Public Schools as Partners in Elementary-Aged Children’s Mental Health

Current Themes and Opportunities in North Carolina

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Children’s Mental Health: What’s the Problem?

While children’s physical health and development is well understood, measured, and monitored, children’s mental health is still not well understood or fully integrated into the United States’ care delivery system. This lack of understanding and coordinated approaches to treatment may lead to a misconception that few children suffer from mental health problems. However, the National Institute for Mental Health estimates that one in five children will suffer from a debilitating mental health condition by the time they turn 18.5

Mental illness in children can present as problems in the ways children cope, learn, interact, handle emotions, or reach developmental milestones. These illnesses may be categorized as attention disorders (such as Attention-Deficit/Hyperactivity Disorder (ADHD)), behavior disorders (including Oppositional Defiant Disorder), mood (depression or Disruptive Mood Dysregulation Disorder) and anxiety disorders, thought disorders (Schizophrenia and Psychosis), attachment disorders (Reactive Attachment Disorder), or developmental disorders such as Autism Spectrum Disorder.

Early identification and treatment of mental and behavioral health disorders can ameliorate their morbidity later in life, including psychiatric disorders, academic failure, and risk-taking behaviors as the child matures.6,7 Unfortunately, symptoms of mental illness or developmental disorders may be ignored or dismissed because of misconceptions about normal behavioral and developmental expectations.8 Behavioral health problems, in particular, may be misunderstood as discipline issues or misidentified because of perceptions of gender and race. This leads to inappropriate handling of the problem and may even risk physical and emotional harm to the child.8
Emotional, developmental, and behavioral health problems affect children in every community, but North Carolina has a higher-than-average prevalence. In a national survey conducted by the Center for Disease Control’s National Center for Healthcare Statistics, 12.1% of children ages 6-11 in the United States had one or more of the following emotional, behavioral, or developmental conditions: ADHD, autism spectrum disorder, anxiety, depression, oppositional defiance disorder or conduct disorder, developmental delay, or Tourette’s Syndrome. In North Carolina, the prevalence was 18.3% in the same population.

The particular problem in the elementary population

Despite the prevalence of mental health problems in the general and elementary school-aged populations, efforts to prevent and treat these issues have yet to reach the evidence-based, coordinated effort they deserve. In fact, most children with mental health needs receive no services at all. Many interventions in children’s developmental and behavioral health are targeted at children in the birth to five-year age range. This is recognized as a critical developmental period, receives high priority for funding and public
support, and coincides with more frequent well-child visits and linkages to other social supports.\textsuperscript{12}

While early identification is valuable, not all emotional and behavioral health issues will present during the first few years of life. Catalysts a child experiences for mental health problems may not occur in early life, or symptoms not be apparent yet; whether it be through genetics, trauma, instability, or bullying at school, children’s mental health is vulnerable during the elementary school years.\textsuperscript{6} However, with less attention from the health care and public health spheres, emotional and behavioral health issues may go undetected or be mishandled as behavior problems. While Bright Futures recommendations include social and behavioral assessments at every well child visit, they do not begin assessment for depression until age 11.\textsuperscript{13} Additionally, primary care providers are burdened by time and administrative constraints, so most behavioral health diagnoses by primary providers are parent-initiated.\textsuperscript{8}

The mental health system in general is fragmented and complex for patients at any age, and navigating the system is made more complex by stigma, lack of public understanding and prioritization for children’s mental health, and a lack of “ownership” for the problem by any one sector.\textsuperscript{6,14,15} The ownership problem is especially problematic for funding what programs do exist. Compensation tends to flow disproportionately to programs aimed at children with the most severe needs and mandated services (residential treatment and hospitalization), rather than to prevention or school-based services.\textsuperscript{11,14} Likewise, residential facilities and healthcare corporations tends to have stronger networks and lobbying power to obtain state funding.\textsuperscript{14} Even the Affordable Care Act’s reforms do not guarantee full coverage of all the services a child with special mental health needs might need, nor does it guarantee that covered services are available in the child’s community.\textsuperscript{14}
Schools as Partners

Because the vast majority of children ages 5-18 will matriculate through the public school system, often spending half their waking hours there, schools are a natural community milieu for services to this population. Indeed, schools provide numerous supports to children beyond basic educational requirements. These include transportation, meals, screening for hearing and vision problems, and occupational and physical therapies. Additionally, school social workers coordinate specific services as needed to meet the needs of children and their families.

Schools also provide the majority of children’s mental health services, from promotion to intervention. In fact, for children who receive mental health services, 70-80% of them receive those services through the educational sector. Most schools have some level of mental health programming in place: 63% have preventative services, and 59% have behavioral problem services. However, there are inconsistencies in models of service delivery to these students, and little is known about their quality. Only half of schools use school or district personnel, a quarter use a combination of district and community providers, and the remainder use only community-based providers for children’s mental health services.

School mental health is a young field rooted in the disability education movement of the 1970s and 1980s; in fact the first national school mental health conference did not take place until 1995. The Education of All Individuals with Disabilities Act, which would later become the Individuals with Disabilities Education Act (IDEA), stipulates that states provide all children with a free, appropriate education regardless of disability. This legislation specifically included the mental health needs of children with emotional disturbances,
functionally shifting responsibility from community mental health to the school system in an unfunded mandate.\textsuperscript{15} School mental health provision remains hampered by confusion over how to characterize issues and interventions and who (the school system or the community mental health system) ought to provide them.\textsuperscript{15,18} Integrating more mental health services into schools may require not just creative thinking, but re-defining schools’ purpose to a whole-child service model and addressing the pressing needs of funding these services through stronger national policy.

Schools have strengths that clinical settings cannot reasonably hope to achieve, namely that they are able to provide a steady network of people and resources who can positively influence the development of the children within the school community.\textsuperscript{16} Schools can capitalize on their existing structures and strengths to be at the forefront of children’s mental wellness, from universal programs and screening to providing intensive services to children most in need. Despite the newness of the field, school mental health is gaining momentum for intervention at all three of these levels.\textsuperscript{19} After all, children must be healthy in order to attend school and to learn; mental wellness is as important as physical wellness to a child’s functioning in the classroom.\textsuperscript{6,17}

**Common mental health structures in public school districts**

**Individualized planning for students**

Individualized Education Plans (IEP) provide the basic blueprint for services and accommodations provided to children with special needs (including learning differences and mental health) through the public school system. These plans are developed jointly with the family, administrators, special education teachers, school counselors, and other relevant staff. An IEP may include academic and behavior goals for the student, accommodations such as
extra time to complete tests, and specific procedures for handling manifestations of the disability.

As a supplement to the IEP, the IEP team can develop a Behavior Intervention Plan (BIP) that supports the student in trying to change specific behaviors. BIPs complement the IEP by focusing on positive reinforcement, skills training, and environmental accommodations to assist the child replacement behaviors, emotional coping skills, and triggers; the plans also address changing the responses of the adults, reducing negative stimuli, and supporting the child. As children with emotional and behavioral health challenges may not outwardly appear disabled, the BIP is an important tool for addressing behavior issues that are actually manifestations of the disability.

**Mental health staff**

Various stakeholders serve student mental health on or through the child’s campus. These individuals usually work for the school or the district, but they may also be employed by outside organizations that contract with the school to provide services. District personnel, especially in remote or poorly-funded districts, may share time between multiple campuses.

- Counselors at the elementary level support student education with school-wide social development programs, offer counseling for individuals and groups, and may run character education and other prevention-oriented programs.
- Schools psychologists, while qualified to handle counseling, are usually utilized for educational assessments, monitoring progress for children with special needs, and meeting with parents and personnel.
• Mental health specialists are available at some schools, but may have a constrained role. For example, they may work only with students in a self-contained classroom, and not with the entire student body.

• Social workers, while sometimes responsible for counseling and school-wide initiatives such as Positive Behavior Intervention Supports, typically focus on at-risk children and their families, connecting them with services and resources at school and in the wider community. These could include assistance with transportation, accessing free and reduced breakfast and lunch, housing support, medical care, and other needs that can affect a child’s ability to thrive at school.

• School nurses, while theoretically well positioned to be key players in the school mental health team, are constricted by heavy workloads, lack of role ownership, and varying degrees of training in mental health issues.\textsuperscript{21} Between managing injuries, illnesses, and dispensing psychiatric and other medications throughout the school day, a school nurse’s workload is an especially large barrier.\textsuperscript{21} However, they are also uniquely positioned through their training and interactions with students to be identifiers and first responders for students in crisis, especially in schools without devoted, full-time social workers or counselors.\textsuperscript{22} With the right support from mental health staff in the school or district, nurses may be able to take on more of a role in school mental health promotion, assessment, referral, and care coordination.\textsuperscript{22}

• Classroom teachers and teacher assistants often play the role of counselors when counseling staff are unavailable on campus or if a student’s IEP does not specifically provide for counseling services. This is a role for which they may not have any specific training, and is in addition to their myriad other responsibilities.
Self-contained classrooms

While the Individuals with Disabilities Education Act (IDEA) stipulates that children should be integrated into regular classrooms as much as possible, children with very great needs may function better in self-contained classrooms. The Chapel Hill-Carrboro City Schools District, for example, has two self-contained classrooms at the Estes Hills Elementary campus. Unfortunately, this means that some of the children served by the self-contained classrooms are not attending their closest elementary school, and similar classroom structures do not exist at the middle and high school levels.

Special Needs Advisory Council (SNAC)

Within the district, an advocacy role may be played by the Special Needs Advisory Council (SNAC). These groups meet regularly to address themes within the district, partner with other community advocacy groups, and to help parents and teachers coordinate to meet the needs of students with special educational needs.

Problems, Barriers, and Disparities

Complications and inconsistencies in North Carolina’s care system

Mental health care in North Carolina, including services for children, has endured continual changes to its leadership, funding, and basic structure in the past decade and a half.23 Because federal law now mandates that persons with mental illness must be treated in the least restrictive environment possible (consistent with educating children in the least restrictive environment), North Carolina has seen thousands of patients move from residential to community-based treatment – a 46% increase from 2001 to 2011.23 Further, the state moved from a community health model to a tightly-consolidated Managed Care Organization (MCO) structure in which 11 MCOs manage all Medicaid and state-funded
services across the state. Concurrently, state funding in the same time period has fluctuated by hundreds of millions of dollars; funding has ranged from a high of $743 million in FY 2008-09 to $696 million in FY 2012-13. Mental health services have also absorbed budget shortfall blows, such as in FY 2009-10, when the state budgeted $820 million to the Division of Mental Health, but had to reduce actual funding to $664 million. With considerably greater demand for services than supply, too often only the most dire cases (financially or medically) are able to access treatment through the system. With services withdrawn from appropriate mental health sources, those in need (including children) may wind up going without care or receiving their mental health services through the justice system.

While families who qualify for care through MCOs may be eligible for an array of coordinated services, families who have private insurance do not have a comparable system of care; they often have access to fewer services, and must coordinate them themselves. Out-of-pocket expenses, including co-pays and services not covered by insurance are also are burden on privately insured families.

North Carolina has also followed the national trend of seeing emergency rooms become the default service entry point for adults and children in acute mental health crisis, even though they are not designed or equipped to deal with psychiatric care delivery. Even for hospitals with psychiatric units, there are usually fewer beds available than people who need them. There are only 371 child and adolescent in-patient psychiatric beds in North Carolina, and only 80 of those are in the three state hospitals. This is especially problematic because even when a community hospital has a bed available, they may choose to refer a patient to a state-run hospital due to co-morbidities such as an intellectual or developmental disability.
The Division of Mental Health, Developmental Disability, and Substance Abuse Services projects a need for 72 community hospital child and adolescent beds, and an additional 154 beds (72 for children) in the state hospitals, while researchers at the University of North Carolina at Chapel Hill and Duke University estimate that the number of state hospital beds would have to increase by 356 total beds (a 165% increase) to reduce the wait time to 24 hours or less. Meanwhile, patients admitted into emergency rooms in acute mental health crisis wait an average of 3 ½ days for a bed, which may be hundred of miles away in another part of the state. Based on the estimate of a 165% increase to reduce wait times to <24 hours, North Carolina should be adding 243 more community and state child and adolescent beds; in other words, even with proposed expansions, the state still faces a shortfall of 99 beds for this population.

Geographic barriers to care

Another problem North Carolinians face is that, despite a system of care model that theoretically has least-restrictive, community-based care for its children with special health care needs, the care a child requires may not be available in his or her own community.

For example, children who require long-term, residential treatment for mental and behavioral health problems in a Psychiatric Residential Treatment Facility (PRTF) may not be
able to find one with space available in their home community. As of 2011, the Division of Mental Health/Developmental Disabilities/Substance Abuse Services listed 29 PRTFs within North Carolina or within 40 miles of its borders. The capacity of these facilities ranges from about 6 to 6 dozen beds, and they have varying admissions criteria regarding age, gender, and whether they accept individuals with developmental disabilities.

This map illustrates the distribution of PRTF facilities in the state; while some geographic disparities are obvious, what is less apparent is the actual burden a family might face in locating a PRTF. For example, a girl needing PRTF care in Fayetteville, NC, could not attend the facility in nearby Hope Mills, as its admissions are restricted to males. If she were at least 12 years old, her family could travel one hour to Garner; if she were younger than 12, her family would face an hour and a half drive to Kinston. These travel times assume that the nearest appropriate facility has capacity to accept the child, and that the family has a car it can use to make such a trip. They do not account for the time missed from work or other commitments, nor the emotional cost to the family of being unable to see a child on a frequent basis.

**Disparities in diagnosis and treatment: Race and family income**
Surveillance of children with mental health disorders reveals disparities in diagnosing and accessing care for these problems. The data shows that race, SES, and insurance status all play a part in identification and treatment of children’s behavioral and emotional problems. For example, ADHD is the most common mental health diagnosis for children ages 6-11 nationwide, but non-Hispanic white children and children with insurance are the most likely to be diagnosed. However, in a study of children who used the New York State Public Mental Health System, the prevalence rate of ADHD in white children was significantly lower than Hispanic and black children. The higher nationally reported rates among white children nationally may reflect better access to private psychiatric and primary care. The New York data may also reflect cultural differences in care seeking and diagnosis among minorities, so the lower reported rates of ADHD diagnosis among Hispanics and children of other races may not reflect actual prevalence.

The impact of living in poverty is clear from national data trends. Children living below the poverty line were twice as likely as children in the 6-11 age group to have received a diagnosis of depression in the last 12 months. Not counting the multi-race, non-Hispanic group due to its
high standard of error, racial differences in depression diagnosis were relatively small; white children were slightly more likely than black and Hispanic children to have been diagnosed with depression, which again may represent better access to care.⁵

A final illustration of the injustices in mental health disorder diagnosis is shown in the prevalence of children who have ever been diagnosed with a behavior or conduct problem.

![Prevalence of Children Ages 3-17 Ever Diagnosed with a Behavioral or Conduct Problem](image)

National Survey of Children's Health, 2007

Poor, black children are far and away the most likely to have received such a diagnosis.⁵ Black children were twice the odds of being diagnosed as Hispanic or white children, and children living below the poverty line had three times the odds of a diagnosis as those whose family income was greater than 200% of the federal poverty line.⁵

**School variations**

Service models, therapeutic approaches, and delivery differ between states and districts, and even between schools in the same district.¹⁵,²⁶ Unsystematic and inconsistent planning and implementation means that resources may not be used effectively, and students may have to travel outside their neighborhood schools to access services.²⁶ IEP plans are not invalidated by transferring schools (even out of state), but services provided at one school may not be available at another. Fewer than half of US school districts have a policy that someone must oversee and coordinate mental health services.²⁶ These inconsistencies at the
state and districts levels lead to further gaps and fragmentation of care for children, and have created a fundamental injustice in mental health service provision for children.

**Monitoring and evaluation**

Little is known about the degree to which most school-based mental health programming is evidence-based, or the fidelity with which evidence-based practices are implemented. Because the majority of services are delivered through the school system, it is imperative that schools address this. Feasibility and acceptability may trumps effectiveness when programs are developed, a situation that would not be accepted in regular health care settings, and ought not to be the case in schools either.18

As of 2012, fewer than 50% of states evaluated school mental health or social services programs or policies, and only about a third evaluated students’ use of and satisfaction with these services.26 There are many opportunities for research into the best practices for mental health service delivery in schools; much of the existing program evaluation has been with small sample sizes, did not analyze cost-effectiveness, and/or showed little evidence that the program was implemented with high fidelity.6 Furthermore, researchers need to establish guidelines for screening and interventions by age and level (universal, selective, or targeted), explore interventions for a wider variety of specific mental health diagnoses, develop consistent quality indicators for evaluation of programs.6

**Family-level barriers**

While parents are natural partners with school systems and healthcare providers in pursuit of the well being of their children, this partnership cannot be taken for granted. Barriers to parental and guardian support may include distrust of the system, stigma about emotional and behavioral health problems, language barriers, and availability of the parents.6
Additionally, parents who themselves suffer from mental health challenges may be unable to meet their children’s needs. Even when parents seek care, they are likely to encounter geographic limitations and systemic issues like lack of personnel, long wait times, and limited funding from Medicaid or private insurance.

Family engagement is also a challenge for many school-based providers of children’s mental health services. School operating hours, parental transportation and work schedules, childcare for siblings, and parents’ comfort in addressing mental health concerns all contribute to this difficulty. School clinicians also vary in their comfort level engaging with parents, particularly if there are language or cultural differences between themselves and the parent; they may need additional support in cultural competence training and in challenging their own assumptions and labels of families. With myriad competing responsibilities, it may feel like too much effort to reach out to parents beyond what is minimally required.

**Staffing barriers**

Regardless of whether they work for the district or an outside agency, school mental health providers face numerous hurdles to delivering services to their students. Basic logistical barriers include scheduling limitations, coordinating with staff and competing requirements (such as core curriculum classes), and difficulty finding space and financial support. School-based staff also have large caseloads and competing responsibilities of their own, or they may be pulled from crisis to crisis rather than being able to follow an orderly schedule. While community clinicians may have fewer responsibilities competing for their time, those employed by the school may be more competent with navigating school logistics. Staff employed by schools may also not be utilized in the best way.
psychologists, for example, may focus on testing or working with small groups of students without doing any counseling.\textsuperscript{11}

Administrators, teachers, and other leaders in the school community may have limited experience and understanding about mental health issues, and this can affect how well plans are implemented and supported in the school environment. While teachers are excellent gatekeepers for mental health referrals, the school climate and performance demands for teachers can also function as obstacles to students’ mental health services.\textsuperscript{6} Teachers are understandably exhausted by the demands of the profession, and teachers report that dealing with disruptive behavior in the classroom contributes to burnout and even towards leaving the profession.\textsuperscript{6} Adjusting for inflation, North Carolina’s teacher salaries declined 17.4\% from 2004 to 2014; they would be justified in feeling too underpaid and over-extended with academic responsibilities to add addressing their students’ mental and behavioral concerns to the equation.\textsuperscript{6,28} Staff who feel pressure to bring children’s academic performance up to state standards may be reluctant to release students from class for treatments (especially if the student is struggling academically), and burned-out, overworked educators may not understand the value of the program or feel they have a role to play in student mental health.\textsuperscript{6,10,17}

Supportive administrators help bridge program staff and teachers, and can set emotional well-being as a priority for the school campus.\textsuperscript{10} Mental health providers can further facilitate their programs by offering mental health education at teacher in-services, by engaging the community with focus groups and Parent Teacher Association relationships, and by partnering with community services and professional networks.\textsuperscript{10}
Behavioral Management Techniques

Seclusion, corporal punishment, and restraint

Restraint means holding a student in a way which prevents free movement, including prone positions which could restrict breathing, or using mechanical restraints (devices or equipment) to restrict movement, while seclusion means isolating a student in a room or area which they are physically prevented from leaving.29,30

Despite efforts by lawmakers and policy advocates, restraint and seclusion are disciplinary techniques that are not specifically addressed by any national law, and which are legislated inconsistently at the state level.29,30 This is inconsistent with juvenile justice and mental health facilities, whose use of seclusion and restraint is regulated at the federal level, as well as adult institutions like nursing homes and hospitals.29 66,000 incidents of restraint and seclusion were reported nationwide in the 2009-10 school year, but since these reports are not mandatory (15% of school districts did not report, including New York, Los Angeles, and Miami), the actual incidence of these practices is probably considerably greater.29 Reporting to parents is also inconsistently mandated; even among states that require it, the laws may be structured to allow reporting loopholes and inconsistencies.29

Seclusion and restraint are used disproportionately against students with intellectual or mental disability; while these students make up approximately 12% of the typical school population, they are the subject of over three quarters of reported seclusion and restraint incidents.31 The psychological effects of restraint and seclusion can include anxiety, despair, post-traumatic stress, and distrust of adults, which adds another layer of burden to children who already suffer from mental disabilities.29

North Carolina allows seclusion and restraint for non-emergency situations like class disruption and property destruction.29-31 These practices are recommended, but not required,
to end when the behavior ends.\textsuperscript{31} Seclusion and restraint are allowed to be used in IEP plans in North Carolina even when the behavior is a manifestation of the child’s disability.\textsuperscript{29,31} In North Carolina, the seclusion room must be lit, ventilated, free from dangerous objects, and a supervising adult must be able to hear and see the child at all times.\textsuperscript{31} Parental notification law in North Carolina requires that the parent be notified of restraint or seclusion within 2-4 business days, with written follow-up within 30 days.\textsuperscript{31} However, parents do not have to be notified if the child does not have observable injuries or if the action lasted for less time that was specified in the child’s IEP.\textsuperscript{31} While North Carolina schools may not have to report all incidents to parents, they are required to submit data about the use of seclusion and restraint to the state and local education agencies.\textsuperscript{31}

Corporal punishment such asspanking, while still legal, is on the decline in North Carolina, and as of 2016 only three school districts in the state still use it as a disciplinary tactic.\textsuperscript{32} Unlike seclusion and restraint, corporal punishment is not used disproportionately on students with disabilities; however, since parents are allowed to opt out of corporal punishment under state law, it is disappointing that these students are being disciplined in such a way at all.\textsuperscript{32}

The Every Student Succeeds Act instructs states to develop plans that support local schools in reducing, “the overuse of discipline practices that remove students from the classroom, [and] the use of aversive behavioral interventions that compromise student health and safety.”\textsuperscript{33} Meanwhile, parents usually have little to no recourse in preventing seclusion and restraint, nor in pursuing legal actions against schools because of due process procedures within the districts.\textsuperscript{29} Even in the case of severe physical harm, a parent’s only option may be to remove the child from the school altogether.\textsuperscript{29}
What Works: Best Practices and Recommendations

Three-tiered approach

Many researchers advocate three-tiered approaches to screening and treating mental health in schools.\textsuperscript{11,15} Both are approached with universal screening and population-based interventions, targeted screening and interventions for those children deemed at higher risk, and individualized services and testing for children with an identified need.\textsuperscript{11}

Universal interventions

Mental health can be addressed at the whole-school level with programs that focus on overall mental wellness and which seek to assess and improve population-level health.\textsuperscript{34} Universal interventions are the least-intrusive level of intervention, impact individual students through school climate, and have the benefit of building on students’ existing strengths while helping to identify those who need additional intervention.\textsuperscript{6} These interventions are low-cost and have a high rate of adoption as long as the school administration and staff support it and are coordinated in implementing them.\textsuperscript{6} Finally, school-based universal interventions carry little to no stigma with them because all children participate. From a public health perspective, schools are an excellent milieu for universal treatment modalities because they have access to a large number of children during a critical time developmentally.\textsuperscript{34} While assessment and symptom reduction for individuals does little to influence a population’s health, all individuals benefit from improving the population’s health.\textsuperscript{11}

Positive Behavior Interventions and Support

Positive Behavior Interventions and Support (PBIS) is an evidence-based system used by about one-fifth of United States school districts.\textsuperscript{29} PBIS is based on reinforcing positive behavior to reduce the role of disciplinary actions and to improve social and academic
functioning.\textsuperscript{35} While not exclusive of consequences and disciplinary action, PBIS operates with a prevention framework that aims to improve a child’s functioning in the classroom by understanding and reducing triggers for negative behaviors and reinforcing conditions that foster and maintain positive behavior.\textsuperscript{29,35} PBIS classrooms are able to be more inclusive, and its prevention approach, if used early in a child’s academic career, can help the child operate more independently as he or she ages into middle and upper grades.\textsuperscript{29}

**Resilience and other character education**

Character education programs are another common prevention-level program that schools can use universally to emphasize desirable behaviors and social/emotional traits that help children succeed emotionally and academically.\textsuperscript{15} Resilience is generally understood to mean the collection of protective factors such as family support, social competence, and coping mechanisms that provide a protective effect in the face of challenges, and which may support improved mental health outcomes.\textsuperscript{34} Resilience-based programs in schools seek to build these skills with children in hopes of improving community mental health and reducing poor outcomes both in childhood and in adolescence and adulthood.\textsuperscript{34}

**Mental health screening**

Schools already screen for certain physical health measures, as well as academic achievement, with every student.\textsuperscript{11} Adding universal mental health screening via surveys would enable top-tier population-based measures to be identified and applied.\textsuperscript{11} Surveys of mental health help monitor the population health of a school or district to determine the prevalence of youth mental health problems, prioritize resource allocation, and track trends over time.\textsuperscript{11} Data on the entire school population also supports and targets other school-wide interventions like PBIS.\textsuperscript{11}
The risks of school-wide screenings include invalid results (false “positives” or “negatives”), possible objections from community or parent groups, and adding to the burden of school mental health staff. The stigmatizing risks are similar to other diagnostic methods: giving a child a “label” that follows them through the educational system, and peer rejection.\textsuperscript{16} However, universal screening also has the potential to reduce stigma about “who” has mental health problems, so more children can be identified.\textsuperscript{11} Only about 2% of schools screen for mental health systematically due to lack of practical tools, stigma, and financial and personnel costs.\textsuperscript{11} Therefore, while promising, universal screening should be examined further to determine its place in best practices. Screening tools should be broad, easy to administer, and quick in order to be practical.\textsuperscript{11}

**Selective services for students at risk**

Selective interventions address the needs of groups of students within the school who may benefit from additional mental health support but who do not require individualized treatments. Children with anxiety, behavioral challenges like anger management, or specific situations like grief or divorcing parents are examples of target groups for selective interventions.\textsuperscript{6}

Social skills and problem solving groups are evidence-based practices that can be implemented for groups of children who need them.\textsuperscript{7} These groups are not mental health treatment; rather they are a forum for developing tools to increase mental wellness.\textsuperscript{36} For children with mental illness, peer rejection can exacerbate symptoms and anti-social development, while acceptance by their peers has a protective effect.\textsuperscript{16} Social skills groups give children the opportunity to work on skills to form and maintain relationships and interpret and respond to social cues appropriately in a safe and supportive environment.\textsuperscript{7,16}
Problem-solving programs, such as the FRIENDS program, can be provided universally or in targeted groups to reduce anxiety symptoms using cognitive behavioral therapy techniques. An anxiety affects 10% of children by age 16 and can be a precursor to other psychiatric disorders, yet few children with anxiety are correctly identified and treated. Over 9 one-hour sessions, children practice awareness, regulation, and coping skills with the guidance of a trained teacher or a healthcare provider. The FRIENDS program’s evaluations find it more effective when delivered by a health professional, but children with high anxiety symptoms showed symptom improvement regardless of delivery. While a program like FRIENDS is effective for anxiety, more research is needed on social interventions to address problems that are usually treated with medication, such as ADHD and bipolar disorder.

**Targeted services for children with mental and behavioral health needs**

Targeted, or indicated, interventions address the individual needs of children, including those with depression, post-traumatic stress disorder, or behavioral health challenges like oppositional defiance disorder. Targeted interventions are more beneficial than universal approaches for children with immediate mental health needs. These include on-site counseling services, Individualized Education Plans and Behavioral Intervention Plans, adaptive technologies, and additional therapeutic interventions like occupational therapy and recreational therapy. Targeted interventions also include training for staff on how to handle mental health in schools, such as Youth Mental Health First Aid training. Mental Health First Aid offers lay people tools to recognize, triage, and refer those in crisis, and could be a positive tool for school staff who do not have mental health training.
Conceptual Model for School-Based, Community-Supported Children’s Mental Wellness

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<td>Program monitoring &amp; evaluation</td>
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<td>Policy &amp; law</td>
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<td>Community education &amp; Special Needs Advisory Council</td>
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<td>Funding</td>
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<td>District relationships with mental health institutions</td>
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<th>School Supports Targeted</th>
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<tr>
<td>Appointed person to coordinate mental health</td>
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<td>Support/skills groups</td>
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<td>Self-contained classrooms</td>
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<td>Staff training</td>
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<td>Linking of students &amp; their families to community services</td>
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<tr>
<td>Family Advocacy Network</td>
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<td>Positive after school programs</td>
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<td>Summer programs</td>
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<td>Community safety</td>
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<td>Mental Health First Aid</td>
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<th>Individual</th>
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<tr>
<td>Individualized Education Plans</td>
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<td>Behavior Intervention Plans</td>
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<td>Counseling</td>
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<td>Telemental health</td>
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<td>Mentor programs</td>
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<td>System of care</td>
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<td>Family/parent support: health, resources, respite care, sibling resources</td>
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The conceptual model above shows the three tiers of intervention that support school mental health, along with the corresponding community-level supports that are needed to make the school-based vision a reality. At the top level we have universal interventions and programs that support the well being of all students and create a positive school mental health climate. These are supported by nation- and state-wide policy that funds and provides for mental health services, by community-based forums and education, and by researchers continuing to establish and share best practices. Additionally, national law needs to explicitly
forbid seclusion and allow for restraint only as a last-resort tactic in emergency situations and enforce tougher data collection and reporting requirements.\textsuperscript{29}

Targeted interventions include skill groups for children identified as needing help or being at risk, linkage of families with local resources, and having an appointed person in the school to oversee and coordinate mental health services. These are supported by community-based networks like the Family Advocacy Network, safe and healthy summer and after school programs, and program efforts like Mental Health First Aid. Finally, the individual level includes counseling and individualized plans and services for students, supported by mental health providers, the system of care, and resources for families.

**Workforce & telemedicine**

In North Carolina, primary care providers are allowed to bill Medicaid for up to 26 pediatric mental health visits.\textsuperscript{14} This rule could be expanded to private insurers as well, and supports increased attention to mental health screening during well child visits. Nationwide, we need more child mental health specialists, especially child psychiatrists, and children would benefit from integrating more of these providers directly into the school system.\textsuperscript{37} Out of North Carolina’s 100 counties, 28 do not have any psychiatrist, and 70 do not have a child psychiatrist; there is a desperate need to bring more mental health providers to serve the entire state population.\textsuperscript{38}

In the meantime, telemedicine is a promising way to address workforce shortages, especially for child psychiatrists.\textsuperscript{14} Telemedicine, specifically “telemental health” or “telepsychiatry,” involves the use of video conference equipment to conduct live mental health consultations between a mental health provider and a patient.\textsuperscript{37,38} Telemental health can be leveraged to access mental health assessment and crisis assistance with as little delay as
possible, and allows patients more choices in providers than they may otherwise have available to them.\textsuperscript{38} It is especially promising for rural and remote residents who need monthly psychiatric visits to maintain their medication prescriptions, and for whom travel to see providers can incur considerable time and travel costs.\textsuperscript{37} The technology can also be used for staff trainings, regular counseling sessions, and to provide mental health services in a family's native language.\textsuperscript{37}

This new modality still has barriers to overcome, including clarifying which providers are allowed to provide services in North Carolina, how they are reimbursed, and maintaining HIPAA standards.\textsuperscript{38} Nonetheless, telepsychiatry is already being implemented in North Carolina, with promising results. The East Carolina University Telemedicine Center is a national leader in telemedicine services, providing telepsychiatry to a number of hospitals which include – significantly – residential schools for the deaf and the blind, establishing a precedent for integrating the technology into the public school system.\textsuperscript{38}

Bringing telemental services to schools, which is relatively simple aside from procuring the equipment and a private room, is a very promising strategy to expand services to students who are not able to access them outside the school grounds. Even for children who do have the ability to see a provider outside school hours, streamlining the family’s experience by allowing the child to receive certain services during school hours provides respite and frees parents to use time off work to attend to other needs the child may have.

\textbf{Training}

Schools should understand that students approach the adults with whom they are most familiar and comfortable when they have a problem, and those adults may not be the school mental health expert.\textsuperscript{39} Therefore, all adults who interact with children in the school
should receive a minimum of mental health training and should be aware of the procedures to follow when a child has mental health needs. Schools also have the responsibility to develop procedures to encourage children to use mental health services, and to ensure that staff have availability to see them, and/or to refer to them to other providers if needed.

Teachers are already good sources for making referrals, but their knowledge of mental health can be strengthened. In Minnesota, teachers must have some mental health training to meet continuing education requirements when they recertify. A program like Youth Mental Health First Aid, if adapted to include the needs of children under 12, would be an excellent way of providing teachers and other staff who interact with children with basic skills for helping a child who is experiencing a mental health problem or who is in crisis. Teachers could take the 8-hour program to fulfill continuing education requirements, and trainings could be offered on-site during teacher work days. Because the program is designed for people without a mental health background, it would give participants the basic skills they need to assess students’ situations, and the confidence to know when intervention or referral is indicated.

**Ethical considerations: confidentiality and informed consent**

The school practitioner may face unique challenges if services are warranted but a minor child does not wish to inform their guardian of the situation, or if the parent objects to treatment. Consent for passive services like character education and universal screenings may be implied or unnecessary, but children who need services beyond visiting the school counselor will need consent from a parent or guardian.

Children’s confidentiality also needs to be respected along professional guidelines, so staff (including teachers) must be aware of and follow these policies, and confidentiality
policy should be explained to students before they receive specific services. Protocols regarding the ethical considerations should be well-defined by school districts and disseminated by leaders to all staff, including teachers, coaches, and other personnel in whom students may confide.

Ownership
The educational and mental health sectors must assign responsibility for children’s mental health programming at the national, state, and community level as consistently and efficiently as possible. Though the service structure might vary depending on community resources, the pathway to service ought to be transparent and coherent to a layperson seeking to understand it. The IDEA Act should be refined so that these two under-funded systems are able to collaborate instead of shifting responsibilities to each other.

Alternative Models

Integrated school & community models of mental health care
At least two counties in North Carolina have implemented coordinated services with their local county and private mental health networks to provide comprehensive mental health services in a school-based delivery model. Charlotte-Mecklenburg Schools collaborate with Mecklenburg County and private mental health services to coordinate with and supplement the mental health services, including group and individual counseling, provided by school staff. Buncombe County Schools offer school-based outpatient therapy services to children at all of their schools through partnerships with four partner agencies. All four agencies are able to accept both Medicaid and private insurance; since funding for school mental health services is so complex, this is an especially useful innovation. Children with more acute needs may attend on-campus short-term alternative programs for each age group
(elementary, middle, and high school), and they are given outpatient therapeutic support when they transition back to mainstream classrooms. Coordinated and innovative private-public partnerships can help close the service gap for children with mental health needs, and providing these services on campus makes them accessible to all children regardless of their family circumstances outside the school.

**A state-funded alternative: The Wright School**

North Carolina’s Wright School, founded in Durham in 1963, is a weekday residential facility that serves children ages 6-13 with significant mental and behavioral health needs. Children attend for an average of six months and reside at the school Monday through Friday, returning home each weekend. The Wright School follows a highly structured “re-education” philosophy that supports children’s behavioral and social skills and coordinates with the family and community support system to help the child be successful at discharge.

The school does not qualify for Medicaid funding, so it is entirely funded by state dollars. Unsurprisingly, given the conditions of mental health service and funding in North Carolina, the State Assembly threatens to defund the Wright School on the basis of the small number of children served and its limited geographic reach. Despite its limitations, the Wright School has a strong record of success and parental satisfaction. Rather than defunding it, the Assembly might consider broadening its reach by opening more campuses and expanding school districts’ ability to offer a more intensive program to their students like the Buncombe County model.

**Communities, Children, and Families as Partners**

Family and guardian involvement amplifies programs’ effectiveness and improves the school climate. Furthermore, practicing specific behavioral skills with family members is
critical for children to make behavior changes and to develop self-regulation, especially in a home environment that is supportive, connected, and encouraging of the child’s autonomy.\textsuperscript{19} As mentioned above, this support cannot be taken for granted, but a child’s mental health treatments should not be assumed to take place in a vacuum. Families can be engaged according to Hoagwood’s four domains of family engagement in mental health:\textsuperscript{45}

1) Engagement: School practitioners need to form connections to the families they serve, invite open communication about concerns and experiences, assist with goal setting, and strategize about how to make sessions helpful.\textsuperscript{45}

2) Collaboration: The provider is a partner in the process, not an “expert” or solely a representative of the school.\textsuperscript{45}

3) Support: Practitioners help families connect with services outside the school and support efforts to improve their child’s functioning.\textsuperscript{45}

4) Empowerment: The practitioner identifies strengths to the family and promotes the parents/guardians as leaders in the child’s care; they also support hope and optimism about the child’s options and trajectory.\textsuperscript{45}

Children with mental and behavioral health needs should also have the opportunity to express their needs and preferences for treatment, and they should be able to provide feedback on district policy.\textsuperscript{39}

\textbf{Conclusion}

Schools have an obligation and an opportunity to intervene for children’s mental health. In particular, school leaders have the potential to establish healthy school cultures and work with staff to implement and monitor evidence-based best practices for school mental health. But schools need the support of the community around them to thrive, and
communities (local, state, and national) need to understand that investing in this support will lead to a healthier, stronger future. Community partners such as advocacy groups, mental health providers, managed care organizations, and community youth programs must come together to build relationships with schools and families to support children's mental health, and all these stakeholders must continue to advocate for better policies and funding to expand our knowledge of best practices and implement them in ways that best serve children.
Appendix: Definitions of Common Children’s Mental Health Diagnoses

The following are definitions of some conditions with the greatest prevalence and impact on children. However, this list is by no means comprehensive.

**Anxiety Disorders** Unlike normal, brief periods of anxiety related to normal life events, anxiety disorders are characterized by feelings of worry or fear that do not go away, and may grow worse over time. Types of anxiety might include generalized anxiety disorder, panic disorder, and social anxiety disorder.

**Attention Deficit Hyperactivity Disorder (ADHD)** One of the most common diagnoses of childhood mental illness, ADHD is characterized by difficulty with paying attention, impulse control, and excessive activity. Children may have primarily inattention or hyperactive subtypes of the condition, or a combination of both.

**Autism Spectrum Disorder (ASD)** Typically diagnosed in early childhood, ASD includes a wide variety symptoms and degrees of impairment within the areas of social and occupational functioning or patterns of behavior. Children with ASD may experience severe impairment with communication and social interaction, though the level of skills and abilities varies greatly.

**Depression** Depressive illnesses are characterized by persistent sad or anxious thoughts, symptoms such as excessive sleepiness or insomnia, irritability, appetite changes, suicidal thoughts, or feelings of hopelessness or worthlessness. Depression can take different forms, including persistent depressive disorder (depression last two or more years), psychotic depression (depression accompanied by delusions or hallucinations), or bipolar disorder (a cyclical depressive disorder marked by periods of extreme highs and extreme lows).

**Disruptive Mood Dysregulation Disorder (DMDD)** DMDD is characterized by frequent, temper tantrums that are disproportionate to the immediate situation and the child’s developmental level, as well as frequent irritability between outbursts.

**Oppositional Defiant Disorder (ODD)** ODD is a behavior disorder characterized by extreme defiance to authority along with anger, irritability, and vindictive or disobedient behavior.

**Post Traumatic Stress Disorder (PTSD)** is a condition brought on by exposure to a traumatic event such as violence, abuse, or disasters. Symptoms may include regression, irritability, sleep problems, and detachment.

**Reactive Attachment Disorder** occurs when a young child who has experienced abuse or neglect is unable to establish a bond with his or her primary caregiver. This disorder is diagnosed in very young children (infants through age five) and is characterized by irritability, sadness, and fearfulness with caregivers.
**Schizophrenia** is a condition that affects how a person thinks, feels, and behaves; **psychosis** refers to conditions in which a person has lost contact with reality. While rare in children, current evidence and research such as the National Institute of Mental Health's RAISE project shows that early, coordinated care following first-episode psychosis can decrease the likelihood of future episodes.\textsuperscript{51}
Works Cited


37. Corra AJS, S. H. Telemental Health in Schools. Baltimore, MD: Center for school Mental Health, Department of Psychiatry, University of Maryland School of Medicine;2009.