NORTH CAROLINA
State Board of Education
Department of Public Instruction

Report to the North Carolina General Assembly

School-Based Mental Health Plans and Compliance Report

Session Law 2020-7/Senate Bill 476

Date Due: December 15, 2021
DPI Chronological Schedule, 2021-2022

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REPORT TO THE NC GENERAL ASSEMBLY:
SCHOOL-BASED MENTAL HEALTH PLANS AND COMPLIANCE REPORT
Senate Bill 476. Session Law 2020-7.

Background

This report meets the legislative requirement set forth in NC Session Law 2020-7, section (f) where it states "By September 15 of each year, each K-12 school unit shall report to the Department of Public Instruction on (i) the content of the school-based mental health plan adopted in the unit, including the mental health training program and suicide risk referral protocol, and (ii) prior school year compliance with requirements of this section. The Department of Public Instruction may also audit K-12 school units at appropriate times to ensure compliance with the requirements of this section. The Department shall report the information it receives pursuant to this subsection to the Joint Legislative Education Oversight Committee and the Joint Legislative Oversight Committee on Health and Human Services by December 15 of each year."

This report includes the following:

I. Methodology for collecting required school mental health plans and hyperlinked related resources provided to public school units
II. Findings of the review of school mental health plans submitted
III. Trends identified in the review of school mental health plans submitted
IV. Plan Compliance data on public school units who did and did not submit complete school mental health plans
V. Appendix - Text of Senate Bill 476. Session Law 2020-7 § 115C-376.5. School-based mental health plan required

I. Methodology

The NC Healthy Schools & Specialized Instructional Support Section at the NC Department of Public Instruction (DPI) incorporated reporting requirements of Session Law 2020-7 and State Board of Education Policy SHLT-003 into the annual reporting of the Healthy Active Children (HAC) report already required in State Board of Education Policy SHLT-000. In doing so, public school units (PSUs) add to a pre-existing report with the same due date of September 15 rather than having to complete an additional separate report. Charter Schools, which are not required to complete the HAC report but are required to submit the School Mental Health Plan, have been provided the option to skip directly to the School Mental Health Plan reporting component.

Prior to opening the reporting portal, numerous resources were developed to support PSUs in their development and implementation of school mental health plans, accompanied with communications via PSU email groups and designated PSU contacts, DPI listservs, and the DPI Weekly Top 10. The support resources and additional information are available on the NC Healthy Schools School Mental Health Policy webpages (or nchealthyschools.org).

Review of the school mental health plans began on September 20th, 2021. On that date, there were approximately 24 PSUs who had not submitted anything into the submission portal, and personalized outreach commenced to assist these PSUs with compliance. Upon further review of the plan submissions, additional outreach was initiated due to partial omissions of the required plan

components. PSUs received phone calls and emails notifying them of items that were missing or incomplete, with instructions on how to re-submit and include the required components. Outreach, follow-up, and technical assistance was provided through October 29th, 2021 to assist PSUs with compliance. The findings of this review reflect submissions and re-submissions made through October 29th, 2021.

II. Findings

The School Mental Health Policy Report prompted PSUs to answer eight questions and upload a copy of their school mental health plan, including a suicide risk referral protocol and a training plan. There are 327 PSUs including traditional LEAs (116), charter schools (204), and regional/laboratory (7) schools. All traditional LEAs, and 200 charter schools responded, as well as 3 regional/laboratory schools. All of the data presented includes the 3 regional/lab responses with charter school data. Data from the eight questions is summarized below.

What data sources did you use to help identify priorities?

Answer Choices	% of PSUs	# of PSUs
YRBS (Youth Risk Behavior Survey)	27.59%	88
Annual School Health Services Report	24.45%	78
PowerSchool Data	72.73%	232
Say Something App Data	45.45%	145
SHAPE (School Health Assessment and Performance Evaluation)	54.23%	173
ECATS MTSS Early Warning System Data	37.93%	121
FAM-S (Facilitated Assessment of MTSS - School Level)	45.14%	144
District Report Card Data	49.53%	158
Racial Equity Report Card Data	20.69%	66
Other (please specify)	38.87%	124
	Answered	**319**

Does your plan address universal promotion of mental and social-emotional wellness and prevention through core instruction, curriculum, and school environment?

Answer Choices	% of PSUs	# of PSUs
Yes	99.69%	318
No	0.31%	1
	Answered	**319**

Does your plan include a mental health training program provided to school employees addressing the topics listed below, including at least six hours of content for initial training occurring within the first six months of employment and annual subsequent training of at least two hours?

	Yes		No		Total
	% of PSUs	# of PSUs	% of PSUs	# of PSUs	
Youth Mental Health	97.18%	310	2.82%	9	319
Suicide Prevention	97.49%	311	2.51%	8	319
Substance Abuse	88.09%	281	11.91%	38	319
Teenage Dating Violence	82.45%	263	17.55%	56	319
Child Sexual Abuse Prevention	93.42%	298	6.58%	21	319
Sex Trafficking Prevention	93.10%	297	6.90%	22	319
Adult Social Emotional Learning/Mental Wellness	85.58%	273	14.42%	46	319
				Answered	**319**

Does your plan address early intervention for mental and social-emotional health, including:

	Yes		No		Total
	% of PSUs	# of PSUs	% of PSUs	# of PSUs	
Processes for identifying students who are experiencing and/or are at risk of developing SEL and/or mental health issues at school	99.37%	317	0.63%	2	319
Annual review of the PSU's policies, procedures, and/or practices for crisis intervention	96.87%	309	3.13%	10	319
Identification of methods for strengthening the PSU's response to mental and social-emotional health and substance use concerns in the school setting, including the role of crisis intervention teams	97.18%	310	2.82%	9	319
Annual review of the PSU's discipline policies and practices	93.73%	299	6.27%	20	319
Identification of strategies to	94.04%	300	5.96%	19	319

avoid over-reliance on suspension or expulsion in the discipline of students with identified mental and social-emotional health or substance use concerns					
Inclusion of PSU in the local community emergency preparedness plan	84.95%	271	15.05%	48	319
				Answered	**319**

Does your plan address how students in need will access and transition within and between school and community-based mental health and substance use services, including:

	Yes		No		Total
	% of PSUs	# of PSUs	% of PSUs	# of PSUs	
Strategies to improve access to school and community-based services for students and their families, e.g., by establishing arrangements for students to have access to licensed mental health professionals at school	96.87%	309	3.13%	10	319
Strategies to improve transitions between and within school and community-based services, e.g., through the creation of multi-disciplinary teams to provide referral and follow-up services to individual students	97.18%	310	2.82%	9	319
Formalized protocols for transitioning students to school following acute/residential mental health treatment	86.21%	275	13.79%	44	319
				Answered	**319**

Does your plan address improving staffing ratios for licensed specialized instructional support personnel such as school counselors, school nurses, school psychologists, school social workers, and school occupational therapists?

Answer Choices	% of PSUs	# of PSUs
Yes	75.24%	240
No	24.76%	79
	Answered	**319**

With what mental health and substance use providers does your PSU have a Memorandum of Understanding (MOU) regarding respective roles and relationships on coordination of referral, treatment, and follow-up for individual students in need of services?

Answer Choices	% of PSUs	# of PSUs
None of the above	23.82%	76
Local Management Entity/Managed Care Organization (LME/MCO)	22.57%	72
Local Mental Health Service Provider	56.43%	180
Other (please specify)	15.05%	48
	Answered	**319**

In addition to school personnel, which of the following stakeholders are engaged in your goal of building school, family, and community partnerships to create and sustain coordinated mental and social-emotional health and substance use supports and services for students?

Answer Choices	% of PSUs	# of PSUs
Students	74.61%	238
Families	86.21%	275
Community Service Providers	86.52%	276
County/City Agencies	55.49%	177
Faith-Based Organizations	42.95%	137
Professional Associations	27.27%	87
University/College	27.59%	88
Other (please specify)	6.58%	21
	Answered	**319**

III. Trends

A review and analysis of the uploaded files that PSUs submitted provided additional information about each PSU's understanding of school mental health, where they are in the continuum of care, what supports are already in place, and what efforts are needed to advance their school mental health plans and supports. The components of the plans varied in how comprehensive and/or extensive the details were. Some PSUs did not include information in their uploaded plans that addressed all of the components of the comprehensive school mental health plan. There were also some discrepancies in what PSUs reported including in their plans and what was actually found in their plans upon review. The trends identified from the uploaded plans have been categorized into plan components and explained in greater detail in the following sections.

Data Sources

PSUs were asked to consider data sources to determine the needs and strengths of their social emotional and mental health supports. The most referenced data source was the School Health Assessment and Performance Evaluation (SHAPE), with 79% of traditional LEAs and 58% of charter schools using their school health indicators to determine needs. Also topping the list of data sources utilized was PowerSchool data, the Facilitated Assessment of MTSS - School Level (FAM-S), and the Say Something App data.

Data Source	Traditional LEA	Charter
SHAPE	79%	58%
PowerSchool	45%	43%
FAM-S	52%	25%
Say Something App	40%	34%

Identified Needs

Based on the data sources and assessments used to determine strengths and needs, PSUs identified their areas of need. The most overwhelming need identified was implementation of core social-emotional learning (SEL). The next highest area of need was professional development in the areas of SEL and mental health. A system for record keeping and tracking of outcomes related to mental health was identified as the third-highest need among traditional LEAs. The third-highest need for charter schools was the implementation of Multi-Tiered System of Support (MTSS) with full fidelity. Additionally, 28% of charter schools identified the need to locate and conduct a needs assessment to further determine needs.

Identified Need	Traditional LEA	Charter
Implementation of Core SEL	46%	45%
SEL/MH Professional Development	35%	30%

Record Keeping/Outcome Tracking System	33%	13%
Fidelity of MTSS Implementation	30%	23%

Existing Prevention & Universal Promotion

PSUs were asked to describe existing social emotional learning/ mental health prevention initiatives. There were a wide variety of initiatives in this section of their plans. The most frequent included were Multi-Tiered System of Support (MTSS), Positive Behavior Intervention System, Character Education, restorative practices, social and emotional learning practices, Second Step, Say Something App, bullying prevention, and trauma informed training. Staff wellness and staff development emerged frequently in this section as well.

Building Infrastructure

This section encourages PSUs to make connections to sustainability and mitigation. PSUs listed action steps that support the SEL/MH infrastructure that they either have in place or are currently setting in place. The following trends emerged:

- 68 PSUs indicated action steps to increase the number of Specialized Instructional Support Personnel (counselors, social workers, psychologist, nurses) either through local funding or ESSER funds
- 44 PSUs plan to form school mental health teams and focus more on a teaming structure to support the implementation of their plans
- 41 PSUs have action steps to implement school wide SEL with greater fidelity
- 41 PSUs plan to enter into a memorandum of understanding with a mental health provider
- 33 PSUs plan to increase efforts around parent and stakeholder engagement with the goal of building school, family, and community partnerships to strengthen SEL and MH prevention

Suicide Risk Referral Protocols

It was required that PSUs adopt/implement a suicide risk referral protocol. The NC Project AWARE (Advancing Wellness and Resiliency in Education) director and grantees developed a model suicide risk referral protocol based on The Research Foundation for Mental Hygiene, Inc., 2008, and adapted from the Columbia Suicide Severity Rating Scale (CSSRS) for PSUs to adapt to their own and use in compliance with the School Based Mental Health Policy. Upon review of the plans, approximately 79 PSUs indicated use of the model suicide risk referral protocol from Project AWARE.

After outreach and follow-up, there were 22 traditional LEAs and 62 charter schools that did not submit a suicide risk referral protocol.

Training Plans

It was required that PSUs submit a training plan that included the legislated 6 training topics and a minimum of 6 hours of training in the initial training and subsequent trainings of at least two hours. Popular among traditional LEAs was a training package through their human resources compliance

vendor, Vector/Safe Schools, with 44% of traditional LEAs reported using this to complete training requirements. Local training options utilizing law enforcement, department of social services, school-based mental health professionals, child advocacy centers, and mental health provider agencies were also popular among both traditional LEAs (32%) and charter schools (21%). The RISE Training Guide developed by the NC Center for Safer Schools, in collaboration with other state partners, was utilized among traditional LEAs (27%) and charter schools (20%).

Other training options that emerged frequently in the plans were Classroom Wise, Youth Mental Health First Aid, Act on Facts, Jason Foundation, Say Something Suicide prevention, Maryland Behavior Health Training Center, Prevent Child Abuse NC, Darkness to Light, SOAR/DHHS, and CDC Dating Matters.

After outreach and follow up, there were 21 traditional LEAs and 78 charters with either no submitted training plans or training plans out of compliance with the legislation.

Academic Alignment

There were 90% of traditional LEAs and 51% of charters that referenced using the DPI Social and Emotional Learning Standards Mapping Document to assist them in aligning SEL with academic objectives with the goal of greater integration. PSUs also frequently mentioned the Healthful Living Standards and the Guidance Essential Standards as a method to better align SEL with academic instruction.

Evaluation

PSUs were asked to indicate how they would evaluate their SEL and mental health prevention efforts. The top responses among PSUs were to use a mental health screening tool (23%), analyze specialized instructional support documentations/referrals (23%), utilize PowerSchool data (15%), and administer the SHAPE (15%).

Early Intervention

Efforts to intervene early to address SEL and mental health were recorded in this section of PSUs plans. The action step referenced most often by PSUs was annual review of crisis intervention policies, practices, and personnel and discipline policies, practices, and personnel. This was referenced by 60% of traditional LEAs and 46% of charter schools. The next most referenced action steps were utilizing specialized instructional support to identify risks, use of a universal screener for mental and emotional wellness, and to provide tiered supports in alignment with the MTSS framework.

Action Step	Traditional LEA	Charter
Policy Review	60%	57%
SISP Identify Risks	53%	33%
Universal Screener	41%	46%
Tiered Supports	39%	23%

Treatment, Referral, Re-entry

PSUs were asked about protocols related to the treatment, referral, and re-entry process for mental health related illness. PSUs referenced action steps to improve access to school-based and community-based services for students and their families with the highest frequency (25%). The next most frequent action step among PSUs was to improve transitions between and within the school and community-based services (23%). Creating and/or continuing a memorandum of understanding with a mental health provider was the third most referenced action step among PSUs (20%).

IV. Plan Compliance

With the extended outreach, all traditional LEAs uploaded something into the reporting portal. There were 6 traditional LEAs that submitted documents that were not school-based mental health plans and were out of compliance with legislation and policy requirements. There were an additional 35 traditional LEAs that submitted partial plans (required plan components omitted).

With extended outreach, 200 charter schools uploaded something into the reporting portal. There were 4 charter schools that did not comply. There were an additional 112 charter schools that submitted partial plans (required plan components omitted).

Three regional/lab schools uploaded a school-based mental health plan into the reporting portal. Four regional/lab schools did not comply.

For questions/concerns, please contact:

Mary Hemphill-Joseph, Director, Division of Academic Standards
mary.hemphill@dpi.nc.gov

Ellen Essick, Section Chief, NC Healthy Schools & Specialized Instructional Support
ellen.essick@dpi.nc.gov

APPENDIX

SCHOOL-BASED MENTAL HEALTH PLAN REQUIRED
Senate Bill 476. Session Law 2020-7.

§ 115C-376.5. School-based mental health plan required.

(a) Definitions. – The following definitions shall apply in this section:

(1) K-12 school unit. – A local school administrative unit, a charter school, a regional school, an innovative school, or a laboratory school.

(2) School personnel. – Teachers, instructional support personnel, principals, and assistant principals. This term may also include, in the discretion of the K-12 school unit, other school employees who work directly with students in grades kindergarten through 12.

(b) School-Based Mental Health Policy. – The State Board of Education shall adopt a school-based mental health policy that includes (i) minimum requirements for a school-based mental health plan for K-12 school units and (ii) a model mental health training program and model suicide risk referral protocol for K-12 school units. Consistent with this section, the model mental health training program and model suicide risk referral protocol shall meet all of the following requirements:

(1) The model mental health training program shall be provided to school personnel who work with students in grades kindergarten through 12 and address the following topics:
a. Youth mental health.
b. Suicide prevention.
c. Substance abuse.
d. Sexual abuse prevention.
e. Sex trafficking prevention.
f. Teenage dating violence.

(2) The model suicide risk referral protocol shall be provided to school personnel who work with students in grades six through 12 and provide both of the following:
a. Guidelines on the identification of students at risk of suicide.
b. Procedures and referral sources that address actions that should be taken to address students identified in accordance with this subdivision.

(c) School-Based Mental Health Plan. – Each K-12 school unit shall adopt a plan for promoting student mental health and well-being that includes, at a minimum, the following:

(1) Minimum requirements for a school-based mental health plan established by the State Board of Education pursuant to subsection (b) of this section.

(2) A mental health training program and a suicide risk referral protocol that are consistent with the model programs developed by the State Board of Education pursuant to subsection (b) of this section.

(d) Training and Protocol Requirements. – Each K-12 school unit shall provide its adopted mental health training program and suicide risk referral protocol to school personnel at no cost to the employee. Employees shall receive an initial mental health training of at least six hours and subsequent mental health trainings of at least two hours. The initial mental health training shall occur within the first six months of employment. Subsequent mental health trainings shall occur in the following school year and annually thereafter. In the discretion of the K-12 school unit, the initial mental health training may be waived in the event the employee completed an initial mental health training at another K-12 school unit. School personnel may meet mental health training requirements in any of the following ways:

(1) Electronic delivery of instruction.
(2) Videoconferencing.
(3) Group, in-person training.
(4) Self-study.

(e) Review and Update. – Beginning August 1, 2025, and every five years thereafter, the Superintendent of Public Instruction shall review the State Board of Education's minimum requirements for a school-based mental health plan, model mental health training program, and model suicide risk referral protocol and recommend any needed changes to the State Board of Education. The State Board shall update its policies to reflect those recommendations and publish the updates to K-12 school units. A K-12 school unit shall update its adopted school-based mental health plan in accordance with any updates provided by the State Board.

(f) Reporting; State Audit. – By September 15 of each year, each K-12 school unit shall report to the Department of Public Instruction on (i) the content of the school-based mental health plan adopted in the unit, including the mental health training program and suicide risk referral protocol, and (ii) prior school year compliance with requirements of this section. The Department of Public Instruction may also audit K-12 school units at appropriate times to ensure compliance with the requirements of this section. The Department shall report the information it receives pursuant to this subsection to the Joint Legislative Education Oversight Committee and the Joint Legislative Oversight Committee on Health and Human Services by December 15 of each year.

(g) No Duty. – Nothing in this section shall be construed to impose an additional duty on a K-12 school unit to provide referral, treatment, follow-up, or other mental health and suicide prevention services to students of the K-12 school unit.

(h) Limitation of Civil Liability. – No governing body of a K-12 school unit, nor its members, employees, designees, agents, or volunteers, shall be liable in civil damages to any party for any loss or damage caused by any act or omission relating to the provision of, participation in, or implementation of any component of a school-based mental health plan, mental health training program, or suicide risk referral protocol required by this section, unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing. Nothing in this section shall be construed to impose any specific duty of care or standard of care on a K-12 school unit. (2020-7, s. 1(a).)