NC Child

The Voice for North Carolina's Children

Staff Stories, Student Struggles:

INSIGHTS FROM SCHOOL SUPPORT PERSONNEL ON MEETING RISING YOUTH MENTAL HEALTH NEEDS

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Executive Summary

Across the country, young people are experiencing a crisis of mental health. And this is true in North Carolina, where children are suffering from increased rates of anxiety and depression, and where youth suicide rates have also been on the rise.

The isolation and loneliness that children experienced during COVID-19 lockdowns exacerbated these trends that have been building for more than a decade.

Because of the mental health issues facing children and young adults, there is a pressing need for mental health providers. Unfortunately, many communities across the state lack access to mental health services, with nearly every county in North Carolina classified as a Health Profession Shortage Area for mental health providers. Meanwhile, families that live in communities with providers often face barriers to accessing care, including insurance coverage, transportation and financial barriers, and lengthy waiting lists for available appointments.

School-based mental health services help to remove these barriers and increase access to mental health supports, but school districts across the state have struggled to keep up with the rising needs they see among students. School support personnel, including counselors, social workers, and psychologists, are understaffed throughout North Carolina, with caseloads well above recommended ratios. For example, the ratios of students to school psychologists (1,928 to 1) and social workers (995 to 1) are both nearly four times the ratios recommended by national associations.

To better understand the mental health services available in North Carolina schools, NC Child partnered with Peregrine Strategies, an issues strategy consultancy. Through focus groups with school support personnel, from Clay County in the west to Hyde County in the east, we heard directly from school professionals and administrators who are providing and coordinating services to students. We learned about the challenges facing school personnel and ways that schools are seeking to improve outcomes.

Focus group participants uplifted the sense of camaraderie and commitment among their specialized instructional support personnel teams as the top factor that enables them to meet students' mental health needs. But, at the same time, they also identified a lack of sufficient school counselors, social workers, and psychologists as one of the primary barriers to schools fully meeting the elevated level of need that they have seen.

Similarly, school districts that have partnerships with community-based providers to offer mental health services reported strong success with these collaborations, but many still struggle to maintain consistent community partnerships or continue to fund them after the expiration of COVID-19 relief dollars.

School-based mental and behavioral health care is typically provided through the three-tiered Multi-Tiered Systems of Supports (MTSS) framework. MTSS Tier 1 mental health support typically focuses on preventative, universal services, while Tier 3 represents the most intensive, individualized level of support for students with significant mental health challenges. School districts we spoke with in focus groups find it easier to deliver Tier 1 level supports through social-emotional curriculum and general classroom curricula, but, due to staff capacity and rising needs, they face substantial challenges to provide the most intensive levels of care.

This report details the challenges that prevent schools in North Carolina from meeting the rising mental health needs among students and offers policy recommendations to help improve access to school-based mental health services. Through in-depth conversations with school staff who work daily to meet the non-academic needs of students, the report provides insights into the school-based strategies and interventions that will help address the mental health needs of North Carolina's children.

Background

North Carolina's youth have been dealing with the crisis of mental health for some time. The impact of new technology and social media, the disruption of the pandemic, increased loneliness and isolation, academic and social pressure, and structural factors like poverty and food insecurity have all contributed to the crisis.

As a result, more of our children suffer today from anxiety and depression, more kids report feeling sad and lonely, and more of our youth are seriously considering suicide or completing suicide than the state has seen in years past. North Carolina is not alone in this youth mental health crisis, the trends caused leading health care professionals to declare a national emergency in child and adolescent health in 2021.[1] But on key indicators detailed below, these issues appear to impact North Carolina's youth more so than the nation.

At the same time, North Carolina's mental health workforce is insufficient to meet the large demand for services among the state's child population. Only three North Carolina counties have a sufficient supply of child and adolescent psychiatrists, Orange, Chatham, and Durham, and more than half have none at all, 96% of which are rural counties.

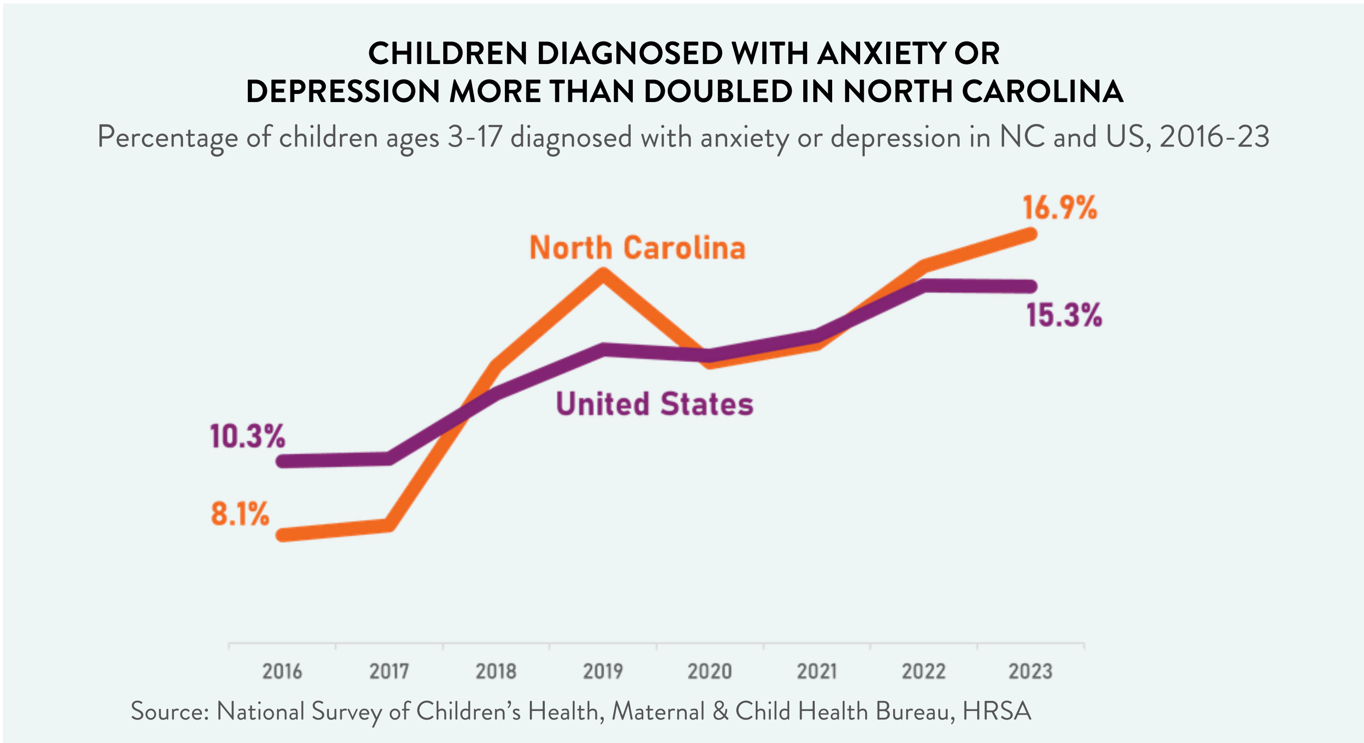
Schools can fill gaps in community-based care by removing access barriers and providing mental and other health services where students spend much of their time. But North Carolina school districts face their own challenges meeting the high and rising level of demand they see among students.

In public schools across the state, existing support personnel like psychologists, social workers, counselors, and nurses fall far below levels recommended by national groups. As detailed in focus group conversations and discussed below, workforce challenges place added pressure on support staff that districts do have, which can contribute to burnout and turnover. Similarly, too few community-based options and funding constraints can pose additional barriers for districts to contract private providers.

1. "AAP-AACAP-CHA Declaration of National Emergency in Child and Adolescent Mental Health." American Academy of Pediatrics.

YOUTH MENTAL HEALTH OUTCOMES WORSENING IN NORTH CAROLINA

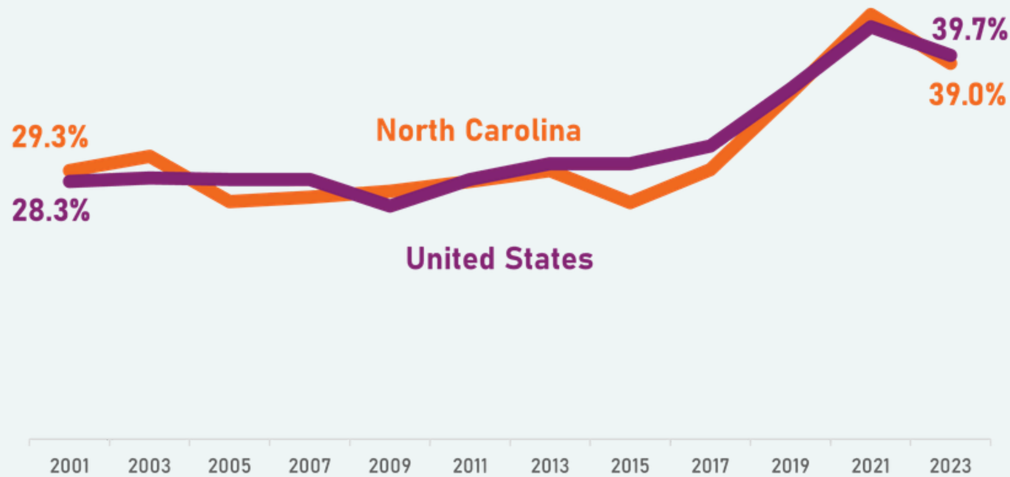
The number of children suffering from anxiety or depression in North Carolina has risen sharply in recent years. In 2023, about 385,000 children between the ages of 3 and 17, or about 17%, had been diagnosed by a medical provider with anxiety or depression at some point in their lives, up by 200,000 children or more than double the level in 2016. North Carolina's percentage increase in kids with anxiety or depression has outpaced the growth observed nationally, which increased by about 47% over the same period.



Similarly, feelings of sadness and hopelessness are much higher today than in the past. According to the Centers for Disease Control and Prevention's (CDC) Youth Risk Behavior Surveillance (YRBS) survey, about 39% of North Carolina high schoolers in 2023 reported feeling sad or hopeless almost every day for two or more weeks to the point that they stopped doing usual activities. While this is down slightly from 42 percent during the COVID-19 pandemic, it reflects the continued challenges that teens are grappling with and the issues that had already started arising.

SHARP RISE IN HIGH SCHOOLERS FEELING SAD OR HOPELESS IN RECENT YEARS

Percentage of high schoolers feeling sad or hopeless for 2+ weeks in NC and US, 2001-2023

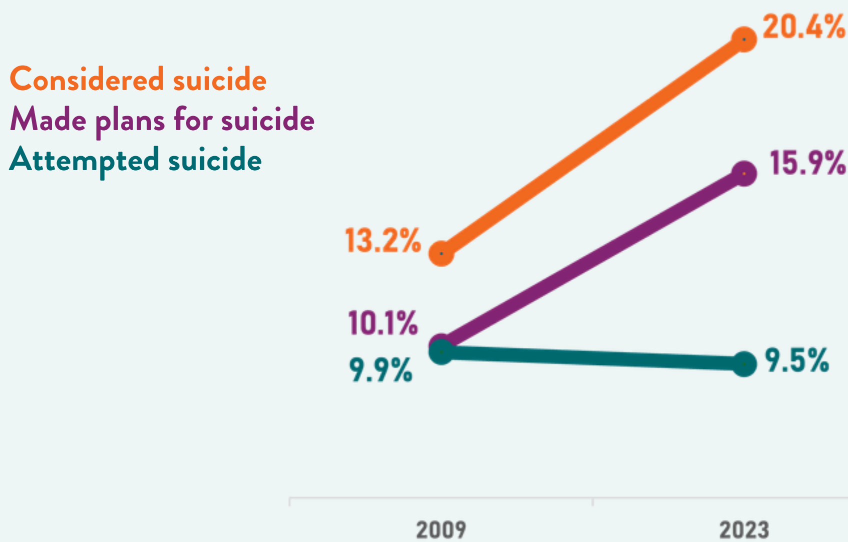


Source: US Centers for Disease Control & Prevention Youth Risk Behavior Survey data

Perhaps more concerning is the rise in suicidal ideation, suicide attempts, and the youth suicide rate in North Carolina. As the chart below shows, about 18% of North Carolina high schoolers reported seriously considering suicide in the 12 months prior in 2021, up about 5 percentage points from levels in 2009. The share of high schoolers who made plans to complete suicide rose a similar amount over this period.

MORE NC HIGH SCHOOLERS SERIOUSLY CONSIDERED OR MADE PLANS FOR SUICIDE

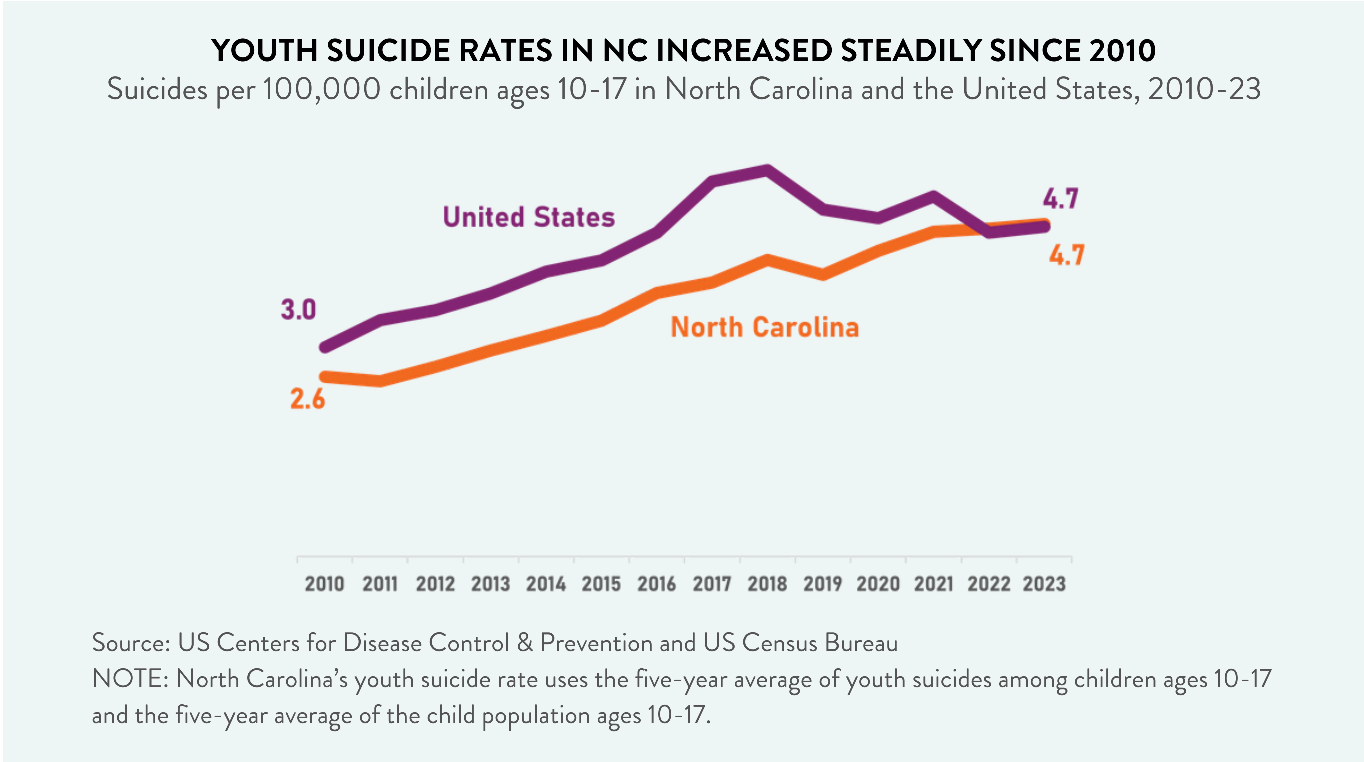
Percentage of high school students who have considered, made plans, or attempted suicide in the last year



Source: US Centers for Disease Control & Prevention Youth Risk Behavior Survey data

Suicide attempts among high school students have remained relatively constant compared to 2009. However, a steadily increasing number of youth suicides suggests more youth are completing suicide, even if the share of high schoolers attempting suicide has remained relatively flat.

CDC data shows that there were 57 youth suicides in North Carolina in 2023, more than double the number in 2010. In 2021, North Carolina had 60 young people take their own lives, the highest number recorded in the last 20 years of data. Similarly, the youth suicide rate in North Carolina—or the number of youth suicides per 100,000 children ages 10-17—has also increased considerably, rising from 2.6 in 2010 to 4.7 in 2023.* This rate increase is larger than the youth suicide rate increase observed nationally over the same period, and the nation's youth suicide rate has declined a bit in recent years while North Carolina's has steadily risen.



Source: US Centers for Disease Control & Prevention and US Census Bureau
NOTE: North Carolina's youth suicide rate uses the five-year average of youth suicides among children ages 10-17 and the five-year average of the child population ages 10-17.

As the chart above shows, the increase of youth suicide in North Carolina is not an outlier. Youth suicides and mental health struggles among kids have been well documented across the country and North Carolina's neighbors in Georgia, Virginia, South Carolina, and Tennessee have seen similar increases in youth suicide rates.

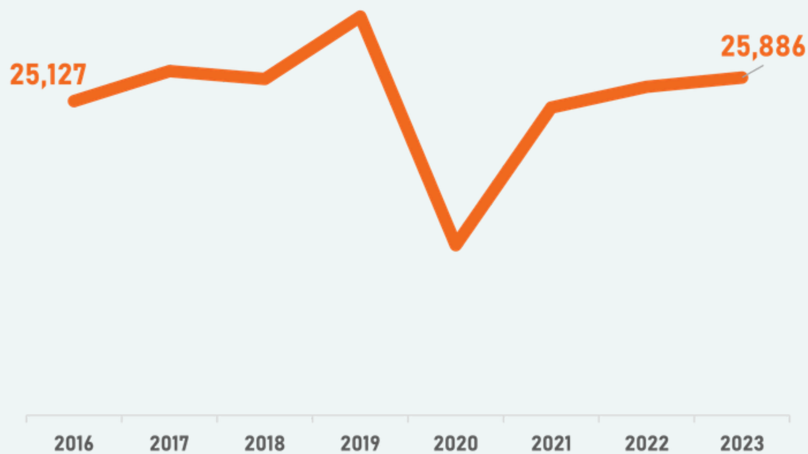
Pediatric behavioral health visits to emergency departments also demonstrate North Carolina's youth mental health crisis. In 2023, North Carolina emergency rooms saw nearly 26,000 pediatric visits to

*NOTE: North Carolina's youth suicide rate uses the five-year average of the number of youth suicides among 10-17-year-old children and the five-year average of the total population between 10 and 17 years old.

to emergency departments for behavioral or mental health reasons, up slightly from levels in 2016. During the early years of the COVID-19 pandemic, pediatric behavioral health visits to emergency rooms fell, likely driven by the public health concerns associated with hospital visits during COVID. As the country came out of the pandemic in 2021, pediatric emergency room usage returned to levels observed before the pandemic and mental health visits shot back up. Since then, mental health crisis visits among children have gradually increased in North Carolina hospitals.

PEDIATRIC BEHAVIORAL HEALTH VISITS TO ERS INCREASING AFTER PANDEMIC DROP

Number of pediatric behavioral health visits to North Carolina emergency rooms



Source: North Carolina Health Care Association data

Data does not tell us why exactly the total number of behavioral health visits increased, but, presumably, the return to in-person school and other activities played a role. School systems have highlighted students' growing mental health needs before and coming out of the pandemic, while acknowledging a lack of resources to adequately address these needs. As Lynn Guillams, a Wake County school teacher, commented in the North Carolina Department of Health and Human Services' School Behavioral Health Action Plan, schools simply cannot handle students increased mental health needs with their existing workforce and service availability.[2]

We know that students struggling with severe mental health issues are more likely to contemplate, attempt, or complete suicide. These same youth have an increased risk of behavioral health visits to emergency rooms. If existing services available through health care and school systems cannot adequately address youth mental health needs, increased levels of pediatric behavioral health visits and youth suicides are likely to persist.

2. "North Carolina School Behavioral Health Action Plan." North Carolina Department of Health and Human Services. March 2023. Accessed at: https://www.ncdhhs.gov/unified-school-behavioral-health-action-plan/open?mc_cid=e6abeb9cef&mc_e...

SUPPLY OF YOUTH MENTAL HEALTH CARE PROVIDERS INADEQUATE IN NORTH CAROLINA

While mental health outcomes have worsened among young people in North Carolina, families across the state struggle to access care. In 2023, more than half (54%) of children who received or needed mental health care in North Carolina reportedly had difficulties accessing care or were unable to do so.[3] This number was even higher among children with existing mental, emotional, developmental, or behavioral problems. Among these children, nearly two-thirds (63%) found accessing care somewhat or very difficult or not possible, according to surveys of their parents.[4]

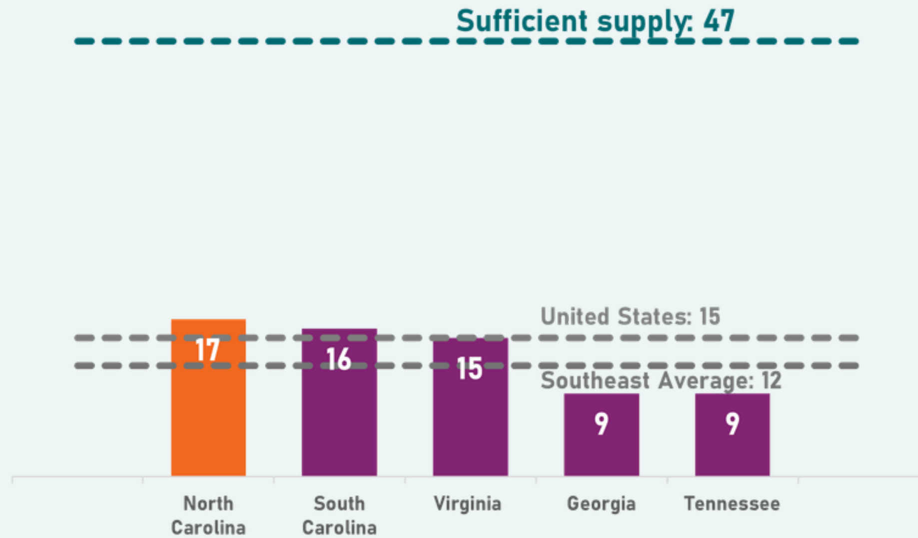
Many North Carolina children live in communities where mental health care is simply nonexistent. In 2024, 97 counties in the state were considered a Health Profession Shortage Area for mental health.[5] There are just two psychologists in North Carolina for every 10,000 people, and nearly one third of counties do not have any psychologists.[6] For counties that do have psychologists, there is no guarantee that they serve children.

Child and adolescent psychiatrists, another key source of mental health services for youth, are in even shorter supply. The American Academy of Child and Adolescent Psychiatry (AACAP) considers 47 or more child and adolescent psychiatrists (CAPs) per 100,000 children in an area a sufficient supply to adequately meet youth psychiatric needs. North Carolina's 17 CAPs per 100,000 children (as of January 2024) falls far below the threshold of sufficient supply. Per AACAP-designated classifications, North Carolina has a severe shortage of child psychiatrists. However, North Carolina children have slightly better access to CAPs than the country, surrounding states, and the southeast average, largely due to the state's concentration of psychiatric professionals at Duke University and the University of North Carolina at Chapel Hill.

3. Health Resources & Services Administration, Maternal and Child Health Bureau. National Survey of Children's Health (2022-23).
4. Health Resources & Services Administration, Maternal and Child Health Bureau. National Survey of Children's Health (2022-23).
5. North Carolina Department of Health and Human Services. "North Carolina Health Profession Shortage Area: 2024 Profile." 2025. Accessed at: https://www.ncdhhs.gov/nc-dhhs-orh-hpsa-one-pager/open
6. North Carolina Health Professions Data System. Cecil G. Sheps Center for Health Service Research, University of North Carolina at Chapel Hill. 2025. Accessed at: https://nchealthworkforce.unc.edu/interactive/supply/

ACCESS TO PSYCHIATRISTS BETTER IN NC, STILL INSUFFICIENT SUPPLY

Child and adolescent psychiatrists per 100,000 children in NC & surrounding states, 2024

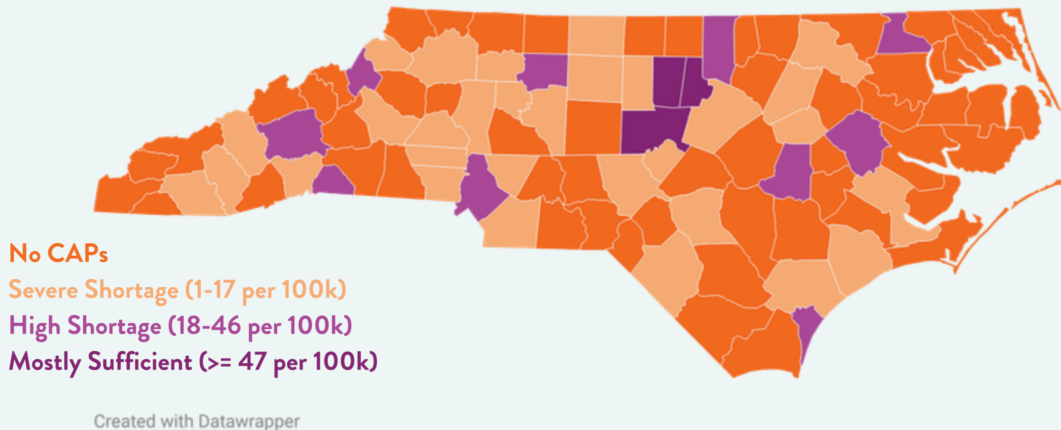


Source: American Medical Association master file via American Academy of Child & Adolescent Psychiatry

CAP rates broken down by county show this concentration of psychiatrists in counties with or near major North Carolina universities. As the map below indicates, Durham, Orange, and Chatham are the only counties in the state that do not have a workforce shortage of psychiatric professionals. In 57 North Carolina counties, there are no child and adolescent psychiatrists at all, while another 31 counties have a severe CAP shortage, meaning there are between 1 and 17 per 100,000 children. Even in large counties with strong hospital systems such as Mecklenburg, Wake, Forsyth, and Guilford counties, a large child and adolescent population places strain on the existing psychiatrist workforce. These four counties are among the 10 with a CAP shortage, between 18 and 46 per 100,000 children.

JUST THREE NC COUNTIES HAVE SUFFICIENT SUPPLY OF CHILD PSYCHIATRISTS

Child and adolescent psychiatrists (CAPs) per 100,000 children by county, 2024



Source: American Medical Association master file via American Academy of Child & Adolescent Psychiatry

As the map makes clear, rural regions of North Carolina face the most significant disparities in access to CAPs. At the aggregate level, there are only 6 child and adolescent psychiatrists per 100,000 children in rural North Carolina counties, while suburban and urban counties have CAP rates of 20 and 25 per 100,000, respectively.* Of the 57 counties with no CAPs at all, 55 are rural counties. Additionally, research shows that rural areas across the country face a shortage of child therapists, often with less access than more urban areas.[7]

North Carolina's psychiatric service access clearly lags levels recommended to adequately meet children and adolescent needs, but there have been positive initiatives across the state to expand access in underserved areas. The North Carolina Psychiatry Access Line (NC-PAL) has provided consultation services to primary care providers across the state since 2019, helping to improve pediatric primary care providers' ability to care for their patients with mental health needs and reduce the need for higher-level care.[8] In the 2022-23 school year, NC-PAL and the North Carolina Department of Health and Human Services launched a school-based behavioral health training and consultation service with 130 public schools in the state.[9] The program responded to the increased mental health needs among students following the COVID-19 pandemic and connects school behavioral health teams with child psychiatry experts to tailor services to students' unique needs.

*NOTE: We adopt the NC Rural Center's definition of county rurality. Counties with average population density of 250 people per square mile or less are considered rural; counties with average population density between 250 and 750 people per square mile are suburban; and county population density of 750 people per square mile or more are rural.

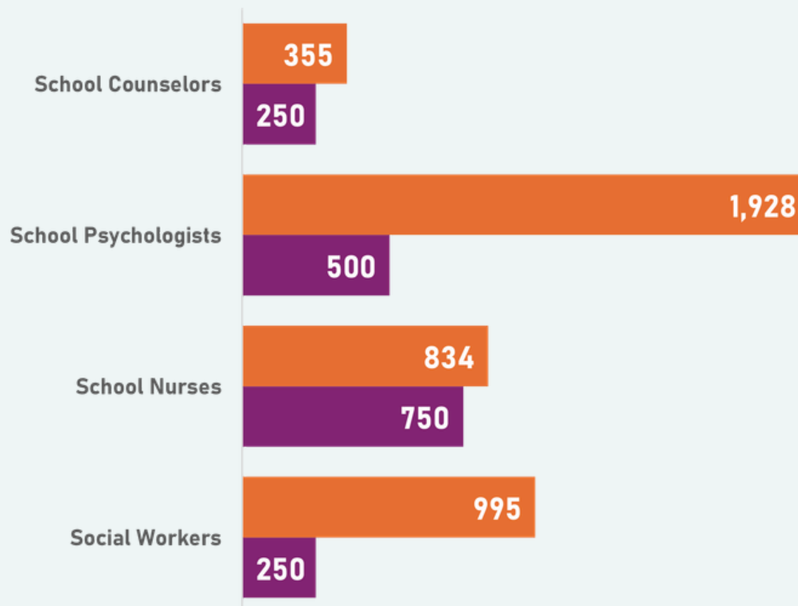
7. Berkowitz, Steven. "The Youth Mental Health Crisis Worsens amid a Shortage of Professional Help Providers." Scientific American. August 18, 2023. Accessed at: https://www.scientificamerican.com/article/the-youth-mental-health-crisis-worsens-amid-a-shortage-of-professional-help-providers/

8. Caldwell, Kenya. "HRSA Grants Improve Child Psychiatry in North Carolina." North Carolina Psychiatric Association. No date. Accessed at: https://www.ncpsychiatry.org/hrsa#:~:text=In%20North%20Carolina%2C%2084%20of,%2D%20North%20Carolina%2C%20n.d

9. North Carolina Department of Health and Human Services. "NCDHHS Launches New Mental and Behavioral Health Training and Consultation Support in K-12 Schools." North Carolina Department of Health and Human Services. December 8, 2022. Accessed at: https://www.ncdhhs.gov/news/press-releases/2022/12/08/ncdhhs-launches-new-mental-and-behavioral-health-training-and-consultation-support-k-12-schools

NORTH CAROLINA SCHOOLS LACK ADEQUATE MENTAL HEALTH WORKFORCE

Ratios of students to specialized instructional support personnel, 2024



Source: North Carolina Department of Public Instruction

Psychiatric support and consultations are much needed in North Carolina schools, as they similarly lack the workforce to meet the demand. Ratios of students to specialized instructional support personnel in school districts across North Carolina routinely fail to meet recommended levels. One study observed that higher caseloads among school counselors predicted higher levels of burnout.[10] High rates of burnout can lead to increased turnover rates, and thus fewer personnel to meet student needs. North Carolina's school psychologist and school social worker workforces fall shortest of national recommendations, as indicated by the ratios in the chart below.

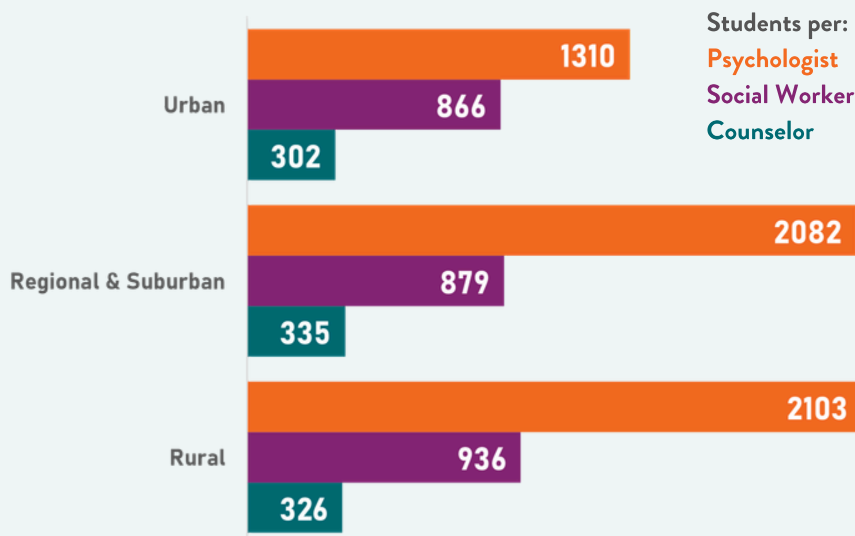
Student-to-support staff ratio data broken down by county illustrates how lack of access to school counselors disproportionately impacts rural and regional/suburban school districts.* While rural, urban, and suburban counties all post school counselor ratios exceeding the level recommended by the ASCA, regional/suburban counties' 335 students to each counselor are the highest, followed closely by rural districts' 326 students to each counselor. At the most extreme, each counselor in Montgomery County Schools serves approximately 572 students in the district.

10. Bardhoshi, G., Schweinle, A., & Duncan, K. (2014). Understanding the impact of school factors on school counselor burnout: A mixed-methods study. The Professional Counselor, 4, 426–443. https://doi:10.15241/gb.4.5.426

*NOTE: We use the NC Rural Center's definition of county rurality to categorize school districts.

LOWER STUDENT TO ACCESS TO MENTAL HEALTH SUPPORT STAFF IN RURAL SCHOOL DISTRICTS

Ratios of students to school counselors, social workers, and psychologists by rurality, 2024-25 school year



Source: North Carolina Department of Public Instruction

Similarly, rural and regional/suburban districts have higher ratios of students to school psychologists and social workers. Six school districts in North Carolina had no social workers at all in the 2024-25 school year, nearly all of them are in rural counties.* Nearly one fourth of districts (20) reported no school psychologist at all, and all but one of these districts were rural.

According to DPI's 2023 School-Based Mental Health Policy survey, 75% of school districts reported that they only somewhat or did not address staffing ratios for specialized instructional support personnel in their schools in the 2022-23 school year. Many districts said that they used grant programs like the Elementary and Secondary Schools Emergency Relief Fund through federal COVID-19 relief packages to expand staffing ratios, but the expiration of these programs resulted in losses of school mental health support staff. Other districts with funds available for support staff struggle to fill open positions.

NOTE: These six districts include Avery County Schools, Newton Conover City Schools, Cherokee County Schools, Whiteville City Schools, Roanoke Rapid Schols, and Elkin County Schools.

Research Design and Methodology

NC Child sought to answer two primary research questions regarding the provision of mental health services in North Carolina's public schools:

- *What mental health services are successfully being provided in NC public schools?*
- *What additional mental health services need to be provided in NC public schools to meet the needs of the student population?*

Through a series of focus groups in spring and summer of 2024 with key school support personnel in school districts across North Carolina, we dug deeper into the state of student mental health and school-based mental health service provision.

Focus groups lasted 60-90 minutes and consisted of 10-15 school personnel, including school counselors, school social workers, directors of student services, teachers, school safety personnel, school psychologists, and other key personnel. These participants were selected due to their direct or indirect involvement in school-based mental health.

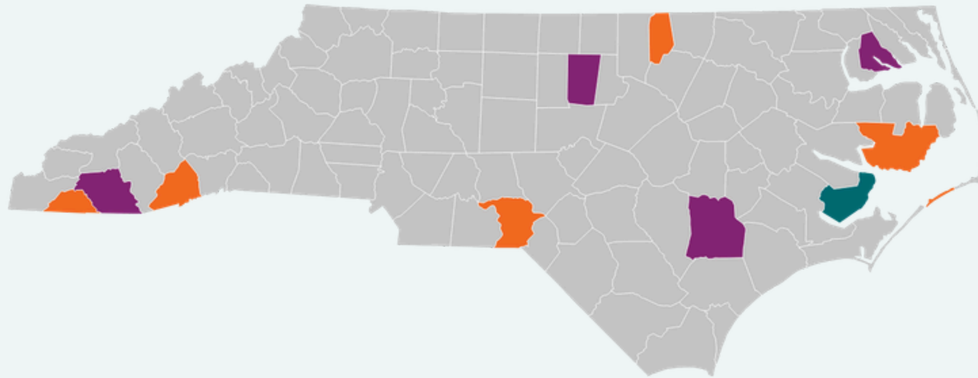
Participants were recruited through targeted outreach to local school district contacts identified by the North Carolina Department of Public Instruction. After establishing contact with the school district's director of student support services or superintendents, we relied on district officials to identify key players in mental health service provision in their school district. NC Child, in collaboration with Peregrine Strategies, engaged 93 participants across 9 focus groups and three supplementary key informant interviews with a 10th school district.

For this qualitative research, all North Carolina counties were ranked using a composite index in terms of higher mental health distress to lower mental health distress. These were the seven factors that were ultimately used in the composite index, listed below with their weights:

- Three-year average of the youth suicide rate per 1,000 kids (25%)
- Pediatric behavioral health visits to emergency departments, rate per 1,000 ED visits (25%)
- Child and adolescent psychiatrists per 1,000 kids in county (15%) – used the inverse here since a lower rate means worse access
- Percent of kids chronically absent (15%)
- Delinquency rate (15%)
- Incidence of substance possession crime @ schools (5%)
- Short-term suspension rate (5%)

NC Child selected 10 counties based on these factors, representing counties with both lower overall distress and counties with higher overall distress. Four counties with lower mental health distress composite scores were selected: Duplin, Orange, Perquimans, and Macon. The remaining six counties had higher mental health distress composite scores, which included Hyde, Pamlico, Richmond, Clay, Vance, and Transylvania counties.

NC CHILD MENTAL HEALTH MAPPING FOCUS GROUP LOCATIONS



Created with Datawrapper

NOTE: Higher "distress" counties are depicted in orange, lower distress counties are in purple. Key informant interviews were held in Pamlico County in lieu of focus groups.
Focus groups with Western NC counties were conducted before the impacts of Hurricane Helene.

NC Child, in collaboration with Peregrine Strategies, developed a literature review of existing research regarding school-based mental health services. A focus group protocol was developed with the primary research questions and informed by the literature review. This protocol was refined and adjusted as needed throughout our process, while still maintaining clear comparability across groups.

NC Child recorded each focus group and transcribed conversations using an online transcription service. Peregrine Strategies then cleaned transcripts to ensure accuracy based on focus group recordings and uploaded the transcript into the qualitative analysis software Dedoose.

We developed an initial qualitative codebook based on research goals and qualitative protocol and revised qualitative codes once data collection was completed. Coding was conducted in three batches over the period June-September 2024 by Peregrine Strategies with frequent input and advice from NC Child staff.

OTHER KEY TERMINOLOGY

Graph Terms

- Factor: A data variable such as "support personnel."
- Hit: An instance of code appearing a transcript excerpt.
- Score: Our outcome measure that allows comparisons between groups of different sizes, produced by our data normalization technique that takes into account differences such as participant numbers in a focus group or regions of the state.

Data Labels

- Challenge: A factor that describes a difficulty with mental health service delivery.
- Success: A factor that indicates successful mental health service delivery.

We analyzed the frequency that codes were applied in a transcript ("hits") and we normalized those frequencies to reflect the size of each focus group ("scores") by dividing the number of hits on each factor by the total number of hits in each focus group. This data was disaggregated by high/low distress composite scores and geographical designations for each county (Eastern/ Western/ Central NC).

Qualitative Findings

PREVALENT TOPICS AND THEMES

When coding, three variables showed high frequency in our focus group conversations.

1. *Multi-tiered System of Supports (MTSS), Tiers 1-3, as they clearly explained the successful delivery of services and the challenges delivering mental health services.*[11]

- Tier 1 services are focused on general prevention and education. About eighty percent of students are served at this level of support. Services include social emotional learning in the general education classroom as well as focused prevention teachings and screenings. Classroom teachers, school counselors, psychologists, and social workers develop and deliver services in the social and emotional learning curriculum in the general education classroom.

- Tier 2 services involve small group and one-on-one targeted support and intervention. Around fifteen percent of students benefit from more focused services, such as small groups, one-on-one school-based therapy, and co-located therapeutic services. Community partners play a critical role in extending schools' ability to provide punctual sustained service delivery for students. School personnel such as counselors, psychologists, and social workers are necessary for the best possible outcomes at this level of support.

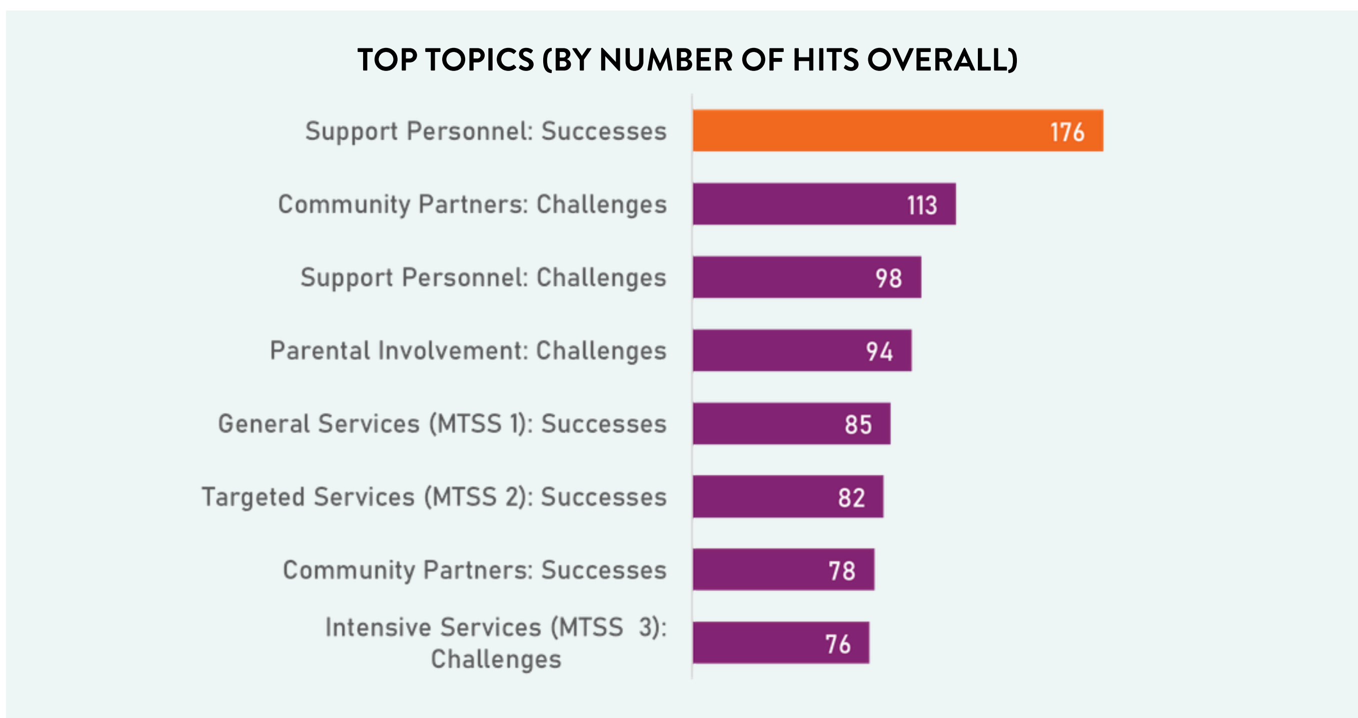
- Tier 3 services include the highest level of intensive intervention for high-risk students. About five percent of students require this most intensive and resource-demanding level of mental health service delivery. These students are struggling with the most severe mental health challenges, such as suicidal ideation and self-harm. School personnel are at the front lines of referring students to mobile crisis units, hospitals, and other mental health facilities. Community partners are critically needed to fill in gaps when there is limited provider availability.

2. *Support personnel providing mental health services in the schools. The people working within the school system are the key to service delivery.*

3. *Community partners deliver additional mental health services. Schools need community partners to provide more targeted and intensive services for students and to fill in gaps in service delivery.*

11. American Institutes for Research. Center on Multi-Tiered Systems of Support. Accessed at https://mtss4success.org/essential-components.

After conducting a qualitative analysis of focus group data, several key themes and trends emerged regarding the state of youth mental health and school-based mental health services. The chart below details the most discussed topics from all focus groups based on qualitative coding frequency:



The successful delivery of services by school support personnel was the most common theme discussed in school-based mental health focus groups. Participants expressed significant pride and gratitude for how instrumental their teams at the school and district level are in ensuring students receive care. Support personnel are often described as "wearing multiple hats," balancing academic responsibilities and mental health service provision. Many school personnel have a caseload of hundreds of students, while current school support staffing levels fall well short of what is needed.

While focus group participants praised the work their school personnel are doing, an inadequate number of school social workers, counselors, psychologists, and nurses places added stress on their ability to adequately meet the needs of all students. This forces districts to prioritize students in need of the most significant mental health care.

The second most discussed topic among school support personnel and other key stakeholders was the need for community partnerships to deliver mental health services.

As more students face acute mental health crises at younger ages, there is a critical need for the intensive services required for targeted and intensive care that community partners can provide. Community partnerships expand a school district's capacity to serve students and supplement in-school services.

While these partnerships are beneficial to expanding school-based mental health services, focus group participants noted barriers to implementation such as a lack of available providers, logistical issues, or non-competitive pay for in-school services.

Focus group participants also highlighted the importance of parental involvement in student mental health. When exploring barriers to mental health services, limited parental involvement in their child's mental well-being or a constrained ability to access mental health care appeared most frequently. These conversations included family or cultural stigma around mental health, the challenge of accessing care outside of school, and the need for mental health support for parents and guardians.

Within each of these discussions, communities, families, and schools—and the interactions between them—stood out as three vital institutions to improving children's mental health. School-related factors dominated much of the conversation; however, schools cannot do it alone. Focus group participants continuously uplifted the partnerships and support from communities and families that are needed to truly address the youth mental health crisis.

SUCCESSFUL MENTAL HEALTH SERVICE DELIVERY

SUPPORT PERSONNEL

Focus group participants credited their success in providing mental health services and tackling a vast array of responsibilities to the overwhelming sense of collaboration and camaraderie among their school support teams. School social workers, psychologists, and other support personnel often split time between several schools in one district. Staff typically take on additional responsibility, which emphasizes the need for collaboration and communication with one another.

"What I'm most proud of is just the culture of collaboration that we build at our school in terms of supporting students, just in all facets. We've got a high acuity and so for our kids, it's huge... I'm definitely proud of my building and our people there." (Macon County)

"I feel like we have a good group that works together, you know, on the district level, all the way down to the schools, I feel like we're a cohesive unit, and we're all pushing in the same direction." (Richmond County)

Support personnel also craft and operationalize procedures to refer students to community-based mental health services or crisis care. These procedures vary across school districts but can contribute to improvements in student academic outcomes. For example, Macon County created checkpoints before suspending students for behavioral issues, sending them to see counselors or mental health specialists prior to suspension. Officials credit these processes with contributing to improvements in school attendance and graduation rates. Having a hierarchy of intervention for referrals streamlines the process

to get students the care they need.

Focus group participants also noted the crucial role support personnel play in providing MTSS Tier 2 and Tier 3 services, which include mental health service provision and coordination for students with elevated and the highest levels of need. School social workers, psychologists, and counselors facilitate support groups focused on anxiety, bullying, anger management, and more with students. At the highest care level, support personnel are instrumental in coordinating re-entry plans. This includes facilitating meetings between students and their parents and crafting follow-up care management for students with in-patient treatment referrals or in suicide risk referral protocols.

Given the multitude of responsibilities school support personnel embrace, these roles can be emotionally demanding and lead to burnout. Orange County school support personnel reported struggles with staff turnover rates and how that can negatively impact providing services. One participant noted that "[the] turnover rate was also negatively impacting me as a school counselor, because the students who I was referring, who I was no longer meeting with... end up being put back on my caseload... I have students I was already working with plus the 10 who no longer are getting that support, trying to figure out how to make it work and see them and do my other roles. It just became a lot."

Richmond County has taken steps to help expand skills of personnel and prevent burnout, providing training on trauma informed practices (student focused, how ACEs can impact learning) and professional resiliency (preventing staff burnout).

"[There] was a two-part training. The first was the trauma informed practices, and then the second was the resiliency. And [Cheryl Fuller's] is based on lived experience. She has two books out currently. First one is based completely on lived experience, and you know, kind of her journey through that. And then the second one addresses compassion fatigue, professional resilience. You know what that looks like in settings like this." (Richmond County)

One Orange County support staff told a story of a student they lost to suicide: "I lost one of my students to suicide and so like, as a counselor in the building, that's something that was always on my mind... having those nights where you like, are constantly wondering and thinking "Is this kid okay? Did I do enough?...Or am I going to see this kid tomorrow?""

"One thing that I'm really proud of right now is the collaboration between departments that's taking place in our district, we are very small, and so we tend to wear a lot of hats, and sometimes that forces us to work in silos. And so we have really tried hard over the last, I would say, probably, you know, 10 or 11 months, to be very intentional about working together among our departments and finding ways that curriculum blends with Student Services and blends with school safety." (Hyde County)

COMMUNITY PARTNERSHIPS

With a lack of school support personnel to meet the increasing mental health needs of students, many school districts turn to partnerships with local mental health service providers to fill the gap. These partnerships can take many shapes; some involve bringing a therapist from a private practice or agency into the school to provide care, others involve taking sessions virtually during the school day, or referring out to brick-and-mortar facilities. Orange County Schools partners with Gaggle Teletherapy, a virtual mental health service that students can access from home or from school. Some schools even partner with local law enforcement to do home wellness visits if they believe a student intends to harm themselves.

A focus group in Duplin County spoke in detail about their partnership with Tar Heel Human Services (THHS), a local mental health clinic based in Beulaville. Licensed clinicians perform consultations with students identified as needing services and meet with the school-based team once a week to discuss their screenings and cases.

Prior to partnership with the school system, many students were receiving mental health services in hospitals. As increasing numbers of children started to be admitted to the hospital for pediatric psychiatric emergency situations, sparking a larger discussion between the school district, hospital, and local mental health providers on strategies to prevent emergencies at the school level and admission to the hospital.

These collaborative discussions between key stakeholders led to the partnership between THHS and Duplin County Schools. With this partnership, THHS has “boots on the ground” in schools with licensed clinicians to provide mental health services, helping to bridge the gap between clinical and school-based services. If a student requires a more comprehensive clinical assessment or there is a more severe trauma case, they are referred to a THHS outpatient clinic. THHS also provides case management assistance on the back-end of services if psychiatric care is recommended.

This in-person care is also supplemented in Duplin County Schools with the ECU Healthier Lives at School and Beyond virtual therapy services to expand care options for students with varying levels of need.

School personnel were overwhelmingly positive about this partnership, reporting that it has helped students get the care that they need and has contributed to increased attendance since students no longer have to leave campus to receive care.

"I mean, it starts with the superintendent, his staff and all the schools. They're really focused on children at every level, that's the priority. And then you know, specific to the community again... is that the collaboration that this community has, has been phenomenal for years, not just in this particular project, but in relation to really anything." (Duplin County)

MULTI-TIERED SYSTEMS OF SUPPORT

Focus groups reported the most success in incorporating MTSS Tier 1 support. About 18% of focus group discussions pertained to success with MTSS Tier 1 support, compared to just 11% of the discussion surrounding successful implementation of MTSS 3. Tier 1 support includes setting social-emotional learning (SEL) goals with students daily, conducting screen time checks, and incorporating more SEL and Positive Behavioral Interventions and Supports (PBIS) content into curriculum.

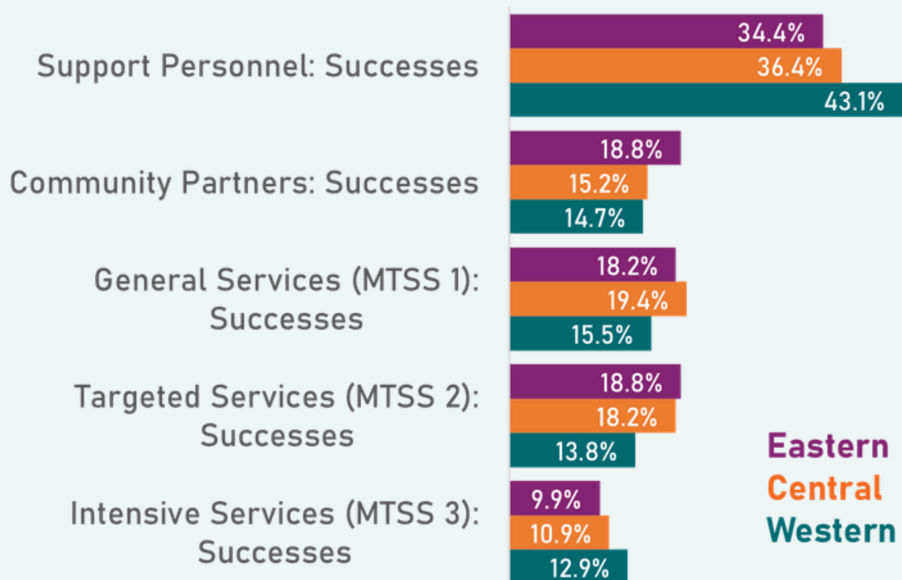
Orange County Schools have mental health teams that provide universal mental health programming. There is a universal SEL curriculum design that teachers at all grade levels can tailor to their class, whether it is in 15-minute segments or in a 45-minute lesson plan. Consistent application of MTSS Tier 1 expectations in each school and classroom are also essential in ensuring students know what to expect as they progress throughout different grade levels.

Vance County participants discuss how it can help students to know that no matter what classroom they are walking into, there are similar expectations regarding phone use, classroom etiquette, and more. Successful delivery of MTSS Tier 2 services were discussed in similar amounts to MTSS Tier 1 in focus groups. These services go beyond students who are having isolated behavioral problems and involve addressing students with more serious mental or emotional challenges. Support personnel often conduct assessments with teachers to see what they need for the year to support their students, like trauma focus groups, grief groups, sessions that focus on students experiencing bullying, and more. Counselors also conduct 15-20-minute targeted sessions with identified students, but this can be difficult with licensing and restrictions around allowed-treatment activities within schools.

"I just meet with them, but I'm also careful because a lot of the social workers and counselors in this district are also legit licensed therapists and mental health counselors outside, but we still have to be careful from what the state allows us to do in a school and then what we do under our therapy license." (Orange County)

Most focus groups reported the least amount of success for intensive MTSS Tier 3 interventions. The most prominent examples of successful MTSS Tier 3 service delivery from our focus groups were suicide risk assessments, mobile crisis care, referrals to ERs as needed, and re-entry meetings after a student is returning from day treatment. School district officials reported that there are more students requiring MTSS Tier 3 services, but schools lack the capacity to provide this level of care, leading to less success providing services in this tier.

"I kind of feel like we're finally getting word out and people are finally listening to how important mental health is. The negative side of that is that even though everyone is listening, we're not even close to where we need to be to receive the kind of support that our students need to be successful on a daily basis. We're blessed because a lot of us do wear different hats. And even though mental health isn't something that's under my job description, we all realize how important it is for us to work together." (Macon County)

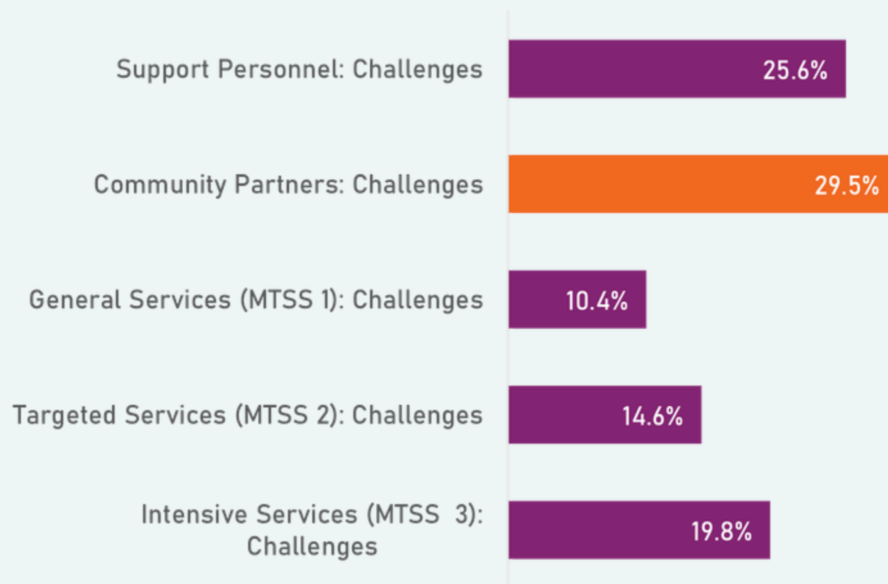


Qualitative findings aggregated at the regional level paint a similar picture. Across Western, Central, and Eastern North Carolina, focus group participants identified strong support personnel as a key reason for successful mental health service delivery. Western NC shows the highest score, which participants attributed to their tight-knit communities. In terms of services by MTSS Tier, schools across all three regions view successes very similarly. School district officials discussed successful management of students with the most intensive mental health care needs like suicidal ideation or self-harm (MTSS Tier 3) the least amount in focus groups.

Topography, rather than regional geography, presents challenges to successful service delivery to students in crisis. Coastal regions like Hyde County have unique challenges with geographic isolation due to rivers and lack of bridges, coupled with very limited access to providers. Similarly, navigating windy mountain roads in the west can present challenges to timely emergency responses and isolation poses comparable problems with provider access.

NEEDS AND CHALLENGES WITH MENTAL HEALTH SERVICE DELIVERY

LACK OF COMMUNITY PARTNERS, SCHOOL SUPPORT PERSONNEL STAND AS SCHOOL DISTRICTS' TOP CHALLENGE MENTAL HEALTH SERVICE DELIVERY.



SUPPORT PERSONNEL

While school district officials in focus groups acknowledged school support personnel as the top factor in their ability to successfully provide school-based mental health services, workforce challenges still remain. As mentioned above, school social workers, psychologists, counselors, and nurses wear multiple hats due to a workforce that struggles to keep up with rising demand for mental health services among students.

Focus group participants noted that school support personnel are so bogged down with their vast array of responsibilities that it is difficult to spend the amount of time with students that they need to build rapport and trust, essential components to effectively providing mental health supports.

In Perquimans County, participants discussed how new initiatives often get stacked on top of current mental health services and supports, forcing them to ask, "what are we willing to put on the back burner?" Some staff also mentioned auxiliary tasks like lunch duty or playground duty taking them away from their large caseload. Additionally, support staff often split their time between multiple schools due to a thin workforce, which also limits the one-on-one time they can spend with students.

"Everybody's stretched really thin... Finding people and hiring people and keeping people, the formula funding hasn't grown to have more people to support but the level of need certainly has grown... And when everybody's working at capacity, some students fall through the gaps and don't get the support that they need, which makes the problem, which was a big problem, an even bigger problem moving forward." (Perquimans County)

Teachers do not carry the direct responsibility to support students' mental health, but they have had to become more skilled in recognizing concerning behavior given the youth mental health crisis. Focus groups reported that teachers that know the signs of negative mental health outcomes have been instrumental in identifying students in need before they reach a crisis point. Rising mental health needs among students sparked many participants to suggest that mental health comprehension should be incorporated into all school job descriptions.

"It's also frustrating for teachers too because [teachers] don't feel equipped to handle it and because even though we have resources in place, the school counselor can't see all the kids that we need them to see in one day. I think part of this conversation needs to be, how do we equip the folks working with these kids day in and day out?...We're seeing more and more and more and so... how do we help our teachers be equipped to handle these situations and know what you know what to do, and when to do it?" (Transylvania County)

Focus group participants identified inadequate funding for school support staff positions as a top challenge to growing their workforce. Funds for support personnel can be minimal, and, in some cases, is not stable or guaranteed. A participant in Macon County stated that, "we're not really funded for these things. We're making it work because there's no other resources." This is especially true with positions funded by pandemic-era Elementary and Secondary School Emergency Relief funds, which have since expired.

Schools also face challenges actually filling positions they are funded for. Participants noted that a lack of providers in the regions where they live makes it difficult to hire school psychologists, social workers, nurses, or counselors, especially in Western NC. Reasons for this were a bit mixed, with some attributing the difficulty to a high cost of living in some areas or a lack of appeal for recent graduates to move to more rural areas.

"So I think we struggle with outside resources in Transylvania County. I don't think it's a lack of effort. I think it's just a lack of people. We have some great community partnerships with Blue Ridge Health who provide some on site therapists which is pretty amazing. We have a partnership with Care Coalition...we had TC strong which is a new collaborative that was formed pretty quickly after we had the three suicides in 2021 that are really strong advocates for our youth. But you know, we have three mental health clinicians in our schools. We could probably use six or ten but they're just not out there. They're looking for them and jobs are posted, but they're just not the people aren't there. So that's what how I feel about the outside resources." (Transylvania County)

Burnout and high turnover rates in mental health complicate school districts' ability to build and sustain services. Some focus groups mentioned that salary for private practice therapy is more competitive than school-based pay and that school-based positions can be more emotionally demanding, leading to professional burnout. More students exhibiting extreme behavior and needing intensive interventions also contributes to burnout. Compared to the past, schools are taking on more of the mental health load of students and focus group participants remarked that this extends all the way down to the youngest students in their schools. For younger children, support personnel and resources to meet their mental health needs are even more sparse.

"I think I am one of two people in this entire county that sees children under 10. Yeah. And the other lady [is] on maternity leave. I mean, that's just what it is." (Macon County)

COMMUNITY PARTNERSHIPS

While community partnerships serve to expand school districts' capacity to provide mental health services, focus group participants discussed issues implementing and operationalizing these partnerships. Barriers to community-based mental health agencies providing services in schools represented the most discussed challenge to school-based mental health service provision, with about 30% of all focus group conversations around school-districts challenges centering around this theme.

Oftentimes, there are just simply no providers in the area to engage in a partnership with school districts, especially providers that see children or speak Spanish. Richmond County described themselves as a mental health desert, noting that the nearest psychiatrist is 75 miles away and there are no significant community resources like a YMCA or Boys and Girls Club. These community organizations often provide indirect mental health services to youth that might not have the ability to seek professional help. Focus groups also discussed that private practice might offer more competitive pay and more control over caseload than school-based mental health.

"Well, unfortunately, in this county, there are no brick-and-mortar buildings where students can go receive mental health services." (Perquimans County)

"I think that's the challenge that many of the schools face, is that we support students with interventions when possible. But when there needs to be a higher level of service that goes beyond what the school counselor can provide, based on their responsibilities to the school as a whole. And the place that we would refer them, we're going to be capped out in northeastern North Carolina, it's really hard to find the support that the child deserves. In fact, I would venture to say... I feel like we've made significant progress behaviorally, post pandemic with our at-risk students. But with our intense students, we've made limited progress because of access to resources. The attempt has been there, it's just been really hard to meet the needs of our most intense behavior needs in our school." (Perquimans County)

Even if there is a mental health provider that school personnel can refer to, that provider often has a long waitlist, which can be several months long. Even for crisis care, waiting times are long and beds in in-patient facilities are not guaranteed, with the rate of release faster than admittance to an in-patient facility. Richmond County support personnel discussed how "there was a kid that was living in the ER for a long time because there wasn't a placement...they spend weeks in the ER." Even if providers are accepting new patients, they might not have expanded availability in the evening when kids are not in school. If a school does not allow students to take time out of class to access teletherapy, this can create a barrier.

"And a lot of times our kids will go into the hospitals and then will get released because there is nowhere else to go. So they sit in the hospital and have to go home." (Clay County)

Community partnerships can also present logistical challenges. Many school districts opt for telehealth with community-based providers over in-person care. While helpful, school support personnel report that some students need to be in person for the level of care they need. Participants also noted that school-based telehealth can be difficult since a staff member has to be there to monitor the student, presenting scheduling and staffing issues. Outside of school, students face barriers to accessing community-based care they may be referred to when therapists work during business hours and have no evening availability. Additionally, focus group participants reported that some parents cannot take off from work to take their child to a provider, which presents another barrier to fulfilling referrals and illustrates the importance of increasing capacity for school-based services that meet students where they are.

MULTI-TIERED SYSTEMS OF SUPPORT

Challenges around MTSS Tier 1 service provision largely relate to growing behavioral challenges among students that complicate effective delivery of general education or school-wide social-emotional curricula. A staff stretched thin providing reactive services to students with increased behavioral or emotional needs finds it difficult to implement proactive services that fall under Tier 1. A participant in the Perquimans County focus group remarked that when "everybody's working in capacity, some students fall through the gaps and don't get the support that they need, which makes the problem which was a big problem an even bigger problem moving forward."

School staff in focus groups reported that more students exhibit externalizing behaviors like bullying, aggression, or defiance and at younger ages while simultaneously noticing more students in post-pandemic classrooms with symptoms of anxiety and depression. More children in crisis makes it more difficult to focus on core behavioral curriculum when dealing with more extreme behaviors.

"I mean, prior to being in this position, I was a building level administrator, and it was rare to have a student that expressed himself in a way that wasn't developmental. Then we thought okay, this is beyond... developmental milestones. This is something out of the ordinary...Especially as young as kindergarten and first grade. But we are seeing increasingly students who are not at their behaviors that are developmentally appropriate. This is not a typical childhood tantrum. I think what we're seeing a lot is some trauma responses these kids are showing." (Pamlico County)

School staff's challenges implementing MTSS Tier 2 services were largely related to staffing challenges. Participants attributed difficulties providing early interventions like small-group counseling, individualized care, or mentoring to students to a lack of school support staff. When schools are trying to triage severe mental health crises that require a higher level of treatment, early intervention services like this can fall by the wayside. Staff are often not able to reach the kids who need support, but are internalizing their emotions, since they are only able to react to more externalized behaviors.

One participant in Perquimans County stated that "we're drinking out of a firehose a lot of the time so you can't get to see every student...I think it really goes back to, you know, to screening and what we can do and find out there."

"So I would say your main triage, you're just trying to help the schools from bleeding out until we can get the three or four month waiting period for therapy, until we can get them somewhere. I just kind of try to partner alongside the schools on like, how can we put a band aid on this... how can we help support for the time being?" (Macon County)

School district focus group participants discussed the most challenges with MTSS Tier 3 service provision, which includes individualized interventions for students with significant distress or functional challenges. Again, lack of school support personnel staffing or partnerships with mental health agencies present significant barriers to providing these supports. Since these services are the most intensive interventions and typically necessitate one-on-one counseling, staffing and community partnerships are crucial to successful delivery.

“We can do everything we can at the school, but sometimes kids need way more than what we can provide at school, especially after a hospitalization, but even a lot of the organizations in this area have extremely long waiting lists. And so it really just depends on what's available.” (Orange County)

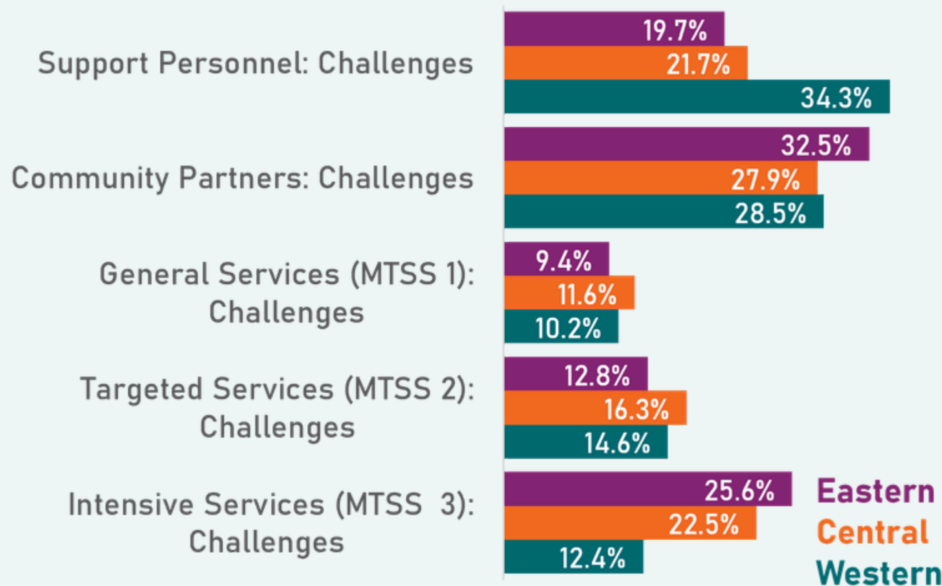
Outside of individualized counseling in school settings, MTSS Tier 3 services include referrals to external treatment facilities, which involve coordination of treatment and school re-entry plans. Focus group participants discussed several challenges when students are admitted to emergency rooms or day treatment for their mental health. Communication breakdowns between school staff and external treatment providers can leave schools in the dark on students' progress toward their re-entry plans.

Richmond County school support personnel reported that they had a student who was hospitalized, and they did not receive that student's discharge summary. This participant noted that “within a week, she was back into facility. But if we had some information, we could have planned appropriately.”

Parents also have a role in ensuring effective provision of the most intensive school-based mental health services. Without parental engagement or progress made at home, students can easily backslide into prior behaviors. Parents can also deny care, even if it has been recommended by school support staff.

“And when they go on to the facilities... There's not a lot of work done at the families. I mean, so they come back into the same environment that they're placed with and so that doesn't seem like there is any wrap around, it just starts the cycle again.” (Clay County)

LACK OF SUPPORT PERSONNEL, COMMUNITY PARTNERS GENERALLY BIGGEST CHALLENGE FOR SCHOOL DISTRICTS, REGARDLESS OF REGION



Challenges to mental health service delivery most discussed by focus group participants by geographic region of North Carolina largely reflect those at the overall level, with some distinct variation. Western, Central, and Eastern North Carolina counties all spent most of the conversation time discussing challenges with school support personnel or community mental health partnerships, which limits districts' ability to provide intensive mental health services.

The need for school support personnel dominated Western North Carolina county focus group discussions more so than other regions. These counties reported that significant challenges funding, attracting, and retaining personnel in the district contribute to their ability to employ a workforce that can meet students' needs, citing issues such as housing affordability and rurality as additional barriers.

While challenges implementing partnerships with community mental health providers were discussed at relatively similar levels across regions, Eastern counties detailed these issues the most, with more than a third of all qualitative thematic codes related to challenges in this category. Eastern focus group participants often cited that the rural and remote nature of their counties complicates their ability to provide the higher levels of service needed for students in distress. Some counties do not have any providers at all for students in need.

Participants across all three regions view challenges with MTSS Tiers 1 and 2 at about the same level,

which is not too surprising. But regional variations in participants' views of MTSS Tier 3 service delivery require further research. From NC Child's qualitative data, it is unclear why Western North Carolina would view MTSS Tier 3 service delivery as so much less of a challenge than the Eastern and Central counties. One potential explanation is that Western counties view all three MTSS levels as similarly challenging to deliver, perhaps a reflection of their top challenge—a lack of support personnel.

BARRIERS TO ACCESSING MENTAL HEALTH SERVICES

As evident thus far, schools and communities face significant barriers to mental health care provision in schools across North Carolina. There is an obvious lack of providers to meet the growing mental health needs of today's youth, both at the school and community level. Some struggles are felt in schools by staff and students, but others originate at home and in communities. After analyzing qualitative data from focus groups, parental involvement and family culture surrounding mental health were the most prominent barriers, followed by a lack of providers, and social determinants of health.

PARENTAL INVOLVEMENT

Parental involvement stood out as the most significant additional barrier to successful mental health service delivery. Negative stigma around mental health, family culture, and parents' ability and/or willingness to follow through with care for students has a substantial impact on student mental health. Parents themselves may also need mental health services, which can be costly, time-consuming, and difficult to access. If parents are not taking care of their own mental health, they cannot provide the appropriate level of care and attention that their children need. Generational trauma and mental health issues can trickle down from parents to their children. Research shows poor parental mental health can lead to stress for children and can be a precursor for negative mental health outcomes in adulthood.[12]

"I think part of the stigma...people feel like that means that something's wrong with them or part of their family... And people don't want to feel that way. Even though that's not necessarily the case, that's the way it makes people feel." (Hyde County)

"Those high needs students, their parents have even higher needs most of the time. And it's like, no matter what we do at school, they're still going to go to that environment. And the parents aren't seeking treatment for themselves. And so we might be able to get their behavior under control in the school setting. But then they go home for spring break, and they come back and they've been able to do whatever they want for a week." (Perquimans County)

12. Kamis C. (2021). The Long-Term Impact of Parental Mental Health on Children's Distress Trajectories in Adulthood. Society and mental health, 11(1), 54–68. https://doi.org/10.1177/2156869320912520

Parents can also have an impact on their children's ability to receive treatment, especially at an in-patient facility. When students exit an in-patient treatment facility, parental cooperation with re-entry plans is crucial to the student's success and recovery. Participants reported that some parents are not engaged with the re-entry plan or fail to take their child to recommended follow-up appointments. A lack of follow-through on a treatment plan can lead to the child being dropped by a provider if their parent is unable or chooses not to take them. School referrals to crisis care also require parental engagement and cooperation. Parents must consent to their students receiving intensive interventions when they are in extreme distress, and some focus group participants reported parental pushback.

"I was getting cursed out because I made a parent aware that the child wanted to [commit suicide]. And the parents curse me out because she said that I needed to know that the child was lying, and she was not doing anything because the child was not being truthful." (Vance County)

Senate Bill 49, more commonly known as the "Parents Bill of Rights" was also mentioned throughout focus groups as a barrier to students receiving care. Provisions in the bill indicate that school personnel must obtain parental consent for any protected information survey given to students that might discuss mental health and must obtain consent before providing any treatment to the student. Since staff are required to receive parental consent before performing threat assessments or suicidal risk screenings, this can lead to a breakdown in care. A parent might refuse consent, or staff might simply be unable to contact a parent.

"Just another roadblock from this year was the Parent Bill of Rights. I feel like it's becoming more and more difficult for us to help students. Because you gotta get an opt in form to ask a kid how they're feeling or to do a suicide assessment and it's ... just as hard to reach parents sometimes. And then oftentimes, they say no." (Transylvania County)

PROVIDER AVAILABILITY

Provider availability is the next most impactful challenge for service delivery. Most North Carolina counties have no providers at all, or have a significant shortage, in specialty areas such as child psychiatry. According to the Cecil G. Sheps Center for Health Services Research, over 20 counties in North Carolina do not have a single licensed psychologist serving children and/or adults.[13] As focus groups routinely highlighted, the sheer lack of providers contributes heavily to districts' difficulties meeting students' mental health needs in schools and through referrals. Focus groups in rural counties assert that they consider themselves a mental health desert due to the lack of providers.

13. North Carolina Health Professions Data System, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. Created January 30, 2025 at https://nchealthworkforce.unc.edu/interactive/supply/.

"You ever heard the term food desert in urban areas access to healthy food choices? Yeah, I would consider a rural area, especially ours, to be a mental health resource desert, it's proportional in my opinion. And there's just a lack of access. And the population densities lower too, which makes it harder to attract the resources and be available. And then they're serving multiple counties." (Perquimans County)

Significant waiting times to see providers or private mental health professionals with full caseloads present barriers in communities that do have a mental health workforce. Some participants reported that students could be waiting months for a bed to open at local in-patient facilities. This can lead to a reliance on virtual services rather than in-person care, which is not as well suited for students with significant mental health needs. In-person mental health services can help students develop stronger connections with their provider, which is especially important for students who need a higher level of care.

"What's available on paper doesn't always feel like it's available.... It feels like you have the carpet on fire.... [providers] are not coming tomorrow to put a little water on it, but in a month or two that student's put on a waiting list." (Macon County)

Focus group participants discussed culturally appropriate providers in schools and communities less than other barriers, but it remains a notable challenge to effective school-based mental health service delivery. Some counties have increasing numbers of migrant families in their communities with children who need mental health care. If there are no school-based providers that speak Spanish, those families are less likely to seek out care.

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health like food access, safe housing, and substance use, were also prominent barriers to mental health access, especially in high distress counties and for students that are referred to community-based care. If a family is struggling to afford basic needs, mental health care is low on the priority list. Some parents work multiple jobs that prevent them from taking their children to therapy or counseling if they do not receive these services at school. School staff report confidence in meeting students' social and mental health needs while they are at school, but they do not have the ability to bridge those services when students are not in school. As participants in Transylvania County noted, addressing those needs outside of school requires larger conversations about meeting the needs of the whole child by meeting the needs of the whole family.

"Alright, there's summer break. How do we get these kids fed? You know, these children don't have clothes. Alright, let's do a clothes closet. All of your schools have some sort of clothes closet. We're like, 'Alright, these kids have mental health needs. Alright, let's bring it into schools [through] school counselors and...school-based therapists.' So all these needs are coming through the school." (Transylvania County)

"What we do at the school is a band aid, right, like, did you eat last night? Where did you sleep last night? And those are real statements that we have to ask [students] every single day, especially the social worker. I think a larger part of the conversation is we have them for eight hours and then they go home to these families that truly are broken." (Transylvania County)

Several focus group participants noted that breakdowns in family structure, often due to parental substance use, also present challenges to children's mental health. Substance use in families can cause adverse childhood experiences (ACEs) that can exacerbate negative mental health outcomes in children. Richmond County support personnel noted that "I'm seeing more and more grandparents raising grandchildren and aunties raising their nieces and nephews, and I think a lot of that's due to the [substance use] that's happening." With the breakdown of the family unit, students might not be supported at home and might be in a situation that is dangerous to their mental health. This ties in with the impact of parental involvement and engagement being a serious indicator of youth mental health.

"The biggest impact is a buffering adult that can buffer that stress. And so I guess that goes back to what I was saying, like, there's not a lot of our kids that have a buffering adult to help buffer what all they experience. " (Richmond County)

As noted previously, focus group participants pointed out how their location in the state can also be a barrier to successful school-based mental health service provision. Many rural areas are already geographically isolated and do not have the same access to services as more suburban or urban areas. On top of this, geographic isolation can make it more difficult for providers to reach schools.

For example, in Hyde County, the coastal environment, including Ocracoke Island, has led to unique challenges. Ocracoke is only reachable by ferry, and ferry availability is limited based on the tide schedule, making it difficult for crisis care to respond in a timely manner. In Hyde, resources are isolated and spread out on the mainland, and it is difficult to attract providers to practice on the island. Hurricane Dorian has also had mental health impacts for this community; school staff report that more students are exhibiting more fear and anxiety around significant weather events.

“Recalling when I first started working with them, just the fear and the anxiety that comes up around weather. So when it's raining outside, the kids are more down, depressed and worried when they know that the temperature is changing, or when there is some storm or something on the horizon, they're a lot more irritable and agitated, they'll concede a lot of anxiety around storms and the trauma that has been left from them experiencing such major hurricanes over the years.” (Hyde County)

FINANCIAL BARRIER

School staff also discussed financial barriers regarding funding for school positions and a family's financial capacity to seek out care. Some families are uninsured and unable to afford care. Even with coverage, co-pays for mental health services can be cost prohibitive for those that have insurance coverage. A Macon County participant stated that “people can't afford a $100 copay and it's not like they get strep throat and go to the doctor. It's like, you've got to come to [therapy] weekly.”

There is even less access to mental health care for children with Medicaid coverage, some participants citing administrative barriers that Medicaid presents and low reimbursement rates as potential reasons that providers might not accept it. Richmond County support personnel reported that a student could be recommended to an in-patient facility, only to be sent back to school because Medicaid is not accepted there.

“Nobody around here wants to take Medicaid, I just saw them pro bono. Medicaid was horrific to work with in mental health, in North Carolina, awful. Look, I think most counselors that I know, that are in private practice, do not want to take Medicaid, which also means that their access to quality providers has substantially limited, never mind their access to providers in general.” (Perquimans County)

School-based positions often also face funding challenges. With some personnel funded through expiring ESSER funds, employment can be unstable. A Duplin County participant captured this sentiment: “I just wish there was more recurring funding that you could count on them because you can't plan when you're always behind.” School-based salaries are also not as competitive as private practice, pushing some mental health providers to take up a career outside of school. Private practice offers more stable employment and a reduced caseload compared with school-based mental health care, some counselors have caseloads of over 300 students, well above the recommended counselor to student ratio of one counselor to 250 students.

Recommendations

1. INCREASE STUDENT-TO-SCHOOL SUPPORT STAFF RATIOS

The most common challenge to successful school-based mental health service provision in North Carolina schools that we found through these conversations with school districts was a lack of school support personnel.

Ratios of student-to-school counselors, social workers, nurses, and psychologists all well exceed recommended levels, with many districts reporting no school personnel in critical roles most directly relevant to mental health services.

Student-to-psychologist and social worker ratios are perhaps the most out of balance. The North Carolina Department of Public Instruction (DPI) estimates that the state would need about 2,400 more school psychologists to meet recommended ratios.[14] Similarly, the state needs about 4,000 new school social workers to meet recommended ratios.[15] However, the pipeline of school support staff graduating from North Carolina universities has not been sufficient to meet the full need in schools across the state, which complicates solving the issue through funding increases alone.[16]

There are several strategies that could increase North Carolina schools' specialized instructional support personnel workforce. Of course, funding new positions and increasing support personnel salary bands to help school districts hire much-needed staff would help, but that will not address the long-standing workforce pipeline issues. The Whole Child North Carolina Advisory Committee has recommended funding a state school psychology position housed at DPI that would, among other responsibilities, recruit school psychologists across the state.[17]

A statewide school psychology internship program would also invest in the workforce pipeline of one of the most critical mental health support staff positions in schools. Research has shown that school psychology internship programs prepare graduate students for careers in school-based mental health and improve retention, with 95% of school psychology interns from a sample of eight universities remaining employed in schools five years after graduation.[18] Some North Carolina universities offer school psychology internships, but the state lacks a statewide program. Former State Superintendent Catherine Truitt's budget recommendations have included state funds to establish a school psychology internship program in North Carolina.[19] In the 2025 legislative session, Senator Kevin Corbin proposed S259, which

14. Brown, Chantal. "State Board of Education considers recommendations for school psychologist shortage, Whole Child policy priorities." EdNC. March 10, 2025. Accessed at: https://www.ednc.org/03-06-2025-school-psychologist-shortage-and-the-policy-priorities-for-the-whole-child/
15. Walkenhorst, Emily. "State Board of Education floats $100M for school social workers, nurses." WRAL. January 5, 2023. Accessed at: https://www.wral.com/story/state-board-of-education-floats-100m-for-school-social-workers-nurses/20658659/
16. Walkenhorst, Emily. "NC education officials float school psychologist internship program, more funding for school buses." WRAL News. April 7, 2022. Accessed at: https://www.wral.com/story/nc-education-officials-float-school-psychologist-internship-program-more-funding-for-school-buses/20225350/
17. Brown, 2025.
18. Morrison, Julie, Davies, S.C., and Noltemeyer, A. "An Analysis of the Workforce Pipeline in School Psychology." Contemporary School Psychology. September 2020. Accessed at: https://pmc.ncbi.nlm.nih.gov/articles/PMC7471529/#:~:text=sample%2C%2099.6%25%20were%20working%20in,years%20into%20their%20professional%20practice.
19. Walkenhorst, Emily. "NC schools lag in hiring school psychologists, as mental health needs and special education disparities persist." WRAL News. May 28, 2021. Accessed at: https://www.wral.com/story/school-psychologists-help-identify-students-learning-needs-but-nc-schools-lag-in-hiring-as-mental-health-needs-and-special-educa/19701087/

would allocate $5 million from the state general fund to establish a school psychology internship program across the state.[20]

Other initiatives that DPI is currently piloting through time-limited grant funds further aim to address pipeline issues and expand access to school-based mental health support personnel. They also offer a roadmap for innovative strategies to scale if proven effective. DPI received a $17 million grant from the US Department of Education in 2023 to start two programs: Project ADS and Project FAST.[21]

Project ADS aims to increase school counselors and social workers serving 120,000 students in eight school districts by offering incentives for general practice counselors and social workers to re-specialize.[22] This would provide pathways for existing counseling and social work professionals to receive training at partnering universities that they need to work in school systems. Similarly, Project FAST provides support for recruitment, re-specialization, and retention of existing school support personnel in six school districts.[23] Participating school districts have access to funds to offer school-based mental health candidates tuition assistance, professional development opportunities, sign-on incentives, supplement increases, and bonuses.

2. EXPAND PUBLIC-PRIVATE PARTNERSHIPS WITH COMMUNITY-BASED PROVIDERS

Given the lack of specialized instructional support personnel and the workforce pipeline issues schools face, funding to support school districts in expanding partnerships with community-based providers could expand access to mental health services for students.

These could take the form of in-person service delivery with licensed counselors or telehealth services provided by health systems.

The state has already taken some steps to expand access to virtual mental health services. The North Carolina Department of Health and Human Services (DHHS) announced in March of this year a new partnership with Hazel Health to provide virtual school mental health care in participating school districts.[24] The partnership is estimated to expand access to nearly 400,000 students across the state. Similarly, the Carolina School-Based Telehealth Learning Collaborative, comprised of health systems, providers, university staff, state officials, and philanthropic representatives, works to expand access to school-based telehealth, including physical and mental health services.

20. Senate Bill 259, North Carolina General Assembly, 2025-2026 session. Accessed at: https://www.ncleg.gov/BillLookUp/2025/S259
21. "NCDPI Awarded Approximately $17 Million in Grant Funding to Increase Mental Health Support for Public School Students." North Carolina Department of Public Instruction. January 4, 2023. Accessed at: https://www.dpi.nc.gov/news/press-releases/2023/01/04/ncdpi-awarded-approximately-17-million-grant-funding-increase-mental-health-support-public-school
22. "NCDPI awarded approximately $17 million in grant funding to increase mental health support for public school students." EdNC. January 4, 2023. Accessed at: https://www.ednc.org/ncdpi-awarded-approximately-17-million-in-grant-funding-to-increase-mental-health-support-for-public-school-students/
23. "NCDPI awarded approximately $17 million in grant funding to increase mental health support for public school students." EdNC. January 4, 2023. Accessed at: https://www.ednc.org/ncdpi-awarded-approximately-17-million-in-grant-funding-to-increase-mental-health-support-for-public-school-students/
24. "NCDDHS Partners with Hazel Health to Provide Virtual Mental Health Services for K-12 Students in North Carolina." North Carolina Department of Health and Human Services. March 2025. Accessed at: https://www.ncdhhs.gov/news/press-releases/2025/03/26/ncdhhs-partners-hazel-health-provide-virtual-mental-health-services-k-12-students-north-carolina

Additional state funding to help school districts bridge the gap and provide mental health services through private, community-based providers would further ensure children have access to care where they spend much of their time.

NC Child has supported the expansion of programs like East Carolina University's Healthier Lives at School and Beyond program which is one such initiative. ECU's program provides virtual mental and physical health care services to students in four rural Eastern North Carolina school districts, with more than half of telehealth services covering behavioral care.

But additional support to school districts to help them partner with local providers to offer in-person counseling and services would also be beneficial. As we learned in focus groups, some school districts have financed these partnerships with federal COVID relief dollars, but as these grants have ended many are left without funding to continue their programs.

3. SUICIDE PREVENTION AND EDUCATION TRAINING FOR TEACHERS

While school districts across the state can ensure children have access to school-based services, we can also ensure teachers, who spend the most time around students, are equipped with the skills to recognize and respond to students in crisis.

Teachers are on the front lines of the youth mental health crisis. They see firsthand the behavioral challenges and elevated mental health needs of children coming out of the pandemic and have witnessed these issues mount for years before. It is essential that our educators can recognize the early signs of crisis in students and respond with care and compassion, while connecting them to trained mental health professionals that can provide the care that they need.

To that end, NC Child supports passage of H578, the Jason Flatt Act of North Carolina. This bill would require teachers to complete one hour of suicide prevention and awareness training each year to maintain their license, which would help fulfill existing Continuing Education Units educators must acquire each year. The legislation does not ask teachers to be counselors but ensures that the adults who spend so much time with our kids are equipped with the tools to be first responders when they notice the early signs of crisis. The program requires no fiscal note, and the Jason Foundation would provide schools across the state with a deep catalog of trainings at no cost.

Since 2007, the Jason Flatt Act has been passed in 21 states, including several other southern states. Teachers who have taken the trainings report that they have found them effective. Of educators who have taken Jason Foundation trainings, 82% said they are more confident in their ability to assist students in getting help if they approach them about suicidal ideation; 81% said they can better recognize the warning signs of suicidal ideation; and 76% said they are more confident in their ability to recognize and approach students who may be struggling with suicidal thoughts.

Conclusion

As the youth mental health crisis continues to persist across the country and in North Carolina, families, communities, and schools all play a vital role in the solution. These conversations with personnel that play key roles in addressing this crisis demonstrated how crucial school-based mental health services can be in getting increasing numbers of students the care they need. Focus group participants affirmed, however, that the increasing need for intensive mental health services is stretching school districts thin in regard to the support they are able to provide. Expanding the available mental health providers in schools, whether through increasing the school-based workforce or engaging in community partnerships, and aiding teachers in recognizing signs of serious mental health need can all help in improving the wellbeing of the students they serve. The impact of getting students crucial mental health care will not only improve their lives, but will have ripple effects for families and communities amid a nationwide crisis of mental health.