Public Schools of North Carolina
State Board of Education
Department of Public Instruction

Report to the North Carolina General Assembly

Recommendations from the Superintendent's Working Group on Student Health and Well-Being

Session Law 2018-32, Part V, Section 5.(a)

Date Due: October 15, 2018
Report # 27
DPI Chronological Schedule, 2018-2019

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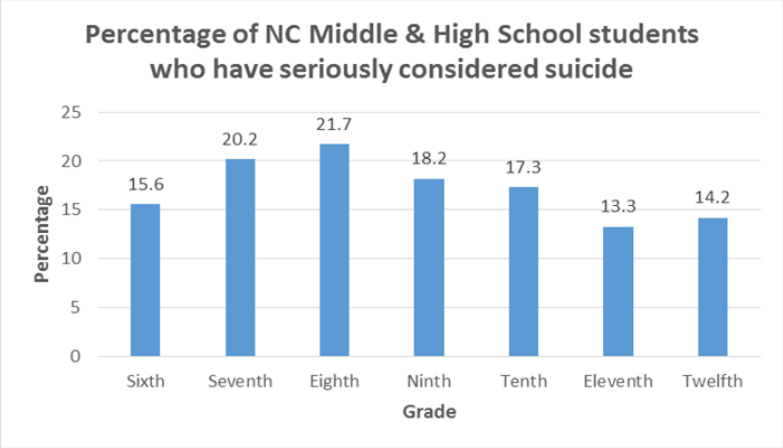
Introduction & Report Summary

North Carolina (NC) is the 9th most populous state with 10.27 million people, of whom 22.7% (or 2.33 million people) are age 18 or younger. NC ranks 41st out of 50 states for median household income and has the 11th highest per capita poverty rate in the nation at 17.2%; Twenty-three percent of NC children live in poverty, and around 47% of NC children are Medicaid-enrolled and 30% live in families that lack secure employment. Poverty is a contributing factor to students' mental health issues and it has direct effects on emotional, behavioral, and psychiatric problems (Bassuk, Richard, & Tsertsvadze, 2015).

With a growing population of students with diverse needs, schools must intentionally create a culture that is conducive to safe and secure learning, specifically as it relates to a prevalence of general mental health issues including, but not limited to, risk of suicide, risk of substance abuse, risk of sexual abuse, and human trafficking.

Suicide. According to information provided by the North Carolina Child Fatality Task Force, suicide is the second leading cause of death for youth between the ages of 10 and 17. According to the 2015 NC Youth Risk Behavior survey, 9.3% of NC high school students surveyed reported attempting suicide, which is almost double the rates reported in 2011 and 2013. In 2014 (just one year), there were 1,681 emergency department visits and 513 hospitalizations for self-inflicted injuries among youth ages 10 to 17 in North Carolina (note that not all self-inflicted injuries are considered suicide attempts). More females than males attempt suicide, while more males than females die by suicide.



Substance Abuse. Among students age 12+, marijuana, cocaine, and heroin use are increasing. NC was 1 of 10 states noted as having significant quarterly increases in opioid use between July 2016 and September 2017.

Sexual Abuse and Human Trafficking. According to Darkness to Light, a national child sexual abuse organization, a study conducted by C. Townsend and A.A. Rheingold, Ph.D. found that approximately one in ten children will be sexually abused before their eighteenth birthday. Approximately 90% of children who suffer child sexual abuse are abused by someone they know, and only10% are abused by a stranger. Approximately 30% of children who are sexual abused are abused by a family member. Children who are sexually abused have a 3-to-5-fold risk of being delinquent, are 2.2 times more likely to become teen mothers, are 3 times more likely to

report substance abuse, and are more than twice as likely to report depression and suicidal tendencies.

Trafficking. While child sex trafficking makes up a small portion of the overall numbers of people who are sexually trafficked, there are still significant risks to children from sex traffickers. The prevalence of human trafficking in North Carolina is due to many factors, including the major highways that run through our state (Highways 40, 85, and 95), a large, transient military population surrounded by sexually oriented businesses, numerous rural agricultural areas with a high demand for cheap labor, and an increasing number of gangs. According to the National Human Trafficking Hotline, in 2017, North Carolina had 221 reported human trafficking cases. This statistic puts North Carolina 8th among all 50 states, in terms of the number of reported human trafficking cases. Training on recognizing sex abuse will reduce the number children who grow up to be victimized by sex traffickers as adults, as 70% to 90% of women who have been rescued from traffickers report being victims of child sexual abuse. Human trafficking is one of the fastest growing crimes in the United States.

These statistics create a picture of the reality that schools across NC face every day. Educators are often in the best position to recognize the needs of students for whom they have the privilege of serving. Teachers should not be expected to be psychologists or counselors, but instead should be equipped to recognize certain signs and behaviors, then refer the children to trained professionals for further investigation that may help to reduce trauma and other offenses. This report will recommend a model mental health program and risk referral protocol for schools and districts to implement in their own communities, ensuring that educators are equipped to recognize warning signs and refer students to the right resources for external support.

Report Background

In 2017, several proposed approaches were considered by lawmakers and policymakers to ensure that every educator in North Carolina could be trained to recognize and seek support for students in need of mental health services.

- SHLT-003 is the School-Based Mental Health Initiative policy that was adopted on April 7, 2017. It required school personnel with contact with students to have 6 hours of training and subsequent training every three years on mental health issues. LEA's and charters would adopt a plan for universal prevention, early intervention services, and referral, treatment, and re-entry. Because this was a policy and not a law, it did not provide immunity protection for staff.
- H285 passed the House and required two hours of training every other year on suicide prevention for all school personnel who interfaced with students in grades 6-12. The proposed legislation provided criteria for training and linked with school protocols, and it provided immunity protection. This legislation was part of the recommendations of the House Select Committee on School Safety.
- S548 proposed training for school staff on human tracking and sexual assault. The training would be every three years, no amount of time specified.

In response to these various approaches, HB155 called for the Superintendent of Public Instruction to convene a working group to study effective and positive intervention measures or policy changes to address risky behaviors and encourage student mental health. The Superintendent's Working Group on Student Health and Well-Being ("Working Group") is comprised of various public and private stakeholder groups across the state who are all invested in the health and well-being of students across NC. The Working Group reviewed their role in serving North Carolina's students and reviewed other initiatives/programs/organizations doing similar work in student health and well-being in North Carolina. The group also discussed the importance of effective training programs for teachers to include general mental health, suicide prevention, substance abuse and sexual abuse/sex trafficking. In terms of training programs, the group felt that any training solutions should be broad enough to respect differences across school districts, and that schools should have the tools, resources, and skills to engage partners and find services for referral so that schools are not expected to serve as actual mental-health clinics. For example, under a few of the 2017 proposals, schools would have to track which staff have completed which training, pay non-certified personnel for trainings because they would be working outside of their normal hours, and be bound by a framework that could be too prescriptive and irrespective of the individual circumstances of diverse LEA's and charters. Solutions must include a structure that allows communications from all stakeholders and create a full continuum of supports and system of care approach. From these meetings, the Working Group made recommendations to the State Board of Education and the Joint Legislative Education Oversight Committee in May 2018. Those recommendations can be found in Appendix B. Members of the Superintendent's Working Group for Student Health and Well-Being can be found in Appendix A.

From these recommendations, the legislature passed Session Law 2018-32. PART V, Section 5.(a) of Session Law 2018-32 called for a few deliverables, which are found in this report:

- Content standards for a mental health training program that includes all of the following topics:
    - Youth mental health
    - Suicide prevention
    - Substance abuse
    - Sexual abuse prevention
    - Sex trafficking prevention
- A model mental health training program
- A suicide risk referral protocol

Definitions

- Content standards: Broad guidelines/parameters describing specific content areas; what educators should be learning and mastering in specific content areas
- Model training: A framework for defining the skill and knowledge requirements; a collection of competencies that jointly define successful completion of a task or job
- Risk referral protocol: standard procedures implemented in cases where a child or youth is identified or suspected to be at risk for suicide or other threats

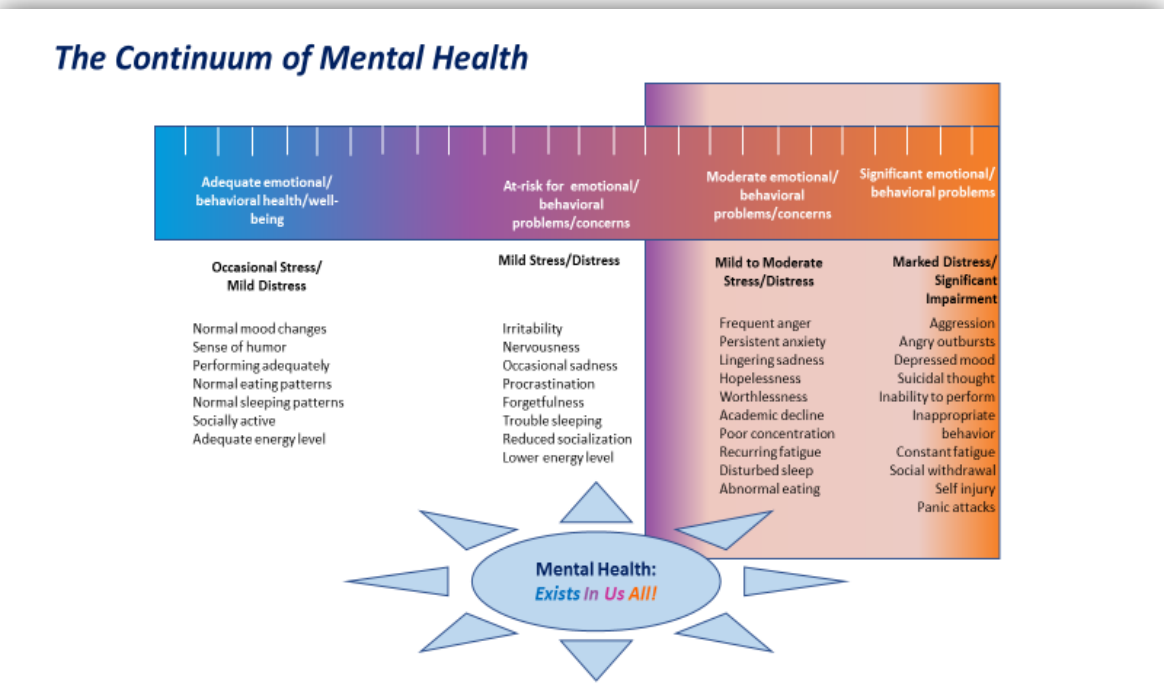
Content Standards & Model Mental Health Program

Based on the directive to DPI in PART V, Section 5.(a)(1) of Session Law 2018-32, the following table outlines the ***content standards*** for a mental health training program that includes the following topics:

- Youth mental health
- Suicide prevention
- Substance abuse
- Sexual abuse prevention
- Sex trafficking prevention

The table also includes the evidence-based ***content*** that would be included in a model mental health training program to meet the requirement of the directive to DPI in PART V, Section 5.(a)(2) of Session Law 2018-32. The model program outlined in the table below could be formatted to enable personnel to satisfy all training requirements through electronic delivery of instruction, videoconferencing, group in person training, or self-study, and would address the required topics within a time frame that is consistent with best practices.

Mental health, like physical health, applies to everyone and exists on a continuum ranging from healthy to terminal. We all fall somewhere along this continuum, and so do our students.



Mental health supports and services are not solely about intensive needs. The goals should be to maximize the number of children who are mentally healthy while responding effectively to those students who demonstrate risk factors or warning signs of problems associated with any of the areas listed above.

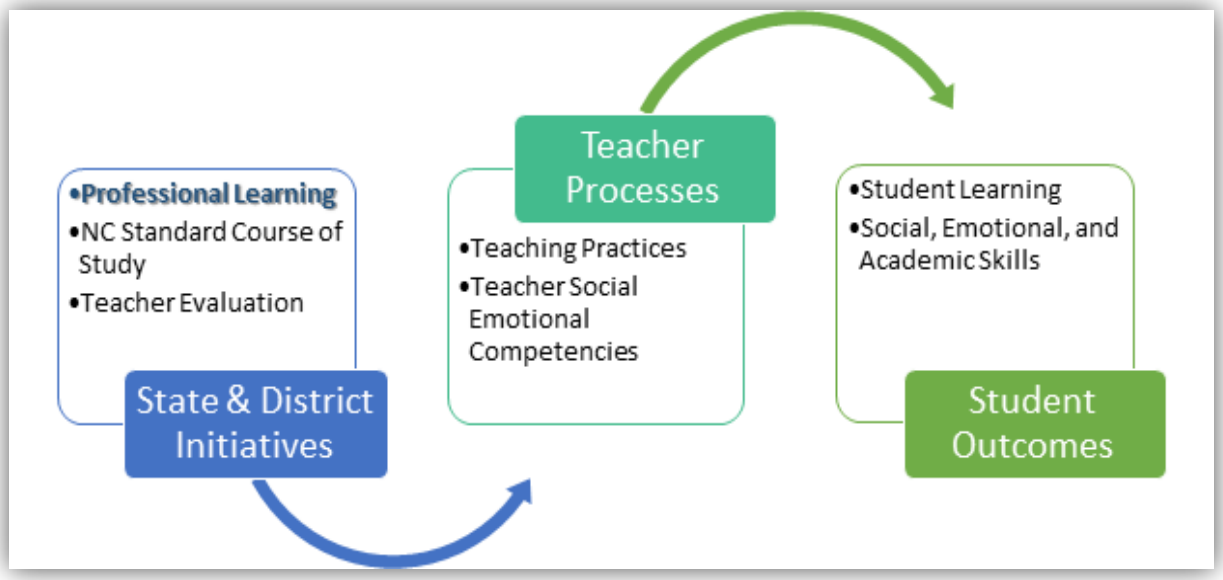
As such, these content standards have been designed and organized to build school staff capacity for addressing mental health, substance use, sexual abuse, and sex trafficking in two ways:

1. To ***promote*** positive mental health and prevent mental health issues by employing universal practices across the education environment to enhance overall school climate and support social-emotional learning and positive behavioral responses. This includes providing integrated, developmentally appropriate, grade-level instruction to students in existing social and emotional learning and healthful living standards in the NC Standard Course of Study (NCSCoS; e.g., Healthful Living Essential Standards and Guidance Essential Standards), as is required in G.S. 115C-81.60 regarding character education.
2. To ***respond*** appropriately to student data/risk factors/warning signs using sound decision-making processes to match student need with appropriate resources through the use of standardized response protocols.

The relevant NCSCoS standards are provided in the right column of the table to demonstrate alignment of these teacher/practitioner training standards with student learning/outcomes. The relationship between staff knowledge, skills, and abilities and student learning is illustrated in the logic model below.

CONTENT STANDARDS AND MODEL MENTAL HEALTH TRAINING PROGRAM FOR SCHOOL PERSONNEL

LOGIC MODEL



Content Standards & Model Mental Health Program

PART I - PREVENTION *Universal practices applied across the education environment to support social-emotional learning, positive behavioral responses and enhance overall school climate*		
Content <u>Standards</u> for Mental Health Training Program:	(Professional Learning to impact Educator Practices) **Model Mental Health Training Program <u>Content</u> for School Practitioners**	(Practices impact Student Outcomes) **NC SCOS Standard Linkage** NC SCOS Resource
Caring and safe environments	● School Climate ● Restorative practices ● Trauma-informed classrooms/schools (ACEs)	*Guidance Essential Standards:* *Social Emotional and Cognitive* (1) intrapersonal strategies (2) interpersonal strategies (3) communication strategies (4) creative thinking (5) analytical thinking (6) self-awareness *Healthful Living Standards:* *Communication and Relationships*

Student-centered discipline	● Proactive classroom management strategies
	  ○ Shared classroom norms/rules, and values
	  ○ Practice and feedback
	  ○ Self-directed students
	● Developmentally appropriate disciplinary response strategies
	  ○ Logical; consequences connected to norms, rules, and function
	  ○ Continuum of data-informed responses
		Guidance Essential Standards:
		Social Emotional and Cognitive
		(1) intrapersonal strategies
		(2) interpersonal strategies
		(3) communication strategies
		(4) creative thinking
		(5) analytical thinking
		(6) self-awareness
		Healthful Living Standards:
		Mental and Emotional Health

Responsibility and choice	● Service learning/ community service ● Peer support (e.g., STAMP) ● Consensus decision-making ● Cooperative learning ● Conflict resolution and problem-solving	*Guidance Essential Standards:* *Social Emotional and Cognitive* (1) intrapersonal strategies (2) interpersonal strategies (3) communication strategies (4) creative thinking (5) analytical thinking (6) self-awareness *Healthful Living Standards:*

		Mental and Emotional Health

Teacher/Practitioner language and modeling	Teacher/Practitioner models, grows in, and explicitly instructs:
	
	● Self-awareness
	  o Cultural competence
	  o Implicit bias
	● Self-Management/ Emotional Regulation
	● Growth mindset
	● Social-Awareness
	  o Perspective taking
	  o Empathy
	● Relationship/Social Skills
	  o Conflict resolution
	  o Cooperation
	  o Active listening
	● Responsible Decision Making
	  o Use of evidence
	● Filter and focus on whole-group outcomes
		Guidance Essential Standards:
		
		Social Emotional and Cognitive
		
		(1) intrapersonal strategies
		
		(2) interpersonal strategies
		
		(3) communication strategies
		
		(4) creative thinking
		
		(5) analytical thinking
		
		(6) self-awareness
		
		Healthful Living Standards:
		
		Mental and Emotional Health

PART II - RESPONSE (Recognize, Assess, Refer)

Data sources and decision-making processes used to match student need to appropriate resources through the use of standardized response protocols

Content Standards for Mental Health Training Program:	(Professional Learning to impact Educator Practices) **Model Mental Health Training Program Content for School Practitioners**		(Practices impact Student Outcomes) **NC SCOS Standard Linkage** NC SCOS Resource
Procedures/ Protocols	**CONTENT AREA:**	**CONTENT INCLUDED:**	
	Communication Structures **Universal screening and other data sources** **Referral/response protocols**	• School teams addressing student health • Using data to identify students at-risk • Types of potential referral • Risk referral procedures	
Youth Mental Health Problems **(Risk & Referral)**	**CONTENT AREA:**	**CONTENT INCLUDED:**	*Healthful Living* *Healthful Living Standards:* *Mental and Emotional Health*
	Definition and Statistics - **National statistics** - **State statistics** **Myths and Facts**	Topics covered may include: depression and mood disorders, anxiety disorders, trauma, psychosis, substance use	
	Recognize Risk Factors **Leverage Protective Factors**	Recovery and resiliency	
	Respond to Warning Signs	**Understanding warning signs;**	

		• Warning signs associated with specific mental health disorders by topic area **Decision-making processes and procedures**	
	Additional Resources	**Resource Guide for Educators**	
Suicide **(Risk & Referral)**	**CONTENT AREA:**	**CONTENT INCLUDED:**	*Healthful Living* *See Unpacking Standards documents, Middle and High School:* http://hlnces.ncdpi.wikispaces.net/K-12%20Instructional%20Tools
	Definition and Statistics - **National statistics** - **State statistics** **Myths and Facts**		
	Recognize Risk Factors **Leverage protective factors to reduce risk**	**Understanding Risk Factors:** ● Previous suicide attempt(s) ● Isolation and aloneness ● Non-suicidal self-injury (e.g., cutting) ● Mental illness including depression, conduct disorders, and substance abuse ● Family stress/dysfunction ● Family history of suicide ● Environmental risks, including presence of a firearm in the home ● Situational crises (e.g., the presence of a gun in the home, bullying and harassment, serious disciplinary action, death of a loved one, physical or sexual abuse, breakup of a	

		relationship/friendship, family violence, suicide of a peer)	
	Respond to Warning Signs	**Understanding warning signs:** ● Types of threat (direct, indirect) ● Suicide notes and plans (including online postings) ● Making final arrangements (e.g., giving away prized possessions) ● Preoccupation with death ● Changes in behavior, appearance, thoughts, and/or feelings including out of character expressions of happiness (could be happy because they now have a plan in place) **Decision-making processes and procedures**	
	Additional Resources	**Resource Guide for Educators**	
	CONTENT AREA:	**CONTENT INCLUDED:**	*Healthful Living Standards:* *Mental and Emotional Health* *Alcohol, Tobacco & Other Drugs*
	Definition and Statistics - **National statistics** - **State statistics** **Myths and Facts**	**Understanding Risk Factors:** ● Early Aggressive Behavior ● Lack of Parental Supervision ● Substance abuse peer group ● Drug Availability ● Poverty	

Substance use **(Risk & Referral)**	**Recognize Risk Factors** **Leverage protective factors to reduce risk**		
	Respond to Warning Signs	**Understanding warning signs:** ● heightened secrecy ● bizarre excuses or lying behavior ● difficulty thinking or keeping focus ● withdrawing from classroom participation ● resistance to discipline or feedback ● increased tardiness or absence ● paranoia, irritability, anxiety, fidgeting ● changes in mood or attitude ● significant weight loss or gain ● loss of interest in hobbies or activities ● decline in school performance ● abandonment of long-time peer group **Decision-making processes and procedures**	
	Additional Resources	**Resource Guide for Educators**	
	CONTENT AREA:	**CONTENT INCLUDED:**	*Healthful Living Standards:*

Sexual abuse (Risk & Referral)	**Definition and Statistics** - **National statistics** - **State statistics** **Myths and Facts**		*Mental and Emotional Health*
	Recognize Signs of Sexual Abuse **Leverage protective factors to reduce risk**	**Understanding Risk Factors:** ● Unusual weight gain or weight loss ● Unhealthy eating patterns, like a loss of appetite or excessive eating ● Signs of physical abuse, such as bruises ● Sexually transmitted infections (STIs) or other genital infections ● Signs of depression, such as persistent sadness, lack of energy, changes in sleep or appetite, withdrawing from normal activities, or feeling "down" ● Anxiety or worry ● Falling grades; or a significant change in attention to studies ● Changes in self-care, such as paying less/more attention to hygiene, appearance, or fashion than they usually do ● Self-harming behavior ● Expressing thoughts about suicide or suicide behavior ● Drinking or drug use	

	Respond to warning signs that a teen may be in an abusive relationship	**Understanding warning signs:** ● Tries to get them to engage in sexual activity that they aren't ready for ● Sexually assaults them or coerces them into unwanted sexual activity ● Refuses to use contraception or protection against STIs during sexual activity ● Hits them or physically harms them in any way ● Doesn't want them spending time with friends or family ● Makes threats or controls their actions ● Uses drugs or alcohol to create situations where their judgement is impaired or compromises their ability to say "yes" or "no" **Decision-making processes and procedures**	
	Additional Resources	**Resource Guide for Educators**	
	CONTENT AREA:	**CONTENT INCLUDED:**	*Healthful Living Standards:*

Sex trafficking **(Risk & Referral)** http://endsextrafficking.az.gov/sites/default/files/asuschooleducatorsadminbrochure.pdf	**Definition and Statistics** - **National statistics** - **State statistics** **Myths, Stereotypes and Facts**	**Understanding Myths, Stereotypes and Facts:** ● promiscuity ● only happens in bad parts of town, foreign countries ● is part of the immigration problem ● consensual ● prostitution is a victimless crime ● choice/ no one is controlling victim ● only happens to girls - not boys	*Mental and Emotional Health*
	Recognize Risk Factors **Leverage protective factors to reduce risk**	**Understanding Risk Factors:** ● Runaway ● Foster care ● Juvenile Justice ● Gangs ● Victim of Child Sexual Abuse	
	Respond to Warning Signs	**Understanding warning signs:** ● unexplained absences and truancy ● sudden change in behavior sudden academic decline or newfound obsession with academic success ● sudden possession of expensive clothing, purses, or electronics ● sudden change in dress/appearance ● surprising change in friends/peer relationships ● uncharacteristically promiscuous behavior or references to sexual situations	

		• signs of physical abuse or restraint • signs of self-mutilation (cutting) • sexually transmitted infection/disease • Use of terminology like “the game” “the life” “daddy” “manager” “date/trick” • suicide attempt • presence of, or reference to, older boyfriend • gang affiliation • depression • extreme anger • loss of or lack of school ID or other state issued ID such as a driver's license • deprivation of food, sleep or medical care • loss of contact with parent/guardian • running away/couch surfing • thrown out of house by parent/guardian **Decision-making processes and procedures**	
	Additional Resources	**Resource Guide for Educators**	

These content standards will be organized into an online mental health training program, based on the following recommendations:

(a) Each LEA and charter school will develop a plan to promote mental health, safety, wellness, and success of students through a coordinated continuum system of services and support.

(b) From recommendation (a), this plan must include a training plan, relevant to the needs of the schools and/or district, for licensed/certified personnel to receive training on various issues, including but not limited to: general mental health, suicide

prevention, substance use, and sexual abuse and trafficking of minors. The training requirements do not apply to employees who are anticipated to have minimal or no direct student contact.

(c) From recommendation (b), trainings should be completed within the first six months of employment, ideally during pre-service. Subsequent trainings shall follow national best-practice, yet LEAs and charter schools must have flexibility to determine the level and content (e.g., initial or refresher) as well as the length of the training and when and how the training will be provided. LEAs are encouraged to use this flexibility to minimize the impact of training requirements on classroom and school operations.

(d) An LEA or charter school may waive the initial training requirement for a new employee who completed such training at another LEA or charter school within the previous twelve months.

(e) The training requirements should not be construed to impose a specific duty or standard of care toward any person.

(f) LEAs and charter schools will develop a plan for assessing and improving upon the effectiveness of existing supports for the mental health, substance use, sexual abuse, and sex trafficking needs of their student populations, including plans for staff training; the plan will operate on a three-year review cycle.

Minimum Requirements for a Suicide Risk Referral Protocol

Educators must understand suicide risk factors and have the ability to identify the warning signs of suicidal behavior. It is critical for schools and educators – especially school mental health personnel and crisis response teams – to have clear procedures for assessing and responding to suicidal thinking and behavior. Suicide prevention efforts must be an integral component of a comprehensive program of school mental health supports and services.

Requirements of licensed/certified school personnel:

- All licensed/certified school personnel should receive training on identifying suicidal behavior. Best practice expects this training to be completed every two years.
- All licensed/certified school personnel should also be aware of the referral procedures for reporting concerning behaviors.

Requirements of crisis teams:

Schools should have a crisis team that can help identify and intervene when students are at risk for suicidal behavior. Crisis teams, in addition to other school safety responsibilities, may be responsible for implementing suicide risk assessments, interventions, and postventions.

- This team should consist of the following school personnel:
  - administrator
  - school-based mental health professional
  - school security personnel
  - other school personnel
  - representative from local law enforcement.
- Each member of the crisis team should have a clearly defined role
- One member of the crisis team should be assigned the role of "designated reporter."
  - The designated reporter will review and address reports of potential students who may be experiencing suicidal ideations or behaviors.

Requirements for Identification and Intervention:

- Early action is critical. If school staff have concerns about a student exhibiting potential suicidal behavior, they should immediately escort the student to school's designated reporter so that a risk assessment can be conducted.
  - A child exhibiting potential suicidal behavior should not be left alone for any reason.
- Appropriate school personnel will complete a suicide risk assessment to determine the student's level of risk and what steps should be taken to best assist the student.
  - The risk assessment will include questions to gauge a student's suicidal ideation, potential plan for committing suicide, and past attempts at suicide or self-injurious behavior.
  - Students may be found to be at low, moderate, or high risk for engaging in suicidal behavior.
- Even in low-risk situations, caregivers should always be notified when a student demonstrates signs of suicidal ideation or behaviors.

    - Parents should be encouraged to remove any lethal means (i.e., firearms or poisons) that a child may have access to.
    - If child abuse is suspected, then child protective services should be contacted.
- Appropriate school personnel should help students create a list of coping strategies and list of supports that can be utilized if the student begins having suicidal ideations.
    - If necessary, schools should refer students and families to community-based services for additional treatment.
- Because schools risk being held legally responsible for addressing suicidal behaviors exhibited by students, schools must document all steps of their assessment and intervention process.
    - This should include any intervention actions taken by staff and logs of any caregiver communication.

MODEL SUICIDE RISK REFERRAL PROTOCOL:

This model protocol will be addressed within the ***Procedures/Protocols*** content standard, through the content areas listed below:

	CONTENT AREA:	CONTENT INCLUDED:
Procedures/ Protocols	**Communication Structures** **Universal screening and other data sources** **Referral/response protocols**	● School teams addressing student health ● Using data to identify students at-risk ● Types of potential referral ● Risk referral procedures

APPENDIX A

Members of the Superintendent's Working Group on Student Health and Well-Being

Frank Addonizio
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Jim Deni
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Cynthia Floyd
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Valerie Nasser
Ann Nichols
Ashley Perkinson
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Beth Rice
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Lee Teague
Steven Walker
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Leanne Winner

APPENDIX B

Public Schools of North Carolina
State Board of Education
Department of Public Instruction

Report to the North Carolina General Assembly and State Board of Education

Recommendations from the Superintendent's Working Group on Student Health and Well-Being

Session Law 2017, HB 155, Part IV, Section 4.(a)

Date Due: May 31, 2018

NC DEPARTMENT OF PUBLIC INSTRUCTION

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Summary

In 2017, several training initiatives were considered by lawmakers and policymakers to ensure that every educator in North Carolina could be trained to recognize and seek support for students in need of mental health services.

- SHLT-003 is the School-Based Mental Health Initiative policy that was adopted on April 7, 2017. It requires school personnel that have contact with students to have 6 hours of training and subsequent training every three years on mental health issues. LEA's and charters would adopt a plan for universal prevention, early intervention services, and referral, treatment, and re-entry. Because this is a policy and not a law, it does not provide immunity protection for staff.

- H285 passed the House and requires two hours of training on suicide prevention for all school personnel who interface with students in grades 6-12 every other year. The proposed legislation is provides criteria for training and links with school protocols, and it provides immunity protection only for this training. This legislation was part of the recommendations of the House Select Committee on School Safety.

- S548 proposed training of school staff on human tracking and sexual assault. The training would be every three years without an amount of time specified.

The trainings proposed in legislation and policy are important and effective strategies in promoting student safety and well-being; consideration should be given for limiting the burden of implementation to schools where possible.

Legislative Directive

PART IV, Section 4.(a) of HB 155 from the 2017 legislative session called for the Superintendent of Public Instruction to convene a working group to study effective and positive intervention measures or policy changes to address risky behaviors and encourage student health and mental health. The group shall be comprised of personnel from the Department of Public Instruction with expertise in student health issues, including mental health, as well as personnel from the Department of Health and Human Services, Division of Public Health, along with other representatives from various public and private stakeholder groups as well as representatives from local administrative units and charter schools. The Superintendent would report on the working group's findings and recommendations to the State Board of Education and the Joint Legislative Education Oversight Committee.

Members of the Superintendent's Working Group on Student Health and Well-Being

- Caroline Daily, Teacher, Johnston County Public Schools; Chair of Commission
- Michelle Guarino, Gang Free NC & Director of Program Development and Faculty, Social Work Department, North Carolina State University
- Steven Walker, General Counsel & Policy Director, Office of Lieutenant Governor
- Walker Wilson, Assistant Sec for Policy, NC DHHS
- Ann Nichols, School Health Nurse Consultant, NC DHHS
- Dr. Frank Addonizio, Director of Clinical Services, Holly Hill Hospital
- Leanne Winner, Director of Government Relations, NC School Boards Association
- Lee Teague, Teague Advocacy Group
- Bill Hussey, Director of Exceptional Children Services, NCDPI
- Susan Robinson, Mental Health Program Manager/Planner, NC DHHS/DMHDDSAS
- Rachel Johnson, Statewide Administrator, Children with Complex Needs, NC DMHDDSAS
- Drew Pledger, Social Worker, Wake County Public Schools
- Racheal Gliniak, North Piedmont Regional Representative, NC School Psychologist Association
- Dr. Jim Deni, Professor of Psychology, Appalachian State University
- Lindalyn Kakadelis, member of the NC Charter School Advisory Board, The Roger Bacon Academy
- Ashley Perkinson, Perkinson Law Firm, NC Child
- Kym Martin, Executive Director of NC Center for Safer Schools
- Greta Metcalf, Chief Officer of Community Engagement, Meridian Health Services
- Charles Miller, Chief Deputy, Brunswick County Sheriff's Office
- Kathy Boyd, Senior Staff Attorney, NC School Boards Association
- Terri Grant, State System of Care Coordinator, DMH/DD/SAS
- J'taime Lyons, Student Supports Specialist, Communities in Schools NC
- Valerie Nasser, Military Liaison Counselor, Craven County Schools

Summary of Discussions

The Superintendent's Working Group on Student Health and Well-Being reviewed their role in serving North Carolina's students and reviewed other initiatives/programs/organizations doing similar work in student health and well-being in North Carolina. The group also discussed the importance of effective training programs for teachers to include general mental health, suicide prevention, substance abuse and sexual abuse/sex trafficking. In terms of training programs, the group felt that any training solutions should be broad enough to respect differences across school districts, and schools should have the tools, resources, and engage partners to find services and refer, not serve as actual mental-health clinics. Solutions should also include a structure that allows communications from all stakeholders and create a full continuum of supports and system of care approach.

Recommendations

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1	Keeping in line with SHLT-003 School Based Mental Health Initiative, each LEA and charter school will develop a plan to promote mental health, safety, wellness, and success of students and their families through a coordinated continuum system of services and supports. This plan must include a plan for licensed/certified personnel to receive training on various issues, including but not limited to: general mental health, suicide prevention, substance use, and sexual abuse and sex trafficking of minors.
2	Trainings should be conducted within the first six months of employment, preferably during pre-service. The initial trainings must cover the following issues, but are not limited to these issues: student mental health, sexual abuse and sex trafficking at least every four years, and suicide prevention at least every two years.
3	The Department of Public Instruction, in consultation with DHHS subject matter experts, will put together a menu of training options from which school districts may choose. Details of each option must include, but not be limited to: topic, duration of training, and cost of training, if any.
4	Training options provided by the Department of Public Instruction shall be offered online and may be offered face-to-face through universities, local management entities/managed care organizations, or licensed providers.
5	The General Assembly should legislate immunity protection to staff and schools.
6	The State Board of Education shall examine opportunities for institutions of higher education to develop coursework as a part of their educator preparation programs that address student mental health, behavioral health and well-being. Thus, educators can receive some basic instruction prior to becoming a licensed educator in the K-12 system.
7	To improve coordination and access to early intervention, treatment, Memorandums of Agreement should be established between DHHS (Division of Medical Assistance and Division of Mental Health, Developmental Disabilities and Substance Abuse Services), Department of Public Instruction, Local Management Entities and Managed Care Organizations and public schools to ensure coordination of funding and services for students with behavioral health care needs. This will serve to reduce barriers to access.
8	The Working Group recommendations the General Assembly continue to work towards the goal of increasing the number of school support personnel, including school nurses, school counselors, school social workers, and school psychologists, to ensure and improve the continuum of support to meet the social and emotional needs of students and early intervention and care for students with specific social, emotional, and mental needs. Additionally, this Group supports license reciprocity for school psychologists.

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR A TRAINING PROGRAM ON YOUTH SUICIDE AWARENESS AND PREVENTION AND OTHER ISSUES OF STUDENT MENTAL HEALTH AND A RISK REFERRAL PROTOCOL FOR SCHOOL PERSONNEL.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-5 is amended by adding a new subdivision to read:

"(11) The term "public school unit" means a local school administrative unit, charter school, regional school, or lab school."

SECTION 2. Article 25A of Chapter 115C of the General Statutes is amended by adding a new section to read:

"**§ 115C-375.10. Youth mental health and suicide awareness and prevention training and suicide risk referral protocol for school personnel.**

(a) State Board Training Program and Protocol. – The State Department of Public Instruction, in consultation with the Department of Health and Human Services, Division of Public Health, shall develop a mental health training program and a model suicide risk referral protocol for public school units to provide to school personnel as part of the public school unit's plan required by subsection (d) of this section. Trainings shall address the topics of: mental health, suicide prevention, substance use, sexual abuse prevention, and sex trafficking prevention. Trainings shall be (i) evidence-based or evidence-informed with respect to contents and format shown to yield effective prevention outcomes according to subject matter experts; (ii) formatted to enable employees to satisfy all training requirements through electronic delivery of instruction, videoconferencing, group in-person training, and/or self-study; and (iii) formatted to address one or more of the required topics within a time frame consistent with best practices. Resources shall also include a model risk referral protocol that provides guidelines to public school units on identification of students at risk of suicide or may be suspected of being victims of child abuse, neglect, sexual abuse or sex trafficking, along with procedures and referral sources that address actions that can or must be taken to address those identified as being at risk or suspected victims. The State Department of Public Instruction shall determine the content standards for the training and shall periodically review and update training programs and protocol as necessary.

(b) Training and Protocol Requirements. – Each public school unit shall provide the training programs and referral protocols described in subsection (a) of this section to all licensed personnel who work directly with students in grades kindergarten through 12, unless a locally developed plan that meets the requirements of subsection (c) of this section is being utilized. An employee's initial training shall cover each topic addressed in subsection (a) and shall consist of no more than six hours of training. After initial training is completed, all employees subject to the training shall receive two hours of training annually. Annual training must address one or more of the topics required in subsection (a) and must address suicide prevention no less than every two years and sexual abuse and sex trafficking no less than every four years. Each board of a public school unit shall require licensed school employees who work directly with students in grades kindergarten through 12 to complete the initial mental health training program within six calendar months of employment with that board and to meet the annual training requirement every year thereafter while employed with that board. A board of a public school unit may waive the initial training requirement for a new licensed employee if the employee completed the initial training required by this subsection at another public school unit. This subsection shall not limit the discretion of the board of a public school unit to offer or require mental health training, including but not limited to suicide

awareness and prevention and referral protocol training, for any employee to whom the training requirements of this subsection do not otherwise apply.

(c) Locally Developed Training and Risk Referral Protocols. – A board of a public school unit may comply with the suicide awareness and prevention training, suicide risk referral protocol, and other mental health training requirements of this section by developing a local training plan that meets the requirements set out in subsection (b) and meets the content standards for the training established by the State Department of Public Instruction. A board of a public school unit that develops a local training plan under this subsection shall notify the State Board of Education of its intent to provide locally-developed training.

(d) Local Plan of Support. – Each public school unit shall develop and implement a plan for promoting student mental health and well-being. The plan must be developed in accordance with a framework established by the State Board of Education for school-based mental health and must include the mental health training program and suicide risk referral protocol required by this section. Notwithstanding any State Board of Education guideline or policy to the contrary, no public school unit shall be required to provide any specific training, supports, or services, whether direct or indirect, for mental health or substance use disorders, beyond what is required by this section or other State or federal law. This subsection shall not limit the discretion of the board of a public school unit to offer or provide training, supports, or services for mental health or substance use disorders beyond what is otherwise required by this section or other State or federal law. Further, nothing in this subsection shall preclude the State Board of Education from recommending specific practices or strategies for public school units to consider when developing the local plan of support.

(e) Audits. – The Department of Public Instruction may periodically randomly audit public school units to ensure compliance with the mandatory training and activities for suicide awareness and prevention required by this section for licensed employees who work directly with students. The Department may also audit a public school unit if the Department has reason to believe the public school unit is not in compliance with those requirements. The Department of Public Instruction may report on the results of the audits by December 15 annually to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee.

(f) Limitations. – Notwithstanding the requirements in subsections (b) or (d) of this section, nothing in this section or in the State Board of Education framework for local plans of support referenced in subsection (d) of this section shall be construed to impose any obligation or responsibility on public school units to provide referral, treatment, follow-up, or other services for mental health or substance use disorders, or any such services related to identification of students at-risk of suicide and suicide prevention procedures specifically, beyond what may be required by other State law or federal law.

(g) Liability. – No board of a public 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 any plan, referral protocol, or training program 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."

SECTION 3. G.S. 115C-218.75 is amended by adding a new subsection to read:

"(g) Youth Mental Health and Suicide Awareness and Prevention Training and Suicide Risk Referral Protocol. – A charter school is subject to and shall comply with all requirements of G.S. 115C-375.10."

SECTION 4. G.S. 115C-238.66 is amended by adding a new subdivision to read:

"(14) Youth Mental Health and Suicide Awareness and Prevention Training and Suicide Risk Referral Protocol. – A regional school is subject to and shall comply with all requirements of G.S. 115C-375.10."

SECTION 5. G.S. 116-239.8 is amended by adding a new subdivision to read:

"(17) Youth Mental Health and Suicide Awareness and Prevention Training and Suicide Risk Referral Protocol. – A lab school is subject to and shall comply with all requirements of G.S. 115C-375.10. For purposes of G.S. 115C-375.10, a lab school shall be a public school unit."

SECTION 6. The State Board of Education shall amend its School-Based Mental Health Initiative policy, SHLT-003, to the extent it is inconsistent with this Act and such policy shall provide the framework for school-based mental health required by subsection (d) of this section.

SECTION 7. This act is effective when it becomes law and applies beginning with the 2018-2019 school year. All licensed employees of a public school unit who work directly with students in grades kindergarten through 12 and who were employed by that public school unit on or before the first day of the 2018-2019 school year shall receive the initial mental health training required by this section no later than the last day of the 2018-2019 school year.