services that will increase the efficiency of systems (policies, regulations, and procedures) at the state and local levels to advance collaboration, capacity, integration, and coordination of services by piloting the project at the three selected school divisions/communities and with state agencies.
- Expand the availability and delivery of Youth Mental Health First Aid (YMHFA) throughout Virginia to improve mental health literacy among youth serving-adults.

School Climate Transformation

The School Climate Transformation (SCT) program focuses on expanding and enhancing the implementation of Positive Behavioral Intervention Supports (PBIS) within the Virginia Tiered Systems of Supports (VTSS) in Virginia school divisions. PBIS is an evidence-based, multi-tiered behavior framework for improving behavioral outcomes and learning conditions for all students. The goals of this initiative include:

1. Building capacity at the state level for supporting the sustained and broad-scale implementation of VTSS-PBIS.
2. Enhancing the capacity of Virginia school divisions for implementing and sustaining VTSS-PBIS.
3. Incorporating a multi-tiered system of mental health supports as a component of VTSS through coordination with the Project AWARE.

Currently the SCT program is supporting the expansion of VTSS in 13 school divisions in Virginia as follows:

- Accomack County Public Schools
- Accomack County Public Schools
- Fairfax County Public Schools
- Fairfax County Public Schools
- Hanover County Public Schools
- Madison County Public Schools
- Montgomery County Public Schools
- Northumberland County Public Schools
- Prince Edward County Public Schools
- Pulaski County Public Schools
- Virginia Beach City Public Schools
- Warren County Public Schools
- Waynesboro City Public Schools
- Williamsburg-James City County Public Schools
- Wythe County Public Schools

Appendix E Literature Review

Adelman, Howard S., PhD, and Linda Taylor, PhD. *Mental Health in Schools and Public Health*. Rep. Vol. 121. Los Angeles, CA: Association of Schools of Public Health, 2006. Print.

Health policy and practice call for health and mental parity and for a greater focus on universal interventions to promote, prevent, and intervene as early after problem onset as feasible. Those in the public health field are uniquely positioned to help promote the mental health of young people and to reshape how the nation thinks about and addresses mental health. And schools are essential partners for doing the work.

American Academy of Pediatrics, Addressing mental health concerns in primary care, a clinician's toolkit. Mental health screening and assessment tools for primary care. *Pediatrics*. Revised 2012: 1-20.

The Mental Health Screening and Assessment Tools for Primary Care table provides a listing of mental health screening and assessment tools, summarizing their psychometric testing properties, cultural considerations, costs and key references.

ASTHO. "Comparison of FERPA and HIPAA Privacy Rule for Accessing Student Health Data" Fact Sheet (2012).

This document compares key aspects of the Family Educational Rights and Privacy Act (FERPA) and Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule related to the use and disclosure of information. A chart provides a snapshot of the rights, duties, and limitations imposed by FERPA and HIPAA.

Becker, L.D., Bailey, T., Summers, K.H., Hlavin, A., Lara, M., & Subramony, R. (2010). *A critical review of common social emotional screeners*. NASP Annual Convention

Current initiatives focusing on mental health promotion suggest the need for school psychology practitioners to explore the use of social emotional screeners. Social-emotional screeners are instruments that purport to aide in the identification of students at-risk for social-emotional problems. Early intervention based on this screening information allows for effective strategies to improve social emotional skills that in turn, are related to improved academic achievement. Best practice research suggests that universal screening tools are: administered to all students in the school, used to inform instruction, used to indicate potential problems, quantitative in nature, cost effective, aligned with instruction, and easily administered, scored, and interpreted.

Chamberlin, Jamie. "Schools Expand Mental Health Care." *American Psychological Association* 40.1 (2009): 64-67. *Www.apa.org*. Web. 03 Aug. 2015.

Mental services are the fastest-growing component of school-based health care. Yet some school mental health experts say that school-based health centers are an inefficient use of public funds, especially in urban areas that have untapped community mental health services. Psychologists on the front lines in school based health centers agree that setting up shop on school grounds is the best way to reach children. However there continues to be debate over whether these in school services are the best model to serve students.

Commonwealth of Virginia. (2004) *Standards for School Counseling Programs in Virginia Public Schools*. Richmond, Virginia.

This document reviews the standards for school counseling programs.

Eklund, K., Universal Screening to Inform Intervention for Behavioral and Emotional Concerns. *Now is the Time, Technical Assistance Center, PowerPoint presentation*. Viewed March 12, 2015 from <https://emt.ilinc.com/join/xmjzpw>.

A webinar on SAMHSA's "Now is the Time" Initiative Project AWARE (Advancing Wellness and Resilience in Education). This initiative seeks to improve mental health literacy among youth-serving adults and to build cross-system capacity for comprehensive mental health approaches in states and communities.

Essex, M., Kraemer, H., Slattery, M., Burk, L., Boyce, W., Woodward, H., & Kupfer, D. (2009). Screening for childhood mental health problems: Outcomes and early identification. *Journal of Child Psychology and Psychiatry*, 562-570. Retrieved January 21, 2015, from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC268224>

This study aimed to develop a universal school-based screening procedure based on the answers to three questions: (1) What are the broad patterns of mental health problems from kindergarten to grade 5? (2) What are the grade 5 outcomes of these patterns? (3) How early in school can children likely to develop the most impairing patterns be identified accurately?

Gionfriddo, Paul. "Let's Take A More Comprehensive Approach To Mental Health Systems Reform In 2015 Beginning With Children." Web log post. *Health Policy Lab*. N.p., 6 May 2015. Web. 10 Aug. 2015.

Blog post on prevention, early identification, and early intervention. Additionally, this blog post stresses the need to rethink how mental health issues in children to address seriously the vast disparities that exist throughout the county in both mental health status and access. The author focuses on early mental health screenings and early intervention.

Gregory Riggs, Taking HIPAA to School: Why the Privacy Rule Has Eviscerated FERPA's Privacy Protections, 47 J. Marshall L. Rev.1047 (2014)

Current law creates an undesirable situation because it forces school social workers to choose between creating accurate documents or maintaining confidentiality. Confidentiality in treatment is a bedrock principle of the social work profession, and has come to be widely recognized over the course of the twenty-first century. However, FERPA's alleged "confidentiality protections" are nothing more than an illusion of privacy. Without amending FERPA and HIPAA, school social workers will continue to be denied the protections provided by technological advancements to their peers practicing in analogous non-educational settings.

Gudeman, R. (Director) (2015, August 17). Sharing Information: Appropriately Applying HIPAA, FERPA and Other Confidentiality Laws. *Now Is the Time: Project Aware, State Management Team Meeting*. Lecture conducted from Virginia Department of Education, Richmond, VA.

A PowerPoint presentation, from Rebecca Gudeman with the National Center for Youth Law in Oakland, CA. This presentation used case examples to explain the differences between HIPAA and FERPA. The importance of consulting with legal counsel when any school based mental health services are being developed was stressed throughout the presentation.

HIPAA or FERPA? A Primer on School Health Information Sharing in California. Oakland, CA: California School Health Centers Association, 2010. Print.

Physical and mental health programs are a critical component of student support services.

When developing school-based health programs, there are several considerations that the health provider(s) and education agency should address early on. Generally, FERPA limits disclosure of information in education records maintained by schools, and HIPAA limits disclosure of health information maintained by health care providers. Whether FERPA or HIPAA applies and how those interact with state confidentiality law will impact school-based health service operations in large and small ways—from framing how school staff and health providers collaborate; to shaping policies about how to deal with suicide threats and other emergencies; to determining the content of consent forms and other paperwork used by health services providers. For this reason, educational agencies and health care providers should carefully consider the HIPAA/FERPA question when entering into an agreement to develop school-based health program, be it for mental health or medical services.

Kutash, K., Duchnowski, A.J. & Lynn, N, (2006). *School-based mental health; An empirical guide for decision makers*. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies., Research and Training Center for Children's Mental Health.

The aim of this monograph is to contribute to the dialogue that addresses barriers preventing school-based mental health services from meeting the hoped for potential to improved service effectiveness and capacity. The history of mental health in schools, a summary of the major conceptual models that currently influence the implementation of services, federal policies and funding strategies are reviewed. Additionally, an overview of evidence-based for school based interventions is provided.

Mann, Cindy. "Medicaid Payment for Services Provided without Charge (Free Care)." Letter to State Medicaid Director. 15 Dec. 2014. MS. Department of Health & Human Services, Baltimore, Maryland.

Guidance letter that addresses Medicaid payment for services covered under a state's Medicaid plan to an eligible Medicaid beneficiary when the service does not have a charge. It clarifies that when a child is screened for free, Medicaid can be billed for every Medicaid eligible child.

Mental health interventions in schools in high-income countries, Mina Fazel, et al., *Lancet Psychiatry*, published online 8 October 2014.

This review describes the salient issues in delivery of mental health services within school settings. The review is broad and includes example of different interventions. The different models of mental health services delivery in schools are discussed. The authors emphasize the need to reconfigure both health and education services to better promote children's learning and development.

Partnering with School-Based Health Centers: What Schools Need to Know. HIPAA and FERPA Confidentiality and Disclosing Health Care Information.

It is critical that everyone—health care providers and school personnel—understand when HIPAA applies and when FERPA applies and how these interact with state laws. Student health information is subject to HIPAA if it is part of a program that is funded, administered or operated by or on behalf of a public or private health, social service or other non-educational agency or individual. Student health records are subject to FERPA if it is part of a program that is funded, administered or operated by or on behalf of a school or educational institution. HIPAA and FERPA can never apply to the same information at the same time. The rules for mental health information are much stricter than those for medical information.

Student Records and Confidentiality. Madison, Wisconsin. Wisconsin Department of Public Instruction, 2013. Print.

State and federal statutes provide specific protections to students and parents regarding student records. In some circumstances, the state law provides additional protection not included in federal law and vice-versa. School districts must comply with the most restrictive statute. State and federal statutes also provide protection of student information maintained by community agencies and dictate how schools exchange information with agencies and systems outside of education. This bulletin has been designed to help local school districts develop their own local policies regarding student records and confidentiality.

University of Maryland School of Medicine, Center for School Mental Health Analysis and Action. (2007, June 11). *School-based early intervention services: An opportunity to improve the well-being of our nation's youth*.

Congress reauthorized IDEA in 2004. The reauthorization allows up to 15% of IDEA 2004 Part B federal funds to be used for early intervening services for students ages 3-21 “who have not been identified as needing special education or related services but who need additional academic and behavioral support to succeed in the general education environment.” This change allows for a portion of IDEA funds to be directed toward the general education population. The purpose of this brief is to advance understanding of this particular change to IDEA and to discuss its potential implications for school mental health services.

Weist, M. (2010). *The Excellence in School Mental Health Initiative: Final Report*. University of Maryland, Center for School Mental Health

School mental health programs are growing related to the increased recognition that building more comprehensive services for youth in this universal natural setting has many advantages (Evans, Weist, & Serpell, 2007; Flaherty & Osher, 2003; Robinson, 2004; Weist, Evans & Lever, 2003). However, as we build promotion and prevention for children and youth, capitalizing on the significant advantages of doing this work in schools, there are many other dimensions of infrastructure and implementation support needing attention. This report provides a cogent example and recommendations to integrate in a full continuum of empirically supported approaches to promote student wellness, mental health and school success into the real world setting of schools.

Weitzman, C., Wagner, L., and the section on development and behavioral pediatrics, committee on psychosocial aspects of child and family health, council on early childhood, and society for developmental and behavioral pediatrics (2015). Promoting Optimal Development: Screening for Behavioral and Emotional Problems. *American Academy of Pediatrics*, 135(2), 384-395. Retrieved January 28, 2015, from www.pediatrics.org/cgi/doi/10.1542/peds.2014-3716

This clinical report focuses on the need to increase behavioral screening and offers potential changes in practice and the health system, as well as the research needed to accomplish this. This report also (1) reviews the prevalence of behavioral and emotional disorders, (2) describes factors affecting the emergence of behavioral and emotional problems, (3) articulates the current state of detection of these problems in pediatric primary care, (4) describes barriers to screening and means to overcome those barriers, and (5) discusses potential changes at a practice and systems level that are needed to facilitate successful behavioral and emotional screening.

Appendix F Citations

i

<https://www.cdph.ca.gov/programs/cclho/Documents/LERNER%20Mental%20Health%20Screening%20and%20Early%20Intervention%20in%20Schools%20CCLHO%20presentation.pdf>

ii

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_149102

iii <https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-children-and-adolescents-screening> l

iv

http://www.doe.virginia.gov/support/health_medical/virginia_school_health_guidelines/conducting_health_assessments.pdf.

v <http://www.nasisp.org/Descriptions.html>

vi

<http://www.dbhds.virginia.gov/library/children%20and%20family%20services/cfs%20child%20and%20family%20-%20plan%20for%20behavioral%20health%20services.pdf>

vii <http://www.sswaa.org/?page=459>

viii <http://cqrcengage.com/naspweb/practicemodel>

ix <http://www.schoolcounselor.org/asca/media/asca/home/rolestatement.pdf>

x http://www.doe.virginia.gov/statistics_reports/enrollment/fall_membership/

