

Mental Health Services in North Carolina's Public Schools

Brandon K. Schultz, Deanna Al-Hammori, Karlie Mirabelli, Lauren Gaither

Most school-age children who receive mental health services do so in their public schools, but the scope and quality of those services can vary. This article describes current school mental health efforts in North Carolina, as well as policy initiatives that could shape those practices in the coming years.

A large proportion of children and adolescents who receive mental health services do so in their public schools. Among poor and minority youth, school-based services are often the only form of help received [1]. These school-based services are referred to broadly as school mental health (SMH). SMH service providers include school counselors, psychologists, and social workers, but in some special cases—referred to as “expanded” SMH—can include community-based professionals (eg, clinical psychologists, psychiatrists) in meaningful partnerships with schools. The research on SMH shows that these efforts can be effective, resulting in significant reductions in childhood mental health problems [2] and tertiary care costs [3].

In recent decades, SMH services have become increasingly vital as the rates of child and adolescent mental illnesses have risen nationwide. In North Carolina, a particularly troubling indicator of this trend has been the near doubling of the suicide rate among adolescents since 2008, from 2.2 per 100,000 then to 4.2 per 100,000 now [4]. This increase has been especially dramatic among children aged 10 to 14 [4]. SMH can play a central role in reversing such trends by circumventing many of the barriers that prevent families from receiving community-based mental health services (eg, lack of transportation, the stigma of visiting mental health clinics). Unfortunately, the scope and quality of SMH services varies considerably across school districts.

A comprehensive overview of all SMH services, laws, and policies in North Carolina is beyond the scope of this article, but two major service delivery modalities are instructive: 1) school-based tiered prevention models and 2) special education. We review these efforts and then explore recent policy developments with clear implications for SMH in North Carolina in the coming years.

Tiered Prevention Models

School-based tiered prevention models, or Multi-Tiered Systems of Support (MTSS), are systemic efforts to triage student academic and mental health needs, similar to epidemiological models of disease prevention [5]. Positive Behavioral Interventions and Supports (PBIS) is a specific tiered prevention model meant to improve student behavioral outcomes by matching evidence-based psychosocial interventions to student needs. PBIS has the distinction of being identified by name in the federal laws governing services for students with disabilities, owing to an extensive and growing research base. PBIS has been supported by key investments from the United States Department of Education and is guided by a PBIS technical assistance center that tracks dissemination and implementation nationwide (www.pbis.org) as well as regional networks that provide resources and training for educators.

PBIS is comprised of three tiers. In Tier 1, also referred to as “core support,” the objective is to teach and model positive behaviors (eg, respect others) to all students in a school. Ideally, all students are also screened periodically for emotional or behavioral difficulties that might require additional supports. In Tier 2, students who fail to respond effectively to Tier 1 (eg, frequent office referrals), or who screen positive for social-emotional concerns, receive additional supports based on need. Tier 2 interventions are typically delivered in small groups, often outside of the classroom, and generally focus on coping skills (eg, problem-solving strategies). Students in Tier 2 are continuously monitored by educators, and those data are used to assess intervention response over time. In Tier 3, the most intensive level of support, interventions are individually tailored to meet specific student needs. For students with mental illnesses, Tier 3 services might involve one-to-one psychotherapy with either a

Electronically published March 2, 2020.

Address correspondence to Brandon K. Schultz, East Carolina University Department of Psychology, 213 Rawl Building, Mail Stop 565, Greenville, NC 27858-4353 (schultzb@ecu.edu).

N C Med J. 2020;81(2):111-115. ©2020 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved. 0029-2559/2020/81207

school- or community-based mental health professional, but resources to support intensive mental health services in schools are often lacking, particularly in small, rural school districts. Strategies to enhance PBIS through sustainable family-school-community partnerships have been tested but are not yet standard practice. Currently, when community-based mental health services are provided in schools it is typically in a temporary and non-integrated fashion [6]. Otherwise, Tier 3 services are often delivered within the context of special education (description follows).

In North Carolina, the Department of Public Instruction (DPI) has encouraged all schools to implement MTSS, in part by making grant funds available to support local PBIS efforts. Still, dissemination and implementation have proven challenging. In 2008, 691 North Carolina schools were

reportedly using PBIS, second only to the number using it in Illinois [7]. But six years later, researchers found that roughly the same number of North Carolina schools were implementing PBIS *effectively*, suggesting that any expansion during this same period was among schools in nascent implementation phases. It is also clear that PBIS has been attempted in far more North Carolina elementary schools than secondary schools [8], a trend that is consistent with other states. As of 2016, adoption of PBIS in North Carolina high schools appeared exceedingly rare [9]. Given such findings, it seems safe to conclude that most North Carolina schools are currently implementing PBIS ineffectively or not at all. Thus, it remains unclear a) what proportion of North Carolina schools screen for social-emotional disorders; b) to what degree evidence-based behavior interventions are

implemented as intended in schools; and c) the degree to which tiered prevention models are successful at preventing the unwanted outcomes associated with childhood mental illnesses.

Special Education

As mentioned above, some students with mental illnesses are eligible for special education. The federal law governing special education, the Individuals with Disabilities Education Act (IDEA), outlines 13 categories of disabilities that can be considered when determining program eligibility. Among these, several directly pertain to mental disorders, including the categories of “emotional disturbance,” “autism,” and in some cases the catchall category “other health impairment,” the latter often applied to markedly impairing cases of attention-deficit/hyperactivity disorder (ADHD). Note, however, that a formal medical diagnosis of

any kind does not automatically entitle a child to special services; rather, those determinations are based on the degree to which the condition impairs school performance.

Each student accepted into special education receives an Individualized Education Plan (IEP) that outlines interventions for reducing academic impairments and/or increasing prosocial school behavior. The specific components of an IEP are decided by a local team consisting of parents, educators, and administrators (“IEP team”). By law, IEPs must include an initial assessment, annual goals, description of services, documentation of modifications or accommodations in the school setting, and a progress monitoring plan. The quality of these plans, however, depends on local practices. For example, researchers examining IEPs for students with ADHD found that measurable annual goals and objectives were only identified in 47% of examined documents. In other words, the majority of IEPs fell short of the standards

set forth by federal and state laws [10]. The services targeted in these documents are also imprecise. For example, researchers examining IEPs for students with emotional and behavioral problems found that specific accommodations were rarely matched to the stated student needs [11]. Based on such findings, it seems safe to conclude that special education offers one school-based mechanism to address individual student needs, but practices can vary considerably based on local knowledge, skills, and resources.

North Carolina Policy Initiatives

In recent years, state policies have changed regarding SMH funding and training. The following paragraphs provide an overview of two momentous policy changes that will have implications for SMH in the coming years.

Medicaid Rule Change

Until 2014, schools could only bill Medicaid to cover health services for students with IEPs, a policy referred to as the “free care rule.” But in January 2019, North Carolina joined a growing number of states in reversing this policy to include all Medicaid-enrolled children with documented medical needs, regardless of IEP status. The result is that qualified providers can now bill Medicaid for specific school-based services, including psychological evaluations (ie, testing) and treatment (eg, cognitive behavioral therapy, family therapy), whenever a medical need is documented and the child’s parent consents. This policy reversal offers a revenue stream that can expand and sustain North Carolina’s SMH efforts for its most vulnerable students, while integrating school-based services into the broader health care system. Moreover, it applies to the entire population of over 860,000 Medicaid-enrolled students in North Carolina, not just the roughly 56,700 who have IEPs. But local education agencies are not required to participate in Medicaid, and under the old policy most did not. To do so, service costs are first incurred locally and then reimbursed up to a certain amount by the federal government through an exacting billing process [12]. As a result, many schools may continue to opt out, particularly in relation to services that are not already offered.

It is too early to assess the impact of this policy change. For example, it is still unclear how many local educational agencies are eligible for Medicaid, or how many have established appropriate billing systems to take advantage of this change. But, based on a legislative report conducted prior to the policy change, it was estimated that local education agencies would incur up to \$488,752 in uncovered costs to receive over \$1 million in reimbursements for counseling services alone in the 2017-2018 school year had the policy been implemented at that time [13]. So, although it is unclear how many schools will pursue Medicaid reimbursement, the likelihood that Medicaid-enrolled children will receive services in their North Carolina schools will almost certainly increase in the coming years.

Staff Training

In October of 2016, an advocacy group called the North Carolina School Mental Health Initiative (NC SMHI) was established in response to the high rates of mental health disorders [8] and suicide in youth across North Carolina [4]. The NC SMHI reflects partnerships across disciplines, including community mental health providers, educators, advocates, lawyers, university officials, and parents, with the goal to provide policy/legislative support and recommendations for accessible, high-quality, and coordinated mental health services. The overarching purpose is to achieve a continuum of sustainable child support services through the active engagement of stakeholders [14].

In April of 2017, the NC SMHI successfully advocated for the School-Based Mental Health Initiative (Policy ID: SHLT-003), which was implemented in October of 2018 [15]. This policy requires school staff to engage in a minimum number of training hours on mental health issues. In addition, each school district was required to set forth plans for early intervention, universal prevention, the referral process, treatment plans, and reentry. To support the policy, the North Carolina General Assembly approved \$35 million of the state budget to be spent toward various school safety initiatives, such as the creation of grants to support students in crisis, staff trainings, and hiring additional school mental health providers [15]. Given that the policy implementation was delayed until 2018, however, outcome data are limited, and the impact is still unclear. Still, these developments are likely to increase capacity in schools for early screening and identification of student mental illnesses. Other recommendations by NC SMHI, including the hiring of sufficient SMH providers to achieve ideal student-provider ratios, could push this capacity even further if fully adopted.

Conclusion

The future of SMH in North Carolina appears promising, but there continue to be clear challenges. In order to address the high rates of mental health disorders, suicide, and social-emotional needs in children and adolescents, school-based services are crucial. Especially in rural communities, these services are critical for removing treatment barriers. Without school-based services, many children with mental illnesses—particularly poor and minority youth—will not receive any help at all. The resulting implications of untreated mental illnesses include unwanted and costly outcomes (eg, poor academic performance, increased risk for school failure or drop out) that warrant additional efforts to fully fund and support integrated school-based mental health services. **NCMJ**

Brandon K. Schultz, EdD, NCSP associate professor, Department of Psychology, East Carolina University, Greenville, North Carolina.

Deanna Al-Hammori, BA doctoral student, Department of Psychology, East Carolina University, Greenville, North Carolina.

Karlie Mirabelli, MA doctoral student, Department of Psychology, East Carolina University, Greenville, North Carolina.

Lauren Gaither, MA/CAS project coordinator, Department of Psychology, East Carolina University, Greenville, North Carolina.

Acknowledgments

Potential conflicts of interest. The authors have no relevant conflicts of interest.

References

1. Ali MM, West K, Teich JL, Lynch S, Mutter R, Dubenitz J. Utilization of mental health services in educational settings by adolescents in the United States. *J Sch Health*. 2019;89(5):393-401. doi: 10.1111/josh.12753
2. Sanchez AL, Cornacchio D, Poznanski B, Golik AM, Chou T, Comer JS. The effectiveness of school-based mental health services for elementary-aged children: A meta-analysis. *J Am Acad Child & Adolesc Psychiatry*. 2018;57(3):153-165. doi: 10.1016/j.jaac.2017.11.022
3. Aos S, Lieb R, Mayfield J, Miller M, Pennucci A. Benefits and Costs of Prevention and Early Intervention Programs for Youth. Olympia, WA: Washington State Institute for Public Policy; 2004. <https://www.wsipp.wa.gov/ReportFile/881>. Accessed January 6, 2020.
4. North Carolina Child Fatality Task Force. Annual Report to the Governor and General Assembly 2019. Raleigh, NC: North Carolina Child Fatality Task Force; 2019. <https://www.ncleg.gov/DocumentSites/Committees/NCCFTF/Reports%20and%20Data/Annual%20Reports/CFTF%202019%20Annual%20Report.pdf>. Published January 2019. Accessed January 6, 2020.
5. Walker HM, Horner RH, Sugai, G, et al. Integrated approaches to preventing antisocial behavior patterns among school-age children and youth. *J Emot Beh Disord*. 1996;4(4):194-209.
6. Barrett S, Eber L, Weist M. Advancing Education Effectiveness: Interconnecting School Mental Health and School-wide Positive Behavior Support. Washington, DC: OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports; 2017. https://assets-global.website-files.com/5d3725188825e071f1670246/5d76c6a83444facab50085275_final-monograph.pdf. Accessed January 6, 2020.
7. Spaulding SA, Horner RH, May SL, Vincent CG. Evaluation Brief: Implementation of School-wide PBIS across the United States. Washington, DC: OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports; 2008. https://assets-global.website-files.com/5d3725188825e071f1670246/5d8a9a0f287a8b538f0f044a_Implementation%20of%20School-wide%20PBIS%20across%20the%20United%20States.pdf. Accessed January 6, 2020.
8. Splett JW, Michael KD, Minard C, et al. State of the Carolinas: Implementing school mental health and positive behavioral interventions and supports. Report on Emotional and Behavioral Disorders in Youth. 2014;14(4):87-95(9).
9. Freeman J, Wilkinson S, Vanlone J. Status of High School PBIS Implementation in the U.S. Washington, DC: OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports; 2017. https://assets-global.website-files.com/5d3725188825e071f1670246/5d82b2c1be860b83d41d6f7b_Status%20of%20High%20School%20PBIS%20Implementation%20in%20the%20U.S.-2.pdf. Accessed January 6, 2020.
10. Spiel CF, Evans SW, Langberg JM. Evaluating the content of individualized education programs and 504 plans of young adolescents with attention deficit/hyperactivity disorder. *Sch Psychol Q*. 2014; 29(4):452-468. doi: 10.1037/spq0000101
11. Kern L, Hetrick AA, Custer BA, Comisso CE. An evaluation of IEP accommodations for secondary students with emotional and behavioral problems. *J Emot & Beh Disord*. 2019;27(3):178-192. <https://doi.org/10.1177/1063426618763108>
12. North Carolina Department of Health & Human Services. North Carolina State Plan Amendment (SPA) #: 18-0005. Raleigh, NC; NC DHHS; 2018. <https://files.nc.gov/ncdma/documents/Medicaid/Proposed%20State%20Plan%20Amendments-8-17-18.pdf>. Accessed January 6, 2020.
13. North Carolina Department of Health and Human Services. Legislative Report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and Fiscal Research Division 2016. Raleigh, NC: North Carolina Department of Health and Human Services; 2016. <https://www.ncleg.gov/document/sites/committees/BCCI-6660/Reports%20to%20the%20LOC/Reports%20Received%20in%202016/SL%202016-94%20Sec%2012H.9-School%20Based%20Health%20Services%2011.1.2016.pdf>. Accessed January 6, 2020.
14. North Carolina School Mental Health Initiative. North Carolina School Mental Health Initiative. Raleigh, NC; NCSMHI; 2016. <https://ec.ncpublicschools.gov/instructional-resources/behavior-support/mental-health/nc-smhi-report-final.pdf>. Accessed January 6, 2020.
15. Wyatt J. North Carolina Enhances School Safety Measures Through Law Changes, New Grant Programs. North Carolina Association of School Administrators website. <https://www.ncasa.net/site/default.aspx?PageType=3&DomainID=4&ModuleInstanceID=9&ViewID=6446EE88-D30C-497E-9316-3F8874B3E108&RenderLoc=0&FlexDataID=3431&PageID=1>. Accessed January 6, 2020.