SCHOOL-BASED MENTAL HEALTH SERVICES

WHAT: A full array of collaborative, coordinated mental and behavioral health services for ALL students in North Carolina schools provided by well-trained personnel

WHY:

- Mental health is essential to overall health!
- Early identification and intervention is critical.
- Half of all neurobiological brain disorders (NBD) begin by age 14.
- Schools are major providers of mental health services to children and adolescents.

HOW:

- Strategic state plan developed by State Collaborative for Children and Families.
- Partnerships formed among various agencies serving children/ families – Mental Health, Public Health, DPI, DJJDP, family organizations.
- Local plan to be developed and implemented by Community Collaboratives.

DESIRED OUTCOMES FOR STUDENTS, TEACHERS:

- Improved attendance; improved test scores.
- Reduction in the gap between majority and minority students.
- Drop in retention, suspension, expulsion, and dropout rates.
- Decrease in discipline problems in classrooms.
- Improved social and emotional functioning.

DESIRED OUTCOMES FOR FAMILIES:

- Increased access to information.
- Increased access to community-based services for their children.

- Improved quality of family life.
- Enhanced support from peers, school and mental health personnel, and from the community.

DESIRED OUTCOMES FOR COMMUNITIES:

- Decreased stigma around mental health issues.
- Decreased need for more intensive mental health services.
- Fewer youth in juvenile justice system.
- Safer, more effective schools.

Healthier, more productive citizens. SCHOOL MENTAL HEALTH STRATEGIC PLAN
School-Based Mental Health Services Subcommittee
NC Collaborative for Child and Family Services

PLANNING FOR COMPREHENSIVE SCHOOL-BASED MENTAL/BEHAVIORAL HEALTH SERVICES AND SUPPORTS IN ALL NORTH CAROLINA SCHOOLS

Why was a planning effort convened?

In the spring of 2004, the State Collaborative on Child and Family Services formed the School-Based Mental Health Subcommittee to respond to the leveling-off of scores on standardized testing and growing concerns about escalating mental and behavioral needs among North Carolina students. The subcommittee quickly learned that no coordinated effort to address school mental health services and supports in the state existed. With a $10,000 seed grant from the IDEA Partnership through the Department of Public Instruction, the School-Based Mental Health Subcommittee convened a collaborative work group, representative of both state and local entities, to develop a strategic plan for comprehensive school-based mental and behavioral health services and supports. A stated assumption of the work group was that services and supports should be distributed equitably and easily accessible to all North Carolina students. In addition to increasing access to services, such a plan would also facilitate improved coordination of services, thus reducing duplication and fragmentation in service delivery. Further, a well-crafted plan allows for increased efficiency and efficacy in service delivery. Finally, careful approaches capturing and analyzing outcomes of services allows both for continuous improvements in service delivery and for access to increased and diversified funding sources.

What are indicators of the need for comprehensive school-based mental/behavioral health services?

For several years, the primary emphasis in most schools has been on improving academic skills among North Carolina students, as captured by End of Grade and End of Course testing. This important and laudable goal brought improvement in test scores. However, in many schools such improvement has tapered off, indicating the importance of analyzing any remaining barriers to continued improvement in academic performance and graduation rates. Research has repeatedly demonstrated that the mental, social, and emotional well-being of students is an important contributor to academic success. (Zins, Joseph, Weissberg, Roger P., Wang, Margaret C., and Walberg, Herbert J. *Building Academic Success on Social and Emotional Learning: What Does the Research Say?* New York: Teachers College Press, 2004.) Ensuring that students' mental, social and emotional needs are met will contribute to

- Improved test scores,
- Reduction in the gap between majority and minority students,
- Reduced retention, suspension and dropout rates,
- Improved attendance, and
- Reduced discipline problems in the classroom, which, in turn, would likely increase teacher retention, a matter of great concern across North Carolina.

Prevalence of Child and Adolescent Mental Disorders

The North Carolina Division of Mental Health/Developmental Disabilities/Substance Abuse estimates that 10 to 12 percent of the state's children meet the criteria for Serious Emotional Disturbance (SED). This prevalence rate and definition for SED are cited in the Federal Register, June 1998. The definition of SED in children is as follows:

Children with SED are persons from birth up to age 18, who are currently or at any time during the last year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the criteria specified within the DSM-IV, that resulted in functional impairment which subsequently interferes with or limits the child's role or functioning in family, school, or community activities.

(North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse*, Child Mental Health Plan,* March 2004.)

With a school population of 1,370,124 (public and charter schools) in North Carolina in 2003-04, the 10-12% SED rate translates to an estimate of between 134,725 and 161,670 children and adolescents with serious emotional disturbance in our state-supported schools in need of professional mental health care. Another 20 percent of the school population experience less severe mood, anxiety, and behavioral disorders, making the total of school children with mental health needs reaching 408,750. Approximately 70 percent of students will have no mental health needs in a given year. (NC Public School Statistical Profile 2005, http://www.ncpublicschools.org/fbs/stats/statprofile05.pdf
Adrian Angold, M.R.C. Psych. Et al., *Improving Mental Health Services for Children in North Carolina: Agenda for Action*, Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, North Carolina State Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, June 1998.)

Half of all lifetime cases of mental illness begin by age 14 and three-quarters have begun by age 24. Long delays in receiving treatment – sometimes ten years or more – lead to increased number of episodes which are more severe and more difficult to treat. Child-hood onset mental disorders which are untreated lead to academic failure and problems with employment. (CMHS Consumer Affairs E-News Vol. 05-86, *NIMH: Mental Illness Exacts Heavy Toll, Beginning in Youth,* June 2005.)

These are very treatable disorders; however, only one child in five gets the help he or she needs. This means that in North Carolina, 327,000 children are not getting the services they and their families need.
(U.S. Public Health Service, *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda.* Washington, DC: Department of Health and Human Services, 2000.)

Table 2-7. Children and adolescents ages 9 to 17 with mental or addictive disorders,* combined MECA sample

	Prevalence (%)
Anxiety disorders	13.0
Mood disorders	6.2
Disruptive disorders	10.3
Substance use disorders	2.0
Any disorder	20.9

* Disorders include diagnosis-specific impairment and Child Global Assessment Scale <or=70 (mild global impairment).

Source: Shaffer, D., Fisher, P., Dulcan, M. K., Davies, M., Piacentini, J., Schwab-Stone, M. E., Lahey, B. B., Bourdon, K., Jensen, P. S., Bird, H. R., Canino, G., & Regier, D. A. (1996). The NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC- 2.3): Description, acceptability, prevalence rates, and performance in the MECA Study. Methods for the Epidemiology of Child and Adolescent Mental Disorders Study. *Journal of the American Academy of Child and Adolescent Psychiatry, 35* , 865?877.

The Importance of Early Intervention

Research has demonstrated clearly that early identification and intervention is critical to the success of children. With early intervention, a faster, more complete recovery is possible. Given appropriate and sufficient intervention, the rates of suicide, substance abuse, unprovoked aggression and involvement with the justice system would be reduced. (New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* DHHS Pub. No. SMA-0303832. Rockville, MD: 2003.
The National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment. "*Blueprint for Change: Research on Child and Adolescent Mental Health."* Washington, D.C.: 2001.)

Students with mental, emotional and behavioral needs are at risk of school failure as well. One-half of the students identified as having a behavioral or emotionally disability (BED) will drop out of school. Only 42% of those who remain in school will graduate with a diploma. (U.S. Public Health Service, *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda.* Washington, DC: Department of Health and Human Services, 2000.)

Many students with a mental illness cannot cope with the demands of the traditional classroom, even if they do not need or qualify for special education services. They need teachers who can help them experience success. Their teachers need to be able to recognize the warning signs of

brain disorders and use appropriate and effective intervention. An effective plan for school-based mental/behavioral services must, therefore, include technical assistance and training for school staff.
Children with mental health issues need home and community-based services that follow best practice guidelines. Strength-based services focusing on the entire family are critical, as is continuity of care.

(U.S. Public Health Service, *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda.* Washington, DC: Department of Health and Human Services, 2000.)

What recommendations have been made on the national level?

- Increase professional mental health resources in the schools, where children can easily take advantage of services.
- Develop and expand models for area health programs to deliver services in schools.
- Encourage early identification of mental health needs.
- Promote cost-effective, proactive systems of behavior support at the school level.
- Consider universal, primary prevention methods, but also recognize unique differences among youth. Some students will have more intense, long-term needs.

(Adrian Angold, M.R.C. Psych. Et al., *Improving Mental Health Services for Children in North Carolina: Agenda for Action*, Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, North Carolina State Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, June 1998.
U.S. Public Health Service, *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda.* Washington, DC: Department of Health and Human Services, 2000.)

Conclusion

In developing recommendations for a strategic and comprehensive approach to school-based mental and behavioral health services, the collaborative body reviewed developments on the national level, in other states, and within North Carolina. After careful reflection, the following plan is recommended for implementation in North Carolina.

GOAL ONE: To plan and deliver a continuum of collaborative and coordinated mental and behavioral health services to all students within NC schools

OBJECTIVES	STRATEGIES	OUTCOMES
Every Local Education Agency and Local Management Entity, in conjunction with other local agencies and partners, jointly create a plan for coordinated school based mental and behavioral health services.	❑ Develop Memorandum of Agreement between Department of Public Instruction, Department of Health and Human Services, Department of Juvenile Justice and Delinquency Prevention, Administrative Office of the Courts and Guardians Ad Litem encouraging and promoting coordinated plans and establishing protocols for local collaboratives to implement the plans. ❑ Develop Memorandum of Agreement between appropriate local partners. ❑ Link funding to coordinated plan and implementation. ❑ Coordinated plan is part of school improvement plans ❑ Determine appropriate reporting structure for Local Education Agency and Local Management Entity	❑ Memorandum of Agreement which speaks to continuum of services and coordination at state and local level ❑ Structure to identify/plan based on needs ❑ State and local plans
Increase the number of Local Education Agencies and Local Management Entities reporting on-site school-based programs promoting positive development and behavior, on site MH/B treatment services for students, and increased liaison with and access to community-based mental health services .	❑ Develop structure of community collaboratives through steps such as (1) Survey School Health Advisory Committees to determine existing collaborative efforts (2) Identify common characteristics of successful community collaboratives to create a model (3) Recommend process guidelines for collaboration (4) Disseminate survey results and new info to School Health Advisory Committees (5) Continue data collection (6) Provide Technical Assistance and training supporting local efforts (7) Create a statewide mechanism for information sharing ❑ Develop reporting system	❑ More children receive service ❑ Reduced suspensions and dropouts ❑ Improved behavior ❑ Increased access and referrals to community-based services

Include in the NC school "report card" ratings on support staff ratios per student.	❑ Establish workgroup to create functional approach to this. Should include such ratings as % of time support staff spends at each school and full time equivalents, make sense to public	

GOAL TWO: To provide an adequate number of trained personnel in communities and schools to offer the full array of mental health services and supports for students.

OBJECTIVES	STRATEGIES	OUTCOMES
Develop a Memorandum of Agreement between Department of Public Instruction and Department of Health and Human Services to commit to the implementation of a full array of School Based Mental Health services and supports and the training of staff needed to provide these services and supports.	❑ Use internal structures in Department of Health and Human Services and Department of Public Instruction to inform department heads ❑ Have School Based Mental Health sub-committee ask that the State Collaborative request that Department of Public Instruction and Department of Health and Human Services develop Memorandum of Agreement	Memorandum of Agreement
Identify at the Department of Public Instruction, Division of Mental Health and Eastern Allied Health Education Consortium positions to coordinate implementation of strategic plan for School Based Mental Health services	❑ Obtain support from heads of Department of Health and Human Services and Department of Public Instruction for such a position ❑ Request that state agencies (Department of Health and Human Services, Department of Public Instruction , Department of Juvenile Justice and Delinquency Prevention, etc) designate funds to help support position ❑ Seek grant funds to support a position	Strategic Plan will be carried forward Technical assistance will be provided for local collaboratives so that efforts will be clearly connected and functions clarified.
Implement through Department of Public Instruction / Department of Health and Human Services pilot projects to establish a local School Based Mental Health Coordinator who will collaborate with community partners to provide training and to coordinate SBMBH services and supports.	Request that a member of the School Based Mental Health Subcommittee serve on the Child & Family Leadership Council Monitor activities of Child & Family Leadership Council ❑ Work with local pilot projects of the school-based Child and Family Team Initiative	❑ Pilot communities selected; hire Coordinators ❑ Community partnerships formed, begin to coordinate efforts ❑ Reduced duplication and fragmentation
Assure that Allied Health Education Consortium develops	❑ Submit request to Mental Health Directors to develop a	❑ Training plan ❑ Training experiences

School Based Mental Health, provides training for the provision of services and support, including infrastructure development, with input from a representative advisory committee.	training plan ❑ Form or use existing Advisory group to develop training plan ❑ Include mechanisms to encourage local agencies to support personnel in attending training opportunities	offered through the state
Require (by Department of Health and Human Services) that Local Management Entities assure equitable geographic coverage by contract providers in the provision of School Based Mental Health services/support.	❑ Request Department of Health and Human Services to review/ revise contract requirement and provide incentives to providers	Contract established Services available at equitable levels across the state
Ensure that staff are culturally and linguistically competent and aware of the impact of poverty.	Department of Health and Human Services develops a process for ensuring that Local Management Entities use hiring and training opportunities to ensure such competence	Diverse populations of students are served more effectively, with the reduction or elimination of language and cultural barriers

GOALTHREE: Increase the effective and efficient use of available funding and generate additional sources of funding, both within/ and across agencies

OBJECTIVES	STRATEGIES	OUTCOMES
Increase knowledge and awareness of available funding sources	❑ Create a master list of funding sources and their requirements, restrictions (e.g. public and private insurance, government, non-profits, faith-based, etc.) ❑ Disseminate this information through various channels and methods (local collaboratives, Health Dept., Local Education Agencies, Local Management Entities, local Department of Social Services, local DJJDP agencies, DMA, medical community and family organizations.) ❑ Maintain/continue to disseminate info, with updates and changes.	❑ List is created and maintained ❑ Effective use of existing resources improves
Develop a climate to encourage blended and braided use of funding within/across all service providers.	❑ Develop and implement technical assistance and training for Local Education Agencies/ Local Management Entities personnel about how to use sources of public and private insurance to pay for	❑ Increased level of blending and braiding of funds ❑ Funding used more effectively and efficiently, allows for more services

	services ❑ Develop technical assistance and training (for agencies, non-profits, faith-based community, etc.) about how to blend and braid funds within local communities ❑ Implement Technical Assistance and training	
Assure that families receive information about available resources to support their needs (including access to health insurance)	❑ Develop materials that inform parents and students about ways school support staff can provide specific help to families. ❑ Distribute information about access to health insurance.	More families access services Increased number of students have insurance
Gather evidence of effective use of funding.	Develop questions about effective use of funding for survey Disseminate survey Distribute information about models of where/how funds are used effectively	Database of programs that work well
Identify gaps, overlaps, inadequacies in funding for specific services.	Analyze data from all sources Develop report	Visible product; needs assessment for planning
Use information about gaps and effective uses of funding to influence legislature, advocacy groups, schools, agencies, communities.	Provide information to advocacy groups Connect to public awareness strategies Develop specific legislation.	Climate promoting additional funding and staffing

GOAL FOUR: Develop shared outcomes and a data collection system to evaluate these outcomes.

OBJECTIVES	STRATEGIES	OUTCOMES
Identify measurable shared outcomes which promote every student's well-being through a collaborative/coordinated approach.	❑ Research existing models for sharing data ❑ Establish Memorandums of Agreement to share data	❑ Local and state agencies agree on what outcomes to measure and how to share both existing and additional outcomes data ❑ Progress can be measured and reported, both locally and state
Identify shared indicators which measure progress on the identified outcomes.	❑ Convene collaborative meetings at state and local level to identify desirable outcomes and indicators	❑ Effective evaluation of impact of services ❑ Increased collaboration ❑ Shared responsibility
Identify and develop a system to collect and analyze data for the identified indicators	❑ Analyze current data systems—can communication occur across agencies or are new systems needed?	❑ Shared data collection

	❑ Develop system	
Gather baseline and trend data to modify and improve the access, delivery and evaluation of services. Effective use of data should be tied to outcomes.	Each agency submits data on regular schedule to shared system. This is a continuous process.	❑ Ability to track student progress and impact of services ❑ Decision making, on-going planning for services based on shared data ❑ Access to additional funding
Design and implement a quality improvement process which incorporates national outcomes and best practices.	❑ Collaborative teams meet to analyze data; determine needs and successes ❑ State and local quality improvement teams research best practices ❑ Teams develop a NC Best practices guideline ❑ Locally monthly team meetings continue	❑ NC Best Practices handbook ❑ Training in best practices ❑ Continuing improvement in staff competence ❑ Service improvement ❑ Student outcomes continue to improve

GOAL FIVE: To expand public awareness of and advocacy for community mental and behavioral health issues with a focuson children and youth and their families.

Develop and distribute educational materials related to mental and behavioral health issues and resources.	❑ Identify target audiences ❑ Develop key messages and info for each ❑ Develop materials and distribution plan	❑ Reduced stigma around mental and behavioral health ❑ Increased knowledge about services
Develop and promote a mental health awareness campaign.	❑ Task force develops campaign, first using existing events ❑ Every county agrees to highlight issues ❑ Integrate mental health materials within school curriculum ❑ Inventory of what is already available.	❑ Greater awareness of needs of students and families, as well as resources available
Create a legislative agenda about school based mental and behavioral health.	❑ Examine existing policies and identify changes needed ❑ Explore advocacy agenda of other groups ❑ Join forces with related groups (traditional partners and others) in moving coordinated agenda forward	Success in getting priority policy changes and increased funding
Connect to existing advocacy network, using both champions and grassroots efforts.	❑ Increase involvement with/contributions to promoting mental health by many groups, including children, youth, families, legislators, public officials, key leaders, teachers, school staff, and the public.Research successful advocacy networks to use as models ❑ Identify champions (legislative, business, etc) ❑ Connect with grassroots organizations, develop communication system	Effective and timely advocacy efforts, leading to improved policies and increased funding

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