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Increasing Student Access to Mental Health Services in Virginia Through Staffing and Structures

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Abstract

This dissertation in practice is a response to a request for assistance (RFA) submitted by the Virginia Department of Education (VDOE) Office of Student Services (OoSS). To help school divisions meet Standards of Quality (SOQs) and serve student needs, the VDOE OoSS aims to increase the pipeline of licensed school-based mental health professionals (SMHPs). This Capstone examines staffing and service models that create equitable access to student mental health supports using problem and context analysis, a review of literature, and a three-phased mixed methods data collection. Focus group participants consisted of students and practitioners in the fields of school psychology, counseling, and social work. Document analysis of mental health practice integration was conducted for schools implementing advanced tier models in Virginia Tiered Systems of Support (VTSS) and schools implementing VTSS in conjunction with Recognized ASCA Model Program (RAMP) certification. Additionally, a survey was administered to division-level leadership and SMHPs to examine their understanding of the roles and everyday responsibilities of SMHPs in schools across the state of Virginia.

Keywords: student mental health access, school mental health professionals, multi-tiered systems of support

Contents

List of Abbreviations

Abbreviation or Acronym	Definition
ACE	Adverse Childhood Experience
ASCA	American School Counselor Association
AWARE	Advancing Wellness and Resilience in Education
CBITS	Cognitive Behavioral Intervention for Trauma in Schools
CDC	Centers for Disease Control and Prevention
DASH	Division of Adolescent and School Health
GYO	Grow Your Own
MSC	Master Schedule Collection
MTSS	Multi-Tiered Systems of Support
NASP	National Association of School Psychologists
OoSS	Office of Student Services
PELP	Public Education Leadership Project at Harvard University
RAMP	Recognized ASCA Model Program
RFA	Request For Assistance
SBMHS	School-Based Mental Health Services
SEL	Social Emotional Learning
SMHP	School Mental Health Professional
SSWAA	School Social Work Association of America
SOQ	Standards of Quality
TFI	Tiered Fidelity Inventory
T/TAC	Training and Technical Assistance Center
VCU	Virginia Commonwealth University

VDH	Virginia Department of Health
VDOE	Virginia Department of Education
VTSS	Virginia Tiered Systems of Supports
VTSS-RIC	Virginia Tiered Systems of Supports Research and Implementation Center
WHO	World Health Organization

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Introduction: An Urgent and Rising Need

Students' mental health needs are more prevalent than ever in the wake of the COVID-19 pandemic, and how to increase student access to the services they require is at the forefront of educational discussions. The need for increased mental health access for students in both schools and the community is well documented and has only been exacerbated by the pandemic (Hoover & Bostic, 2021; Leiva et al., 2021; Ohrt et al., 2020; Weist, 1997). School mental health professionals (SMHPs) and educators made necessary adjustments in order to meet the academic, social-emotional, and mental health needs of students both in-person and online. Disparities in responses and interventions across states, divisions, and schools, combined with inequitable access to reliable internet and technology, have led to disproportionate access to mental health support for all students, particularly those from low-income families or those living in rural settings (Lancker & Parolin, 2020).

The mental health and well-being of America's children is an important focus for K-12 educators that predates the COVID-19 pandemic. National statistics from the Centers for Disease Control and Prevention (CDC; 2019) paint an alarming picture.

- 1 in 6 U.S. children aged 2–8 years have a diagnosed mental, behavioral, or developmental disorder, and only 20% of those children receive care from a specialized care provider for mental health.
- Of children ages 3-17, 4.5 million have diagnosed behavior problems, 4.4 million have signs of anxiety, and 1.9 million suffer from depression.
- Suicide is the second-largest cause of death for people ages 10-34.

- 1 in 5 U.S. public school students report significant issues of peer bullying.

The Virginia Department of Health (VDH) also conducts a Virginia Youth Survey supported by a 5-year grant with the CDC (VDH, 2019). This survey is randomly administered to middle and high school students in selected schools on odd numbered years. The most recent 2019 survey indicated alarming results. For instance, 72.8% of male, middle school students reported that they "never or rarely get the kind of help they needed" when they were in emotional distress. The number of high school students reporting feelings of sadness for two weeks or more increased by 6.9% from 2011 to 2019, and 39.1% of those high schoolers indicated that they had considered suicide (VDH, 2019).

The COVID-19 pandemic adds another concerning layer to students' mental health. The pandemic has had social, emotional, and behavioral effects on students (Jones et al., 2021; Naff et al., 2020; Pfefferbaum 2021). Since March 2020, students have dealt with increased uncertainty about school. School closures led to decreased social interactions and physical activity, increased screen time for students, and less access to school-based services and support (Pfefferbaum, 2021). Students relying on schools for breakfast and lunch during the school week may have lacked proper nutrition at home. Additionally, students experienced a variety of emotions including fear (of the virus or situations at home), heightened anxiety, grief, loneliness, hopelessness, and even loss of loved ones. Naff et al. (2020) refer to the pandemic as a traumatic event that produced a multitude of psychological concerns with negative emotional, physical, cognitive, or social impacts on students' mental health. As students across the country have returned to schools, there is an urgent need to increase equitable student access to mental health support due to the trauma, anxiety, and loss as a result of COVID-19 as well as the significant need that existed prior to the pandemic.

Increasing Focus: Policy and Resources

Student mental health is an area of concern supported by national and state leaders. On his first day in office in January 2021, President Joe Biden signed an executive order related to meeting the needs of children, families, and staff affected by the COVID-19 pandemic; this guidance addressed trauma-informed care, behavioral and mental health support, and family support, as appropriate (Exec. Order No. 1400, 2021). Congress signed the American Rescue Plan Act of 2021 into law in March 2021, allocating more than $120 billion in grants to states through the Elementary and Secondary School Emergency Relief Fund. The majority of this funding will be distributed to local education agencies, which could use these subgrants to provide mental health services and support and to implement interventions that address learning loss while responding to students' emotional needs, among other purposes (Randi, 2021).

The National Academy for State Health Policy identified multiple federal initiatives regarding the mental health needs of students (Randi, 2021).

- The CDC's Division of Adolescent and School Health (DASH) provides funding at state and local levels to promote health and well-being through schools, including programs and services to support students' mental health.
- Project Advancing Wellness and Resilience in Education (AWARE) provides funding from the Substance Abuse and Mental Health Services Administration to state education agencies to partner with state mental health agencies to increase awareness of mental health in schools, provide training to school staff, and connect students with behavioral health needs to services; and
- The School-Based Mental Health Services (SBMHS) Grant Program, authorized by the 2020 U.S. Department of Education budget, provides $10 million to six

states (including Virginia) to increase the number of mental health service providers in schools.

These state and federal resources could be integral in problem-solving and creatively meeting the mental health needs of Virginia's students, especially on the heels of the COVID-19 Pandemic.

Problem of Practice

After years of advocating for increased mental health services in schools, advocates in Virginia won a crucial battle to gain the support of state legislators. In 2020 and 2021, the Virginia General Assembly passed an amendment to the Code of Virginia to reduce ratios for SMHPs to students, thus increasing the overall number of SMHPs required throughout the state (§ 22 1-253.13:2O, 1996/2021).

New standards became effective in the 2021-2022 school year to increase staffing, however, meeting guidelines for SMHP staffing is a challenge exacerbated by a decline in school support staff over the past decade. According to a report developed jointly by the Commonwealth Institute and the Legal Aid Justice Center, school mental health and support providers decreased by 2,356 positions between 2007 and 2018 (Egerton et al., 2018). During that same timeframe, the student population in Virginia increased by approximately 57,000 students. The decline of SMHPs is markedly higher in schools with larger populations of students of color and in schools with higher populations of economically disadvantaged students. Previous ratios were 1 SMHP per 375 students in elementary school, 1 per 325 in middle school, and 1 per 300 in high school. The Code change now requires all local school boards to employ one full-time counselor for every 325 students in grades K-12. Additionally, criteria defined in the Code of Virginia (§ 22 1-253.13.2, 1996/2021) specify that schools with more than 50% of

students receiving free lunch and reduced lunch hire one school counselor and one school social worker for every 250 students enrolled. In 2021, the Code of Virginia was also amended requiring schools to employ three specialized support personnel school social workers, school psychologists, school nurses, licensed behavior analysts, licensed assistant behavior analysts, or other licensed health and behavioral positions) per every 1000 enrolled students (§ 22 1-253.13.2O, 1996/2021). The original bill included a proposal for a $1 billion increase in school staffing funding from the state but was modified and passed with a $50 million increase in school staffing funds from the state.

Overall, these changes require school divisions to increase the number of SMHPs employed within their divisions based on individual building enrollment. However, there are fiscal constraints to meeting these policy changes. While the Virginia Department of Education (VDOE) provides financial support to school divisions to fill standards of quality (SOQ) positions, there was no specific line item to fund the additional school counseling positions included in the final FY21 State Budget. Each division will need to ensure equity and fund the positions to meet the SOQ staffing requirement. The need for mental health services and supports in schools is clear (Hoover & Bostic, 2021; Leiva et al., 2021; Ohrt et al., 2020; Weist, 1997). Now steps must be taken to equitably meet the SOQ requirements.

Request for Assistance

The Virginia Department of Education's Office of Student Support (OoSS) recognizes the need to expand the pipeline of SMHPs to increase student access to school-based mental health services in schools. They are concerned about school capacity and other barriers to meeting the increased ratio of SMHPs required by the SOQs. In fact, their request for assistance (RFA) through an EdD Capstone states: "Although these initiatives and legislations reflect a

commitment to increasing the number of SMHPs across the state, they do not address the limited pipeline of professionals licensed to work in schools and available to fill these positions (Saimre, 2021; See Appendix A for the full Request for Assistance from the VDOE.)." Additionally, the VDOE OoSS requests included support to outline possible paths to expand the pipeline of SMHPs along with key considerations and recommendations for policy change. To provide this support and a better understanding of the underlying issues at play, we outline relevant literature to inform efforts to improve student access to mental health services in Virginia and meet the state law requirements for increased numbers of SMHPs.

Literature Review

In an effort to understand ways VDOE can increase student access to school-based mental health services, this review of the literature uncovered two overarching themes: staffing and structural system changes. When researching staffing, we considered current policies, laws, and practices of SMHPs. For structures, we considered the roles and responsibilities of SMHPs as defined by the Code of Virginia. We then compared these roles and responsibilities to their respective national organizations, school partnerships with outside mental health providers, programs that are already in place to universally support student mental health, and ways to increase direct access to SMHPs. Table 1 outlines the research questions guiding the review, which align with key themes, while Appendix B outlines search terms used for the review.

Table 1

Research Questions

To increase student access to mental health supports in Virginia schools, we must consider:	
Staffing	● What modifications can be made to existing licensure requirements and options through the VDOE? ● How can the VDOE generate interest with postsecondary students to explore careers as a SMHP? ● What are the recruitment or retention issues preventing SMHP roles from being filled?
Structures	● Are the roles of SMHPs appropriately defined and are responsibilities delegated accordingly and consistently within schools? ● Are there opportunities to integrate outside mental health professionals within schools? ● How can current school staffing be modified to allow increased student mental health support?

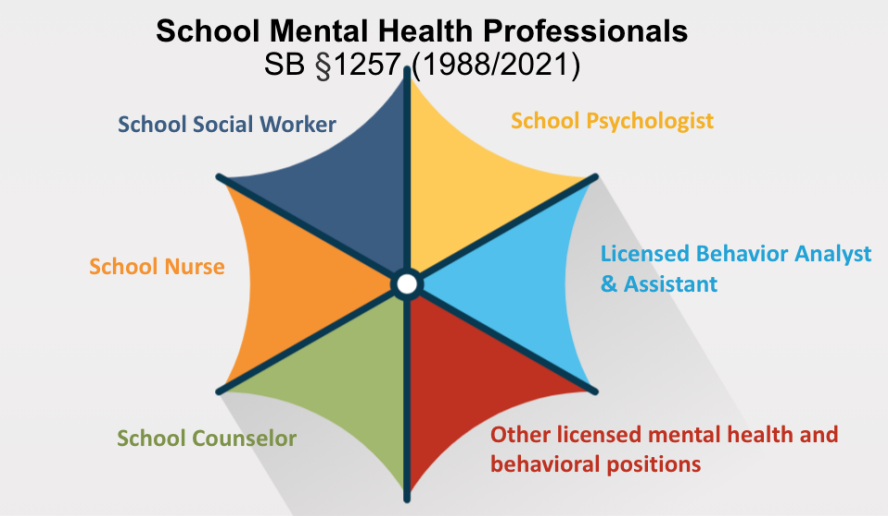
Staffing: Roles, Responsibilities, and Pathways to Licensure

There are various roles under the umbrella of SMHP. Roles include positions with language defined in state code as well as *other* licensed health and behavioral positions (see Figure 1). Individual divisions determine the roles of school social workers, psychologists, counselors, nurses, and other behavior support positions and may vary between schools within a division. Divisions often cite differences in how they utilize SMHPs based on the unique mental health needs within their student population (Gobat et al., 2021). Those differences may also include utilizing SMHPs for various staffing needs such as assisting with standardized testing, facilitating special education meetings, or supporting student supervision in understaffed schools. But these additional responsibilities may have unintended consequences, occupying the bulk of the SMHPs' day and limiting the amount of time dedicated to the mental health needs of students. These inconsistencies in staff utilization can negatively impact the efficacy of

school-based mental health teams (Leiva et al., 2020). Furthermore, inefficiencies can create role confusion, stemming from a lack of role clarity. In a study conducted by Marsh and Mather (2020) teachers reported that they were "unclear" of the roles and responsibilities of SMHPs. A lack of understanding about their roles, especially among teachers who serve as first-responders, may lead to the underutilization, pigeon-holing of current mental health providers or SMHP turnover, ultimately creating barriers to access for students. This is a particular risk if the educational leaders responsible for assigning responsibilities and supervising SMHPs are unclear on their training and background. Therefore, we draw on state and national research to develop a clear understanding of key positions for SMHPs and their staffing functions.

Figure 1

School Mental Health Professionals Listed Under the Code of Virginia §22 1-253.13.2.O (1996/2021)



School Counselors

Per the Code of Virginia (§20-23-670, 1996/2018), the licensure process to become a school counselor requires candidates to complete a master's degree in a state-approved school counseling program in addition to 200 hours of internship or practicum experiences across the

K-12 setting. Of the five outlined positions in the Code of Virginia §22 1-253.13.2.O (1996/2021), school-based counselors, psychologists, social workers, nurses, and other licensed health and behavioral positions, school counselor is the only position with roles and responsibilities defined in state law or regulation. This code further defines the services provided by PreK-12th grade school counselors as:

- Academic guidance which assists students and their parents to acquire knowledge of the curricula choices available to students, to plan a program of studies, to arrange and interpret academic testing, and to seek post-secondary academic opportunities;
- Career guidance which helps students to acquire information and plan action about work, jobs, apprenticeships, and post-secondary educational and career opportunities;
- Personal/social counseling which assists a student to develop an understanding of themselves, the rights and needs of others, how to resolve conflict and to define individual goals, reflecting their interests, abilities and aptitudes. Such counseling may be provided either (i) in groups (e.g., all fifth graders) in which generic issues of social development are addressed or (ii) through structured individual or small group multi-session counseling which focuses on the specific concerns of the participant (e.g., divorce, abuse or aggressive behavior).

At the national level, the American School Counselor Association (ASCA, 2021) developed guidance related to appropriate and inappropriate roles and responsibilities for school counselors. Appropriate activities include a combination of services that support student mental health such as providing individual and small group counseling, consulting with teachers about

noncognitive student needs, and activities that do not directly relate to mental health such as records interpretation and analyzing school data. Additionally, there are activities outlined as inappropriate for school counselors including building master schedules and computing grade point averages, but these activities are part of counselors' responsibilities in some divisions and schools. It is also important to note that, while school counselors should be supporting students with social-emotional learning and mental health needs, ASCA clearly states that "providing long-term counseling in schools to address psychological disorders" is an inappropriate activity for a school counselor.

School Psychologists

Although the Code of Virginia does not outline roles for school psychologists, the National Association of School Psychologists (NASP; 2021) lists school psychologist's responsibilities as (a) direct support and interventions to students; (b) consult with students and their educational team; (c) improve support strategies; (d) work with administrators on school-wide interventions and policies; and (e) collaborate with community providers to coordinate student services. School psychologists in the state of Virginia require a pupil personnel services license (NASP, 2021). To meet the minimum requirements for this license, candidates must complete a state-approved master's program in school psychology and complete a one-year full-time or two-year half-time internship experience.

Although these recommendations were developed and shared by national organizations, school psychologists spend a great deal of time engaged in other tasks not related to providing direct services to students or consulting with other staff (Schaffer et al., 2021). Specific barriers that prevent school psychologists from providing direct mental health services to students include: (a) someone else has that role at their school; (b) there is a lack of time to accomplish all

that is on their plate; and (c) they have a perceived lack of support from the administration and/or their school division (Eklund et al., 2017).

In addition, Schaffer et al. (2021) indicate that school psychologists often spend the majority of their time completing activities related to special education eligibility such as administering assessments, writing assessment reports, and participating in special education eligibility meetings. While school psychologists are qualified to administer and interpret specific assessments, their skill set extends far beyond testing. When determining staffing responsibilities and structures for direct student service, it is essential to consider how to best align the assigned responsibilities of school psychologists with NASP (2021) recommendations, particularly by increasing time allocated to direct student service.

School Social Workers

The licensure requirements for school social workers as outlined by the Code of Virginia (§20-23-670, 1996/2018), require the completion of a master's degree in a state-approved school social work program in addition to 400 hours of supervised practicum or field experiences in a K-12 setting. The School Social Work Association of America (SSWAA) defines the role of school social workers across the following categories: (a) related services; (b) services to students; (c) services to parents and families; (d) services to school personnel; (e) school and community liaison; and (f) services to divisions (SSWAA, 2021). Within each category, four to six action steps are listed, with most services and action steps related directly to student mental health. Some examples include providing individual counseling, assisting parents with accessing community mental health resources, assessing student mental health concerns, assisting teachers with mental health interventions, and communicating with staff about concerns that may impact a student's behavior and engagement. These recommended roles for school social workers are

fully or partially adopted by some divisions, as divisions and schools ultimately determine how school social workers will be used to provide services since it is not outlined in the Code of Virginia.

A descriptive study of the role of school social workers found that a lack of understanding of school social workers' roles within divisions and schools often led to organizational inefficiencies across student support teams and underutilization of social workers' training and expertise, even seeking external support rather than relying on division-level talent (Forenza & Eckhardt, 2020). While school social workers' primary roles include providing direct services to students and families and linking families with external resources, schools and divisions often lack understanding of their skill sets. This results in role misalignment, which may ultimately lead to job dissatisfaction and attrition (SSWAA, 2021).

School Nurses

While a majority of the literature reviewed focused on school counselors, school psychologists, and school social workers, researchers also underscore the significant role of school nurses. School nurses are considered SMHPs under the Code of Virginia (§22 1-253.13.2.O, 1996/2021) and they are an essential link facilitating partnerships between school and community mental health agencies (Bains, 2015). When developing structures and service models related to providing direct support to students, school nurses act as liaisons with outside agencies and serve as members of the school mental health planning team (Bohnenkamp et al., 2015). Furthermore, school nurses are clinically trained to handle mental health needs (Weist et al., 2020). In fact, some divisions reported that school nurses spent up to 33% of a school day addressing mental health, but school nurses are often not considered part of the "mental health team" (Bohenkamp et al., 2015).

The exclusion of school nurses from the mental health team may be attributed to the variation in school nurses' training, experiences, and licensure status across Virginia (VDOE, 2021a). A school nurse must be a registered nurse in the state of Virginia, but no other specific requirements exist. Additionally, divisions are not currently mandated to have a school nurse in each school within their division (Virginia Association of School Nurses, 2021). This lack of guidance related to both licensure pathway and staffing requirements makes it difficult for schools and divisions to consider how school nurses can and should be used to provide student mental health support.

Other Licensed Health and Behavior Positions

Although VDOE released a guidance document defining *other licensed health and behavioral* staff (VDOE, 2021a), a great deal of ambiguity exists regarding who can serve in these roles to meet new ratios. For example, employed and contracted personnel may include licensed community mental health providers, marriage and family counselors, and nurses. Schools have significant discretion to make decisions based on the mental health needs of their student populations. However, this creates a fragmented and inequitable system where some schools can employ innovative staffing strategies that truly meet students' mental health needs, whereas other schools lack the capacity and resources to adequately staff their SMHP team.

Summary

Currently, candidates interested in seeking positions as a school social worker, school counselor, or school psychologist must complete a state-approved master's program and an extensive internship or practicum experience in the field. Time and financial commitments to meet these requirements could deter individuals from seeking these career paths. The newly added category of other licensed health and behavioral positions provided some flexibility for

those seeking licensure in SMHP roles, although the lack of clarity outlined in the guidance document may discourage school divisions from hiring these professionals.

Our review also indicates there is limited research on the roles of SMHPs and how they use their time. With roles and responsibilities often left to the division to define, there could be great variation between job functions, services provided, or student access to these SMHPs. The National Association of School Psychologists in their 2020 Membership Survey report that 88% of school psychologists surveyed spend "quite a bit to a great deal of time" on evaluation tasks, yet only 47% report spending the same amount of time on mental and behavioral health services (Goforthet al., 2020). These differences in student access and services have the potential to lead to further inequities and perpetuate student mental health needs.

Recruitment and Retention

Research suggests recruitment and retention efforts are critical to maintaining a strong supply of SMHPs (NASP, 2021). However, the misalignment of current roles and responsibilities for SMHPs may make it difficult to purposefully recruit candidates. Each of the outlined SMHP positions requires a separate licensure pathway and therefore should be recruited individually. Since limited research and workforce data exist on various positions under the SMHP umbrella, divisions are inhibited from strategic recruitment and retention of SMHPs to reflect their needs and the new policy. We discuss recruitment and retention as key components of staffing.

Recruitment: "Grow Your Own" Programs

"Grow Your Own" (GYO) programs are recruitment methods that establish a pipeline of local residents for employment (Schmitz et al., 2021). Although limited research exists on GYO programs for recruiting SMHPs, Schmitz et al. (2021) indicate that GYO programs offer potential solutions to recruit candidates interested in education from special education or related

health professional programs, but researchers also acknowledge that the sustainability of these programs can be enhanced with university partnerships and federally funded grants that provide financial assistance to students returning for graduate training. Indeed, these findings suggest that additional evidence from teacher recruitment programs may be adapted to meet SMHP recruitment needs.

GYO programs are mostly associated with teacher recruitment and development in schools, but these existing programs can provide a template for developing a SMHP GYO program. These initiatives can also support the recruitment of diverse SMHPs. Lindeman (2020) emphasizes that the GYO programs supporting community and paraprofessionals are successful in recruiting diverse teacher candidates. GYO programs also offer social and financial support, intensive mentoring, and flexibility for completion, which enables programs to attract non-traditional candidates, while providing the structural support necessary for success. Evidence from a GYO in Washington State that allows high school students to participate in collegiate coursework for teacher preparation programs indicates that, with state grants for increased university-school division partnerships, the program increased recruitment of bilingual teachers (Garcia et al., 2019). Although there is no existing literature on GYO programs for SMHPs, the findings may be generalizable to SMHP recruitment efforts.

Retention

Recruitment, however, is only one aspect of staffing, it is equally important to retain SMHPs. In general, retention may be supported through incentives, increased salaries, and job satisfaction. There is also research to suggest that clarity in roles and responsibilities may have a direct impact on retention. School psychologists that reported the least amount of role ambiguity

reported higher levels of job satisfaction (Brown & Sobel, 2021), which suggests clearly defined roles and responsibilities may correlate with higher retention.

One policy tool often used to recruit and retain workers is financial incentives. Although studies show mixed effects, research from the teacher workforce suggests financial incentives are commonly used for recruiting and retaining teachers. Teachers are drawn to working in qualifying schools or may consider high-need subject-area fields when they have access to loan forgiveness options such as the TEACH Grant, Stafford Teacher Loan Forgiveness, or Perkins Loan Teacher Cancellation (U.S. Government Accountability Office, 2015). However, there are fewer federally-funded or state-based loan forgiveness options for school counselors, school social workers, and school psychologists. SMHPs, in addition to teachers, are mainly eligible for loan forgiveness through the Public Service Loan Forgiveness Program, but barriers such as no late payments for a consecutive decade often limit this program's accessibility. In the most recent version of the Higher Education Opportunity Act (2008), mental health professionals became eligible for loan forgiveness if they worked in a low-income area. Lastly, the only option specific to SMHPs is loan forgiveness through the Patient Protection and Affordable Care Act, Title V: Health Care Workforce (NASP, 2021). Making loan forgiveness programs available to all professional school employees could facilitate the recruitment and retention of SMHPs.

Structure: Current Mental Health Practices

Increasing SMHPs in schools is an important component to supporting students' mental health. However, this does not necessarily ensure students' access to *high-quality* mental health support (Bains & Diallo, 2016). The collective success of school-based mental health programs and their sustainability warrants additional considerations for structures, programs, staffing, and community connections. In 2005, Dr. Carl Paternite reviewed school-based mental health

practices and determined the following criteria were essential to the success of school-based mental health programs:

- School-family-community agency partnerships
- Commitment to a full continuum of mental health education, mental health promotion, assessment, problem prevention, early intervention, and treatment
- Services for all youth, including those in general and special education

These are essential components of a larger structural framework designed to support the mental health needs of students. Extending these components, Kern et al. (2017) made the recommendation to establish systems of care with community mental health service providers, revenue sources, juvenile justice facilities, and others to create the needed networks of support.

A full continuum of mental health education and services for youth should be natural starting points for many schools. Mental health supports in schools may include a number of interventions such as mental health literacy, direct instruction on coping skills, instruction on brain function in emotion regulation, small group therapy sessions, and trauma-informed practices (Berger & Martin, 2021). While schools continue to work to best support their students, all areas must be addressed individually but no one component can be considered in isolation as student mental health is multifaceted. It is imperative to view the complex nature of student mental health support within the context of a defined structure rather than addressing mental health practices, student access points, and leveraging staff skills in isolation.

Mental Health Structures in Schools

Current mental health approaches are varied and implemented differently across contexts. Schools in the United States recognize the importance of creating interventions that match the needs of their specific populations while also providing a level of universal services for all

students (Marsh & Mathur, 2020; Paternite, 2005; Splett et al., 2018). In order to provide targeted interventions to match student needs, data on student needs must be collected. Some schools and divisions report major concerns with the ethical implications of implementing a universal screener because they may not have the capacity or resources to meet student needs identified from universal student screening programs (Marsh & Mathur, 2020; Splett et al., 2018; Whitaker et al., 2018). Briesch, Chafouleas, and Chaffee (2017) identified additional barriers with the implementation of universal screeners:

> (a) teachers' concerns that their input will be reduced, (b) additional work involved, (c) potential stigmatization of identified students, (d) questions about the validity of discrepant rates of disorders related to gender, race/ethnicity, and economic status, and (e) parental concerns about labeling and consent (p.148).

As a result, until robust structures are adopted, many schools continue to implement whole school programs that support social-emotional learning, mental health awareness, and trauma-informed practices (Arnold et al., 2020).

For example, a school in Wales, unable to increase staffing, applied a whole-school restorative approach that entailed various efforts such as: identifying innovative local practices, reviewing evidence-based programs, establishing an action research committee to include multiple stakeholders, and planning for feasibility and outcome evaluations (Gobat et al., 2021). Using an action research approach, Gobat and colleagues identified strengths and weaknesses of the restorative approach, but their key findings highlighted structural concerns including alignment of the approach, funding, staff training, and policy alignment rather than their specific intervention model. They emphasized the importance of using existing research and models to support students with new and innovative practices.

PREPaRE Model. The PREPaRE model is a nationally designed curriculum describing the roles and responsibilities of educators who serve on school crisis response teams. While this model was developed to leverage pre-existing structures within schools and to help prevent and prepare for crises, it also addresses the mental health implications associated with crises. Given that all schools are required to have a school crisis response team, the NASP developed a sequential acronym defining action steps to be taken by the team in order to meet students' needs (Brock et al., 2016):

P-Prevent and prepare for psychological trauma

R-Reaffirm physical health and perceptions of security and safety

E-Evaluate psychological trauma risk

P- Provide interventions

a-and

R-Respond to psychological needs

E-Examine the effectiveness of crisis prevention and intervention

The PREPaRE model was developed to reflect the school setting and aligns with all federal guidance related to crisis response and emergency management (Schaffer et al., 2021). This model is heavily focused on the prevention of both physical and mental trauma (Brock et al., 2016), with an emphasis on crisis prevention and preparedness. Under this model, crisis management training is required annually for school and division-level teams, which ensures consistent messaging and learning, even if schools experience staff turnover.

A limitation to this program is that it does not address the mental health needs of students who are not experiencing a crisis. Though some students may be identified as needing additional support during the *response to mental health needs* portion of the intervention, that would only

occur in the event of a school safety or crisis situation. Therefore, the PREPaRE model is limited holistically, and it is unable to meet the full spectrum of students' mental health needs. PREPaRE may be adopted as part of a larger structural student mental health program, but schools should also consider complementary practices in order to develop a comprehensive mental health service model that supports all students, not only those experiencing crisis situations.

Multi-Tiered Systems of Support. The term *multi-tiered system of support* (MTSS) is used to describe a structure where all students have access to universal intervention for academics, behavior, or social-emotional learning (SEL) (Marsh & Mathur, 2020; Splett et al., 2018; Stephan et al., 2015). While all students have access to tier 1 universal support, students in need of additional support have access to a system of tiered interventions designed to meet their individual needs. This model of tiered supports can be applied to mental health as well.

Core Components of MTSS. While all students' needs may not be met in school, schools are the primary mental health access point for youth in the United States (Arnold et al., 2020). The World Health Organization (WHO) recommends four levels of mental health intervention (Kumar, 2021):

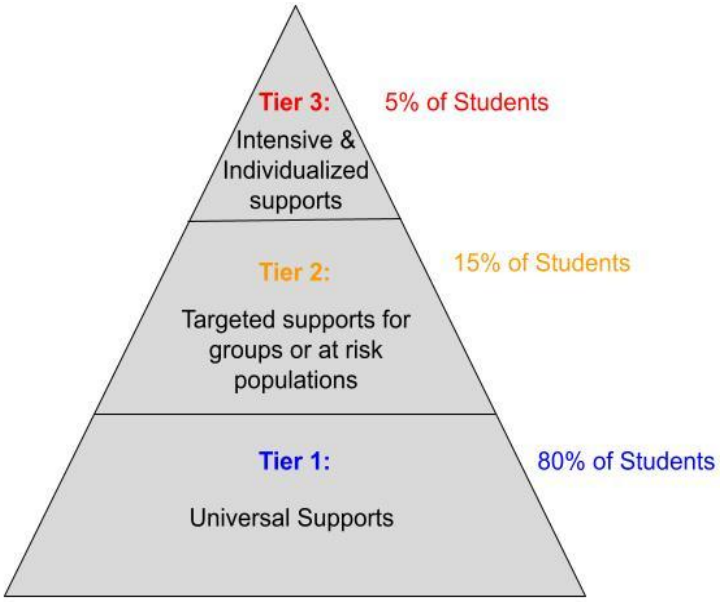
1. Mental health supports are integrated into school curriculum.
2. Focus on mental health education in the general curriculum.
3. Focus on students who need additional psycho-social interventions.
4. Focus on students who need professional help.

Figure two illustrates what percentage of students are anticipated to receive each level of support in a mental health MTSS model. All students have access to tier 1 supports, but approximately 80% of students will access these supports, which include instruction on SEL, positive behaviors, classroom expectations, core academic instruction, and how to access

additional supports. Tier 2 supports are inclusive of tier 1 supports and are typically accessed by approximately 15-20% of students. Examples of tier 2 interventions may include group sessions with school counselors, check in/check out with trusted staff, academic tutoring groups in addition to classroom instruction, or other small group interventions. Tier 2 services align with the WHO's third recommendation and incorporate psycho-social interventions. Students accessing tier 3 require individualized interventions in addition to tier 1 and tier 2 interventions. Tier 3 services may include: check in, check out with a trusted staff member; school counseling group sessions; individual meetings with the school counselor; mentoring; family engagement activities; social skills instruction; or clinical interventions (Anderson & Borgmeier, 2010). Referral to school-based mental health services and/or outside clinical interventions in tier 3 supports the WHO's final recommendation, linking students with professional mental health supports.

Figure 2

Multi-Tiered Systems of Support Intervention Model



Note: This figure was adapted from a tiered systems model developed by The National Center for Pyramid Model Innovations. *Pyramid model overview.* University of South Florida. https://challengingbehavior.cbcs.usf.edu/

Data-driven decision-making is a basic tenet of all MTSS models (Splett et al., 2018), but despite the availability of data (e.g., attendance information, grades, discipline referrals, etc.), data may not be regularly reviewed or used to drive decision-making. Therefore, constant review of student data and individual trends should be implemented to identify students in need. This data alone will not support the identification of students requiring tier 2 or tier 3 mental health interventions as some students may not present externalizing behaviors, therefore reliance on these data sets could limit identification of these students. It is for this reason that staff referrals

and the incorporation of universal mental health screeners should be considered in the identification process.

The MTSS model is a widely used mental health approach because it enables broad identification for services, even if students are not identified during a screening process or if they refuse additional levels of intervention. In a study conducted by Splett et al. (2018), researchers found that schools using an MTSS model and universal mental health screeners were better able to identify students in need of mental health support and collect data to inform evidence-based strategies for supporting students' needs. Importantly, once students are identified, schools must adopt a clear and consistent framework to ensure continuity in services. In some schools, the MTSS plan may encompass academic, SEL, and mental health strategies and interventions into one framework. This implementation strategy recognizes the interconnectedness of each facet of the student's experience and success, but tiered interventions may vary between school and division contexts based on resources, capacity, and student population, therefore specific data must be collected to address division specific needs.

The Role of SMHPs in MTSS. While SMHPs are still integral to meeting the needs of students, MTSS models leverage existing staff to provide targeted services to students. For example, a student who has a noted change in attendance or one who becomes more withdrawn may benefit from daily check-ins with a trusted staff member. In this case, that student may still require individual or group counseling with a SMHP but would have continuity of access to other supports with daily check-ins with the staff member. A school with a well-developed MTSS model will be able to identify what specific intervention in their tiered system is necessary, either group or individual counseling, and identify which SMHP will be providing those services. This maximizes opportunities for clinical intervention, while ensuring students

receive the most appropriate service from a SMHP for targeted intervention (Marsh & Mathur, 2020).

Virginia's Use of MTSS. Virginia has its own framework that aligns with the same structures as MTSS. The Virginia Tiered Systems of Supports (VTSS) is used to establish a process to provide academic, behavioral, and social-emotional support to students. There are currently 58 school divisions of 133 (44%) in Virginia implementing the VTSS model (VTSS, 2021). VTSS itself is not a set of specific practices or strategies. Instead, VTSS is a data-informed decision-making framework used to impact processes including:

- Aligned Organizational Structure
- Data Informed Decision-Making
- Evidence-Based Practices
- Family, School and Community Partnerships
- Monitoring Student Progress
- Evaluation of Outcomes and Fidelity

VTSS Systems Coaches assist divisions and schools by supporting them as they create a solid framework that incorporates systems, data, and practices in order to facilitate student outcomes. The *practices* component focuses on identifying evidence-based practices across academics, behavior, and social-emotional wellness to meet divisions and schools' needs (VTSS, 2021).

Each school and division participating in VTSS completes a Tiered Fidelity Inventory (TFI) annually to determine the extent to which core components of VTSS are being implemented within the division and school (Algozzine et al., 2014). Virginia recently created a tool that can be used in conjunction with the TFI titled *TFI Companion Guide: Mental Health Planning Tool* (VTSS, 2021). This tool is intended to be used as an action planning resource for

divisions and schools seeking to incorporate mental health supports into their VTSS framework. During the 2020-2021 school year, 18 schools in Virginia used this Mental Health Planning Tool. Its incorporation demonstrates that evidenced-based mental health practices are now being considered within the VTSS framework within some schools.

While MTSS and VTSS frameworks can be incorporated into any existing school structure, inadequate structural elements related to resources and capacity can impede its implementation. Indeed, a sustainable and successful MTSS or VTSS model requires ongoing data collection and analysis, assigning and monitoring of staff members providing tiered interventions, training for all staff members, and regular communication with the community. Additionally, these action steps require oversight and a shift in the allocation of duties, at minimum, to ensure successful implementation. Such oversight can be managed by redistribution of duties among staff in order to leverage the strengths of their team members, potentially using testing coordinators to monitor data collection and analysis while administrators or teachers plan for professional development and community communication. In this way, all team members make valuable contributions to student mental health based on their training and expertise.

Evidence-Based Mental Health Practices in Schools

Social-Emotional Learning (SEL). The terms *mental health* and *social-emotional learning* are often used interchangeably. While SEL is not synonymous with mental health, it is an important practice to consider within structural supports for student mental health. SEL is a process that supports students in developing healthy habits, relationships, responsibility, and self-awareness (CASEL, 2019). In addition to promoting healthy behaviors and success among students, SEL is also an evidence-based practice that supports student mental health. Some schools and divisions use internal resources to develop SEL lessons that are taught to students by

their classroom teacher, a counselor, or presented in a prerecorded format. There are also many packaged SEL programs that schools and divisions may choose to purchase, allowing them to implement a prewritten SEL curriculum. Whether created internally or purchased through a vendor, SEL programs are often implemented as universal interventions, with all students receiving baseline SEL instruction, an evidence-based practice that supports student mental health.

In 2019, Dr. Thayer and a research team from the University of Minnesota examined *Second Step*, a universal SEL program implemented in primary schools in five school divisions. To account for baseline mental well-being of students, researchers used a Dual Continua Model of Mental Health to assess student mental health outcomes, determining that SEL was an effective strategy to support student mental health, but noted that it was not truly a universal intervention as specific supports were provided to students based on needs identified by school staff (Thayer et al., 2019).

Similar findings emerged from an assessment of a different SEL program, *SPARK,* with middle school students in two middle schools in a large southern school division (Green et al., 2020). Both SPARK and Second Step incorporate SEL recommendations from CASEL, focusing on resilience, emotional regulation, problem solving, decision-making, and empathy building (CASEL, 2019). Green and colleagues (2020) found that school-based delivery of tiered SEL instruction resulted in positive mental health and academic outcomes for adolescent students. Yet these outcomes are dependent on how SEL instruction is delivered to students and which staff members are providing that service. For example, professional development to support teachers in SEL instruction increases student access to an evidence-based best practice in mental health

support without requiring direct service from an SMHP. This is one step to building capacity within a larger structure for school-based mental health support.

Cognitive Behavioral Intervention for Trauma in Schools (CBITS). Cognitive behavioral intervention for trauma in schools (CBITS) is an evidence-based mental health practice designed for the school setting. CBITS is a group counseling intervention designed to reduce depression and post-traumatic stress disorder symptoms in adolescent students who experience traumatic events (Jaycox et al., 2012). Unlike SEL, which can be implemented by any school employee with training on SEL, CBITS requires a mental health clinician with training in cognitive behavioral therapy (Langley et al., 2010). Due to the level of specialization required to provide this support, and the intensity of the intervention, this mental health practice would only be appropriate for students experiencing a traumatic event negatively impacting their mental health rather than an intervention for all students. Students in need of this level of support may be identified through universal screening, review of academic and behavioral data, staff referral, or referral by the student or parent.

Langley et al. (2010) noted positive academic, behavioral, and social-emotional outcomes for students who participated in CBITS. The entire implementation of CBITS takes approximately 10 weeks with only weekly meetings. Implementation barriers identified in the study were competing responsibilities, parent engagement, logistics, and support from administrators and teachers. Researchers also highlighted that schools experiencing the most success with CBITS implementation were those partnering with community-based mental health providers, which enabled schools to build structural capacity to focus on other interventions. It is, however, possible for SMHPs with appropriate training to provide this intervention. While this has the potential to be a highly effective strategy to support students who experience

significant trauma, it is important to consider this within the context of both structural and staffing decisions. The school's internal capacity and community-based partnerships may affect adequate staffing and structural implementation.

Trauma-Informed and Trauma-Sensitive School Programming. While CBITS is designed to support smaller groups of students who experience significant trauma, there are other approaches that can be employed to support larger groups of students through universal interventions. In the mid-1990s the CDC and Kaiser Permanente conducted a study on Adverse Childhood Experiences (ACEs) and their impact on the social, emotional, and physical well-being of adults who experience early adversities (CDC, 2021a). Findings indicated a strong correlation between high levels of ACEs and negative adult outcomes, especially for individuals exposed to challenging living and work conditions.

Based on the study's findings, public sectors sought best practices for both preventing ACEs and supporting students and adults with these experiences (CDC, 2021a). In medical and behavioral health fields, practitioners are able to seek out training and certification to become *trauma-informed* practitioners (Trauma and Learning Policy Initiative, 2021). Some educators also choose to participate in training or certification to become trauma-informed while other educators and schools may strive to become *trauma-sensitive.* This term is used to describe an individual or organization who has a basic understanding of trauma and ACEs and uses that knowledge to create an environment where all students can learn and experience success regardless of potential traumatic experiences or cumulative effect of adverse events. Any staff member has the ability to become a trauma-informed professional through professional development, regardless of their job title or educational background.

Successful implementation of trauma-informed practices is contingent on multiple factors (Morton & Berardi, 2018), including staffing. Morton and Berardi (2018) recommend that teachers should be provided with basic training on the nature and impacts of trauma to inform their practice and empower them to seek out additional resources from licensed clinicians when necessary. Incorporation of trauma-informed practices as a tier 1 intervention is an opportunity to build internal capacity for meeting student mental health needs with minor modifications to existing staffing and structures.

The need for trauma awareness is exacerbated by the COVID-19 global pandemic and school closures. Students who struggled to thrive in a traditional classroom under normal circumstances were more likely impacted by a temporary closure compared to a peer better able to adjust to independent learning (Wall, 2021). Just as SEL is not synonymous with mental health, neither is trauma. Many mental health issues and trauma can result in negative behavioral, social, physical, and academic outcomes for students. Fortunately, providing universal support using SEL strategies and supporting resilience are tenants of trauma-informed practice. This means that many universal tier 1 interventions are likely to have positive impacts on most students regardless of their academic, behavioral, or social struggles.

Responding to Structural Barriers of Student Mental Health Access

Even when a comprehensive, tiered mental health structure exists, barriers can still limit or prevent students' access to services. Barriers may include but are not limited to, Medicaid eligibility, prohibitive practices for students needing multiple tiered services, continuity and effectiveness of SMHPs, demographic stigmas, and culturally competent practices (Anderson & Borgmeier, 2020; Jones et al., 2021; Lancker & Parolin, 2020; Marsh & Mathur, 2020). It is

essential to recognize and identify these barriers in order to increase equitable access and remove extraneous variables that may limit the effectiveness of MTSS.

Students in schools with existing mental health frameworks may not be entitled to access all levels of support due to prohibitive practices such as requiring Medicaid or limiting access to a single tiered service per student. For example, some schools or divisions do not allow tier 2 or 3 referrals for students receiving special education or other services (Marsh & Mathur, 2020). This is particularly concerning when you consider systems with multifaceted MTSS frameworks that incorporate academic, SEL, and mental health supports. Denying students access to advanced tiered interventions and mental health services because they are receiving another specialized service, like special education, fails to meet the mental health needs of those students. While it is important to consider each case on an individual basis as not to over-serve students, there should be few, if any, circumstances where students are prevented from accessing mental health services in schools.

Data indicate high turnover rates for mental health professionals, especially among those working in entry-level clinical positions, as another barrier to accessing services (Shapiro et al., 2020). School systems have very little control over staffing within external partner organizations; therefore, maintaining continuity of services is another barrier to developing consistent and effective mental health support. Even when fully staffed, not all SMHPs have the same skills and expertise to successfully meet the varying mental health needs of students. Determining who delivers these supports, how they are delivered, which supports are appropriate for all students, and when students have access to the supports are crucial in removing barriers to student mental health services (Bains & Diallo, 2016; Paternite, 2005).

Stigmas associated with mental health support in certain demographic groups also serve as barriers. Males, for example, have the highest suicide rate of college students but were less likely than their female peers to seek mental health support (Sagar-Ouriaghli et al., 2020). Young men are more likely to seek support if they perceive interventions will be different from what women receive and if they interact with male mentors. Although Sagar-Ouriaghli et al. (2020) focused on college-aged students, Whitaker et al. (2018) identified similar findings when assessing the predictors of mental health access and retention in K-12 schools. Researchers found that male students, African-American students, and students in low-resource settings were less likely than their peers to continue mental health services after their first visit. This is concerning because students in these demographic groups are often disproportionately suspended in schools (Riddle & Sinclair, 2019) and access to proactive interventions and services may prevent unnecessary suspensions. Additionally, services are also essential to support students as they transition back into the classroom after extended suspensions.

While many factors contribute to students seeking continued services, school contextual factors and the demographic makeup of SMHPs play a pivotal role in reversing this pattern (Lester et al., 2013). Although these studies focused on a slightly older demographic, findings suggest the need to consider not only what services are provided to students, but also who is providing these services. Service structures and staffing are interconnected and must be considered simultaneously to effectively support students.

Community Mental Health Centers and School Partnerships. To expand staffing and structural capacity, community-based mental health providers may include, but are not limited to, private clinical psychologists, social workers, psychiatrists, or behavior analysts and technicians. These individuals provide mental health services to students through third-party contracted work

or as full-time employees of school divisions hired in a non-traditional clinical capacity (National Center for Pyramid Model Innovations, 2021), which may be appropriate for large divisions unable to staff existing positions. Rural and small divisions may also benefit from part-time or contracted roles due to low enrollment numbers or the geographic barriers preventing shared staff (Traub et al., 2017). This joint approach adds clinicians to the building during the school day and creates the highest level of access for students, bypassing financial, transportation, and scheduling barriers for students and families. Additionally, these partnerships may strengthen racial, ethnic, and gender diversity in the SMHP workforce.

Collaborating with outside providers and agencies could significantly impact student access to mental health services. It also develops the groundwork needed to establish more complex systems and networks between schools and mental health organizations (Hoover & Bostic, 2021). This may include data sharing related to student universal mental health screeners and collaboratively developing tiered systems of support across the school and other agency settings. Establishing systems of care that increase student access to mental health professionals in and outside of schools creates opportunities for increased revenue sources through policy change within the school system and in local government while increasing equitable access to quality mental health services for students (Kern et al., 2017).

Virtual Mental Health Services. Although virtual instruction and mental health services existed for years prior to the pandemic, the COVID-19 pandemic illuminated inequities within student mental health services. For some families and students, accessing virtual services proved to be more effective and efficient (Rusch et al., 2021). However, low-income families and families living in rural internet deserts experienced greater difficulty accessing mental health support. Even when agencies were able to reach families, they were faced with stigmatization

and skepticism often associated with virtual counseling. The pandemic also forced some community-based mental health providers and SMHPs to adapt to online counseling support, learning to accommodate and shift practices to a virtual setting. These shifts may affect their ability to evaluate nonverbal cues and assess the physical demeanor of the student (Stoll et al., 2020). Additionally, a virtual environment limits their ability to assess students' comfort level--whether students are in close proximity of family members or peers--which may impact their willingness to share information with the community-based mental health providers or SMHP. While virtual mental health services do increase opportunities to receive support for many students, recent events also underscore structural inequities.

Summary of Literature Review

Collectively, our findings on staffing and structures of SMHPs indicate inadequacies for meeting students' mental health needs based on current staffing and service models. Evidence based practices are used in some settings, but they are reactionary and unsustainable. Disparate levels of access to mental health services and inconsistent staffing across the nation create alarming inequities in student access to mental health support. Virginia took a critical step in the right direction by increasing SOQs for SMHPs in Virginia. This step alone will not increase equitable student access to mental health support, but sets the stage for VDOE action, future policy and recommendations for best practice.

Theory of Action

Through literature review and analysis, the team identified key themes related to staffing and structures that are integral in the development of a comprehensive plan to address student mental health access. The team used the PELP Coherence Framework (Appendix C) as a diagnostic tool to outline implications related to culture, stakeholders, resources, systems, and

structure (Public Education Leadership Project at Harvard University, n.d.). This framework links strategies and environments to provide sustainable coherence through a theory of change that connects current practices to desired outcomes. We propose the following theory of action: If VDOE offers guidance to school systems on how to implement a tiered system of supports with clearly defined staff roles and student mental health access points, then VDOE will support Virginia schools as schools work to increase and sustain staffing of school mental health professionals while ensuring equitable access to quality mental health supports for all students. Data collected through the implementation of a tiered system both supports fidelity and creates a robust data set for VDOE as they make future SOQ recommendations.

Methods

Positionality

Our Capstone team is composed of five Doctor of Education candidates in Leadership. Our proposed theory of action reflects the varied experiences and insights we bring as an interdisciplinary team of school and community educators. All team members identify as middle-class, White females and provide perspectives from elementary and secondary public schools across the state of Virginia and across rural and suburban settings, including trade and technical and virtual school settings, as well as the private sector in museum education. During the Capstone process, one team member took a position as a VTSS Systems Coach; however, there was prior knowledge with all team members related to VTSS and MTSS before this career change. Although no team member is a licensed SMHP, our various roles in educational and community organizations afford us insight into various opportunities and challenges of responding to VDOE's Request For Assistance.

Overview of Study Design

We employed a mixed-method approach to examine how Virginia's schools can increase the number of SMHPs in schools and expand access to mental health services for students. We collected data to identify current student mental health practices and service delivery pathways in schools, divisions, and communities. Data were identified from document analysis, surveys administered to division-level SMHP leadership and practicing SMHPs, and focus groups with students in various mental health fields. This mixed-method approach utilized a convergent parallel design that allowed us to examine quantitative data through statistical analysis of survey responses and employ a contextualized approach through qualitative methods to identify existing systems for student mental health support, roles and responsibilities of SMHPs in Virginia, and recruitment and retention barriers exist in SMHP pipelines (Castro et al., 2010; Creswell & Pablo-Clark, 2011). The following research questions outline guiding questions for this study.

Research Questions

The guiding research question for this study was: *How can VDOE ensure that Virginia schools and students have access to high-quality mental health services?* To capture aspects of staffing and structure, we explored the following questions:

1. Which divisions have effectively addressed the mental health needs of students? In these divisions, what is their pipeline for SMHPs? What strategies, resources, and practices are in place in these divisions to ensure the use of high-quality providers and equitable access to mental health services?
2. How are roles and responsibilities for SMHPs in school divisions defined across Virginia? How and in what ways are current SMHPs used in school? (SMHPs to include: school psychologists, school social workers, school counselors, school

nurses, licensed behavior analysts and assistants, and other licensed mental health and behavioral positions.)

3. What attracts SMHPs to work in schools? What strategies are currently being used to recruit SMHPs to the workforce? What barriers in recruitment or retention exist that could affect the pipeline and licensure for SMHPs?

Data Collection & Participants

Our fieldwork consisted of three phases, spanning three methods of data collection that aligned with our research questions. The methods and participants are described below.

Document Analysis. The Capstone team reviewed 235 school websites, and then 42 websites associated with each school's division in an effort to identify eight to ten exemplar schools or divisions with student mental health programs or structured mental health access points available to students. We identified a total of seven documents that outlined the roles of SMHPs and/or mental health access points for students in schools, then conducted an additional search on the websites of each SMHP's national organization which resulted in three additional documents for analysis. Data from these ten documents were collected and analyzed through an iterative process to identify emerging themes.

These exemplar schools and divisions were identified by cross-referencing the list of Recognized ASCA Model Program (RAMP) certified schools with a list of Virginia schools implementing VTSS. We then conducted a document analysis of mental health supports within these schools and divisions to identify best practices as well as limitations. Documents included MTSS Resource Maps, school board presentations, SMHP staffing allocations, job descriptions of current SMHPs and job postings, school websites, and MTSS staff manuals. All documents were public facing and acquired through websites, publications, and presentations. Due to

limited Virginia-based documents, we did not reach theoretical saturation with our document analysis, but addressed these limitations by reviewing professional MTSS publications and Positive Behavior Interventions and Supports (PBIS) national conference materials to identify schools, divisions, and states nationwide that incorporated mental health supports into practice.

Survey. The purpose of the survey was to gain a better understanding of roles and responsibilities of current SMHPs. To identify similarities and differences in the perception of roles and responsibilities, the survey targeted division and school supervisors and administrators and practicing SMHPs. All participants were sent an introduction email outlining the reason for the survey. The email also shared that participation was optional and that there would be a small incentive with one randomly selected participant receiving a $10.00 Amazon gift card. Appendix D includes survey questions administered through QuestionPro. The survey consists of eight questions focusing on demographics, job title, and work experience and six questions requiring participants to allocate the amount of time spent on specific job related tasks. These six questions were broken into the following categories: *administrative tasks, testing/evaluation/assessment, meetings,* and *student services.* The list of job tasks and responsibilities was developed using recommendations made by the American School Counselor Association, the National Association of School Psychologists, the School Social Work Association of America, and responsibilities identified during the literature review process (ASCA 2021; NASP, 2021; & SSWAA, 2021). The final question was an open-ended response item, prompting participants to provide additional information about staffing and structures related to school mental health professionals.

We originally identified one school within each of the eight superintendent regions in the state and were intentional about choosing school divisions with varying enrollment sizes to

account for geographic and student diversity across the state. We first emailed the superintendents of each division to explain our research and request permission to distribute the survey. Some division superintendents responded immediately granting permission for the survey, two never responded, and others had a committee or approval process. Some of these processes were rather involved and, therefore, could not be completed within our timeline. This resulted in six of the eight divisions represented in the survey, with no representation from Regions 7 and 8. To capture the demographics of the missing rural regions, additional rural schools with similar populations within Regions 1 and 3 were invited to participate. The percentage of participants by region is indicated in Figure 3, which varies by region size and population. Table 2 illustrates demographic information for school divisions that participated in the survey.

Figure 3

Survey Respondents by Region

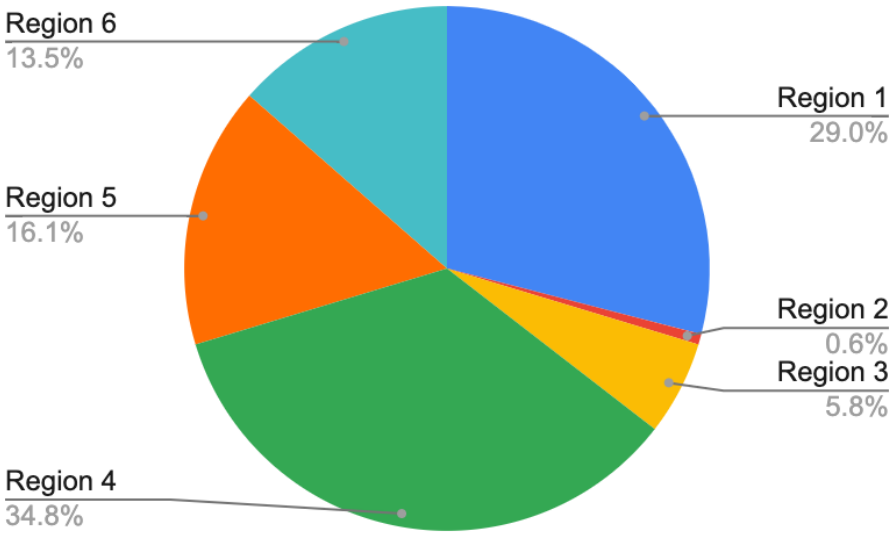


Table 2

Demographics of School Divisions Participating in Survey

Region	Locale from NCES	Membership	Total Schools	Elementary	Middle	High	Free and Reduced Meal Eligibility
1	Suburb: Large (21)	16,519	23	15	4	4	22.60%
1	Rural: Distant (42)	3,040	4	2	1	1	24.30%
2	City: Midsize (12)	27,118	38	26	6	6*	76.40%
3	Rural: Distant (42)	2,007	4	2	1	1	29.50%
3	Rural: Distant (42)	1,166	3	1	1	1	51%
3	Town: Distant (32)	804	2	1	0	1*	33.20%
4	Suburb: Large (21)	81,326	94	59	17	18	18.70%
5	Town: Distant (32)	9,175	19	13	3	3	40.20%
6	Town: Distant (32)	1,028	3	1	1	1	56.30%

Note. Membership and Free and Reduced Meal Eligibility is based on reports from the 2020-2021 school year.

* One high school includes grades 6-12.

The Capstone team conducted an a-priori sample size t-test calculation using beta function, Cohen's d effect size for t-test, gamma function, lower incomplete beta function, noncentral t-distribution cumulative distribution function, noncentral t-distribution non centrality parameter, and regularize lower incomplete beta function. The team hypothesized that there

would be no difference in SMHPs perception of their time allocation across different responsibilities and administrators' perception of SMHPs time allocation across the same responsibilities. These calculations determined that with an anticipated Cohen's *d* effect size of .5, a desired statistical power level of .9, and a probability level of .05, the desired sample size for a two-tailed hypothesis would fall between 86 and 172 participants in the survey. A total of 283 participants began the survey with 82 participants dropping out prior to completion, accounting for a 71.02% completion rate. Data were analyzed only for the 201 participants who completed the survey.

Table 3 illustrates the demographic information of the 201 participants who completed the survey. These participants consisted of 39.78% (n = 109) School Counselors; 11.31% (n = 21) School Psychologists; 5.84% (n = 3) School Social Workers; .36% (n = 1) Licensed Behavior Analyst; 2.55% (n = 7) Other Licensed Mental Health or Behavioral Positions; .36% (n = 1) Superintendent; 29.2% (n = 80) Building Administrators, which for the purposes of this research, and particularly the survey, is defined as principals and assistant principals of schools; 4.01% (n = 11) Division-Level Supervisors, which for the purposes of this research work within the central office of a division and oversee mental health functions; and 6.57% (n = 18) participants who reported their job category as "other." Out of those who reported their job as "other," five were school nurses. A vast majority of respondents, 91.82% (n = 146) identified as female while 6.29% (n = 10) respondents identified as male, .36% (n = 1) identified as non-binary or third gender, and 1.26% (n = 2) prefered not to answer. Survey participants reported their years of experience which ranged from first year educational professionals to having had more than 30 years in the field, with the most common response for years of experience reported as 5 years by 9.68% (n = 15) of participants.

Table 3

Survey Participants by Job Category

	School Counselor	School Psych	School Social Worker	Licensed Behavior Analysts	Other Licensed Mental Health	Super-intendent	Building Admin	Division Supervisor	Other
Number	109	21	3	1	7	1	80	11	1
Percent	39.78%	11.31%	5.84%	0.36%	2.55%	0.36%	29.20%	4.01%	0.36%

Focus Groups. To address research question three, we conducted three focus groups with potential and/or future SMHPs as well as practicing community-based mental health professionals to determine the level of interest and awareness in working as a SMHP to inform recruitment strategies. The three focus groups targeted the following groups and demographics:

- Undergraduate students pursuing degrees in Psychology and Social Work from Virginia Commonwealth University (VCU),
- Graduate students in School Psychology, School Counseling, and School Social Work programs from VCU,
- Community-based mental health professionals throughout Virginia with an emphasis placed on diversity in gender, location, and ethnicity of participants.

Overall, 21 people expressed interest in participating across all three focus groups, but seven participated. Two of the participants were community mental health providers, while five were students. Of the students, two were graduate students and three were undergraduate students. The median age of participants was 29 years old, with the youngest being 20 and the

oldest being 52. All but one of the participants were female, with the lone male participant being a community mental health provider with previous experience in schools. In terms of race or ethnicity, three of the participants identified as White, while two identified as Black and two as Hispanic or Latinx. Among undergraduate and graduate students, all were enrolled at VCU, although recruitment efforts were also targeted at students from Radford University and Virginia Union University. The two community mental health providers worked in urban and rural areas, averaging approximately ten years of experience.

Each focus group consisted of one session conducted via Zoom for about one hour with questions gauging interest and overall awareness of SMHP positions, as well as potential incentives or barriers for a career or educational change. All focus group questions (Appendix E) were designed to limit researcher and/or respondent bias and most were open-ended with differentiated follow-up questions based on response. This semi-structured approach allowed for a natural conversational flow without a predetermined outcome. Participants were informed of purposes, procedures, the voluntary nature, the risks and benefits, and confidentiality of their participation before and during the focus group.

Data Analysis

Data analysis consisted of reviewing and aggregating the data to identify emerging trends and themes across documents, interviews, surveys, and focus groups. We used Dedoose to analyze qualitative data and QuestionPro and SPSS Statistics for the quantitative survey data and subsequent analysis. While each instrument was constructed at the same time and administered simultaneously, data integration occurred during data analysis. An integrated approach to data analysis provided a more comprehensive understanding of where alignment and misalignment occurred regarding students' access to mental health supports in schools, staff knowledge of these

mental health supports, and implications these misalignments have in regards to SMHP recruitment efforts (Tashakkori & Teddlie, 2003). Specific data analysis techniques for each method are described below.

Document Analysis. Document analysis was ongoing throughout the study as new information emerged from focus groups and survey data. We organized documents in a spreadsheet including information regarding the school, division, geographic location, region within Virginia, level of school (elementary, middle, high, or all), year of RAMP designation if applicable, and VTSS involvement. The document analysis aligned with research question one which focused on identifying how SMHPs are used to provide student mental health services, how resources are allocated in divisions with mental health structures, where there are mental health access points for students, and how staff roles and responsibilities align with job descriptions for those positions across the state.

Based on our preliminary review of literature, three members of the Capstone team developed a coding scheme to analyze the documents, with initial codes including student access, universal screener, school social worker role, school psychologist role, school counselor role, teacher role, referral for service, tiered intervention, counseling, community partnership, family partnership, SEL, staff mental health training, and family resources. Other codes were added iteratively, reflective of data-driven codes from the analysis. One example of this is a code for restorative practices. Intercoder reliability tests were conducted on a minimum of two documents with 85% or greater intercoder reliability achieved prior to continued document analysis (O'Connor & Joffe, 2020). This level of intercoder reliability was met after coding two documents with 87.4% interrater reliability achieved between the three coders, with two of the three team members coding each document.

Survey. We analyzed surveys to identify perceived and actual roles of SMHPs from school and division leaders and compared responses from SMHP and their supervisors regarding time allocation. Throughout this process, we paid close attention to divisions of different sizes and localities as these contextual dimensions affect services, resources, and shape implementation. This level of differentiation helped us better understand approaches to mental health practices, types of SMHPs in schools, and how SMHPs are utilized across the state. We used data analytic software like QuestionPro analytics to identify and summarize demographic trends and SPSS to run statistical analyses

Focus Groups. Our focus groups provided valuable data for confirming findings from the literature review and revealing recruitment strategies. By analyzing the transcript data from the focus groups and interviews, we identified factors that motivated or discouraged undergraduate and graduate students as well as community mental health practitioners to pursue SMHP positions.

To maintain consistency and minimize preconceived bias influencing coding, we bracketed by starting with the third research question and expanding to child codes based on the parents codes that populated from that question. Parent codes from bracketing included recruitment, roles and responsibilities, perceptions of SMHPs, current SMHP strategies, career motivation, career barriers, SMHP awareness, and policy. Other codes were added iteratively, reflective of data-driven codes from the analysis like policy, policy awareness, as well as more specific child codes like informal and formal recruitment. Using Dedoose, we conducted an intercoder reliability test on one focus group transcript to achieve a desired goal of 85% (O'Connor & Joffe, 2020). Two team researchers completed coding during the transcript analysis

process with both coders coding each of the transcripts. This created consistency in coding while allowing for diversity in perspective in order to shed light on emerging themes.

Study Limitations

As with every study, there are limitations. Given the structure and design of the request for assistance from VDOE OoSS, time was a limiting factor during data collection. The timeline of this study prevented us from conducting a more rigorous document analysis, limited our recruitment efforts to attain a diverse group of participants, and restricted our ability to conduct additional follow up interviews. Regardless of these time constraints, we believe that data collected through each method will contribute significantly to understanding how to improve access to mental health services and professionals.

A key limitation of this research is a lack of diversity in the data pool. There were a limited number of divisions represented through document analysis due to lack of public facing documents. A total of seven documents were identified from schools and divisions in the state of Virginia. These documents were identified after review of 235 school websites and social media accounts as well as review of 41 division websites, and social media accounts. Four additional documents were identified at the national level through review of materials on national websites for professional organizations for SMHPs (ASCA, 2021; NASP, 2021; SSWAA, 2021). The lack of accessible mental health frameworks provides contextual data that will be further analyzed in the data analysis section. The lack of diversity was also evident in demographic information shared by survey respondents. A vast majority, 87.34% (n =138), of survey respondents identified as White. This lack of diversity is also reflected in division and building level leadership and SMHPs in the state of Virginia and nationally (Castro et al., 2018; Calkins, 2020) and we address these limitations as potential recommendations in subsequent sections.

Findings

Data collected from document analysis, surveys, and focus group responses were assessed in order to better answer our research questions. Each method of data collection aligned with one specific research question and was considered holistically in order to determine the possible interconnectedness of findings within the broader context of this study. Throughout the data analysis process, we identified three main findings related to student mental health support and SMHPs. The first key finding is a lack of existing structure surrounding student mental health services with no clear framework outlining what services are available to students, how they can access those services, and who provides them. A major finding related to SMHP staffing is the lack of clear and consistent role definition and outlined job responsibilities both within individual school divisions and across the state. Finally, there is an evident need for intentional recruitment practices. We address each of these key findings to offer recommendations for practice and policy.

Lack of Existing Structure for Providing Student Mental Health

The Capstone team used the PELP Coherence Framework (Appendix C) to identify and outline key components of structure such as incorporation of mental health screening, services, and access points into existing state structure (VTSS/MTSS), clearly defined mental health supports and staff roles, and ongoing professional learning communities. Data collected supports the use of the MTSS or VTSS structure because schools require a framework outlining what services are available to students, and who provides those services, in order to support a variety of student mental health needs.

MTSS and VTSS

MTSS is a structure that school divisions can utilize to provide support where students are showing needs. VTSS is an MTSS system utilized in the state of Virginia. Document analysis revealed that some schools and divisions in Virginia use the acronyms VTSS and MTSS interchangeably to refer to a tiered system of support. There was no clear evidence from these public-facing documents that indicates that school divisions use multi-tiered structures to support students' mental health, as well as SMHP organizations that encourage the use of these structures, with the exception of one school division. A comprehensive multi-tiered structure includes academics, non-academic programming, roles of staff members, and community partnerships, which allows schools to target interventions and provide that continuum of services from education to treatment so that all students are served and those with more needs receive more support. Non-academic programming, within the context of this document analysis, is defined as direct student service or student instruction related to non-academic topics including mental health, social-emotional learning, restorative practices, and school attendance. Schools need to educate the whole child which includes more than academics or standards of learning (SOLs) in Virginia.

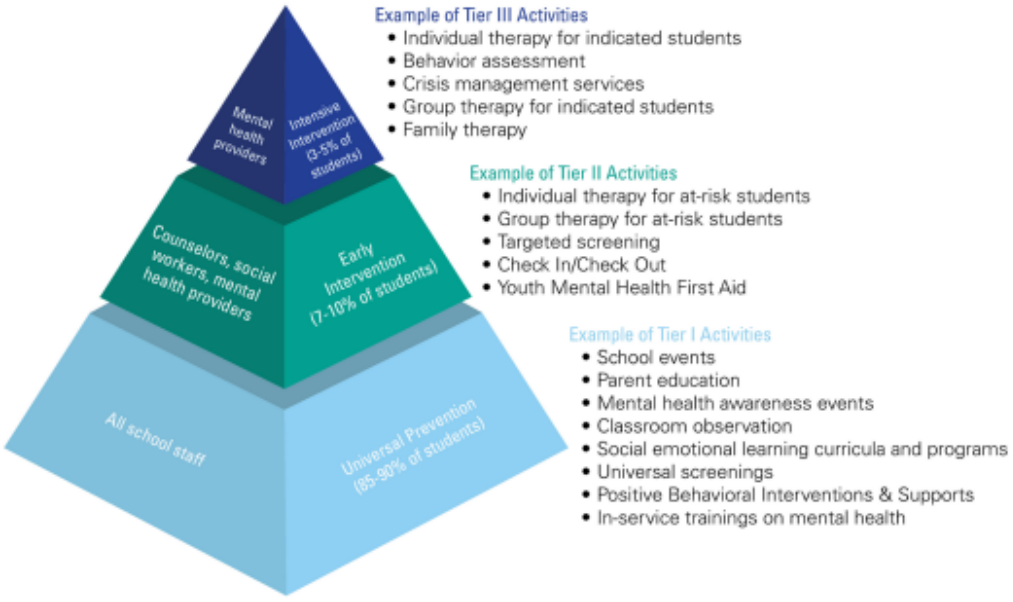
One document identified during document analysis was created by a superintendent task force that analyzed existing mental health programming within the division in order to make recommendations for future practice. Within this division, existing practices included programs for social-emotional learning, restorative practices, universal mental health education programs, and programs designed to serve students at risk in the areas of academics and attendance (Loudoun County Public Schools, 2022). One school and one division website referenced these programs within the context of school mental health, for example, linking SEL programming to

the division's website for school counseling. All other school and division references to school mental health programs or services were linked to the main school website or described in a school handbook, but not described within the context of a larger structure for providing non-academic support to students. Without a comprehensive approach to mental health support in a school or across a school division, student access is variable and appropriate supports are more challenging for staff and families to determine or provide.

The Center of Excellence for Children's Health (2018) tiered model of support (Figure 4) illustrates how the tiered system approach can be used to support differing mental health and non-academic needs of students.

Figure 4

Three-Tiered Approach to school-based Mental Health



Note. This figure was produced by The Center of Excellence for Children's Behavioral Health. (2018).

Following a tiered approach as described in Figure 4, schools can better address their capacity to provide mental health support by asking what services or programs are currently available, how many students are accessing these supports, and who is providing this support to their students. Within the context of a MTSS structure, schools should consider where their available mental health services fall within the tiered model of support or what services might need to be added to support students' mental health.

Access to Mental Health Services

Through document analysis we found that mental health services are reactionary, in that they provide links to outside resources, often in response to mental health crises, but do not address the mental health supports available to students at school. Only 23% (n=64) of the 277 websites reviewed redirected viewers to pages outside of the school website, and most frequently to a website for the local Community Services Board or to information on the national suicide hotline. These are essential services for families in crisis; but for those caregivers or students seeking in-school mental health support, the school division websites did not provide information on how to access them. Redirection to an external website also may create a perception that mental health supports and school supports are mutually exclusive, which is contradictory to establishing partnerships between schools and community mental health providers.

Defining Roles and Responsibilities of SMHPs

Definitions of the roles and responsibilities of SMHP staff need to be clear and consistent so that all stakeholders understand what each SMHP is tasked to do. Clearly defining these roles will support data collection efforts. This is essential when considering misalignment between

SMHPs and administrator perceptions of time allocation between tasks. Clear roles have the potential to also support recruitment of SMHPs.

Roles of SMHPs

The systematic review of public facing documents resulted in the location of seven documents regarding SMHP roles in school mental health support, but we were unable to find consistent and clearly defined staff roles for SMHPs. Only three of these documents, all found on Newport News Public School's division-level website (n.d.), outlined the roles and responsibilities of school psychologists, school social workers and school counselors and were adapted from recommendations from professional organizations (ASCA, 2021; NASP, 2020; SSWAA, 2021). The documents provide clarity to stakeholders about the different services each SMHP provided in this school division. Unfortunately, this was not a common or consistent practice apparent in analyzed documents across the state.

Lack of clarity about SMHPs roles might also hinder potential candidates from entering the SMHP field. Focus group participants mentioned the discrepancies of roles between specific SMHP and daily responsibilities as a deterrent to work in school based positions. Community practitioners with experience working in schools cited frequent misunderstandings of their roles by school leaders. This resulted in tensions for these practitioners as they felt that they were being asked to forgo their professional expertise to fit in the school division's structure. One school psychology graduate student stated, "It would be really hard to fulfill whatever those responsibilities and duties are within that role because of what a system wants you to do versus what you've been hired to do from an outside agency." In most cases, those outside agencies are contracted behavioral or mental health support organizations that send clinicians into the school setting to serve identified student mental health needs. Participants reported being unable to meet

those needs due to muddled roles and responsibilities from school divisions. Eventually, one community practitioner left their agency and reported “no desire” to ever return to public school partnerships. These sentiments demonstrate the necessity for clearly defined roles and responsibilities so that SMHPs can perform the job as intended.

In addition to community practitioners and school-based partners, current college students also voiced concerns about the difference between expected and actual roles, as well as responsibilities assigned to SMHP positions. A graduate student shared that a professor told a class of aspiring social workers, “If you are trying to do therapy or counseling, and you think you're going to be able to do groups, that's not what it's going to be [in schools].” Instead, they described school mental health as “glorified babysitting.” Another graduate student with internship experience in social work recalled, “Even the teachers don't fully understand your role. You're probably going to be doing a lot of educating and a lot of explaining and even teaching what the therapeutic process is in a school setting because many people don't know what that's like.” Showing agreement, several participants nodded their heads and recounted that their administrators were not clear on their responsibilities, which also shaped misinformation and misunderstanding among teachers within the school. When there is a lack of clearly defined roles and responsibilities it leads to a disconnect between SMHPs, teachers, administrators, students, parents, and prospective recruits, creating structural and staffing concerns.

Role Misalignment & Time Allocation for SMHPs

Role misalignment also was evident in the survey results. In an open-ended response, a school counselor from Region 1 shared:

> As school counselors, we are trained to provide short-term, solution focused sessions focused on identifying coping skills and refer out mental health concerns. Our

competency is not in treating depression, anxiety, etc. nor in providing long-term, extensive counseling. Yet, with the lack of available providers in the community and/or parents opting not to pursue outside resources, school counselors are used as a band-aid for significant mental health concerns.

Survey data show that SMHPs spend their time on a variety of tasks during the school day, with great variability in reporting from SMHPs across the state. Specifically, 51% of SMHPs (n = 75) reported that they spend a great deal of time on direct support and intervention to students and 4% (n = 5) never provide direct support and intervention to students. Only 35% (n = 47) reported they spend quite a bit of time on actual direct mental health services for students, and 5% (n = 7) spend no time on mental health services because they spend quite a bit of their time addressing student behavior and providing crisis interventions. Overall, participants reported the tasks that pull SMHPs away from student service time include staff development, the college application process, parent presentations, homeschool coordination, time spent in special education meetings and on special education evaluations, non-counseling tasks, and large caseloads. Role misalignment impacts access to mental health support for students.

Perception of Time Allocation Between SMHPs and Administrators

An independent samples t-test compared SMHPs' reporting of their time allocated to specific responsibilities with administrators' perceptions of SMHPs' time allocation. It should be noted that the varying sizes of the SMHP (N = 66) and administrative (N = 134) groups may contribute to type 1 errors and affect statistical power. Independent sample t-tests were run with a significance level of .05 and .01 to compare variability. Both tests resulted in a statistically significant difference between mean responses from SMHPs' reports of time allocation when compared to administrator perception of SMHPs' time allocation for 11 out of 30 of the job

responsibilities as seen in Table 4. As a result, the team's hypothesis that there was no difference in SMHPs perception of their time allocation across different responsibilities and administrators' perception of SMHPs time allocation across the same responsibilities was correct for 19 of the 20 responsibilities included in the survey. This indicates a disconnect between what SMHPs actually provide to students and how administrators perceive SMHPs spend their time. While the varying group sizes and other factors may impact statistical significance, these data, considered in conjunction with the literature review, document analysis, and focus groups, were enough to support our finding that misalignment in perception of time allocation is an area of concern in Virginia.

Table 4 illustrates the difference between administrators' perception of SMHPs' time allocation compared to SMHPs' reporting of their *actual* time allocation. Administrators believe more time is spent on residency (MD = 0.35), special education testing (MD = 0.92), child study lead (MD = 0.80), and attendance lead (MD = 0.43) than what SMHPs reported for those categories. Conversely, SMHPs reported spending more time on suicide assessment (MD = -0.38), student intervention (MD = -0.60), student mental health (MD = -0.58), student behavior (MD = -0.61), crisis intervention (MD = -0.67), link community resources (MD = -0.48), and parent communication for suicide assessments (MD = -0.41) than what administrators think they do. This suggests that SMHPs are spending more time with students than perceived by administrators, but SMHPs still feel as though there is not enough time in the day to complete all of their job responsibilities.

Table 4

Allocation of Time for Responsibilities: Statistically Significant

Job Responsibility	Role	N	Mean	Std. Deviation	Std. Error Mean	p	Mean Difference
Residency	SMHP	132	0.6364	0.90184	0.07850	0.760	0.34825
	Admin	65	0.9846	0.94360	0.11704		
Special Education Testing	SMHP	134	0.9701	1.45582	0.12576	0.896	0.92379
	Admin	66	1.8939	1.42644	0.17558		
Suicide Assessment	SMHP	133	2.1504	1.04081	0.09025	0.002	-0.38115
	Admin	65	1.7692	0.74518	0.09243		
Child Study Lead	SMHP	133	0.2556	0.75533	0.06550	0.000	0.80497
	Admin	66	1.0606	1.31124	0.16140		
Attendance Lead	SMHP	134	0.5597	1.17947	0.10189	0.754	0.42515
	Admin	66	0.9848	1.07406	0.13221		
Student Intervention	SMHP	134	3.2164	1.10611	0.09555	0.228	-0.59521
	Admin	66	2.6212	0.87293	0.10745		
Student Mental Health	SMHP	134	2.7313	1.17085	0.10115	0.006	-0.57983
	Admin	66	2.1515	0.93220	0.11475		
Student Behavior	SMHP	132	2.7197	1.14794	0.09992	0.326	-0.61200
	Admin	65	2.1077	1.09149	0.13538		
Crisis Intervention	SMHP	133	2.6391	1.11013	0.09626	0.000	-0.66940
	Admin	66	1.9697	0.85880	0.10571		
Link Comm Resources	SMHP	134	2.5224	0.94762	0.08186	0.000	-0.47693
	Admin	66	2.0455	0.71105	0.08752		
Parent Commun Suicide Assess	SMHP	134	2.0746	1.14134	0.09860	0.001	-0.40796
	Admin	66	1.6667	0.68687	0.08455		

Note. Response choices for participants were as follows: *none* (0), *very little* (1), *some* (2), *quite a bit* (3), or *a great deal* (4). These job responsibilities represent the 11 out of 30 that were determined statistically significant from the survey results.

In examining survey results from SMHPs, it is apparent that school counselors are spending a considerable amount of time on high level and reactive mental health needs of students. When looking specifically at school counselors, 50% (n = 42) reported spending somewhat, quite a bit, and a great deal of time on suicide/self-harm risk assessments and 71% (n = 60) reported spending somewhat, quite a bit, and a great deal of time on crisis interventions for students. The survey data show that a lot of SMHPs' time with students is spent on higher level mental health needs such as suicide assessment and crisis intervention instead of classroom guidance or small group SEL lessons. One school counselor responded to the open-ended question by sharing they "are dealing with so many tasks and dealing with students who are suicidal has become a large part of our job with nothing else removed." Another school counselor mentioned there are other trained SMHPs employed in their organizations but "the majority of mental health duties continue to fall on us, because the others are not licensed by the state." It is of note that the majority of the SMHPs spending time on these high level mental health services with students, including student intervention, suicide risk assessments, and crisis intervention, are school counselors and not school psychologists or school social workers. These comments highlight a mismatch between the perceptions of administrators and SMHPs around job responsibilities and time allocation as well as a mismatch between the responsibilities of roles assigned and the responsibilities for which they have been trained.

Increasing the Pipeline of SMHPs

In addition to having clear structures for mental health services and clear responsibilities for the roles of those carrying them out, recruitment is critical to maintaining a strong workforce of SMHPs; however, recruitment of SMHPs is hindered by a lack of motivating factors and missed opportunities. Our analysis reveals that recruitment can be impacted across the following

key areas: (a) motivations for becoming a SMHP; (b) current recruitment strategies; and (c) barriers to becoming a SMHP.

Motivations for Becoming a SMHP

An intuitive starting point for improving recruitment of SMHPs is in leveraging intrinsic motivators. All of the focus group participants expressed that they wanted to enter the mental health field based on a personal interest in the field. Two of the student participants and one of the community practitioners indicated that a desire to work with children led them to their field of study or career. A graduate student participant stated, "I wanted to work with high school students. So, you know, for me, I get excited when they have their whole life ahead of them and trying to figure out their careers and that kind of counseling, recognizing that you've got this other piece." This sentiment also resonated for the community practitioner who indicated that they wanted to work with adolescents early on in their career. For one student, seeing "many kids [who] really were struggling with depression and anxiety and the limited resources that they had" served as a motivation to enter the SMHP field.

Beyond a desire to work with students, four student participants indicated that past experiences with their own mental health led them to pursue a career in mental health. Potential SMHPs desired to either recreate a positive experience from their youth, create more equitable access, or fill a void in mental health that they once experienced first-hand. Three of these participants expressed that they wanted to be the person that they needed when they were younger. One student, in particular, said, "When I was a kid, I had a couple of doctors who just like, were very, very helpful when I was in the hospital, or whatever, and I want to be that to a kid." One of the students reflecting on their own mental health recognized the resources they had at their disposal and commented on the disparities in access in places like rural areas and urban

settings, where, they explained, “The school counselor may be the only counselor that those kids get to see.” Another student mentioned that other students in their school counseling cohort entered the program “because they want to be the school counselor that they didn't have.” These personal experiences with mental health care can lead to opportunities for future students to explore the field, but it is unclear to what extent or through what strategies school divisions or state agencies are leveraging these experiences to improve recruitment.

Current Recruitment Strategies for SMHPs

Data collection revealed that current recruitment strategies include both informal and formal measures. Informally, participants received information and were connected to positions through personal relationships and word of mouth, while formal recruitment processes included university-based recruitment and GYO programs. Overall, our findings indicate that informal recruitment efforts made more of an impact on potential SMHPs than formal recruitment, especially pertaining to opportunities for diversifying the pool of SMHPs. Both types of recruitment efforts should be used to secure a diverse and stable pipeline of SMHPs.

Informal Recruitment. Informal SMHP recruitment is defined for this study as less formalized strategies that resulted in recruitment decisions based on timing, chance, or interpersonal connections. Four focus group participants (graduate and undergraduate), indicated that they had been recruited to the SMHP field by word of mouth from trusted sources such as professors, family members, and peers. This was often as simple as hearing someone share a positive experience or personal motivation for entering the field. A graduate student participant noted that “working with school counselors in my previous job, talking to them, getting a better understanding and fortunately having some of them mentor me” had influenced them to consider school mental health. These informal conversations seemed to have a significant impact on

participants and their memories of recruitment efforts. For example, an undergraduate participant had a friend who encouraged them to try substitute teaching, and despite any formal recruitment efforts, they followed through and tried it. Participants emphasized the role of their social networks in providing mentorship as they navigated the SMHP field.

Formal Recruitment. By contrast, formal recruitment is defined within this study as intentional, direct recruitment efforts designed to increase awareness of school mental health professions, increased enrollment in a SMHP program of study, or efforts targeted at increasing employment in schools. These might include scholarships for specific candidates or guaranteed employment post-graduation. Six participants indicated that they had not been formally recruited to enter their school's program or an SMHP career. Participants felt these were missed opportunities for formal recruitment efforts, especially because successful recruitment approaches could be scaled and transferred across divisions or universities to increase potential student or graduate SMHPs.

Intentional efforts were made by the Capstone team to recruit people of color and LGBTQ+ individuals to participate in focus groups. One community practitioner shared that the agency they work for was actively searching to hire licensed clinicians of color. They went on to emphasize that as schools looked towards hiring, "recruitment efforts should continue to focus on black and brown clinicians… especially [in] school divisions that are urban neighborhoods that have high populations of black and brown children." Another participant reflected on their undergraduate recruitment experience as a member of the LGBTQ+ community: "...post-coming out I did see a lot of recruitment for gays or LGBTQ+ students, but I did not see any of that when I was applying because I wasn't out yet." Participants felt strongly about recruiting historically

underrepresented SMHPs because they had shared personal experiences and could have benefited from having an SMHP that they needed.

University-Based Recruitment. Few participants experienced strong university-based recruitment engagement practices. One undergraduate student shared that their university's psychology program sent weekly emails with resources and opportunities. However, they explained that it was not an effective means of recruitment because, "if I ever hear anything about these opportunities, it's usually like in the site grad email once a week and it's usually like either very close to the due date that applications or interests emails need to be sent." Participants also indicated that public school system opportunities communicated via email lacked intentionality in target audiences and often were received by potential SMHPs as arriving after deadlines had passed.

Two of the student participants highly recommended job fairs and networking events, which enabled participants to easily connect to opportunities. Another shared that they were "attracted to whichever table involves kids and schools." That same student also stated that more representation at events like VCU Hiring Day with incentives to apply would help students discover the SMHP field. In addition to in-person networking, students also emphasized the power of social media. One participant suggested greater engagement on platforms like LinkedIn, while another pulled from their own experience about how social media posts encouraged more student participation versus sending an e-mail. Capitalizing on these intentional recruitment and marketing strategies could lead to an increase in enrollment of students in SMHP based programs.

GYOs. GYOs benefit universities as well as school divisions. They ensure college enrollment and incoming tuition while allowing public schools to retain local graduates and

secure employees in critical shortage areas. One graduate student noted a program at Christopher Newport University that provided a scholarship for someone to get their master's degree in teaching if they would then work for that school system after they graduated. Another graduate student suggested that SMHPs could help identify high school students who might be interested in the field. They went on to share that an issue with current recruitment in schools is the lack of understanding of "what the role is and how we serve in the school setting. Students at the high school level think all we do is schedule and help them go to college or some other career, and there's so much more that we do." A GYO program could increase awareness of SMHPs at the local level and formally recruit potential SMHPs while still in high school. Overall, there were positive feelings regarding GYO programs, but respondent experiences only related to teaching opportunities and not for SMHP opportunities.

Barriers to Becoming a SMHP

To intentionally recruit SMHPs, we found it is necessary to also address barriers to entering the profession, which could be understood as any condition, perception, or requirement that could potentially hinder participants from entering the SMHP field. Data indicated that education and licensure requirements, a lack of awareness of SMHP opportunities, negative perceptions of working conditions, and extrinsic motivators were constraints that limited entry into the profession.

Education and Licensure Requirements. A primary structural barrier limiting the number of SMHPs entering the profession is the education and licensure requirements, especially as it relates to time and money. A student pursuing their Ph.D. in clinical social work shared, "There's a reason all mental health professionals in schools are White women because it is a privilege, and a lot of resources are needed to get a master's in general. So that is a major barrier

across the board for why we all look alike and aren't representative of schools." Noting that the ability to receive a master's level of education is a "privilege" highlights the lack of diversity referenced in formal recruiting and signals opportunities to create more equitable access to the field.

There were also conversations regarding the time it takes to become a SMHP. For example, a community practitioner commented that "going to school for seven to ten years and coming out to *just* [emphasis added] work in a public school is a huge barrier to getting people similar degrees into schools." In other words, the participant felt the opportunity costs did not justify the investment of time in a course of study for the current salary. Similarly, a graduate student referenced needing "something like three thousand hours" to pursue a school counseling degree. They went on to say, "it's almost like after you get your hours though, and after you become licensed and all this hard work, I can't continue because it burns you out." With time and money perceived as barriers to entry, potential SMHPs candidates may overlook the field altogether, especially when structural incentives like loan forgiveness or tuition subsidies are not available, as there are other career options requiring less education, time investment, and offers greater salary.

Awareness of SMHP Positions. The lack of knowledge or awareness of SMHP opportunities is a major barrier to growing the SMHP pipeline. Potential candidates often make alternative career choices before they learn about careers in school mental health, if they ever learn about them at all. None of the focus group participants, even those currently practicing in the community or with school experience, were aware of all six of Virginia's SMHP positions. For example, having learned that school nurses fell under the SMHP umbrella, many described

that knowledge as "a shocker they're considered mental health." However, just increasing participants' awareness briefly in conversation made an immediate impact on their perceptions.

Many students in the focus groups were also not aware of how to become a SMHP. For example, one undergraduate student simply stated they "didn't know at all what it requires." Even many graduate students were aware of broad licensure requirements but questioned whether "the clinical license goes through a licensed counseling board, but licensed school counseling goes through a different board. I think. I'm not really familiar with the requirements for that license honestly."

School Bureaucracy. Participants' perceptions of school bureaucracy were another key barrier that limited their interest in schools. One practitioner shared that if they were to switch to a school setting, they would "have to just wait for the principal to tell me what to do instead of being a true mental health provider. I think that's where I'd have a hard time is switching from being a mental health provider to just another teacher who is there to babysit kids and just do whatever needs to be done." When asked if anyone would consider switching to school-based mental health under any conditions, one participant responded:

> That's not part of the goal. I think a lot has to do with the bureaucracy of the school setting, the Department of Education, and the school board. And it makes your job a lot harder than it should be. You had to go through a lot of hoops to get to the students, and that does not make it very welcoming or pleasant to work in.

Several other practitioners agreed with the sentiment of bureaucracy as a barrier within school settings, and they shared similar perceptions that their decisions and expertise would be negated by school leaders without specific mental health training or experience. For many participants, school bureaucracy also meant limited professional autonomy which is a stark

contrast from many clinical mental health options. While one graduate student did note that "the school principal drives the culture and the feeling of that school setting and how different it can be from one school to the next," the overarching perceptions in focus group conversations were that of restriction, bureaucracy, and distance between SMHPs and student outcomes.

Workload. Negative perceptions of SMHP workloads were woven throughout all focus group conversations. While many other careers are considered highly demanding, potential SMHPs cited unrealistic expectations and outrageous workloads compared to clinical settings. One community practitioner said, "it's absurd how many students we are putting [onto caseloads]. Say you are a school counselor taking care of 500 kids. There's just no possible way." Many community practitioners agreed that switching from a personable, often self-managed caseload to being responsible for hundreds of students caused increased tension and personal concern for the ability of services to be provided at the school level. A current social worker said with personal experience "you're one social worker to like five schools. I wish that were an exaggeration, but it's not." All community practitioners agreed that the need existed, yet not being able to meet the need was overwhelming to imagine. One shared that they would not consider becoming a SMHP because it would be too morally difficult "not being able to respond to all of the challenges that could happen throughout the day, and while you are there meeting the students' needs, realizing it's also sad that the teachers need just as much mental health support. And knowing that you don't have the capacity." For people that enter a profession to help others, to take on more responsibility than may be possible to serve, is concerning for many. One participant recommended that "decreasing caseloads may increase how many people want to work in schools".

Motivation Tensions. While there are intrinsic drivers for entering the SMHP or mental health fields, there are also extrinsic factors such as flexible work schedules, pay, benefits, and a guaranteed clientele that competes with previously identified intrinsic factors. Throughout the conversations, there was a resonating understanding that SMHPs were underpaid for their time and expertise, but that they also did not have competitive salaries with clinical mental health practitioners. For many participants, salary for SMHPs in schools was significantly lower than salaries SMHPs could make in the field. For example, the average salary in Virginia in 2022 for a clinical psychologist is $110,335 compared to $64,795 as a school psychologist (Indeed, 2022a; 2022b). In addition to salary, another competing factor that created tension for SMHPs is the level of flexibility afforded to SMHPs in the field as opposed to strict work schedules in schools. These findings are only further exacerbated by findings related to the lack of clarity and misallocation of time which negatively shapes opportunities for recruitment.

Summary of Findings

Document analysis, survey administration, and focus group administration carefully aligned with research questions and provided three key takeaways with regard to increasing student access to mental health support.

First, a lack of existing structures regarding student mental health services leads to inefficient and missed opportunities for student mental health access. Data collected supports the use of MTSS and VTSS structure to frame what services are available to students and who provides those services. The lack of existing structures within the document analysis facilitated more reactionary mental health services and most frequently referred parents to community health support rather than in-school mental health services.

Second, a lack of clear and consistent SMHP role definitions and outlined job responsibilities existed at the school, division, and state levels. This lack of clarity causes a misalignment between SMHPs and administrator perceptions of time allocation and job responsibilities. It may further impact recruitment efforts if potential SMHPs have negative or inequitable perceptions of realistic roles and responsibilities.

Third, recruitment of future SMHPs is impacted by missed opportunities to leverage personal motivating factors and overcome logistical barriers. Despite motivations that emerged during focus groups, including personal experiences and intrinsic value in mental health services for children, barriers often outweighed them. These barriers include education and licensure requirements, a lack of awareness of SMHP positions, school bureaucracy, and the perceived workload. While teachers and many other school staff do not have parallel career options, mental health clinicians have an alternative career path that could eventually involve private or self-owned practices if the barriers to entry, autonomy, or productivity seem too high.

Recommendations

There is an existing and immediate need for student mental health services and a clear shortage of SMHPs (Hoover & Bostic, 2021; Leiva et al., 2021; Ohrt et al., 2020; Weist, 1997). We know the mental health needs of students are continuing to increase, exacerbated by both the current global pandemic and the existing social climate. Key findings from this research, through both literature review and field data collection, indicate three key components that support increased access to high-quality, equitable mental health support for students in K-12 schools: (a) a clearly-defined structure for providing mental health support to students; (b) clearly defined roles and responsibilities for SMHPs, and (c) intentional recruitment of SMHPs. For VDOE

OoSS to help divisions meet student mental health needs immediately and sustainably, we propose short-term, mid-range, and long-term interventions.

Appendix G outlines phased goals specific to structural and staffing considerations. These goals and subsequent recommendations are considered within the context of the PELP Coherence Framework (Appendix C) in order to ensure alignment with the needs of both VDOE and Virginia school divisions in the areas of culture, stakeholders, resources, and systems. This coherence framework is useful for both planning and assessing alignment of efforts between VDOE and Virginia school divisions to best support systemic change. As a result, recommendations made from this lens better support sustainability of practice. The team recommends that VDOE:

1. Collect additional data regarding the number of SMHPs in divisions and licensure type. This can be collected through modification to an existing VDOE data collection tool, such as the annual Master Schedule Collection (MSC). Annual data collection would centralize division-level data regarding SMHP staffing allocation and allow for review of staffing alignment with the SOQs as well as trends in SMHP staffing across the state.
2. Work collaboratively with the VTSS Research and Implementation Center (VTSS-RIC), state Teacher Technical Assistance Centers (T/TAC), and the Virginia Career and Learning Center for School Mental Health Professionals to develop guidance documents and training to help divisions and schools either implement a data-driven tiered system of support regarding student mental health or incorporate student mental health interventions into existing tiered systems of supports. This guidance should place an immediate emphasis on tier 1 universal interventions and a phased plan to incorporate tier 2 and tier 3 interventions. This plan should specify the roles of specific SMHPs,

non-SMHP school staff, and community partners in implementation and direct student service.

3. Build upon existing guidance for the use of specialized student support positions in Virginia (VDOE, n.d.) by incorporating appropriate and inappropriate roles and responsibilities for SMHPs in the state of Virginia. This document should include clear distinctions between the roles of each SMHP job category in providing direct student mental health support and in non-mental health related assignments, including recommendations of time allocation for direct student service and administrative responsibilities.
4. In collaboration with both the VDOE Office of Licensure and state universities, establish a graduate certificate program available to mental health professionals interested in respecialization to school mental health. Additionally, support long-term pipeline improvement through intentional recruitment efforts at both colleges/universities and in the K-12 setting.
5. Update policy recommendations regarding SOQs for SMHPs and annual staff professional development in the field of student mental health. These policy recommendations should build upon existing language in the Code of Virginia by incorporating developed definitions of roles and responsibilities for SMHPs, staffing ratios by each role to address student needs within divisions across the state, and defined need for ongoing professional development.
6. Establish a task force to develop a comprehensive guidance document for schools that includes the Capstone recommendations and takes into account the contextual factors that impact implementation of student mental health services within schools across the state.

Appendix H outlines suggested content for consideration by this established task force. These recommendations align with suggested actions for VDOE discussed in subsequent sections.

Recommendation 1: SMHP Data Collection and Review

Data collection and review should inform both short and long-range plans to increase student access to mental health support in schools. Reporting each school division's SMHPs and current licensure type would help to clearly define existing staffing so policymakers can better assess where there is need for additional support for student mental health in schools. For example, increasing the number of school counselors required in each school does not ensure increased student mental health support if those counselors are assigned administrative or scheduling responsibilities rather than utilized to provide direct student support. It is imperative that data collected regarding the number of specific SMHPs in each division be considered in conjunction with VDOE's recommended roles and responsibilities for SMHPs in order to assess for this type of misalignment. Data collection of the number of SMHPs in divisions and the type of SMHPs in each division will also inform future VDOE guidance and policy recommendations.

VDOE Actions

VDOE should work with Virginia legislators, the governor, and the General Assembly to require reporting of these roles by division in the coming years. However, data collection should not wait until a mandate can take effect. It is recommended that Virginia immediately collect data specifically surrounding the number of SMHPs employed in each division, their licensure type, and their years of experience. This data collection can occur through modifying existing tools and processes in order to minimize the amount of additional reporting required from school divisions.

One existing data collection tool that could be modified and used for this reporting is the Master Schedule Collection (MSC). School divisions are currently required to submit MSC data twice annually, in January and August (VDOE, 2022). The MSC requires school divisions to report each staff member employed in the division including their position title and their specific licensure type. Modifications could be made to the MSC to account for the SMHP categories outlined in the Code of Virginia (§ 22 1-253.13:2.4H, 1996/2021; § 22 1-253.13:2.O, 1996/2021). This would require adding the categories to the MSC of *other licensed health and behavioral positions, licensed behavior analyst* and *licensed behavior analyst assistants.* Additionally, it would require modifying the existing categories within the MSC of *elementary guidance, middle school guidance, secondary guidance,* and *coordinator of guidance* to language that recognizes these positions as *school* counselors rather than *guidance* counselors. Collection of these data through the MSC allows VDOE to ensure divisions are meeting SMHP staffing requirements outlined by the Code of Virginia while allowing school divisions to provide that information through an existing data collection tool.

These data will provide VDOE with critical information about varying needs and trends across the state so they can support the development of school and division-level mental health structures. For example, by looking at the data statewide, VDOE may recognize the need to provide guidance and technical assistance to target identified inequities. Additionally, these data points can inform subsequent policy and budgetary recommendations regarding specific categorical SMHP requirements.

Recommendation 2: Comprehensive Structures of Student Mental Health Support

In order to ensure students are receiving appropriate mental health support, there must be a structure that clearly outlines how students are identified as needing services, what services

students are able to access depending on their identified level of need, who will provide those services, and when those services will be provided.

VDOE Actions

The Capstone team makes three recommendations for comprehensive structures of student mental health support. These include training and technical assistance related to VTSS/MTSS, promote high quality tools and resources to school divisions, and increase the community awareness of school mental health services.

Training and Technical Assistance Related to VTSS/MTSS. VTSS is an existing grant funded program overseen by VDOE, in conjunction with the VTSS-RIC and regional T/TAC. In order for divisions to participate in this VTSS coaching process, divisions are required to apply to VTSS, be accepted to a VTSS cohort, and participate in an exploration and implementation process prior to fully implementing VTSS. While these are best practices for implementation of a tiered system of support, not all divisions have the capacity to fully participate in a VTSS cohort or are not accepted to participate due to the capacity of VTSS.

VDOE should provide guidance and training to support all Virginia school divisions in providing mental health support through a tiered structure or with incorporating mental health services into their existing VTSS/MTSS frameworks. While the capacity does not currently exist within the state to provide VTSS coaching to all divisions, all divisions should have access to basic documents and training materials that would support their ability to provide tiered mental health support through structural and staffing modifications. The established task force should investigate the most efficient way to develop and distribute these materials while leveraging existing resources such as the VTSS-RIC website and VDOE OoSS's existing website of resources.

VDOE should also work with VTSS-RIC and regional T/TACs to ensure guidance is being provided on the integration of mental health practices into tiered systems work for schools that are already receiving formal VTSS coaching through a cohort. Any mental health integration resources developed by schools or divisions as a result of this coaching would also serve as examples for schools that are not currently participating in this level of systems coaching.

In addition to focusing on established SMHP staffing and structures within schools, VDOE OoSS can now rely on a wealth of experience and knowledge gained by clinicians over the past two years in the area of virtual mental health while planning intentionally for these services. VDOE OoSS should provide guidance that each school and division use relevant data to determine how to best incorporate both internal virtual mental health supports and community-based virtual services into their tiered service model. Additionally, the Capstone team recommends that VDOE encourage schools to work with families to provide scheduled student access to a room within the school where that student can participate in virtual, community-based mental health services that typically occur outside of the school building.

Promote High Quality Tools and Resources to School Divisions. It is recommended that VDOE provide guidance that all K-12 schools consider the adoption of a universal screening instrument and use data collected through the administration of this instrument to develop a targeted tiered system of support that meets the needs of that school population. VDOE should provide a list of screeners vetted by VDOE OoSS or an assigned review committee.

There are a variety of tools and resources already in existence, and VDOE has an opportunity to leverage some of these tools to better support student mental health. It is recommended that VDOE ensure access to information for all Virginia school divisions on how to implement basic components of a tiered system within the context of mental health. A

Resource Map template (Appendix I), originally created by VTSS, is available to provide an example of a tool that VDOE can offer for divisions and schools to adapt to their structural and staffing needs. This resource shows evidence-based practices, entry criteria, frequency, parent notification, and staff member responsible potential interventions paired with frequency of intervention, target student population, necessary staffing resources, and progress monitoring considerations (VTSS-RIC, 2021). When considering tier 2 and tier 3 interventions, such as those identified in the resource map, VDOE should also provide examples of what and who would be providing these to students. Appendix J shows suggested delegation of Tier 2 and Tier 3 Mental Health Services for SMHPs.

Another resource that was greatly utilized during the pandemic and is an asset for building capacity for SMHPs within tiered systems of support is virtual-community based mental health services. VDOE should develop a checklist of best practices for students participating in virtual-community based mental health services while in the school environment. This may include information regarding appropriate locations for appointments, staff involvement in scheduling and/or monitoring of appointments, frequency of scheduling availability, and how to assess student readiness to return to class after appointments.

Increase Community Awareness of School Mental Health Services. VDOE OoSS needs to take intentional steps to increase community awareness of mental health and the school's role in providing mental health support. In order for mental health interventions to be successful in the school environment, it is necessary for all stakeholders to be aware of what mental health is, why it is important, and what resources are available. VDOE OoSS has taken a critical step by developing a comprehensive website dedicated to defining mental health and providing links to mental health resources both within Virginia and nationally (2020). This

format, however, may not feel relevant and accessible to all students and families in Virginia. It is also a resource that is likely to be used by families who recognize the need for mental health support and actively search for that tool while going undetected by other families. This website has the potential to be marketed in a way that creates mental health awareness for a broader population.

VDOE OoSS must encourage schools to clearly outline what is provided and available within schools and when it is appropriate for students and families to seek resources within the community. One immediate action step is for VDOE to redistribute information to school divisions through a Superintendent's Memo that highlights the existing mental health resources developed by VDOE OoSS and encourages school divisions to include links to this resource in an easily accessible place on both division level and school level websites.

Recommendation 3: Define Roles and Responsibilities of SMHPs

Lack of defined roles and responsibilities for SMHPs in Virginia was a key finding from this research, which has both structural and staffing implications. Clearly defined roles and responsibilities for each SMHP category would support effective use of each SMHP in direct student mental health service, support VDOE with future SOQ recommendations, and support recruitment efforts by allowing potential SMHPs to understand what they would be doing in the field should they chose a SMHP role.

VDOE Actions

During VDOE's clarification of these definitions, existing recommendations developed by affiliated professional organizations (ASCA, 2021; NASP, 2021; SSWAA, 2021) should be considered (Appendix K). Then, VDOE should work with Virginia legislators, the governor, and the General Assembly to update the Code of Virginia to include those changes to specifically

define the roles of all SMHPs. This will clarify to all division leaders, staff members, students, families, and community members which SMHP is responsible for specific services. Existing recommendations developed by affiliated professional organizations (ASCA, 2021; NASP, 2021; SSWAA, 2021) should be considered during the development of these definitions (Appendix K).

We also recommend that VDOE provide guidance to administrators recommending they reassign more administrative tasks to personnel not licensed to provide tier 2 and tier 3 mental health services. Suggestions for the assignment of specific tier 2 and tier 3 mental health services to specialized SMHPs can be found in Appendices J and K. These recommendations will allow school counselors, school psychologists, and school social workers to share the responsibility of these services while having additional time to implement SEL curriculum, classroom guidance, and other proactive strategies to prevent escalated mental health concerns.

Recommendation 4: Partner to Increase The Pipeline of SMHPs

While structural and staffing modifications should be incorporated to meet the immediate needs of students, long-term sustainability of mental health services in schools requires increased staffing of SMHPs. There is an ongoing shortage of both licensed SMHPs and licensed community-based mental health providers while, concurrently, the mental health needs of school-aged children are rising (Hopeful Futures Campaign, 2022). Intentional recruitment efforts by VDOE and school divisions are essential to increase the pipeline of SMHPs in Virginia. Varying recruitment efforts should target the following populations: K-12 students, college and graduate students in mental health fields, and community-based mental health providers interested in respecialization.

VDOE Actions

In addition to providing guidance to schools and divisions about their role in SMHP recruitment, it is recommended that VDOE support SMHP recruitment through partnering with colleges and universities on undergraduate recruitment efforts. Particular emphasis should be placed on forming partnerships with Historically Black Colleges and Universities (HBCUs) and on intentional recruitment within specific student organizations within all colleges and universities in an effort to recruit diverse candidates to a SMHP field. VDOE OoSS also should work with the VDOE licensure office to develop a certificate program that would allow existing community-based mental health providers and educators with advanced degrees the opportunity to complete a certificate program to become a licensed SMHP rather than requiring an additional advanced degree. Furthermore, VDOE should provide guidance and funding opportunities to K-12 school divisions to help them develop local GYO programs to support SMHP recruitment.

Undergraduate Recruitment. To address student mental health needs and increase the pipeline of SMHPs long-term, it is essential that VDOE partners with colleges and universities to embed SMHP recruitment and marketing of these positions within undergraduate and graduate programs in psychology and social work. Through the creation of a strategic marketing plan that focuses on targeting students preparing to declare their major and students who are preparing to graduate from undergraduate programs in psychology and social work, VDOE has an opportunity to influence students who may be potential candidates for an SMHP graduate program.

VDOE can also work to communicate the information that has been created by the Virginia Career and Learning Center for School Mental Health Professionals about professional development and career opportunities for school social workers, school counselors, school

psychologists, and other licensed school mental health professionals. One of the most prominent findings during focus group administration was the consistent lack of awareness that school mental health preparatory programs existed at colleges and universities. As students prepare to apply for graduate school, it is important that they hear the benefits of school mental health positions including the opportunity to work with a client over a significant span of their life versus a short span of time covered by insurance, a constant client base that does not need to be recruited or solicited, a consistent work schedule, and state benefits.

One of the ways that VDOE can disseminate this information is through the creation of marketing materials that highlight the benefits and responsibilities of being a SMHP. While marketing for SMHP careers would primarily happen through the career centers and advisors, VDOE and division-level SMHP supervisors participating in career fairs would add an additional recruitment opportunity. The budgetary requirements for these marketing efforts would be minimal, however, it would require intentional outreach to universities and staffing considerations for job fairs.

Graduate Certificate. VDOE OoSS should partner with the VDOE Office of Licensure to develop a pathway for those with advanced degrees in education, psychology, or social work, to become fully licensed SMHPs upon completion of a graduate certification program. The addition of a graduate certificate program should be two-fold. First, a certificate opportunity should be created for existing community-based mental health providers who are re-specializing to school counseling, school psychology or school social work. These individuals should already hold a license as a counselor, psychologist, or social worker, indicating they have completed an advanced degree and clinical supervision during community mental health practice. This graduate certificate program should focus more heavily on child and adolescent mental health,

differences between community services and school-based interventions, and logistical and structural considerations related to K-12 schools in Virginia.

The second certificate option will focus on building the capacity for educational staff currently providing mental health services in schools as "other licensed mental health/behavioral positions SMHP." There is currently no operationalized definition for what services these staff members can provide nor are there specific licensure requirements for the roles. For example, individuals who are licensed as teachers may serve in a role that supports student behavior such as a "positive behavior support teacher" and be counted as an SMHP by their division. Individuals with advanced degrees in education do not have the clinical training to complete a certificate program to become a school psychologist or social worker, but it would be appropriate for them to complete a certificate program focused on universal mental health and behavioral interventions in order to more intentionally serve in the "other licensed mental health/behavioral" position. This, in conjunction with operational definitions for this role, will ensure appropriately personnel are providing student services that align with their training.

One of the challenges prospective SMHPs face is that licensure is viewed as a difficult process, particularly for career switchers. This concern is mirrored in current legislation in Virginia awaiting the Governor's signature by April 2022. House Bill 829, if signed by the Governor, will provide school boards the flexibility to fulfill school counselor staffing requirements by allowing individuals who are not currently licensed as school counselors to seek provisional licenses or by contracting with outside entities to fulfill their staffing requirements (VA H.B. 829, 2022). Even with the option to apply for provisional licensure, the time and financial commitment needed to complete a degree program are prohibitive for many. For those that already possess a graduate level degree, the time and financial commitment of seeking an

additional graduate degree to qualify for licensure present significant barriers. These barriers also contribute to a lack of diversity in the SMHP workforce.

There is existing precedent within Virginia for these programs within other high needs areas in education. VCU, for example, already provides certificates in special education, teaching English as a second language, elementary education, reading specialist, and educational leadership (VCU, 2021). These SMHP certificate programs would focus on the most crucial courses needed for the student's chosen SMHP career path while drastically cutting the number of hours required in areas where these professionals already have comparable training, and thus the amount of tuition, without sacrificing the educational content as it would build upon prior degrees.

Leveraging existing partnerships with colleges and universities that already provide certificate programs, and intentionally recruiting HBCUs to offer such programs, is crucial for the success of the certificate programs and long-term pipeline success.

Grant Funding. VDOE should provide similar grant opportunities for higher education institutions that plan to offer SMHP graduate certificate programs with discounted tuition options for some or all program participants. Precedent has also been set for funding certificate programs in high needs areas. The COVE (Certifying Online Virginia Educators) Program, for example, was a grant funded program housed out of VCU that offered reduced tuition rates for special education students working on coursework in special education general education curriculum with the intention of seeking special education licensure in Virginia (VCU, 2019). This online only program provided quality educational services to special education teaching candidates who may have not been able to complete licensure through the traditional pathway.

Additionally, VDOE should provide grant funding opportunities to K-12 school divisions that establish SMHP GYO programs within their divisions. Though there are few examples that exist for GYO programs in the area of school mental health, these programs provide the potential to increase the pipeline of SMHPs through recruitment of community members who are representative of that schools' population. Both federal funding (Schmitz et al., 2021) and funding from the Virginia General Assembly (VDOE, 2019) have been used to support GYO programs for teacher recruitment. To further incentivize effective school division SMH practices, grant funding opportunities could be contingent upon school divisions incorporating recommendations from VDOE guidance.

Recommendation 5: Policy Recommendations

The Capstone team recommends that VDOE OoSS assist in the development of legislation, regulations, and policy updates in three areas: the definition of roles and responsibilities for SMHPs, SMHP staffing in the SOQs, and required staff professional development in the area of student mental health. These recommendations are made based on current literature review and findings, however, it is imperative that VDOE OoSS consider data collected through the implementation of their statewide data collection tool to ensure that changes are data driven and meet the needs of Virginia students.

Defining Roles and Responsibilities of SMHPs

It is recommended that VDOE OoSS support efforts to codify the role and appropriate responsibilities for each category of SMHPs in Virginia, in addition to making recommendations regarding time allocation, while considering the variety of needs across Virginia's geographic and size diverse school divisions. The specific responsibilities and time allocation recommendations should be drawn from data collected as well as the recommended roles and

responsibilities summarized in Appendices I and J (ASCA, 2021; NASP, 2021; SSWAA, 2021). Currently, the Code of Virginia only includes one code that specifies time allocation for any SMHP category (§ 22.1-291.1:1, 1996/2019). This code outlines that school counselors should spend at least 80% of their time during the normal school day engaged in direct counseling of individual students or groups of students. Though this code specifies time allocation, there is no definition of what appropriate direct counseling services entail.

As VDOE supports efforts to specify time allocation, it is recommended that they consider whether additional context is needed within that existing code to ensure time allocation for school counselors is consistent with recommendations drafted for other SMHPs. Data collected through MSC administration, the work of the established task force, and existing recommendations of SMHP affiliated professional organizations should inform the specific code recommendations for each SMHP job category. Additionally, VDOE should work collaboratively with the Virginia Department of Health to develop updated proposals for the time allocation of school nurses, ensuring they account for the varying backgrounds and licenses of the personnel who fill school health positions.

SOQ Policy

Current Virginia SOQs require school boards to provide three specialized student support positions per 1,000 students (§ 22 1-253.13:2.O, 1996/2021). These positions may include school-employed SMHPs or community-based practitioners contracted by the division to provide service to students. This law does not take into account the vastly different professional skills and responsibilities of different specialized support positions. After reviewing data submitted by the divisions regarding current staffing, student mental health needs, and professional responsibilities of SMHPs and recommendations outlined in America's School Mental Health

Report Card (Hopeful Futures Campaign, 2022), it is recommended that VDOE OoSS support changes to Virginia Code Title § 22 1-253.13:2.O (1996/2021), to include more specific recommendations for ratios by position, rather than by category.

The Hopeful Futures Campaign is a coalition of 17 national organizations focused on ensuring all schools in the United States have a comprehensive mental health plan that meets the needs of all students (2022). Recommendations made by this organization indicate that school boards should be required to employ one school counselor per every 250 students, one school social worker per every 250 students, and one school psychologist per every 500 students. Their recommendations do not incorporate ratios for school nurses or for additional specialized support positions. VDOE is encouraged to use data collected through the MSC tool, as well as data regarding current SMHP vacancies, to determine an appropriate ratio for other specialized support positions, as well as when it is appropriate for community-based practitioners contracted by the school division to meet these ratio requirements.

As illustrated in Table 5, there is a significant discrepancy between current SMHP to student ratios in Virginia and those recommended by the Hopeful Futures Campaign (2022). However, in recent years VDOE has made more policy specific to school counselors than other SMHP positions, which may be a contributing factor to a closer alignment between actual and recommended ratios of school counselors to students. While this indicates that policy can positively impact staffing practices, it is imperative that VDOE employ all prior recommendations to support sustainable staffing and structural practice, in order to ensure updated ratio recommendations can be met.

Table 5

Current Ratio of SMHPs to Students in Virginia as Compared to National Recommendations

SMHP Position	Current Ratio in Virginia (SMHP to Student)	Recommended Ratio (SMHP to Student)
School Psychologist	1 : 1,623	1 : 500
School Social Worker	1 : 2,067	1 : 250
School Counselor	1 : 345	1 : 250

Note: This table was adapted from data provided by the Hopeful Futures Campaign. *America's School Mental Health Report Card.* (2022).

Professional Learning Policy

This team recommends that VDOE OoSS propose policy updates to the law that requires each local division to provide mandated mental health professional development, at a minimum, annually. Current Virginia Code indicates that "school boards are required to adopt and implement policies that require each teacher and other relevant personnel, as determined by the school board, employed on a full-time basis, to complete a mental health awareness training or similar program at least once (§ 22.1-298.6, 1996/2020)." This law leaves much to interpretation by divisions in terms of what this training should consist of, who should take the training, and when it should occur. School divisions would benefit from clearer language establishing an annual requirement and differentiation based on role within the division. It is recommended that Requirements for annual, differentiated professional development would support divisions in policy compliance that also helps ensure training quality. Providing divisions with flexibility in how they meet this requirement is essential in order to account for varying levels of capacity to

create and facilitate internal training. For example, divisions may determine it is most efficient to bring in trainers from an outside organization who employ evidence-based or evidence-informed programs such as Mental Health First Aid (National Council for Mental Wellbeing, 2022) or Psychological First Aid (The National Child Traumatic Stress Network, n.d.), while other school divisions may determine they have the staffing capacity and expertise to develop these professional learning programs internally.

Recommendation 6: Establish Task Force and School Guidance Document

To support all of these recommendations, VDOE OoSS should develop a comprehensive guidance document for Virginia's schools, incorporating areas of focus and pulling from suggested content and verbiage in Appendix H. This Capstone team recommends that VDOE do so in a collaborative and "user-centered" way by establishing a task force that can build upon critical needs surfaced in this Capstone. It is critical that all voices are represented on this task force, including representatives from all geographical locations in Virginia as well as administrators, teachers, SMHPs, parents and students. As the task force develops guidance for schools regarding structural and staffing best practices, it is imperative that they provide VDOE with updates on budgetary and policy considerations that would support school and division level implementation of these recommendations. In alignment with VDOE action recommendations made throughout this section, as well as the detailed guidance provided in Appendix H, major areas for the task force to address through VDOE guidance include:

- Ongoing internal data collection to drive continuous planning by assessing (a) existing community partnerships that result in direct student mental health support within the school environment; (b) virtual mental health supports within the school environment; (c) responsibilities assigned to each of the five SMHP roles;

and (d) approximate percentage of time allocated to direct student mental health support by each SMHP direct student mental health support.

- The creation of tiered mental health interventions or the incorporation of mental health supports into an existing tiered system of support. Recommendations regarding tiered mental health supports should include (a) universal practices for all students; (b) additional tiered supports for students in need; (c) the use of universal screening data; (d) defining the roles of SMHPs in tiered interventions; community engagement in mental health supports; (e) the use of community-based mental health providers and virtual services; and (f) ongoing professional learning for staff regarding student mental health.
- Aligning division and school level roles and responsibilities of SMHPs with definitions and recommendations made by VDOE.
- Developing GYO programs and other recruitment opportunities to support increasing the SMHP pipeline at the division level.
- Providing annual, differentiated professional development to staff based on their role in providing student mental health support.

By utilizing a state level task force, VDOE can gather the necessary input from key stakeholders including teachers, administrators, superintendents, current SMHPs, students, and community members. A collaborative effort will ensure that school divisions have the input and capacity to close gaps and that all students have equitable access to high quality mental health services in schools.

Conclusion

The mental health needs of students are vast. The need for increased access to mental health support for students in school is well documented (Hoover & Bostic, 2021; Leiva et al., 2021; Ohrt et al., 2020; Weist, 1997). In recent years, Virginia has responded to this need by increasing the ratio of SMHPs to students through legislation (Virginia Code § 22 1-253.13:2.O, 1996/2021), developing standards for social-emotional learning (VDOE, 2021b), and developing suicide prevention guidelines for schools (Virginia Board of Education, 2020). While there is significant work that needs to be done in order to ensure all students in Virginia have access to equitable and quality mental health supports, implementing these staffing and structural recommendations will result in both immediate and long term-positive outcomes for Virginia's students. These changes, however, must be supported through legislative action and appropriate funding. Student mental health is a recognized concern and one that has gained traction in both the private and public sector. Continued advocacy by legislators like Senator Jennifer McCellan of Richmond and from advocacy private groups such as Voices for Virginia's Children have resulted in few substantial changes to policy and funding that have not met the need. As stated by the director of policy and programs for Voices for Virginia's Children, Allison Gilbreath, "Ultimately, both parties have been in power over the last ten to 15 years and in each scenario, children's mental health has not adequately been funded (Paviour, 2022)."

VDOE's commitment to improving these services is reflected in its request for assistance with ways to increase student access to mental health support and the number of licensed SMHPs in Virginia (Saimre, 2021). This capstone team has responded to the request for assistance from VDOE OoSS with comprehensive recommendations informed by problem and context analysis, review of the literature, and a mixed-methods study that consisted of analysis of public facing

documents regarding student mental health services, a survey of Virginia SMHPs and administrators, and focus groups of prospective SMHPs. The major recommendations in this chapter include specific suggested actions for VDOE OoSE as well as information it can use in the resources it develops for school systems.

It is the hope of this capstone team that continued advocacy and commitment from our VDOE OoSE partners will implement the recommendations above to help school systems address the diverse mental health needs they face. When our schools are appropriately equipped with the necessary resources, only then will they be able to support the mental health needs of all students.

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Appendix A

VDOE's Request for Assistance

Date: March 15, 2021

Client: Virginia Department of Education

Contact Person: Maribel Saimre, Director of Student Services

Contact phone and email: Maribel.Saimre@doe.virginia.gov or (804) 225-2818

Statement of Problem

The need for mental health services in schools far exceeds the educational and mental health systems' capacity to provide those services. In Virginia, school-based mental health service is primarily provided by specialized student support personnel licensed by the Virginia Board of Education, such as school counselors, school psychologists, and school social workers. Their capacity to offer mental health services depends greatly on their scope of responsibilities within the school division and ratios of provider to student populations. The *Code of Virginia* § 22.1-253.13:2 delineates staffing expectations for school counselors, dependent on student population, in the Virginia's Standards of Quality (SOQ). In contrast, currently there are no minimum staffing requirements for school psychologists and school social workers outlined in the SOQ. Consequently, there is great variability among school division staffing ratios for these positions, with almost all school divisions in Virginia exceeding recommendations set by the national professional associations.

While the average caseloads for school mental health professionals (SMHP) in Virginia are well over those recommended by national professional associations, there are initiatives to reduce the ratios for SMHPs in Virginia. In 2020, the Virginia Board of Education recommended that the SOQ be amended to establish minimum staffing level new standards that would require school divisions to staff SMHPs (to include school psychologists, social workers, and nurses) at a minimum 4:1000 ratio. HB 1257 of the 2021 General Assembly session adapted this recommendation to require that local schools employ three specialized support services staff per 1,000 students. Similarly, legislation in 2020 (SB 880 and HB 1508) lowered the school counselor-to-student ratio to 1:325 beginning in the 2021-2022 school year. Although these initiatives and legislations reflect a commitment to increasing the number of SMHPs across the state, they do not address the limited pipeline of professionals licensed to work in schools and available to fill these positions.

The need to expand the pipeline of school mental health professionals is not unique to Virginia. Some states have dealt with this challenge by opening up paths to obtain licensure in a specialized student support personnel field, for example through availability of provisional

licenses while coursework is completed or allowing for a re-specialization in a related field. Other states have explored providing increased training in education to already licensed mental health professionals such as clinical psychologists, licensed professional counselors, and licensed clinical social workers.

While there is consensus in Virginia that there is a critical need to increase school-based mental health services in our schools, there is no clear path for expanding the pipeline of professionals qualified to provide these services.

Background

Need for Mental Health Services

The onset of symptoms for common mental health disorders often occurs during childhood and peaks during adolescence (Das et al., 2016). It is estimated that 20 percent of adolescents suffer from a mental health condition, yet fewer than half receive treatment (Kessler et al., 2005). Students in low-income and rural school divisions have increased barriers to mental health treatment (CDC, n.d.; Stagman & Cooper, 2010) due to a lack of qualified mental health providers, financial constraints, stigma, and location of services. This is a serious problem because youth with undiagnosed or untreated mental health disorders are at a greater risk of failure, drop out, involvement with the juvenile justice system, and overall poor educational attainment. Of all children and adolescents who receive mental health services, up to 80 percent do so in a school setting (Rones & Hoagwood, 2000). However, national data suggest that up to 90 percent of students lack access to SMHPs (ACLU, n.d.). Overall, this research shows that schools play a critical role in the prevention and treatment of mental health difficulties that lead to a broad range of youth adaptation difficulties, but that schools currently do not reach the majority of youth who need mental health services.

There is an urgent need for SMHPs to provide prevention and intervention services to address a series of behavioral health issues, including youth suicide and alcohol and substance use. According to the Virginia Department of Health (VDH), 49 children and adolescents between five and nineteen years old died by suicide in 2017 (VDH, 2019). In the 2019 Virginia Youth Survey, 16 percent of ninth through twelfth-grade students had seriously considered suicide in the previous 12 months and 7 percent had attempted suicide at least once in the previous 12 months (VDH, 2020). Regarding alcohol and substance use, a 2015-2016 survey indicated that 2 percent of Virginia adolescents between the ages of 12 and 17 needed, but did not receive, treatment at a specialty facility for alcohol use and 3 percent needed, but did not receive, treatment at a specialty facility for illicit drug use, and 4 percent of Virginia adolescents in that age range had misused pain relievers in the past year (Substance Abuse and Mental Health Services Administration, 2017).

Virginia State Licensure Requirements

School counselors, school psychologists, and school social workers employed by Virginia school divisions are licensed by the Virginia Board of Education. Virginia regulations (8VAC20-23-670) require that school counselors complete an approved school counselor preparation program, which includes at least 200 hours of internship in schools, and have two successful years of full-time teaching experience or two successful years of full-time experience as a school counselor. Thus, a Licensed Professional Counselor (licensed by the Department of Health Professions) with significant education, training, and experience in counseling is only able to apply for licensure as a school counselor after completing additional coursework as a degree seeking student in a school counselor preparation program, an internship in the schools, and have two successful years of full-time teaching or school counseling experience. Similarly, Virginia regulations (8VAC20-23-690) require that school psychologists complete an approved graduate program in school psychology, including a one-year internship with at least half being completed in the schools, or hold a valid certificate from the National Certification Board in School Psychology (NCSP). Therefore, a Licensed Clinical Psychologist with significant education, training, and experience would also have to complete additional coursework for an additional degree and an internship in schools to be eligible for licensure to work in schools. For a school social worker, Virginia regulations (8VAC20-23-700) require that the candidate earn a Master's of Social Work degree from an accredited school with certain required courses, complete 400 clock hours of practicum experience as a school social worker or complete one successful year as a school social worker.

Resources and Support Available

The Office of Student Services at the Virginia Department of Education would assign a single point of contact to serve as a liaison to the Capstone team. This individual would serve to connect the team to data sets, documents, research items, and any other needed resources owned by the Department of Education that would assist in completing this project. Additionally, the Capstone team would have access to relevant specialist staff in the Office of Student Services, such as the school counseling specialist, school psychology specialist, and the school social work specialist, as well as staff in the Office of Licensure.

Expected Products and Timeline

It is expected that the Capstone Team would produce an executive summary that would outline possible paths to expand the pipeline of school-based mental health providers. This report would also include key considerations as well as recommendations for policy change.

Appendix B

Group Search Narrative

As we started to dive deeper into the current state of education and how the mental health needs of students are being met, we used the following search terms to begin collecting research.

Search Terms for Literature Review

General Search Terms
mental health professionals in schools
mental health partnerships
nonprofit mental health services
community school relationships
roles of school mental health providers
school mental health
implementation school teams
student mental health services
student support
school mental health programs
student mental health interventions
K-12 mental health professionals
MTSS
VTSS
COVID K-12 mental health
school behavior analysts role
school behavior analysts
school behavior analysts recruitment
Virginia legislation school mental health professionals
South Carolina school mental health professionals
North Carolina school mental health professionals
Colorado school mental health professionals
Maryland school mental health professionals
pandemic school mental health professionals
states leading mental health schools

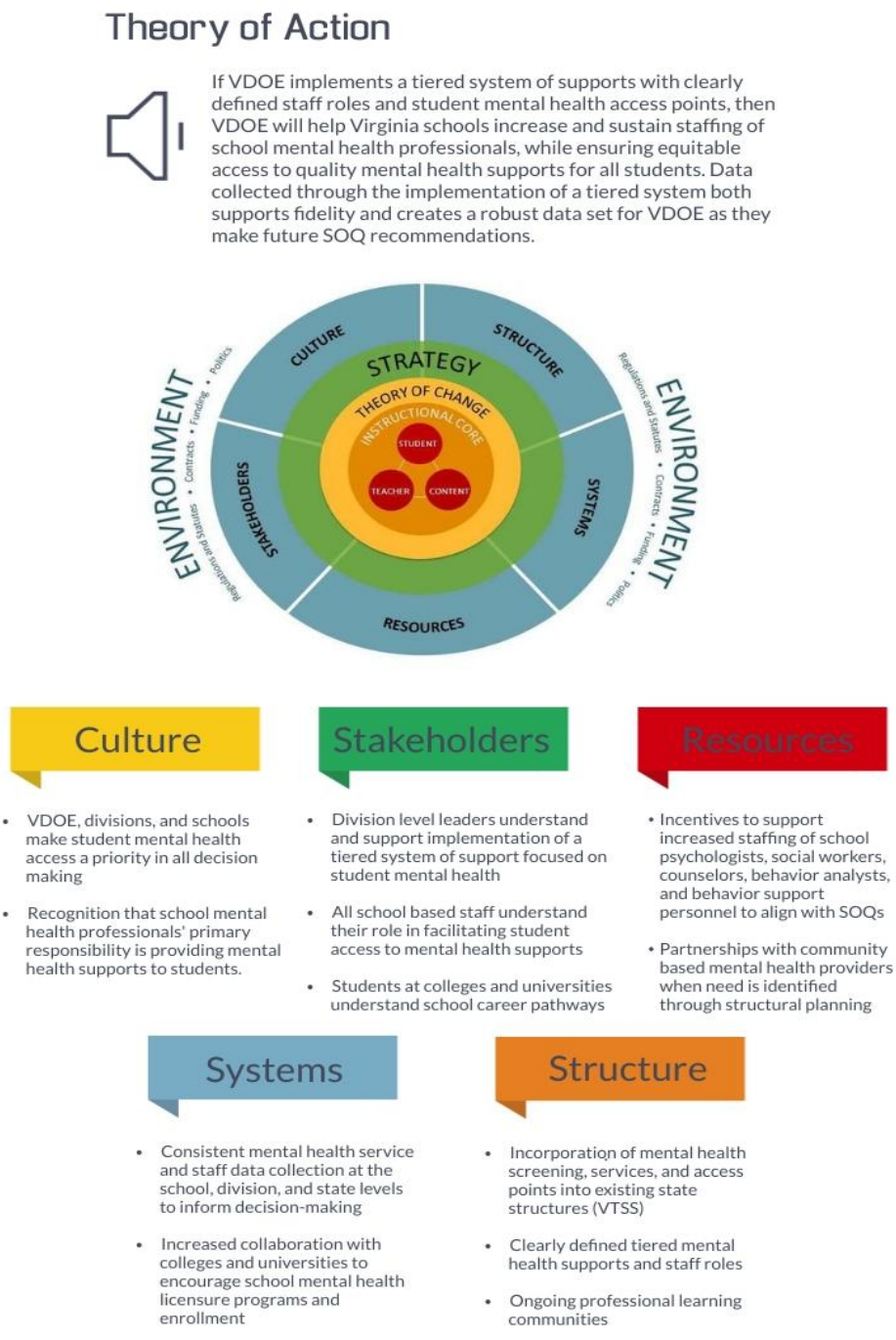
In order to obtain a diverse and relevant sampling of information based on these search terms, we used the online library for VCU, Google News, and Google Scholar. We also looked closely at the references and sources from more pertinent publications and found additional sources. These platforms allowed us to find a variety of peer-reviewed articles and current news publications.

We first posted our research into a topic organizer and further striated our research with a theme grid to categorize information into six identifiable themes:

1. Current policy
2. Roles and responsibilities
3. Recruitment and retention
4. Increased need post-COVID
5. Current mental health practices

Appendix C

VDOE Increasing student Mental Health Access: PELP Coherence Framework

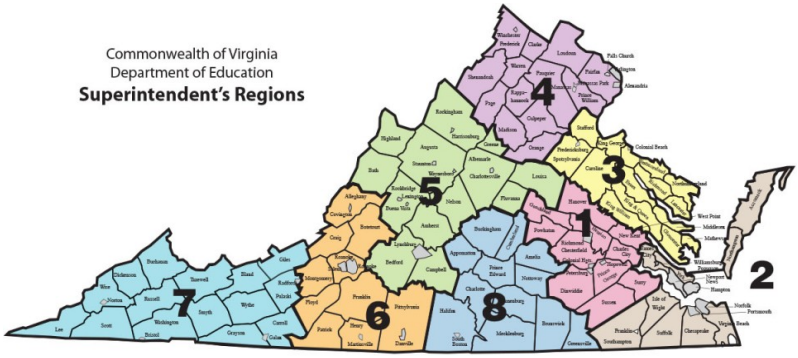


Note: This figure is an adaptation of the PELP Coherence Framework created by the Public Education Leadership Project at Harvard Graduate School of Education.

Appendix D

Survey Questions Added to SurveyPro

Survey Question	**Audience**
What is your current role? ● School Counselor ● School Psychologist ● School Social Worker ● Licensed Behavior Analyst ● Licensed Behavior Analyst Assistant ● Other licensed mental health and behavioral position ● Executive level (Superintendent or Assistant Superintendent) ● Building Administrator (Principal or Assistant Principal) ● division-level Supervisor over School Mental Health Professionals ● Other: _____	**Question branches based on response. All SMHPS continue with survey as shown.**
What is your gender? ● Female ● Male ● Non-binary/third gender ● Prefer not to answer	SMHPs only
What is your race? ● Indigenous ● Asian ● Black or African American ● Hispanic or Latinx ● Middle Eastern or North African ● Native Hawaiian or Other Pacific Islander ● White ● Multiracial (please specify): ____ ● Self-Identify: ____	SMHPs only
What is your ethnicity? ● Hispanic or Latino ● Not Hispanic or Latino	SMHPs only
How many years of experience do you have in education? ● Drop down response ranging from “my first year”, 1, 2, …., 30, 30+	Everyone

How many years of experience do you have in your current role? ● Drop down response ranging from "my first year", 1, 2, …., 30, 30+	Everyone
According to this map from the Virginia Department of Education, in which Region is the school division where you are currently employed?  	Everyone
What school level are you currently working in? ● Pre-School ● Elementary School ● Middle School ● High School	SMHPs and Building admin
In your school, what is the certification level of the lead health care provider who works in your clinic? ● No medical endorsement ● RN ● LPN ● CNA	SMHPs and Building admin
How much time do you spend on the following tasks? **Administrative** ● Scheduling ● Academic and Career Plans ● Truancy ● Residency **Testing/Evaluations** ● Special Education testing ● Classroom/student observation ● Threat assessments ● Suicide/Self Harm Risk Assessments **Meetings** Participate in: ● Child study (as participant)	Everyone answers these questions- wording is changed for admins "how much time do your SMHPs spend on..." Each bold header is a separate question

• Child study (as chair) • 504 meetings (as participant) • 504 meeting (as chair) • IEP meetings • Attendance Meetings **Student Services** • Whole class lessons • Small group • Direct support and intervention to students • Direct mental health services • Career guidance • Address behaviors • Provide crisis intervention • Develop Student Safety Plans • Suicide/Self Harm Risk Assessments • Transition plans after long-term absences **Teacher Support** • Observations • Assist with developing behavior plans **Parent Communication** • Provide advocacy and linkage to community-based services and resources • Review evaluation reports	
Please provide any additional information you believe may be helpful to our research of *Staffing and Structures around School Mental Health Professionals.*	Everyone
If you would like to be entered into the drawing for a $10 Amazon gift card, please enter your email address below	Everyone
How many years of experience do you have in education? • Drop down response ranging from “my first year”, 1, 2, …., 30, 30+	
How many years of experience do you have in your current role? • Drop down response ranging from “my first year”, 1, 2, …., 30, 30+	
What level are you working in? • Pre-School • Elementary School • Middle School • High School	

In your school, who is employed to cover your clinic? ● RN ● LPN ● CNA ● Health Clinic Specialist (no endorsement)	
Please indicate whose primary responsibility each of the tasks are. **Administrative** ● Scheduling ● Academic and Career Plans ● Truancy ● Residency **Testing/Evaluations** ● Special Education testing ● Classroom/student observation ● Threat assessments **Meetings** ● Participate in: ○ Child study ○ 504 meetings ○ IEP meetings ○ Attendance Meetings ● Chair 504 meetings ● Chair Child Study Meetings **Student Services** ● Whole class lessons ● Small group ● Direct support and intervention to students ● Direct mental health services ● Career guidance ● Address behaviors ● Provide crisis intervention ● Develop Student Safety Plans ● Suicide/Self Harm Risk Assessments ● Transition plans after long-term absences **Teacher Support** ● Observations ● Assist with developing behavior plans **Parent Communication** ● Provide advocacy and linkage to community-based services and resources ● Review evaluation reports ● Transition plans after long term absences	
How much time do your SMHPs spend on the following tasks??	

Administrative ● Scheduling ● Academic and Career Plans ● Truancy ● Residency **Testing/Evaluations** ● Special Education testing ● Classroom/student observation ● Threat assessments **Meetings** ● Participate in: ○ Child study ○ 504 meetings ○ IEP meetings ○ Attendance Meetings ● Chair 504 meetings ● Chair Child Study Meetings **Student Services** ● Whole class lessons ● Small group ● Direct support and intervention to students ● Direct mental health services ● Career guidance ● Address behaviors ● Provide crisis intervention ● Develop Student Safety Plans ● Suicide/Self Harm Risk Assessments ● Transition plans after long-term absences **Teacher Support** ● Observations ● Assist with developing behavior plans **Parent Communication** ● Provide advocacy and linkage to community-based services and resources ● Review evaluation reports ● Transition plans after long term absences	
Which of the following roles and responsibilities fall on your school social worker? **Administrative** ● Scheduling ● Academic and Career Plans ● Truancy ● Residency	

Testing/Evaluations ● Special Education testing ● Classroom/student observation ● Threat assessments **Meetings** ● Participate in: ○ Child study ○ 504 meetings ○ IEP meetings ● Chair 504 meetings ● Chair Child Study Meetings **Student Services** ● Whole class lessons ● Small group ● Direct support and intervention to students ● Direct mental health services ● Career guidance ● Address behaviors ● Provide crisis intervention ● Develop Student Safety Plans ● Suicide/Self Harm Risk Assessments ● Transition plans after long-term absences **Teacher Support** ● Observations ● Assist with developing behavior plans **Parent Communication** ● Provide advocacy and linkage to community-based services and resources ● Review evaluation reports ● Transition plans after long-term absences	
Which of the following roles and responsibilities fall on your school psychologist? **Administrative** ● Scheduling ● Academic and Career Plans ● Truancy ● Residency **Testing/Evaluations** ● Special Education testing ● Classroom/student observation ● Threat assessments **Meetings** ● Participate in:	

○ Child study ○ 504 meetings ○ IEP meetings ● Chair 504 meetings ● Chair Child Study Meetings **Student Services** ● Whole class lessons ● Small group ● Direct support and intervention to students ● Direct mental health services ● Career guidance ● Address behaviors ● Provide crisis intervention ● Develop Student Safety Plans ● Suicide/Self Harm Risk Assessments ● Transition plans after long-term absences **Teacher Support** ● Observations ● Assist with developing behavior plans **Parent Communication** ● Provide advocacy and linkage to community-based services and resources ● Review evaluation reports ● Transition plans after long-term absences	
Which of the following roles and responsibilities fall on your other licensed mental health and behavioral positions? **Administrative** ● Scheduling ● Academic and Career Plans ● Truancy ● Residency **Testing/Evaluations** ● Special Education testing ● Classroom/student observation ● Threat assessments **Meetings** ● Participate in: ○ Child study ○ 504 meetings ○ IEP meetings ● Chair 504 meetings ● Chair Child Study Meetings **Student Services**	

● Whole class lessons ● Small group ● Direct support and intervention to students ● Direct mental health services ● Career guidance ● Address behaviors ● Provide crisis intervention ● Develop Student Safety Plans ● Suicide/Self Harm Risk Assessments ● Transition plans after long-term absences **Teacher Support** ● Observations ● Assist with developing behavior plans **Parent Communication** ● Provide advocacy and linkage to community-based services and resources ● Review evaluation reports ● Transition plans after long-term absences	

Appendix E

Focus Group Questions

Questions for an Undergraduate and Graduate Student Focus Group

1. I would like to start by learning more about each other. Can you introduce yourself and provide a little background on your work or experience, such as what is your current field of study and anticipated graduation date?
2. What are your plans following graduation (employment, graduate school, travel, etc.)?
3. Why did you select your current field of study (ex: what drew you to it or convinced you to major in it)?
4. Did you experience any type of recruitment effort that helped to persuade you to major in this field (ex: college fair, department flyers, or social event)
    a. If yes, was any recruitment strategy intentionally targeted to you because of your race, sexual identity, location, or another factor?
5. Would you ever consider utilizing this degree to work in schools as a mental health professional? And if so, what do you anticipate your roles and responsibilities to be upon employment in a school-based setting?
6. Are you aware that there are six different career tracks that are considered "School Mental Health Professionals"?
    a. Those include School Psychologists, School Social workers, School Counselors, School Nurses, Licensed Behavior Analysts and Assistants, and other licensed mental health and behavioral positions.
7. Do any of those six positions sound of interest to you?
    a. If yes, which one/s and why? Are you already aware of their licensing requirements?
    b. If no, why not?
8. What do you perceive to be the biggest barrier in employing students with similar degrees as practicing School Mental Health Professionals (ex: too much school, the pay, lack of interest, lack of knowledge about opportunities)?
9. Based on the personal experiences of yourself and your peers, do you have any recommendations for future recruitment efforts to increase the pipeline from undergraduates like yourselves to employment as a school mental health professional?

Questions for a Community Mental Health Professional Focus Group

1. I would like to start by learning more about each other. Can you introduce yourself and provide a little background on your work or experience, including your current position and years of experience in community mental health?
2. Have you or do you plan to pursue employment as a school mental health professional?
    a. If yes - where and why?
    b. If no - why not?
3. Are you aware that there are six different career tracks that are considered "School Mental Health Professionals"?

    a. Those include School Psychologists, School Social workers, School Counselors, School Nurses, Licensed Behavior Analysts and Assistants, and other licensed mental health and behavioral positions.
4. What drew you to your particular field instead of school-based mental health work?
5. How do you anticipate that your roles and responsibilities would change in a school-based setting if you were to switch careers?
6. Are you aware of the current licensing requirements to work in a school?
    a. If yes, tell us about your experience with becoming educated on and/or completing those requirements?
    b. If no, explain any challenges you have experienced with licensure.
7. Did you experience any type of recruitment effort to consider a school-based mental health career when in school? (ex: college fair, department flyers or social events, etc.)?
    a. If yes, was any recruitment strategy intentionally targeted to you because of your race, sexual identity, location, or another factor?
8. Based on the personal experiences of yourself and your peers, do you have any recommendations for future recruitment efforts to career-switchers for employment as a school mental health professional?

Appendix F

Survey Responses: Time Allocation

Allocation of Time for Responsibilities

Job Responsibility	Role	N	Mean	Std. Deviation	Std. Error Mean	p	Mean Difference
Scheduling	SMHP	131	2.0382	1.55615	0.13596	0.055	-0.38665
	Admin	66	1.6515	1.34155	0.16513		
Academic Career Plans	SMHP	131	1.8779	1.30102	0.11367	0.000	0.04638
	Admin	66	1.9242	0.93333	0.11488		
Truancy	SMHP	132	1.4924	1.17542	0.10231	0.717	0.18939
	Admin	66	1.6818	1.08357	0.13338		
Residency	SMHP	132	0.6364	0.90184	0.07850	0.760	0.34825
	Admin	65	0.9846	0.94360	0.11704		
Special Education Testing	SMHP	134	0.9701	1.45582	0.12576	0.896	0.92379
	Admin	66	1.8939	1.42644	0.17558		
Student Observation	SMHP	134	1.6493	1.19055	0.10285	0.010	0.18408
	Admin	66	1.8333	0.98580	0.12134		
Threat Assessments	SMHP	133	1.6692	0.90220	0.07823	0.041	-0.01766
	Admin	66	1.6515	0.73364	0.09030		
Suicide Assessment	SMHP	133	2.1504	1.04081	0.09025	0.002	-0.38115
	Admin	65	1.7692	0.74518	0.09243		
Child Study Participant	SMHP	134	2.1045	1.25218	0.10817	0.165	0.07734
	Admin	66	2.1818	1.02145	0.12573		
Child Study Lead	SMHP	133	0.2556	0.75533	0.06550	0.000	0.80497
	Admin	66	1.0606	1.31124	0.16140		
504 Participant	SMHP	133	1.7444	1.22260	0.10601	0.096	-0.17090
	Admin	66	1.7273	1.00070	0.12318		
504 Lead	SMHP	134	0.7239	1.31156	0.11330	0.384	0.18521
	Admin	66	0.9091	1.17313	0.14440		
IEP Meeting	SMHP	134	1.6119	1.12998	0.09762	0.242	-0.19656
	Admin	65	1.4154	1.01385	0.12575		
Attendance Meeting	SMHP	134	1.4179	1.20960	0.10449	0.001	0.24876
	Admin	66	1.6667	0.88289	0.10868		
Attendance Lead	SMHP	134	0.5597	1.17947	0.10189	0.754	0.42515
	Admin	66	0.9848	1.07406	0.13221		

Job Responsibility	Role	N	Mean	Std. Deviation	Std. Error Mean	p	Mean Difference
Class Lesson	SMHP	134	2.0299	1.35968	0.11746	0.002	0.1560
	Admin	66	2.0455	1.04413	0.12852		
Small Group Lesson	SMHP	134	1.9179	1.24483	0.10754	0.002	0.23360
	Admin	66	2.1515	0.88130	0.10848		
Student Intervention	SMHP	134	3.2164	1.10611	0.09555	0.228	-0.59521
	Admin	66	2.6212	0.87293	0.10745		
Student Mental Health	SMHP	134	2.7313	1.17085	0.10115	0.006	-0.57983
	Admin	66	2.1515	0.93220	0.11475		
College Career	SMHP	134	1.6045	1.48181	0.12801	0.000	0.06219
	Admin	66	1.6667	0.99743	0.12278		
Student Behavior	SMHP	132	2.7197	1.14794	0.09992	0.326	-0.61200
	Admin	65	2.1077	1.09149	0.13538		
Crisis Intervention	SMHP	133	2.6391	1.11013	0.09626	0.000	-0.66940
	Admin	66	1.9697	0.85880	0.10571		
Student Safety Plan	SMHP	134	1.8507	1.01498	0.08768	0.501	-0.15378
	Admin	66	1.6970	0.91095	0.11213		
Absence Transition Plan	SMHP	133	1.3910	1.07896	0.09356	0.003	-0.14855
	Admin	66	1.2424	0.84235	0.10369		
Staff Observation	SMHP	109	1.1560	1.25591	0.12029	0.014	-0.19944
	Admin	46	0.9565	0.98785	0.14565		
Behavior Mgmt Plan	SMHP	132	1.2727	1.21750	0.10597	0.006	0.19602
	Admin	64	1.4688	0.92528	0.11566		
Link Comm Resources	SMHP	134	2.5224	0.94762	0.08186	0.000	-0.47693
	Admin	66	2.0455	0.71105	0.08752		
Review Evaluation Reports	SMHP	134	1.5672	1.17906	0.10186	0.069	0.20556
	Admin	66	1.7727	1.01974	0.12552		
Parent CommunTransition	SMHP	133	1.3083	1.06729	0.09255	0.001	-0.08100
	Admin	66	1.2273	0.78044	0.09607		
Parent Commun Suicide Assess	SMHP	134	2.0746	1.14134	0.09860	0.001	-0.40796
	Admin	66	1.6667	0.68687	0.08455		

Note. Response choices for participants were as follows: *none* (0), *very little* (1), *some* (2), *quite a bit* (3), or *a great deal* (4). This table includes data for all 30 job responsibilities included.

Appendix G

Phased Staffing and Structural Recommendations for VDOE

Short-Term Years 1 and 2	**Mid-Range** Years 3 to 4	**Long-Term** Years 4 to 6
Establish a task force to create a guidance document for schools on structural and staffing considerations for mental health integration into schools Update the MSC to include numbers and licensure type of "other" SMHPs, along with SMHP title updates for alignment Operationally define the roles and responsibilities of all SMHPs and collaborate with legislators, the governor, and the General Assembly to update these definitions in the Code of Virginia Provide guidance to divisions regarding division-level internal data collection to assess how SMHPs are being utilized Make current MTSS/VTSS documents available to all schools Collaborate with universities to increase awareness of SMHP professions	Publish the mental health integration guidance document for schools created by the task force. This will include guidance pertaining to structural and staffing considerations and effective implementation of mental health services in schools Create and disseminate intentional marketing materials for recruitment of SMHP graduate programs to undergraduate social work and psychology students. Special attention should be paid to marketing at HBCUs Work with the VDOE licensure office to develop a licensure pathway to SMHPs through completion of a graduate certificate program Collaborate with universities to develop graduate certificate programs in SMHP professions in alignment with updated licensure requirements	Collaborate with legislators, the governor, and the General Assembly to update the Code of Virginia regarding: ● SMHP SOQ ratio updates specific to SMHP job category ● Requirement of annual student mental health training for school staff Establish grant opportunities for divisions creating "Grow Your Own" programs for SMHPs and tuition assistance for SMHP graduate students Create additional funding for schools or divisions that submit tiered systems of support data indicating direct mental health service to their students

Appendix H

Suggested Content for VDOE's Guidance Document for School Divisions

Local Data Collection

The use of a regular data collection tool regarding SMHP roles within a division helps school divisions ensure they are regularly assessing the number of SMHPs they have in schools both as a whole and categorically. This data collection tool should capture (a) existing community partnerships that result in direct student mental health support within the school environment; (b) virtual mental health supports within the school environment; (c) responsibilities assigned to each of the five SMHP roles; and (d) approximate percentage of time allocated to direct student mental health support by each SMHP direct student mental health support.

This data would not be provided to the state but should be used as an internal planning tool. Divisions have the flexibility to determine who supervises SMHPs and what roles and responsibilities are assigned to these SMHPs. As a result, there is a great level of variation in how SMHPs are used in Virginia. Internal data compiled through the use of this tool should be used in conjunction with subsequent recommendations to help schools leverage the skills of their current SMHPs to provide high-quality mental health support to all students. The goal of this data collection is not to create extra work for divisions, in fact, if divisions are unable to easily provide this information that is an important finding regarding the use and oversight of SMHPs which will also inform their future practice.

Integration of Mental Health Supports into a Tiered System

In order to successfully create and implement a tiered system of support for student mental health, schools and divisions must commit to taking necessary steps to support student

mental health within their school division. There is a need for ongoing data collection and review through universal screening and progress monitoring, allocating staff responsibilities in alignment with structural recommendations based on the needs defined by data, and partnering with the community to build an understanding of the role of SMHPs and other school staff in providing student mental health support (Center on Multi-Tiered Systems of Supports at the American Institutes for Research, n.d.). Schools should consider universal screeners, existing strategies, SEL instruction and implementation, building staff capacity, providing additional tiered interventions, and virtual mental health.

Universal Screeners. Data-driven decision making is a core component of successful creation and implementation of an MTSS or VTSS framework (Burns & Rapee, 2019; Center on Multi-Tiered Systems of Supports at the American Institutes for Research, n.d; VTSS RIC, 2021). While data can be collected from many sources, universal screeners are a highly effective tool used to identify a school's collective mental health strengths and needs while also identifying the strengths and needs of individual students (National Center for Safe and Supportive Learning Environments, 2021). The intention of a universal screener is not to identify or diagnose mental health disorders. Instead, universal screeners are intended to identify social and emotional risk factors related to emotional regulation, peer and adult relationships, and risky behavior within the context of the school setting that may result in negative emotional, behavioral, and academic outcomes for students (Burns & Rapee, 2019).

Evidence based universal screening may consist of (a) a survey instrument to be self completed by all students in a school; (b) systematic review of extant behavior data; (c) staff or parent completed behavior scales; or (d) any combination of these data sources (Romer et al.,

2020). While each data collection method provides valuable information related to student need, self reporting is a key component in identifying internalizing emotional and behavioral concerns.

Examine Existing Instructional Strategies That Promote Mental Health. Mental health best practices are already occurring in many classrooms even when educators are not aware they are using them. Creating a positive classroom environment, ensuring consistency through routines and procedures, teaching students how to collaborate, and providing behavior specific reinforcement are all examples of best practice in supporting student mental health (U.S. Department of Health & Human Services, 2019). For students experiencing emotional or mental distress even with these tier 1 interventions in place, classroom teachers play the integral role of linking students to the appropriate mental health staff member in the building who can support their needs (CDC, 2021b). A school's tiered system should be developed with clearly outlined practices and a clear delineation of who provides each level of support in order to ensure that all staff members know who to contact when a student is in need.

School-wide SEL. The most recent SEL standards were released by the VDOE at the beginning of the 2021-2022 school year (VDOE, 2021b). This is an indication to school divisions that SEL is a focus area for the foreseeable future. SEL competencies are broken down into the following overarching concepts (a) self-awareness; (b) self-management; (c) social awareness; (d) relationship skills; and (e) decision making. These competencies are skills that, when well-developed, support students' mental health and well-being (CASEL, 2022). However, in order to achieve this goal students must be able to generalize these skills to all environments, not just a PE classroom or a specific setting where SEL skills are taught in isolation. Instead, SEL must become an integral part of the school and classroom culture. Whether this is through morning meetings in the classroom, homerooms in secondary schools, or virtual, asynchronous

sessions, all students should engage with direct SEL instruction aligned with Virginia's SEL competencies.

All students should engage with direct SEL instruction aligned with Virginia's SEL competencies. CASEL's Guide to Schoolwide SEL is a tool that school divisions can use to support wide-scale implementation of SEL (CASEL, 2022). It includes guidance for the following areas: creating the plan, developing a shared vision for SEL, completing a needs and resource assessment, developing an action plan, and how to create a budget. It also provides guidance to use throughout implementation including strengthening adult SEL, promoting SEL for students, and how to practice continuous improvement. As a tier 1 intervention, every conversation regarding SEL should revolve around all students, ensuring that every child has access to both direct SEL instruction and SEL embedded in classroom instruction and content.

A long-term consideration for Virginia's school divisions is the adoption of a specific SEL curriculum. During this process, divisions would need to consider the incorporation of SEL into their long range plan, accounting for budgetary considerations, planning for initial and ongoing professional development for all staff involved in implementation, and would need to determine who would regularly review fidelity data to determine effectiveness of the program. Should a school division consider the adoption of an existing SEL program, focus groups could investigate a variety of available SEL curricula to determine which one would best support their students' needs. The focus groups should keep in mind that their program needs to support all students at tier 1 and possibly provide additional support within the program for students in need of tier 2 and 3 interventions. Even if a school division opts not to adopt a specific SEL program or curriculum, considerations for budgetary, personnel, and professional development still exist in order to ensure that all students are receiving high-quality SEL instruction.

Build Staff Capacity. Staff professional development is necessary to ensure all members of staff, not just teachers and SMHPs, support a culture of mental wellness. Currently, the only required annual training for teachers in the state of Virginia regarding mental wellness is the Signs of Suicide training (Commonwealth of Virginia Board of Education, 2020).While this is important for staff to understand, additional and ongoing training should occur throughout the year related to mental health and mental wellness strategies and interventions. Establishing professional learning communities surrounding tiered mental health supports will assist with ongoing learning.

These professional learning communities should be targeted to the specific needs of staff members based on the tiered interventions they are responsible for providing. For example, classroom teachers should have regular training on tier 1 best practices with a general overview of what work is being done to support students in need of tier 2 and tier 3 support. Classroom teachers should understand how to identify if a student may be in need of additional support and who to contact to request assistance for students as appropriate. It is important to reinforce to teachers and staff providing tier 1 mental health support that it is not their responsibility to provide counseling or intensive mental health interventions. Instead, it is their responsibility to incorporate appropriate strategies outlined by their schools as tier 1 interventions both consistently and with fidelity. As a result, classroom teachers may have their own professional learning community focused on these needs. In order for tiered mental health supports to be effective and sustainable, administrators need to plan for both the time and training resources necessary to support and monitor ongoing professional learning communities.

Additional Tiered Interventions for Students. Universal mental health practices provided at tier 1 meet the mental health needs of 80 to 90% of students. Data should be used to

drive decisions for the 10 to 20% of students in need of additional interventions in order to support their mental health needs. Data sources may include universal screeners, observational data, referrals by staff or family members, or student self-reporting. All students who do not experience success with tier 1 interventions alone, and who are identified through an additional data source, should gain access to small group tier 2 interventions which may include group meetings with the school counselor, mentoring groups, additional instruction on social-emotional learning, small group skill building, or other identified tier 2 interventions. These interventions will vary by school-based on the needs of the students. Additionally, these interventions are fluid and may move between tiers as the needs of the collective student population change.

Determining who provides the tiered supports is another important component for schools to consider. Figure A1, created by NASP (2018), illustrates how both structural and staffing considerations, including the use of community partners, can be integrated into a tiered system of support for students. Internal school SMHPs provide support at all levels for students in need of mental health interventions, with a heavier emphasis on tiers 1 and 2, while community partners work with students in need of more intense support by providing higher tiered interventions in conjunction with school SMHPs within tier 3. This sample can be easily adapted based on available staffing and interventions that are aligned with the needs of the student population.

Figure A1

School Psychologists' Role in Comprehensive School Mental and Behavioral Health Services

This specific model (Figure A1) focuses on the role of SMHPs but is created within the context of a structure that can be adapted to include staffing considerations outside of SMHPs. Teachers, administrators, other staff, and volunteers can be integrated into a tiered model of support in order to build staffing capacity while also increasing the diversity of service providers.

A comprehensive resource map allows schools and divisions to fluidly move interventions between tiers or staff between interventions based on findings during regular data progress monitoring. It is also an essential tool in supporting a collective understanding that every member of the staff is responsible for student mental health within different capacities.

Virtual Access to Mental Health Supports. Virtual access to mental health services provides an opportunity for increased access to high quality, equitable mental health intervention if plans are developed to effectively integrate this modality into a school's tiered system of support. Virtual mental health options have the potential to positively impact all schools and divisions. In smaller, rural communities where SMHPs are shared across the division, virtual mental health services may be provided by SMHPs, allowing them to decrease commuting while increasing direct service.

All school divisions benefit from the ability to contract with outside community-based practitioners who provide specific areas of expertise. Virtual mental health services provide the opportunity to increase the diversity of practitioners students have access to during the school day, especially for underrepresented populations of students who are more likely to engage in mental health services with practitioners from similar backgrounds (Bains & Diallo, 2016; Paternite, 2005; Sagar-Ouriaghli et al., 2020). This support increases the likelihood of students accessing services on a consistent basis by removing the barrier of parents missing work and minimizing the amount of instructional time lost in commute. It increases the likelihood of families completing consent to exchange information forms, allowing ongoing communication between school-based SMHPs and community partners. This increases student access to high quality services and the diversity of available providers without overtaxing school staff, allowing for increased time SMHPs are available to provide services to students in need who do not have

access to community-based services. Perhaps most importantly, this collaboration between schools, parents, and community-based providers creates positive relationships while promoting that schools recognize the importance of mental health.

SMHP Roles and Responsibilities

Guidance from VDOE can include suggestions to local school divisions that reflect language in the Code of Virginia, as well as additional actions that can occur at the local level. School divisions can employ recommended responsibilities for school social workers, school psychologists, and school counselors that align with recommendations from their professional organizations (ASCA, 2021; NASP, 2021; SSWAA, 2021). The duties recommended by these professional organizations largely align with the definition of each role. For example, recommended duties for school counselors such as individual goal setting, skill-building groups, and classroom counseling lessons, align with the definition of a school counselor as a "certified/licensed educator who improves student success for ALL students by implementing a comprehensive school counseling program (ASCA, 2021)." Similar findings are noted when assessing the relationship between duties and definitions of roles for school social workers and school psychologists.

One of the assets of a school mental health team are school nurses. It is estimated that a school nurse spends 33% of their time on mental health support (Bohnenkamp et al., 2015). Thus, VDOE should develop suggested roles and responsibilities for school nurses derived from professional organization recommendations, while considering the contextual factors associated with Virginia licensing. School health positions can be filled by a registered nurse, licensed practical nurse, nurse practitioner, unlicensed assistive personnel, a school health volunteer, or a school health physician (Code of Virginia § 22.1-274B & VDH, 2021).

As a result of the variety of professionals that can serve as school health positions, their educational and clinical training varies greatly and, subsequently, their role in providing mental health support within schools also varies greatly to align with their training and skill set. NASP (2016) created a Framework for 21st Century School Nursing Practice that should serve as a guide to VDOE in crafting defined roles and responsibilities for school nurses as a SMHP. The framework encourages collaborative care, motivational interviewing or counseling, implementation of systems level leadership to partner in public and mental health efforts, surveillance, and outreach. The task force developing guidance should determine if all of these responsibilities are appropriate for all personnel that could serve in a school health position, or if licensure type is important in determining which of these responsibilities are appropriate. It is recommended that the task force work collaboratively with the Virginia Department of Health when making these determinations, as they are the entity that develops state level recommendations for school nurses.

Schools and divisions will need to use professional discretion to consider contextual factors that may impact the assignment of responsibilities, however, a clear explanation of what each professional is responsible and trained for will help with both staffing and the implementation of structures to effectively meet the mental health needs of students while not overloading individual SMHPs. This may result in the reallocation of responsibilities and job functions to non-SMHP employees or hiring of additional support personnel. Additionally, this will allow for effective supervision of SMHPs in divisions where they may be supervised by instructional administration who are otherwise unfamiliar with their level of training and specific areas of expertise.

Increasing the Pipeline of SMHPs

While school divisions have the ability to send division level leadership and building administrators to college and university events, one of the most impactful ways schools can contribute to the SMHP pipeline is through recruitment in their own communities. While specific components of the GYO program would be determined by local needs and context, divisions should consider a partnership with colleges or universities that offer SMHP preparation programs. Colleges and university partners may guarantee a limited number of seats for SMHP students, with discounted tuition, if they apply through the school division's GYO program. School divisions may then agree to pay back a portion of student loans, or provide another financial incentive for SMHPs who complete a certain number of years of service upon completion of the SMHP preparation program.

Due to the nature of a division led GYO program, school counselors and other school staff will naturally discuss and promote school mental health positions as career options within the school setting. As a result, students will learn about SMHPs within the K-12 setting in a positive environment. Working in schools is a vocation that is often driven by passion rather than financial incentives. Fostering that passion in the K-12 environment is essential for long-term SMHP pipeline sustainability. Universities benefit from the predictable and ensured enrollment and divisions benefit by securing SMHPs during a time when they are in high demand. Both parties save time and money on recruitment while securing candidates familiar with the local culture and who are representative of their student population.

Appendix I

Resource Map Example: Tiered Student Mental Health Supports

Evidence-Based Practice	Entry criteria	Time and Setting	Parent Notification	Staff member responsible
Tier 1 (Universally provided. All students.)				
Provide a visual schedule for class		Daily in classroom.	Classroom syllabus	Classroom teacher
Post classroom expectations and review them regularly.			Classroom syllabus and Schoology	Classroom teacher
Teach classroom SEL lessons.		Weekly. Thursday homeroom	Parent newsletter	School SEL team creates lessons. Teacher presents lessons.
Provide a calendar of major assignments for each unit.		At the beginning of each unit. Classroom.	Schoology and teacher weekly emails	Teacher. Can be developed by content or grade level team.
Provide behavior specific praise.		Daily as appropriate. All school environments.	Syllabus	All staff
Tier 2 (Students receiving Tier 2 support are also receiving Tier 1 supports. Approximately 15-20% of the student population.)				
Small group skill building.	Universal screening indicator.	Weekly in counseling office.	Phone call & consent form.	School counselors
Check in Check Out (CICO)	Universal screening. Discipline data review. Staff referral.	Daily. Arrival & departure	Phone call & consent form	Counselor or teacher who has received CICO training.
Cognitive Behavioral Intervention Therapy (CBITs) Groups	Universal screening indicator. Staff or parent referral.	Weekly in counseling office.	Phone call & consent form	School social worker or school psychologist trained in CBITs.
Restorative Circle Homeroom	Universal screening indicator. Staff or parent referral.	2x per week in assigned homeroom.	Phone call & consent form	Restorative practice trained staff member.
Tier 3 (Students receiving Tier 3 support are also receiving Tier 1 and Tier 2 supports. Approximately 5% of the student population.)				
Therapeutic services (short term)	Tier 2 team referral.	Weekly in staff member's office.	Parent consent form	School Psychologist or Social Worker
Functional behavior assessment to address coping skills or identified mental health need	Tier 2 team referral.	Schedule within 10 days of referral.	Parent consent form p	Social Worker, School Psychologist, administrator, teacher, staff member acting as manager of FBA.
Long-term individual therapy with outside counselor. Communication between SMHPs and provider.	Determined by community based provider.	As scheduled. Access to room in school for virtual appointments.	Parent schedules appointments with school support. Signs consent to exchange.	Community based provider. Linkage with School Social Worker for progress monitoring.

Appendix J

Suggested Delegation of Tier 2 and Tier 3 Mental Health Services

	School Counselor	School Social Worker	School Psychologist	Licensed Behavior Analyst	Other SMHPs	Community Based Mental Health Provider
Tier 2 Supports						
Additional SEL Curriculum	X					
Small Group Skill Building	X					
Small Group Counseling	X					
Mentoring Groups	X					
Check in Check Out (CICO)	X					
Cognitive Behavioral Intervention (CBITs) Groups		X	X			
Tier 3 Supports						
One-to-One Student Counseling	X	X				
Transition Planning to/from outside placement	X	X	X			
Collaborative Planning w/ Community Mental Health Provider	X	X	X			
Direct Therapeutic Services (short term)		X	X			
Functional Behavior Assessment		X	X	X	X	
Long-Term Individual Therapy with Outside Counselor		X				X
Crisis Intervention			X			X
Self Harm/Suicide Risk Assessment			X			

Appendix K

Definitions and Appropriate Duties/Services of SMHP Roles

Profession	School Counselor	School Social Worker	School Psychologist
Professional Organization	American School Counselor Association (ASCA)	School Social Work Association of America (SSWAA)	National Association of School Psychologist (NASP)
Definition	Certified/licensed educators who improve student success for ALL students by implementing a comprehensive school counseling program	Trained mental health professionals with a degree in social work who provide services related to a person's social, emotional, and life adjustment to school and/or society.	School Psychologists provide direct support and interventions to students, consult with teachers, families, and other school-employed mental health professionals to improve support strategies, work with school administrators to improve school-wide practices and policies, and collaborate with community providers to coordinate needed services.
Appropriate Duties and Services	-conduct individual student planning and goal setting -conduct school counseling classroom lessons based on student success standards - provide short-term counseling to students - complete referrals for long-term support -collaborate with families, teachers, administrators, and community for student success -advocate for students for individual education plan meetings and other student-focused meetings -analyze data to identify student issues, needs and challenges -act as a systems change agent to improve equity and access, achievement opportunities for all students	-counsel (group, individual, and/or family) -provide crisis intervention -assess students with mental health concerns -assist parents in accessing and utilizing school and community resources -obtain and coordinate community resources to meet students' needs -work with staff to help them understand factors that may affect a student's performance or behavior -develop inservice trainings for staff -provide direct support to staff and assist with behavior management	-conduct psychological and academic assessments -individualize instruction and interventions -monitor student progress -assess student emotional and behavioral needs -provide individual and group counseling -reinforce positive coping skills and resilience -make referrals to coordinate community services provided in schools -support social and emotional learning -provide crisis prevention and intervention services