Mental Health Services in New Hampshire's Schools

April 2009

Authors

Steve Norton
Executive Director

Ryan Tappin
Research Associate

About this paper

This report is one of a series published by the NH Center for Public Policy Studies on the broad topic of mental health in New Hampshire. The Concord-based Endowment for Health has sponsored this work.

This paper, as with all of the Center's published work, is in the public domain and may be reproduced without permission. Indeed, the Center welcomes individuals' and groups' efforts to expand the paper's circulation.

Copies are also available at no charge on the Center's web site: www.nhpolicy.org

Contact the Center at info@nhpolicy.org; or call 603-226-2500.
Write to: NHCPPS, 1 Eagle Square, Suite 510, Concord NH 03301

<u>Mental Health Services in New Hampshire's Schools</u>

Table of Contents

Executive Summary

As the Center has noted previously, as many as 55,756 children, ages 5 – 19 have a diagnosable mental health disorder and almost 14,000 have a serious emotional disturbance.[1] Most of these children are educated in the New Hampshire public school system. Understanding if, and how, public schools manage the behavioral health issues of their students is of obvious public policy significance.

Despite this policy significance, comprehensive information about the role of schools in mental health services in New Hampshire is not available. This work – combining surveys of both school districts and schools and interviews with community mental health centers across the state – is designed to be an initial assessment of how this system is administered and funded, the mental health conditions driving this system, the services that it provides, and the manner in which the system assesses its progress in ensuring the mental well being of its children.

The major findings of this analysis are:

Schools in New Hampshire play a large role in providing mental health services to New Hampshire children.

Nationally, although not all children in need of mental health services receive them, many that do receive them through the school system (Burns et al., 1995).   This analysis confirms that significant energy and resources are devoted to providing mental health services to New Hampshire's children through the schools.   According to the Center's recent analysis of mental health service provision, 25% – or 17,680 children – received services for a mental illness in 2005 through the Medicaid program, and the state's schools were among the primary providers of those services. The Manchester and Nashua School districts billed the state's Medicaid program for almost $1 million each for mental health services in 2005.[2]

The schools indicated that they provide a comprehensive, publicly-funded set of mental health service, but there's little information available about the volume and type of services being provided and the mental health outcomes associated with this care.

When talking about schools providing mental health care, we are talking about something much more comprehensive than guidance counselors providing career help. Schools are providing mental health services to both special education and the general population. Only 9% of schools indicated that they provided mental health services only to special education students. Schools are providing a broad array of mental health services to their students. Slightly more than 50% of schools in New Hampshire provide school-wide screening for behavioral or emotional problems, and 73% of schools provide individual counseling services. Most schools (70-80%) did not note difficulty providing basic mental health services. However, a significantly higher

---

[1] Based on 2005 population estimates, NH Office of Energy and Planning.
[2] *New Hampshire Center for Public Policy Studies.* "Mental Health Services for New Hampshire's Children." August 2007.

share of schools noted difficulty in providing medication management and referral to specialized services.

Although significant resources are being devoted to mental health services, information on the types of diagnoses, the types of services being provided, and perhaps most important, the outcomes associated with this system are not well documented.   Almost 1/3 of schools do not collect any data on services being provided for special education or mental health specific needs.

There is little formal coordination between the various public systems receiving state and local funding to provide mental health services to children.

Like school mental health services, the Community Mental Health Centers (CMHC) are supported primarily by Medicaid – suggesting that potential partnerships between schools and community mental health could maximize resources. In fact, a prior *ad hoc* survey has found that formal relationships between schools and the Community Mental Health Centers exist across the state, but little was known about the administrative arrangements of these agreements. However, the data show that the community mental health system is not as significant a provider as private providers.

Interviews with the children's directors at the CMHCs working in the field revealed that, even though many informal relationships exist, relatively few schools have formal agreements with these clinics and that the scope and provisions of these agreements varies widely across the regions of the state. Although schools may not contract with a CMHC for school-based services, the vast majority of schools have informal, yet frequent, contact with them to help facilitate the coordination of mental health treatment for students in need. Practitioners interviewed also were in agreement that school-based services increase access to mental health services to children who otherwise would never be treated, due to several barriers.

Significant resources are being provided to the public schools for the provision of mental health services, yet there appears to be little public policy coordination across the various funding sources.

This public system of mental health care for children is funded by a myriad of sources, with over 80% of schools reporting the use of some local funds for providing mental health services, a significantly higher share than in national surveys of schools. This is not surprising given the state's historical focus on 'local control.'

In New Hampshire, the two most prevalent sources of funding are local resources and Medicaid, which is funded by both the state and the federal government.   In addition, the state makes a significant contribution to local special education expenditures for those children for whom the cost of an education is significantly higher due to mental or physical disability. Catastrophic Aid – the program in which the state shares in the costs of providing special education services to high acuity children – continues to be one of the primary growth areas in state general fund expenditures.

Despite the fact that significant resources are being expended on these broad school-based mental health services, the issue of children's mental health is only peripherally included in the

major mental health and education policy conversations currently being debated. In the 2007 legislative session, SB 18 increased the dropout age from 16 to 18 years of age. This policy change – which will fundamentally affect the learning plans for students who would have otherwise dropped out – will also have a significant impact on the demand for mental health services, given the demonstrated association between mental health issues and drop-out rates. While legislation specified information on alternative learning plans for completing an education, it did not in any way address the mental health service needs associated with this major change in policy.

Furthermore, in the following legislative session, the legislature passed a definition of adequacy based on the state's minimum standards for public school approval.[3] These standards include a series of standards associated with a psychologist program. Those districts that hire a school psychologist must have a comprehensive continuum of services and must, among other things, be able to conduct basic investigations and program evaluations for improvement of services. From these data, while it is clear that significant resources are being devoted to mental health services, the coordination of the various parts of this system and the ability to evaluate and assess this system does not appear to exist.

Finally, there are a series of mental health plans that emerged, one from the Department of Health and Human Services and the other from the mental health commission. Neither one of these documents spends significant time nor resources on the broad system of school-based mental health services that exist.

---

[3] http://www.ed.state.nh.us/education/laws/documents/306Adopted.pdf

Methods

This study is the first comprehensive assessment of the system of mental health services provided by schools in New Hampshire. Two surveys were fielded as part of this work: one for school districts and the other for schools. We used a slightly modified version of the same surveys used in a 2002-2003 analysis of mental health services funded by *Substance Abuse and Mental Health Services Administration (*SAMHSA).[4] We chose to use these surveys because they were reviewed and analyzed by national experts. We also chose these instruments so that we could compare results in New Hampshire to similar results from the national surveys. A technical panel convened by the Center to review the surveys recommended a number of small changes to the survey. These changes focused on language associated with the various funding sources for mental health services and on specific programs known to exist in New Hampshire, or introduced nationally subsequent to the release of the SAMHSA survey. For more information on the survey methodology, see Appendix 1. The surveys are included as appendices.

Sampling Strategy

School Mental Health Services in New Hampshire, 2008 is a study of public K–12 schools and their associated school districts. The questionnaires were adapted from the Characteristics and Funding of School Mental Health Services 2007-2008: District and School Questionnaires, originally sponsored by SAMHSA. The questionnaire was sent to every New Hampshire school and the associated school district from the New Hampshire Department of Education school list. By sending to all schools and school districts, we hoped to get varied representation of the state's schools and districts by level (elementary, middle, and high school) and by size, as measured by student enrollment: small (from 1 to 250 students); medium (251–500 students); large (501–1,000 students); and very large (1,001 and more students).

Data Collection and Response Rate

Districts

Data collection began in July of 2008, with initial emails sent to superintendents on July 11, 2008 in each of the school districts in New Hampshire with valid emails (80 emails sent in total). The email provided information about the study and its sponsors and included the survey form and instructions for completing it. Superintendents were asked to forward the survey to the person designated by the superintendent as the most knowledgeable about mental health services. District respondents ranged from superintendents to assistant superintendents and directors of student services or special education.

Reminders were sent to districts on July 21 and September 4, 2008. In addition to the reminder emails sent, the NH Commissioner of Education sent two requests to superintendents requesting

---

[4] Foster S, Rollefson M, Doksum T, Noonan D, Robinson G. (2005). *School Mental Health Services in the United States, 2002–2003*. DHHS Pub. No. (SMA) 05-4068. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

their support and participation in this project. Staff from the study's sponsor – the Endowment for Health – also called districts to encourage support. Twenty-five districts completed the survey for a response rate of 31 percent.

Schools

Data collection for the school survey began on August 18, 2008, with initial emails sent to principals of each NH public school with valid emails (N=600). Principals were asked to complete the survey on the internet, and if necessary, forward the survey link to the person in their school who could best respond to questions about mental health staffing and services. School respondents ranged from principals to assistant principals, special education coordinators and guidance counselors.

Reminders were sent to schools on September 4, and September 18, 2008. In addition to the reminder emails sent, staff from the study sponsor also called districts to ask them to encourage support among their schools. One hundred and eleven (111) schools completed the survey for a response rate of 19 percent.

Information on Community Mental Health Centers

Given the important role that the community mental health system plays in the provision of mental health services to children, the Center set out to formally identify the relationship between New Hampshire's schools and the 10 Community Mental Health Centers (CMHC). A brief survey by NH Mental Health Technical Assistance found that the majority of the CMHCs had a contract with a local school. What was unknown, however, were the administrative arrangements of these agreements. This piece of the analysis aimed to describe what kinds of arrangements CMHCs had with local schools.

Between August and November of 2008, Center staff conducted interviews with 18 children's directors and mental health practitioners at 9 of the 10 Community Mental Health Center organizations. A list of interviewees can be found in Appendix 4. Interview questions explored the types of arrangements each CMHC site had with local schools, if any, to provide school-based services and the issues and successes surrounding these agreements. Additionally, these interviews surveyed the opinion of those working in the field of community mental health with regards to barriers to care for children in their areas.

The Center had originally intended to review contracts in order to determine the volume and type of treatment children were receiving via school-based services. However, as will be discussed in detail in subsequent sections, the nature of how these agreements are administered revealed to be an impassable obstacle to accomplishing this analysis. We instead offer a review of the nature of these agreements put into the context of the scope of children that could potentially be served by the relationships in place.

Results

Administration and Budgeting

In order to understand the administrative structure of the school-based mental health services system in New Hampshire, the school district survey included a series of questions, which attempted to clarify the roles and responsibilities of the school districts, the schools, and the degree to which the mental health services system was broader than the system of special education services provided to Individuals with Disabilities Education Act (IDEA) eligible children. In what follows, we provide the findings on the locus of administrative responsibility and the degree to which the mental health service system can be specifically identified in the budgets of school districts.

According to respondents to the district survey, the mental health services system is broader than the special education services provided to IDEA eligible children. As Figure 1 shows below, only 9% of the schools surveyed indicated that they provided mental health services to special education students only.

Figure 1
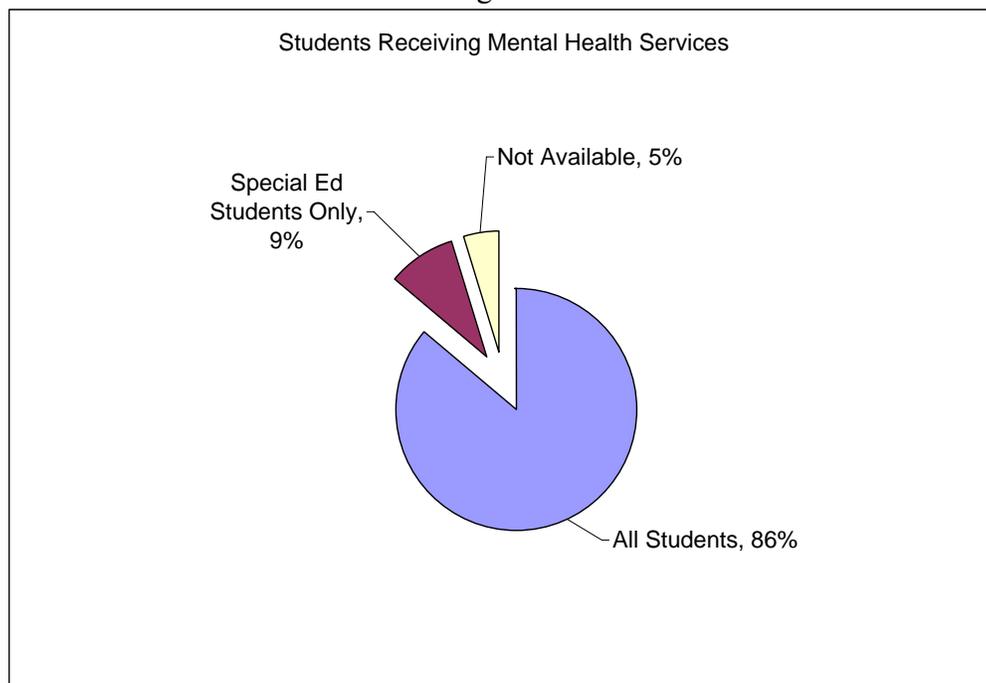
School Districts were asked who had responsibility for administering mental health services in the schools. Almost three-fourths of schools said that the administration of mental health services was managed by the school district, as shown in Figure 2. Which aspects of the administration of mental health services – hiring of clinicians, budget development and management, and development of process measures and accountability – were not clear from the survey. A clearer sense of the specifics of who has management responsibility for the various aspects of the school

mental health system will be important as efforts to enhance and/or transform the system are undertaken.

Figure 2

Administrative Responsibilty for Mental Health Services

School
28%

Administrative
Responsibility at
the School District
72%
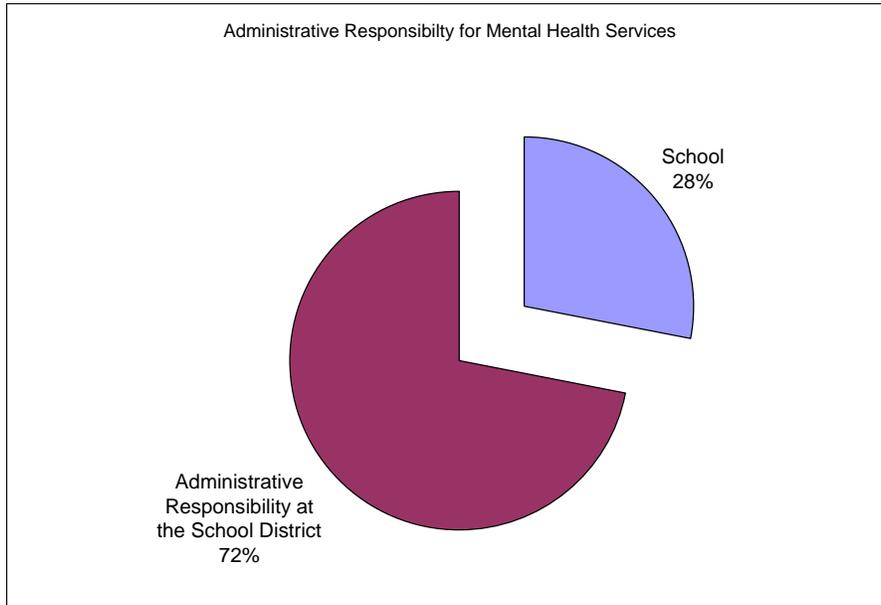
Administration for mental health services is, according to respondents to the school district survey, largely combined with the administration of special education services. Almost one-third (32%) of the school districts indicated that mental health services were administered separately from special education (Figure 3).

Figure 3

Administration of Special Education and Mental Health Services

Separately
32%

Together
68%
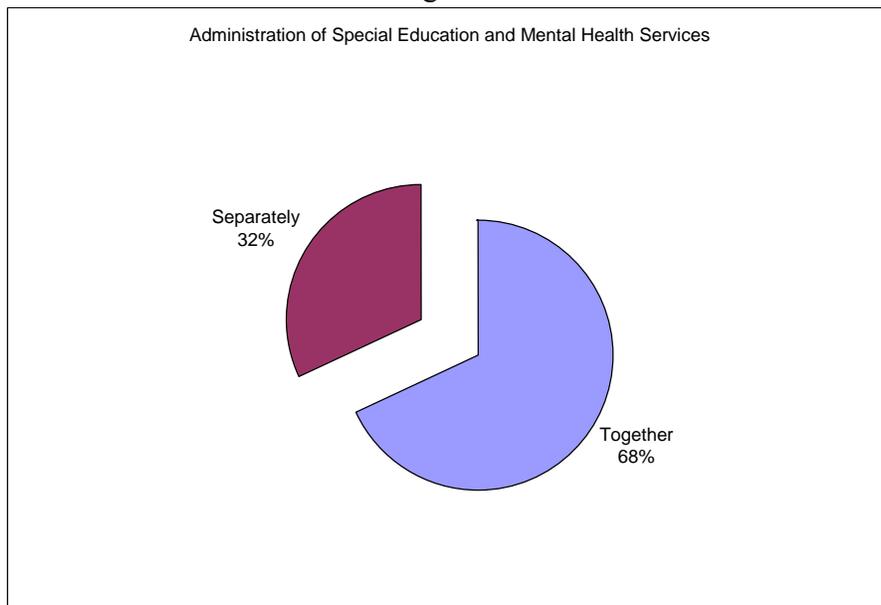
While it is clear from this work that there is a comprehensive system of mental health services provision, and that to some extent it is separate from the set of services being provided by the special education system, for slightly more than half of the schools, mental health services are

not budgeted separately from other education expenditures (see Figure 4). This makes it difficult to understand the scale of the investment local communities, the state, school districts and schools themselves are making in mental health relative to other education services. By extension, this also makes it difficult to hold schools accountable for their efforts in this arena.

Figure 4

Mental Health Services Budgeted Separately from Other Education Expenditures

Not Separately Budgeted 52%

Mental Health Budgeted Separately 48%
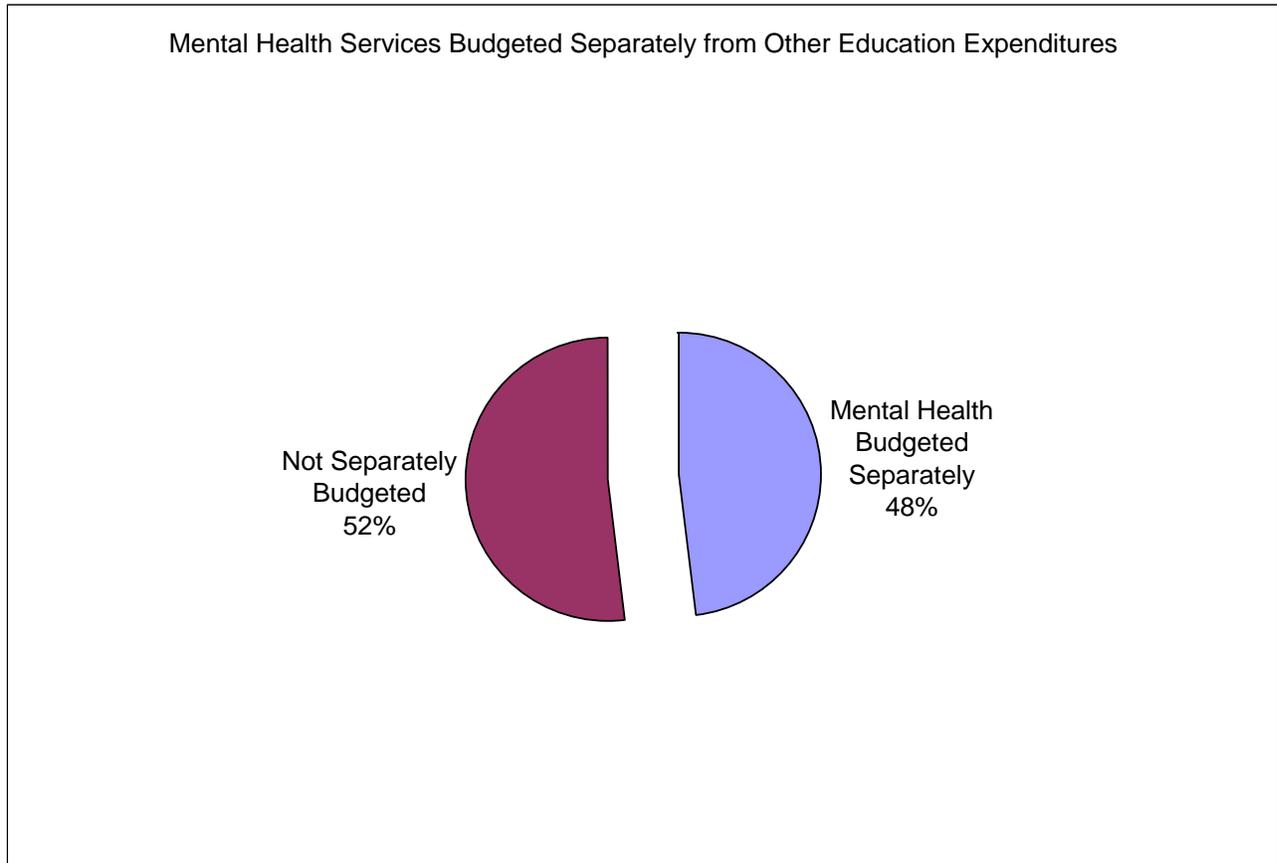
Sources of Funding

The district survey requested information on the source of funding for mental health services. Respondents were asked to indicate those funding sources used to support health services in their schools.

Respondents reported that local funds were the primary source of funding for mental health services provided in the schools, followed by Medicaid, followed by the IDEA (see Figure 5). This was different than other national studies which listed IDEA and Medicaid as the primary source of funds. Schools in New Hampshire were significantly more likely to identify local funds than the nation as a whole (83% to 49%, respectively). The reasons for this are not clear from the survey results, but warrant further analysis, as they suggest that New Hampshire has developed a financing system different from that of the nation generally, and one that relies on a much more varied source of financing.

Figure 5

Percent of School Districts Indicating Each as a Source of Funds for Mental Health Services

Source	Percent
Private Foundation	4%
Self-Pay	8%
Safe Schools Initiative	12%
Title 1	12%
General Fund	16%
Community Health Services Block Grant	16%
Third Party	28%
State Special Ed	64%
Title IV	64%
IDEA	76%
Medicaid	80%
Local Funds	84%
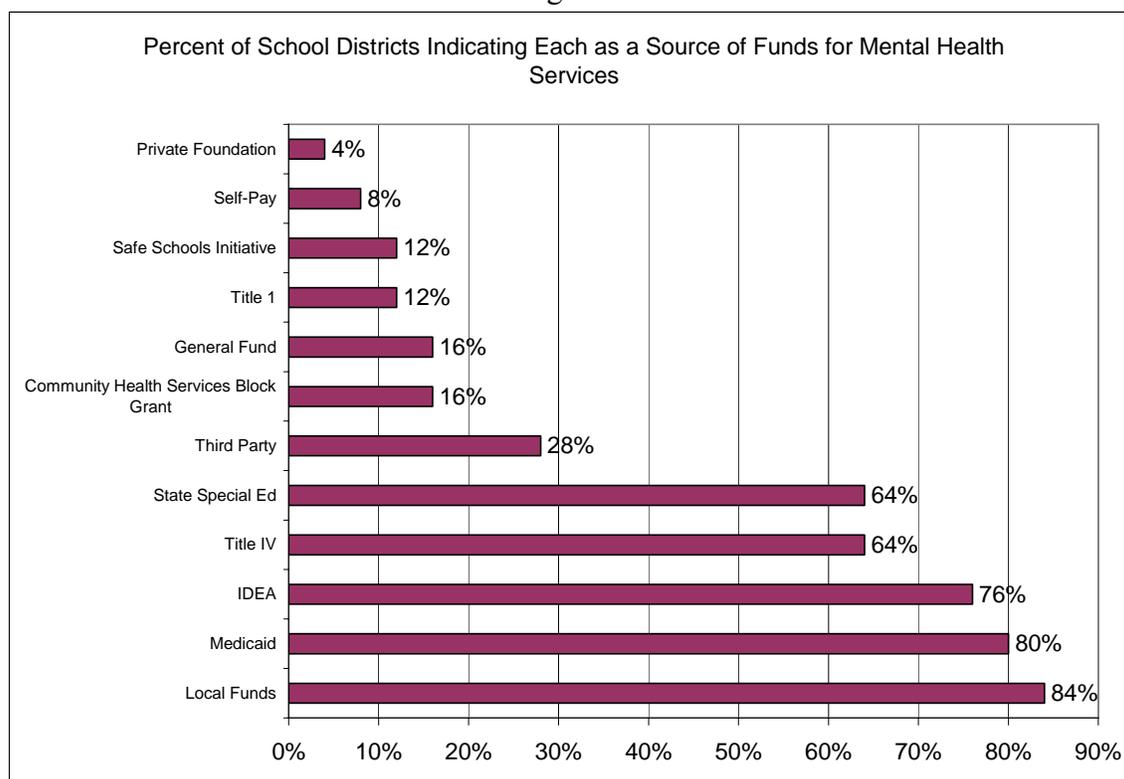
As pointed out in other research by the Center, Medicaid is an important provider (and funder) of mental health services for New Hampshire schools. Under the state's 'Medicaid-to-Schools' program, certain services, including occupational therapy, psychiatric and psychiatric services, and rehabilitative services are available to those children eligible for Medicaid with an individualized education plan (IEP)[5] for children with disabilities.[6] Under this program, school-based services can be reimbursed via this approach.

One important question for the state to answer is whether they have fully leveraged this funding opportunity. New Hampshire has a long history of maximizing Medicaid opportunities. Nonetheless, it might be possible, through the further integration of traditional Medicaid services with IDEA funded services, to expand this again. Others have noted, for example, one possible strategy is developing partnerships between the school districts and community mental health centers, integrating services available for those with Medicaid as well as those eligible for IDEA. Yet another would be the development of an integrated management structure for education based and health and human services based mental health services.

---

[5] Individualized Education Plan (IEP) is a document describing a learning program for a student with a disability under the IDEA. An IEP contains an educational program that is in the least restrictive environment possible and mandates what support services are necessary to provide that education program.

[6] More information is available at:
http://www.ed.state.nh.us/EDUCATION/doe/organization/Instruction/documents/ExecutiveSummaryNHMedicaid2008.pdf

When asked if funding for mental health services had changed over time, 70% said that funding had remained the same or increased. Only 24% of school districts indicated that funding for mental health services had declined (see Figure 6).

Figure 6

Changes in Funding Level for Mental Health Services for Students

Not Available
4%

Decreased
24%

Increased
24%

Remained the same
48%
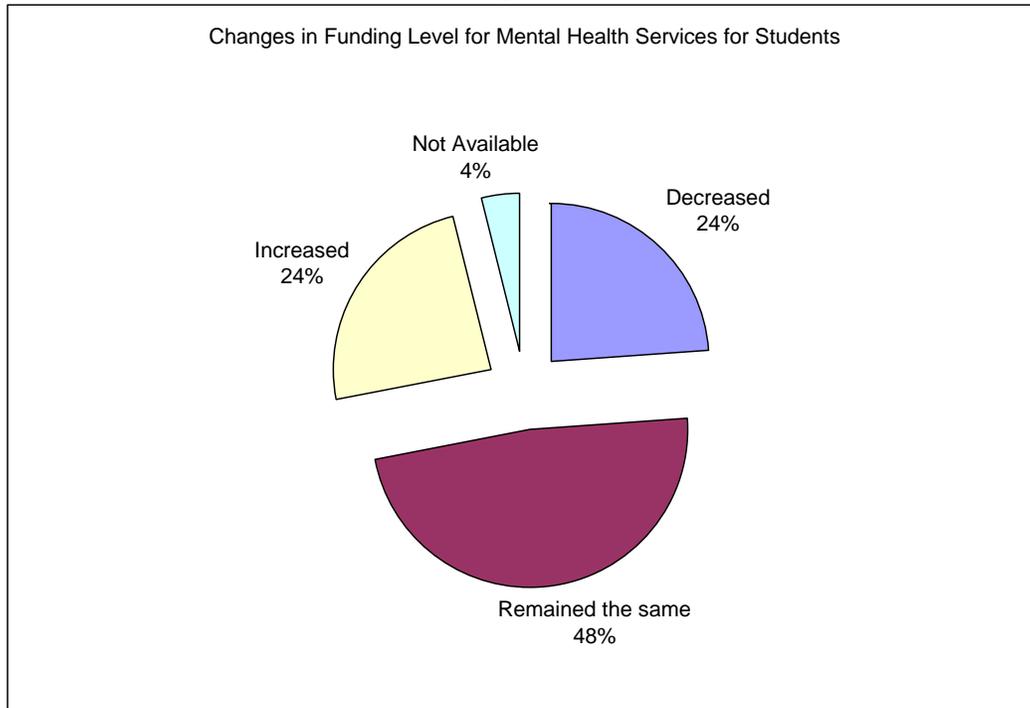
Types of Mental Health Problems

The survey asked respondents to report on the mental health problems most frequently presented by students in their school. The complete list of problem categories provided in the survey instrument was:

- Adjustment Issues
- Social, Interpersonal, or Family Problems
- Anxiety, Stress, or School Phobia
- Depression, Grief Reactions
- Aggression or Disruptive Behavior
- Behavior Problems Associated with Neurological Disorders
- Delinquency or Gang-Related Behavior
- Suicidal or Homicidal Thoughts or Behavior
- Substance Use/Abuse
- Eating Disorders
- Concerns about Gender or Sexuality
- Physical or Sexual Abuse
- Sexual Aggression

Respondents were asked to rank the three most frequently seen problems from this list for male and for female students.   Six problems, overall, were identified as the most frequently presented issues. These were social and interpersonal or family issues, aggressive disruptive behavior, behavior problems associated with a neurological problem, adjustment issues, anxiety stress and school phobia, and depression.

As shown in Figure 7 social, interpersonal, or family problems was the most frequently cited mental health problem category for both males and females. However, the second and third most frequently cited concerns were different for males and females. Anxiety and adjustment issues were cited as the second and third most frequent problems for females. Aggression or disruptive behavior and behavior problems associated with neurological disorders (such as attention-deficit/hyperactivity disorder) were cited as the second and third most frequent problems for males.

The results for New Hampshire were remarkably consistent with the patterns found in SAMHSA's national survey of mental health and schools (See Figure 8).   Schools' ranking of the major issues was consistent across the two surveys, as were, generally speaking, the differences between males and females.
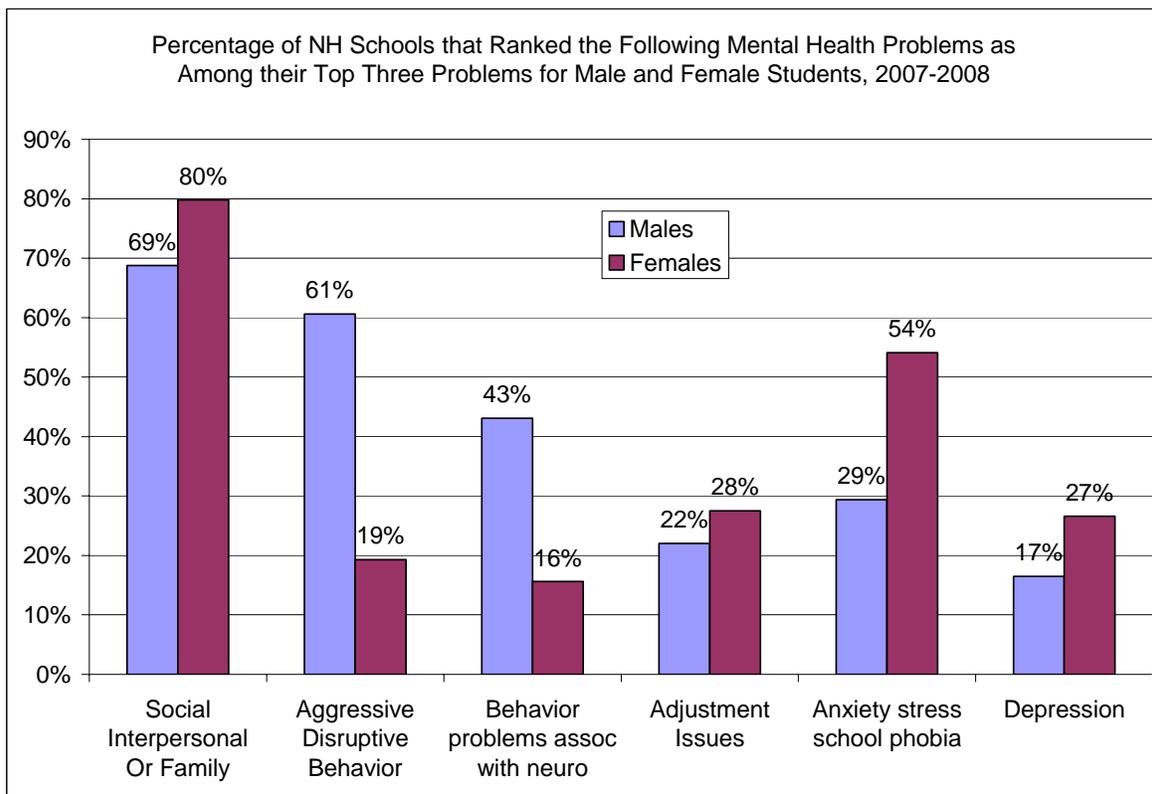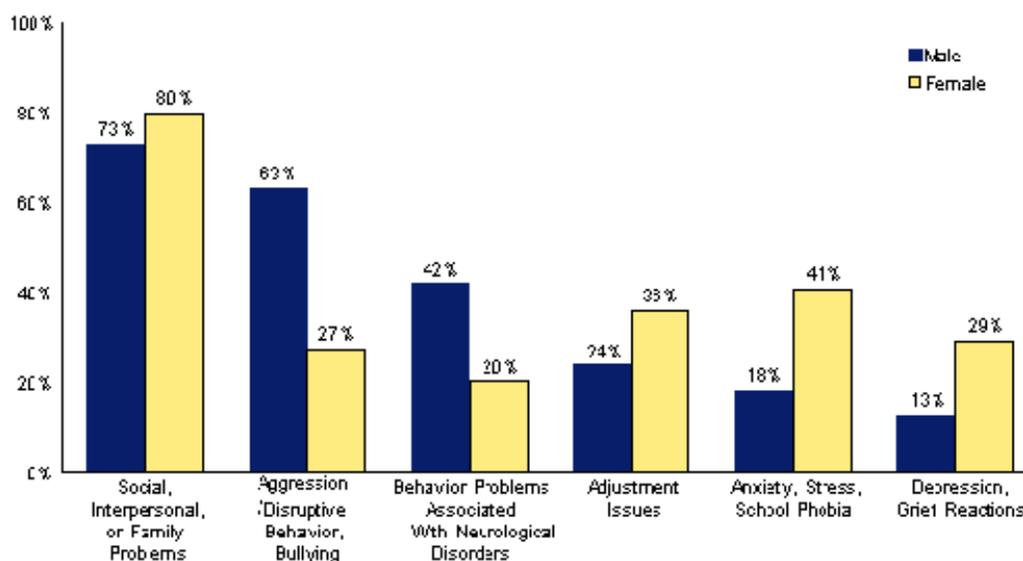
Figure 7

Percentage of NH Schools that Ranked the Following Mental Health Problems as Among their Top Three Problems for Male and Female Students, 2007-2008

Figure 8

Exhibit 2.2 Percentage of Schools That Ranked the Following Mental Health Problems as Among Their Top Three Problems for Male and Female Students, 2002–2003

Source: *School Mental Health Services in the United States, 2002–2003.* Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. School Questionnaire, Item 27, Appendix C, School Tables 15, 15A.

Use of Mental Health Resources

Given the fact that most schools rank social, interpersonal or family problems as the most frequent mental health problem, it should come as no surprise that almost half of a school's resources are used attempting to deal with these problems. Schools were asked which mental health problem consumed most of their mental health resources. The top-ranked mental health problem reported by schools – social, interpersonal, or family problems – was also the most frequently reported as consuming the most mental health resources. (see Figure 9).

And, not surprisingly, what drives resources varies by type of school, reflecting underlying differences in the problems that those schools face (see Figure 10). High schools, elementary schools and middle schools all reported that the problem that used most of the school's resource were social, interpersonal or family problems. However, high schools were less likely to identify aggressive/disruptive behavior and bullying as a driver of resource use and more likely to identify other issues, such as alcohol and suicide, as a resource driver.
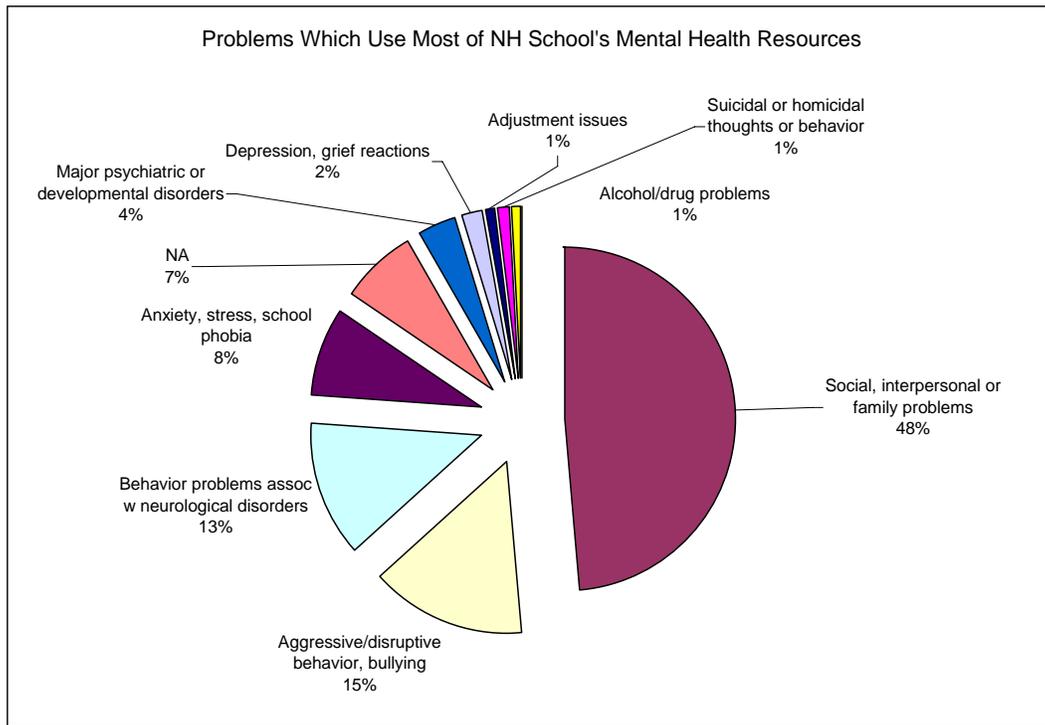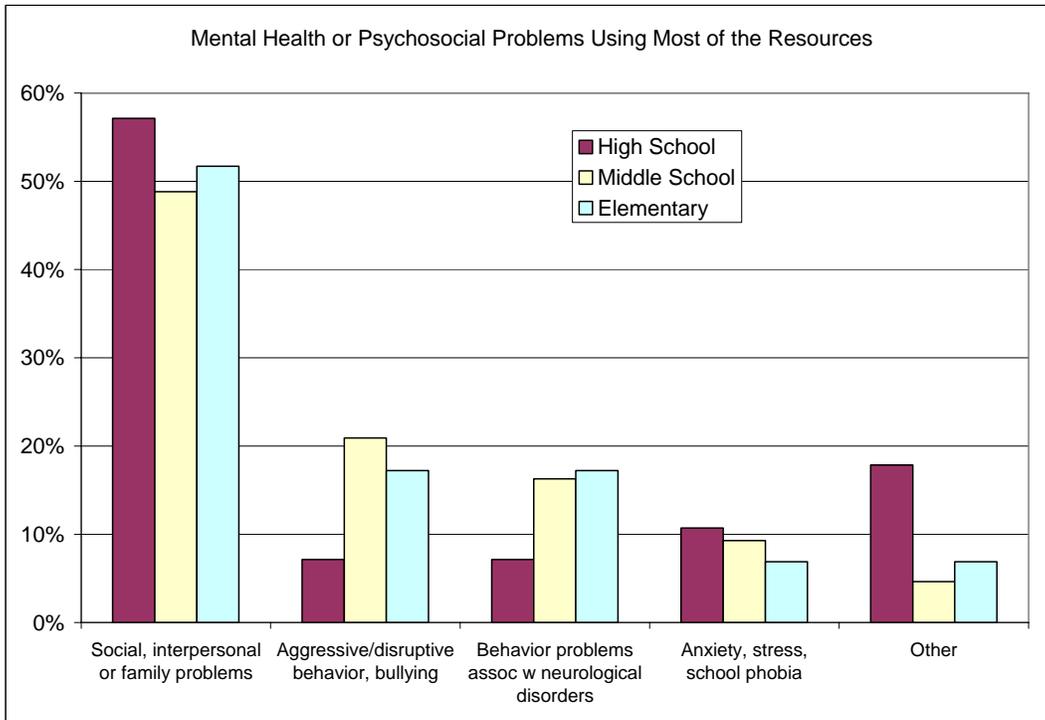
Figure 9

Figure 10

Types of Mental Health Services Provided

The survey asked respondents to report the types of services provided to students in their schools. The survey explicitly requested information on both the services provided directly by the school or the district or through community-based organizations with which the school had a formal arrangement – such as a contract or memorandum of understanding with a community mental health center.

The survey asked schools to identify whether or not they provided 11 specific services. These 11 services were:

- Assessment for emotional or behavioral problems or disorders (including behavioral observation, psychosocial assessment, and psychological testing)
- Behavior management consultation (with teachers, students, family)
- Case management (monitoring and coordination of services)
- Referral to specialized programs or services for emotional or behavioral problems or disorders
- Crisis intervention
- Individual counseling/therapy
- Group counseling/therapy
- Substance abuse counseling
- Medication for emotional or behavioral problems
- Referral for medication management
- Family support services (e.g., child/family advocacy, counseling)

Types of Services Most Frequently Provided

New Hampshire schools provided virtually all of the services listed. As shown in Figure 11, over 80% of schools provided assessment, and referrals to specialized programs. Although provided slightly less frequently, a high percentage (ranging from 70 to 76%) provided services for acute mental health care, including case management, crisis intervention, individual counseling, and group counseling.   Only 39% of schools provided substance abuse counseling and only 50% provided family support services.   These results were very similar to the national average in the SAMHSA survey, as shown in Figure 12.
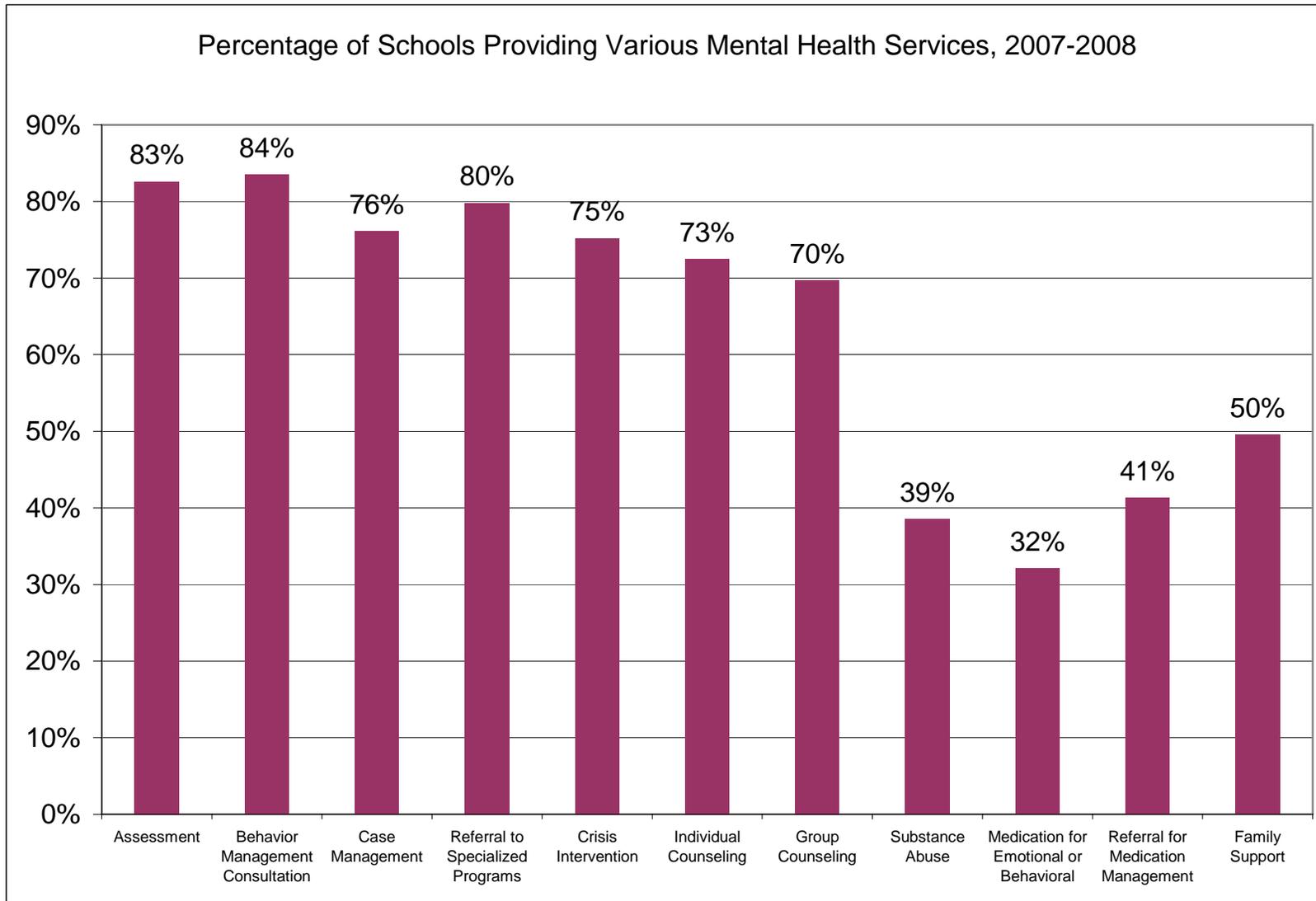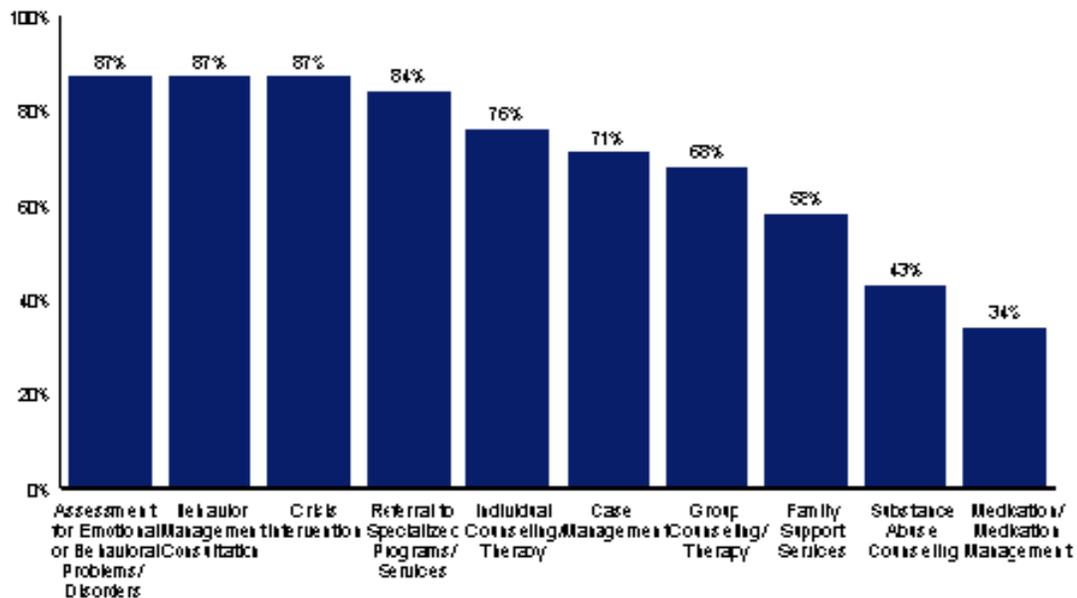
Figure 11

Percentage of Schools Providing Various Mental Health Services, 2007-2008

Figure 12

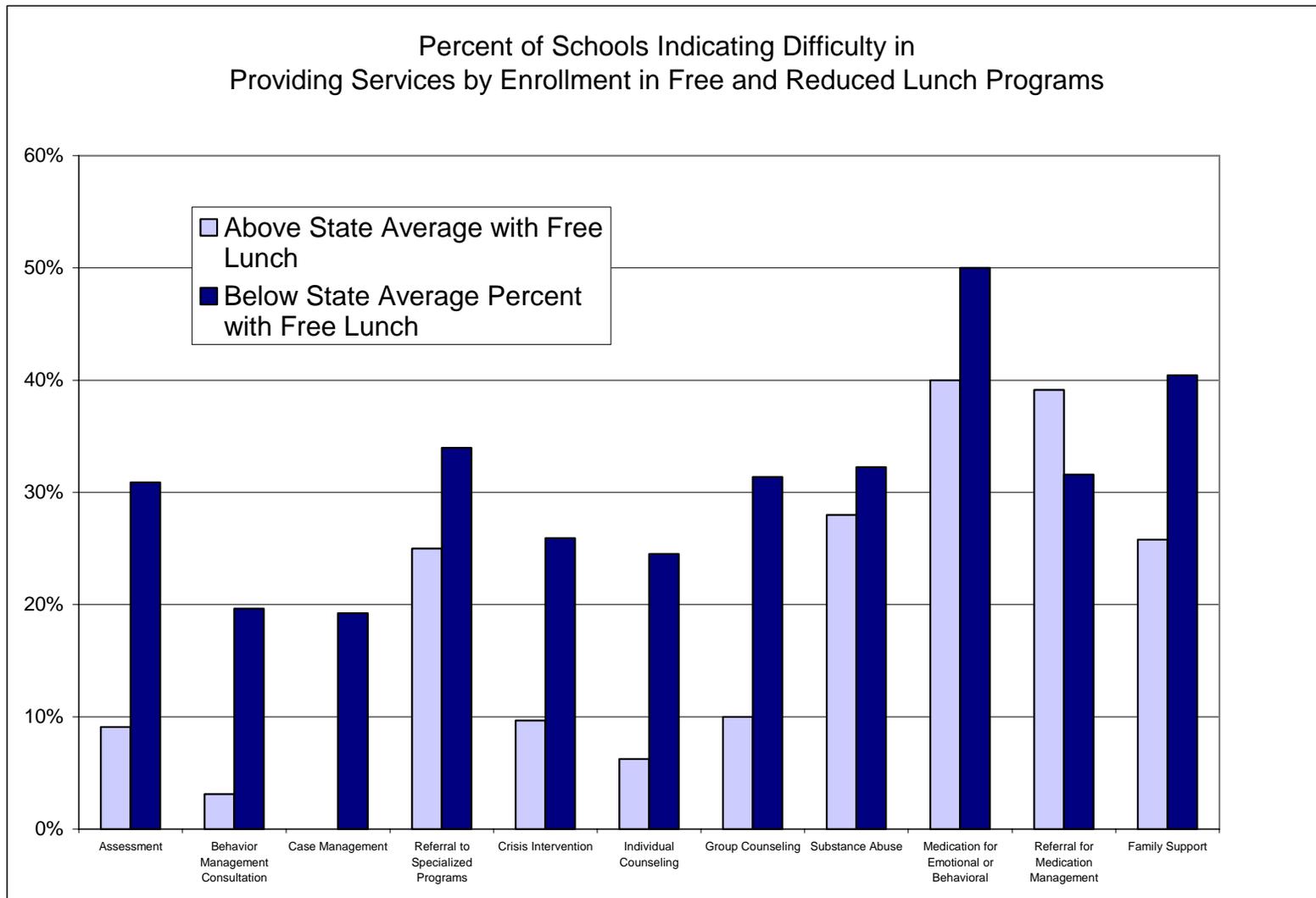Exhibit 2.6 Percentage of Schools Providing Various Mental Health Services, 2002–2003

Source: *School Mental Health Services in the United States, 2002–2003.* Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. **School Questionnaire, Item 29, Appendix C, School Table 17**

While the survey did not collect information on the demographic characteristics of the school's local geography, the survey did provide us with a measure of the income in the community – the number of students that were enrolled in the free and reduced lunch program.   To try and answer the question as to whether lower-income communities had a more difficult time providing these services, we looked at the share of schools with a high concentration (greater than the state average) of students enrolled in free and reduced lunch services compared to those with a lower concentration.   These results are shown in Figure 13.

With only one exception, schools with a higher share of children enrolled in free and reduced lunch programs seemed to have an easier time providing services than those with a lower concentration of free and reduced lunch programs.   For many services, schools with lower concentration of lower income children experienced difficulty providing services at twice the rate of those with a higher concentration of lower income children.   This was particularly true for assessment, behavior management and individual and group counseling.   While these results should be viewed with some caution because the cell sizes are small, the patterns suggest that important questions to ask are whether sufficient resources exist in the higher income

communities, whether private providers are more widely utilized, and whether, as will be discussed in more detail later in the paper, barriers created by insurance coverage or stigma exist.

Figure 13

Percent of Schools Indicating Difficulty in
Providing Services by Enrollment in Free and Reduced Lunch Programs

Legend:
□ Above State Average with Free Lunch
■ Below State Average Percent with Free Lunch

Categories (x-axis):
Assessment, Behavior Management Consultation, Case Management, Referral to Specialized Programs, Crisis Intervention, Individual Counseling, Group Counseling, Substance Abuse, Medication for Emotional or Behavioral, Referral for Medication Management, Family Support

For the past 10 years, schools have moved actively into the development of not only treatment services but also prevention activities.   These programs direct school resources to the entire school population, not just those students with mental health problems. Between a one-third and half of schools conduct systematic school-wide screening for behavioral or emotional problems (Figure 14).   This rate is significantly higher than that shown in the SAMHSA survey of national data in 2008.

Figure 14

Percent of Schools with School-wide Screening for Behavioral or Emotional Problems

Kindergarten Screening for Social-Emotional Problems	Health Class Inventory	My Voice Student Aspiration Survey	Systemic Screening for Behavioral Disorders	Youth Risk Behavior
36%	42%	51%	39%	33%
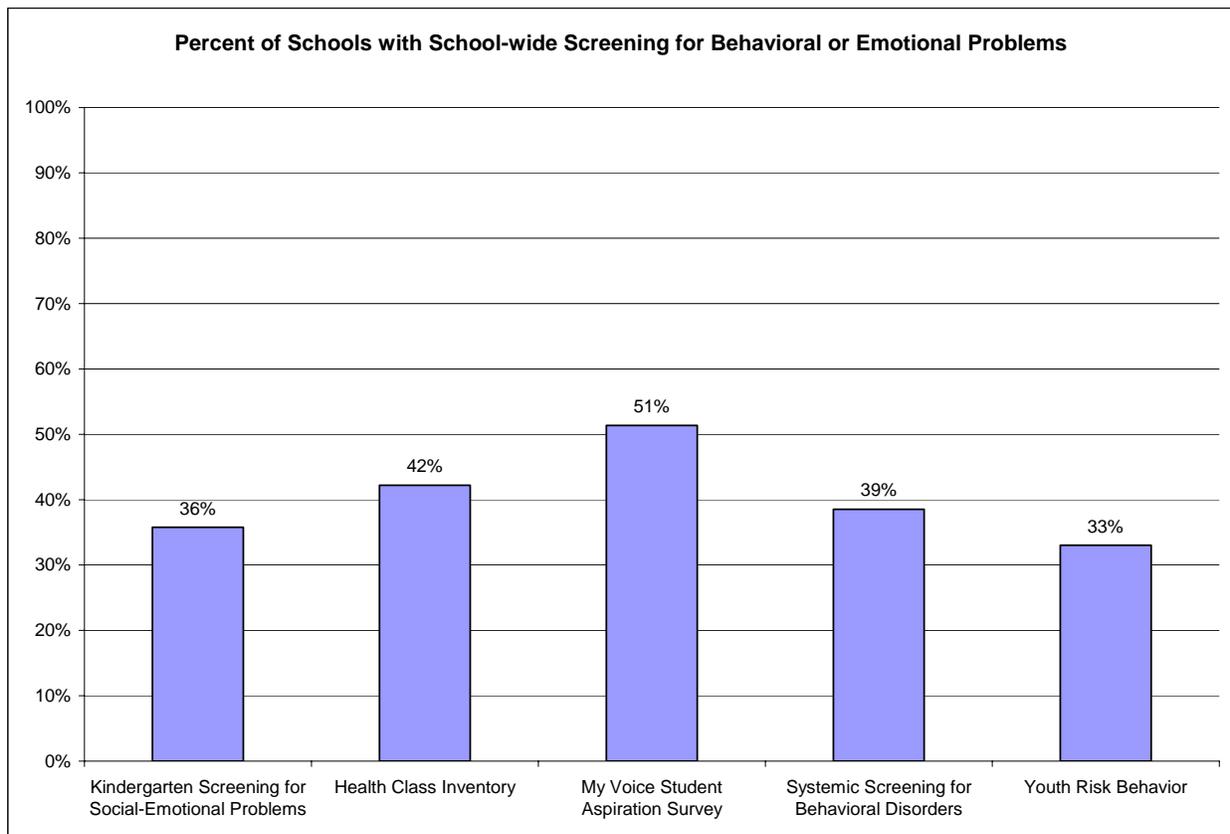
Though schools in the state have a broad set of screening activities, the majority of schools do not use population-based early intervention and prevention activities. Figure 15 shows the share of schools implementing different prevention and early intervention services. Relative to the national data from SAMHSA, New Hampshire schools are much less likely to offer population based services or early prevention activities than schools across the country.

Figure 15

Percent of Schools Offering Prevention and Early Intervention Programs and Services
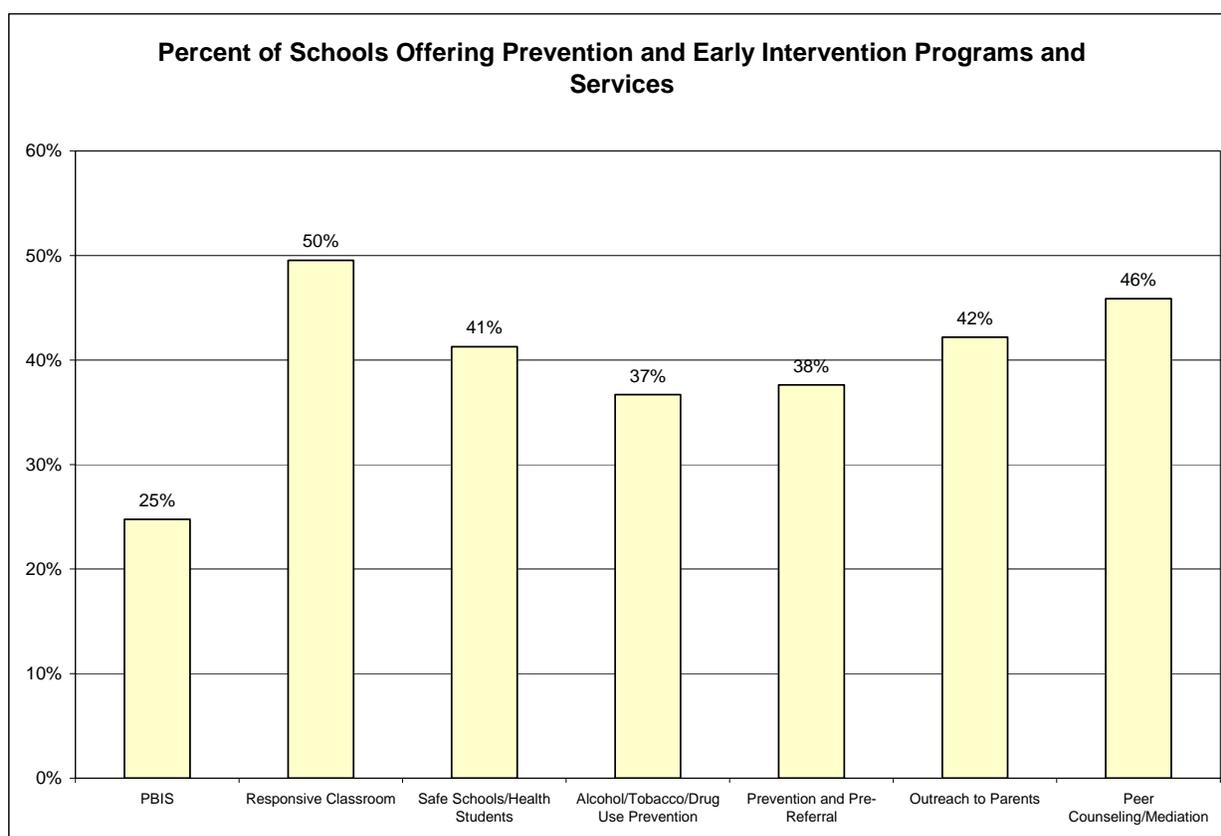
Barriers to Delivery of Services

Schools were asked to rank the extent to which various factors were barriers to the delivery of mental health services, using a scale of 1 to 4, where 1 was "not a barrier" and 4 was a "serious barrier." In the following figure, we compare the share of New Hampshire schools that identified the issue as a barrier (either a 4 or 3 on the scale previously mentioned) and compare that to the national results from the SAMHSA survey.

Schools identified a number of barriers to providing services to children. Financial constraints of families, insufficient school and community-based resources, and transportation issues were the factors most often reported as barriers or serious barriers to care; more than 50% of those surveyed indicated these as barriers to care (see Figure 16). With three exemptions – the degree to which cultural barriers existed, the need for the protection of privacy, and the existence of competing priorities – these results were very consistent with the national results.
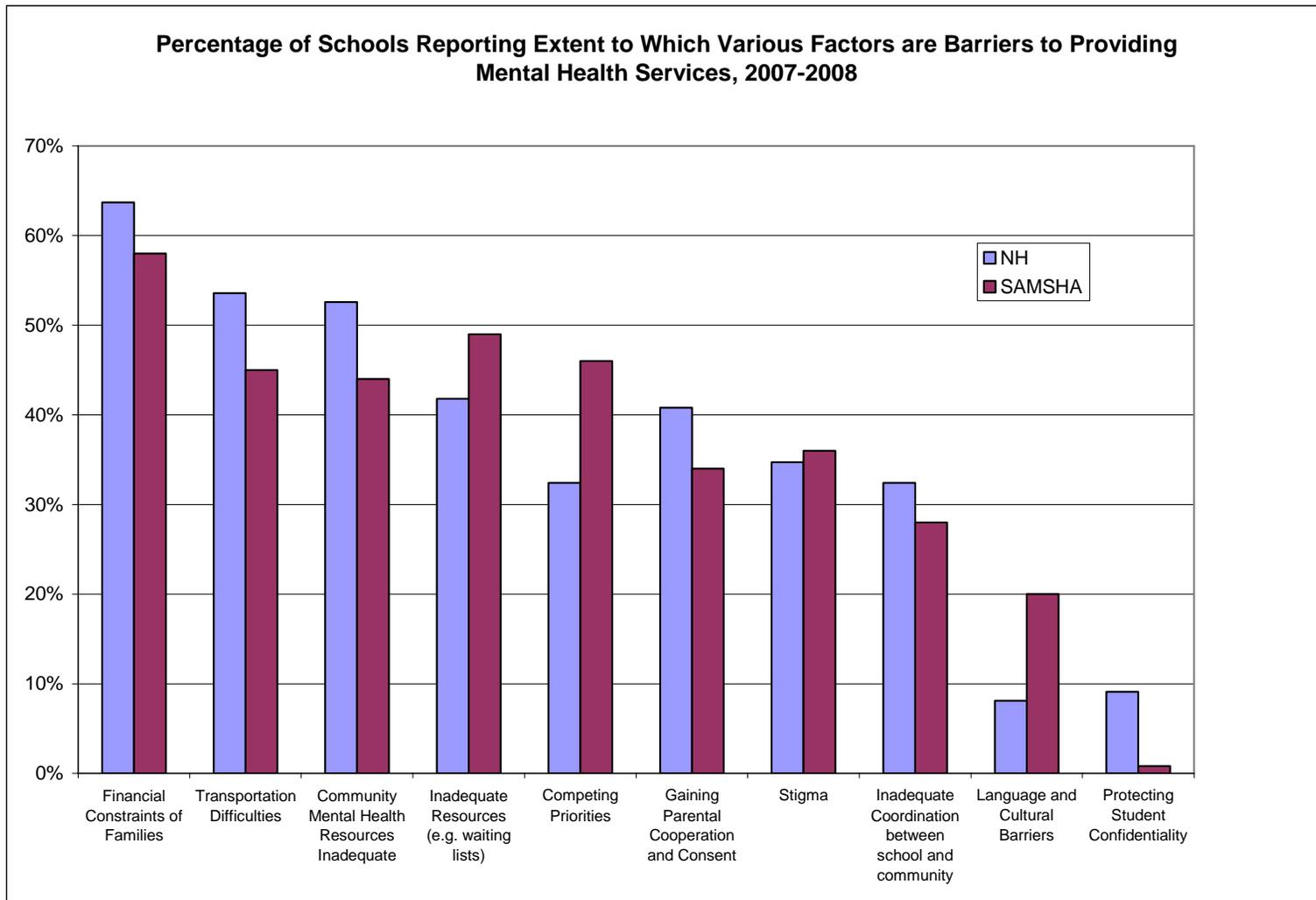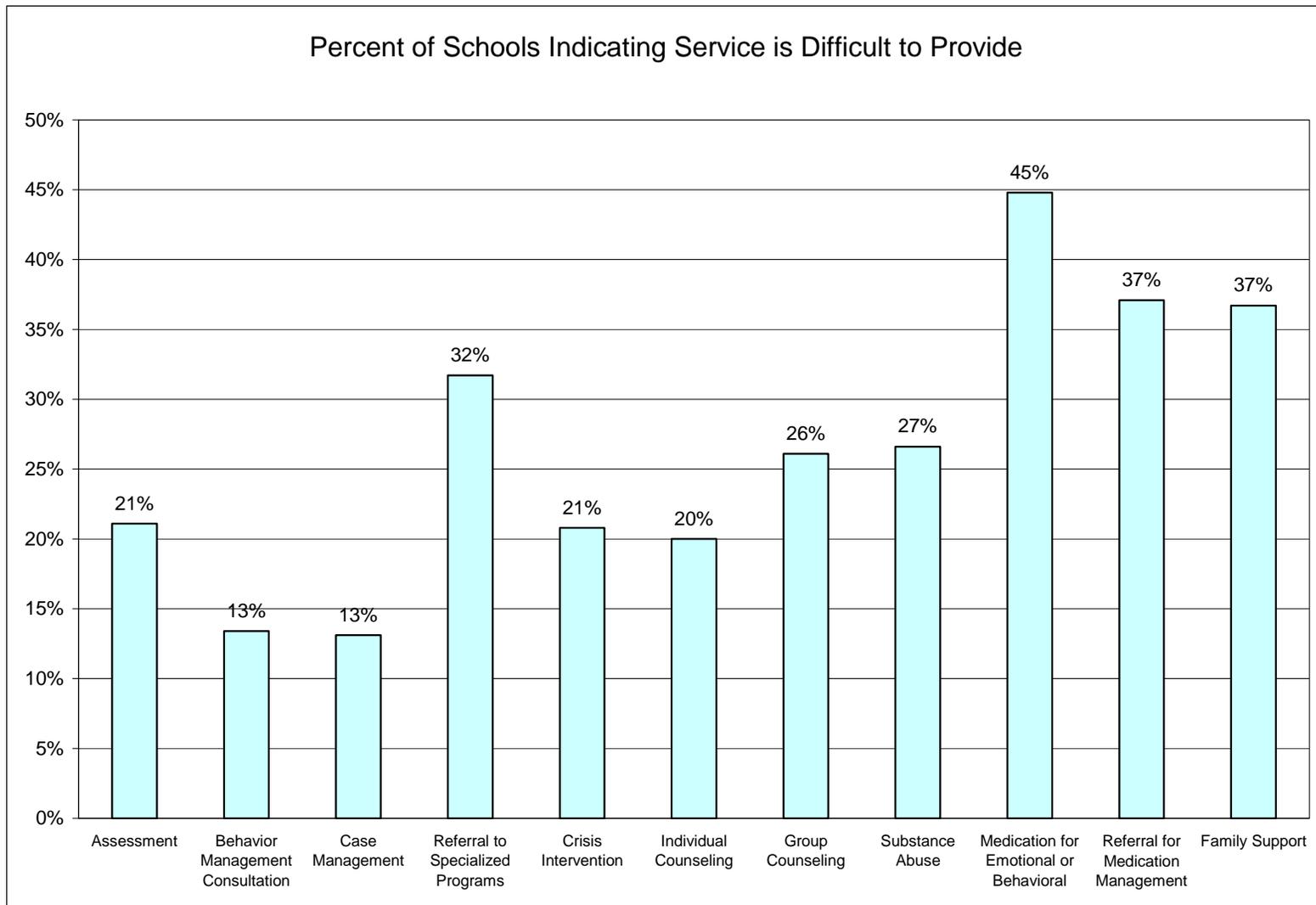
Figure 16

Percentage of Schools Reporting Extent to Which Various Factors are Barriers to Providing Mental Health Services, 2007-2008

Figure 17

Percent of Schools Indicating Service is Difficult to Provide

| Service	Percent
Assessment	21%
Behavior Management Consultation	13%
Case Management	13%
Referral to Specialized Programs	32%
Crisis Intervention	21%
Individual Counseling	20%
Group Counseling	26%
Substance Abuse	27%
Medication for Emotional or Behavioral	45%
Referral for Medication Management	37%
Family Support	37%

Two important differences are worth noting. First, a lower share of New Hampshire schools indicated that competing priorities is a barrier to providing mental health services. This either suggests that since 2003 (when the SAMHSA survey was originally fielded) the need to provide services in mental health has increased in school's priorities, or that New Hampshire schools have put a higher priority on mental health services for children than the average school nationally. Second, a lower share of New Hampshire schools noted language and cultural barriers as a barrier to providing care. This may be a result of the fact that New Hampshire remains one of the most ethnically homogenous states in the country. It also may be a function of the fact that the area with the highest rates of minority population, Hillsborough County, were underrepresented in the survey.

Surprisingly few schools indicated that they had difficulty providing basic mental health services (see Figure 17). Only 21% indicated a problem providing assessment services, and only 13% indicated providing behavior management or case management services.   Medication management services are difficult to provide, according to respondents. Almost 50% indicated difficulty in providing medication management for emotional or behavioral problems.
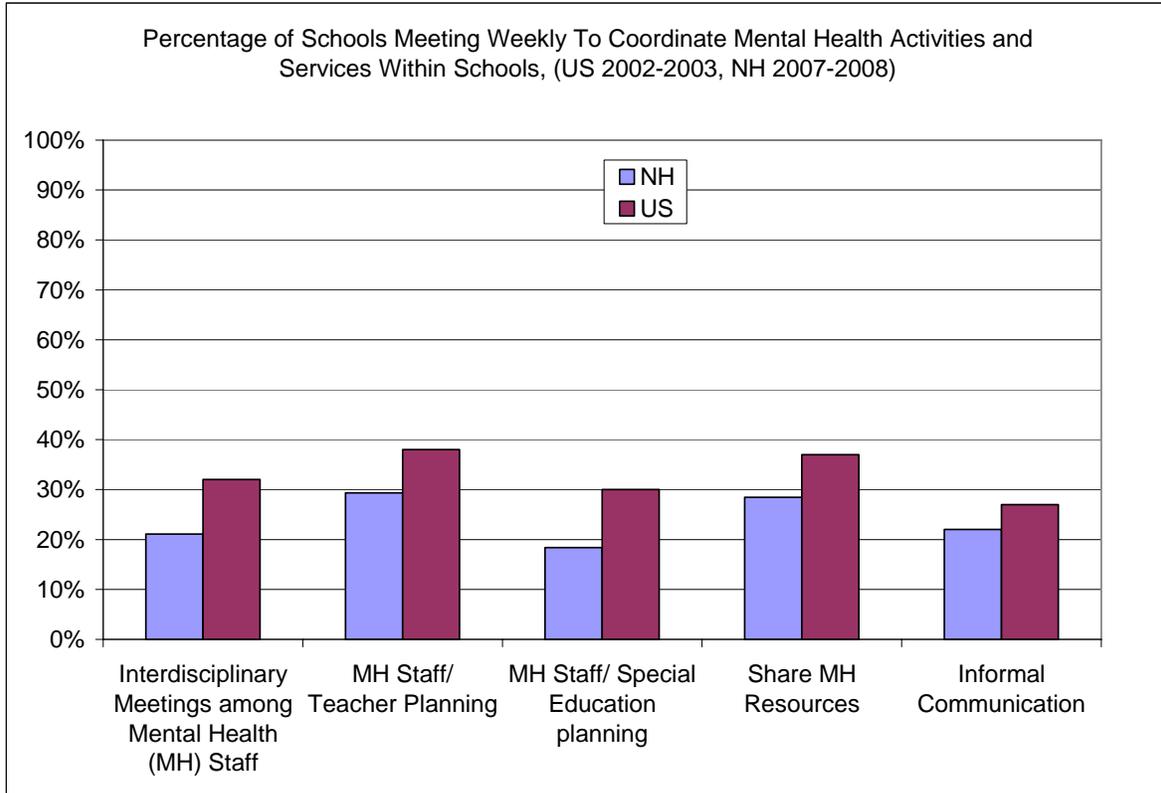
Staffing Mental Health Services

The most common types of staff providing mental health services in schools were school counselors and school psychologists (see Figure 18). Approximately 75% of schools indicated that they had at least one school counselor on staff, and almost 70% indicated that they had at least one school psychologist.   Both of these results were consistent with the results from the national survey in 2003. However, New Hampshire appears to be more likely to have substance abuse counselors and less likely to have school social workers on staff than is the norm based on the national data. Mental health counselors and clinical psychologists and psychiatrists were available much less.

Figure 18

Percentage of Schools with Various Types of Staff Who Provide Mental Health
Services
(NH=2007-2008, SAMSHA US=2002-2003)
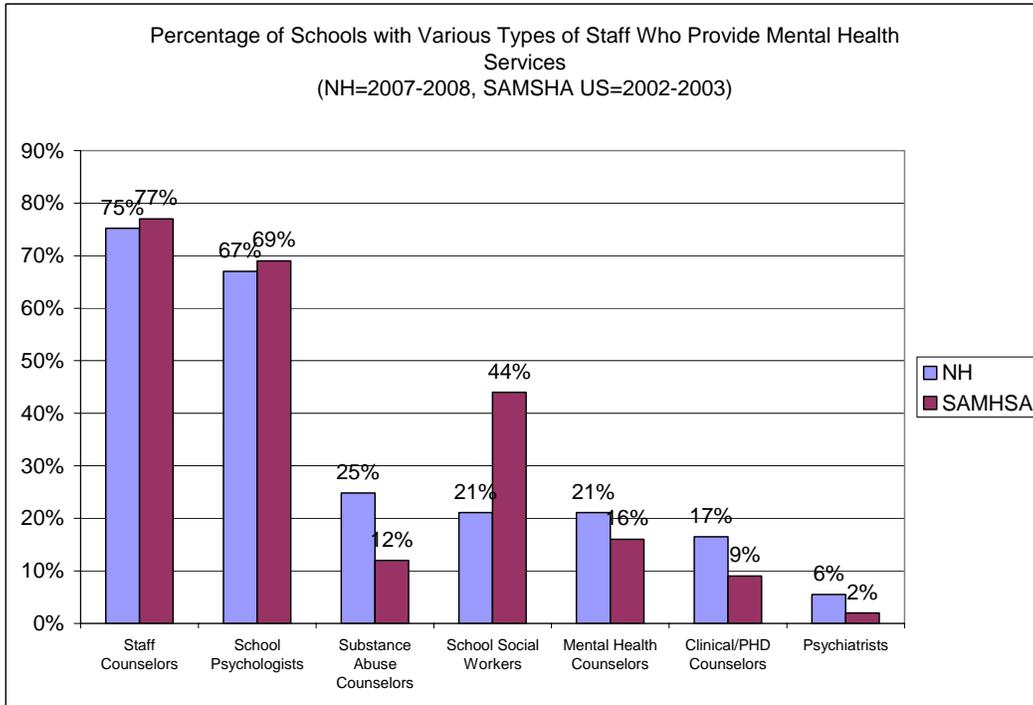
While the patterns in New Hampshire mirrored those of the US more generally with respect to who is providing services on staff, the degree of coordination of mental health activities within the school was less in New Hampshire than in the nation as a whole.   In the results of the SAMHSA survey, approximately one-third of all schools indicated that they had weekly meetings to coordinate activities among staff (see Figure 19). In New Hampshire, less than one-third of schools indicated that there was such coordination.

Figure 19

Percentage of Schools Meeting Weekly To Coordinate Mental Health Activities and Services Within Schools, (US 2002-2003, NH 2007-2008)

About one half of schools indicated that they contracted with community based providers to provide mental health services in New Hampshire.   This was consistent with the national experience, where approximately 49 percent used contracts or other formal arrangements for the management of services.   These contractual relationships were most likely in high schools in New Hampshire (see Figure 20).

Figure 20

Percent of Schools with a Formal or Contractual Agreement with a Community-Based Organization, 2007-2008
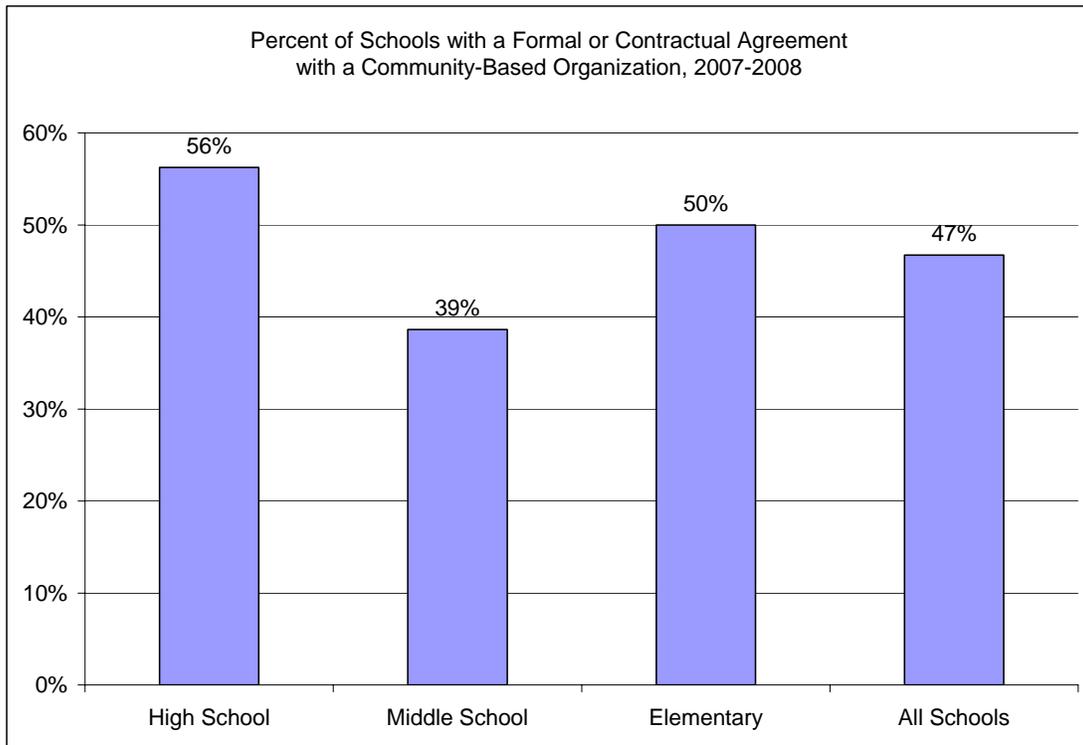
Schools are most likely to contract with individual practitioners to provide mental health services to children. As Figure 21 shows, 74% of schools indicated that they had a formal relationship with individual providers. A smaller share – 62% – indicated they had such relationships with a community mental health agency.

Figure 21

Most Frequent Community Partners for Those Schools with Formal or Contractual Relationships with Community-Based Organizations
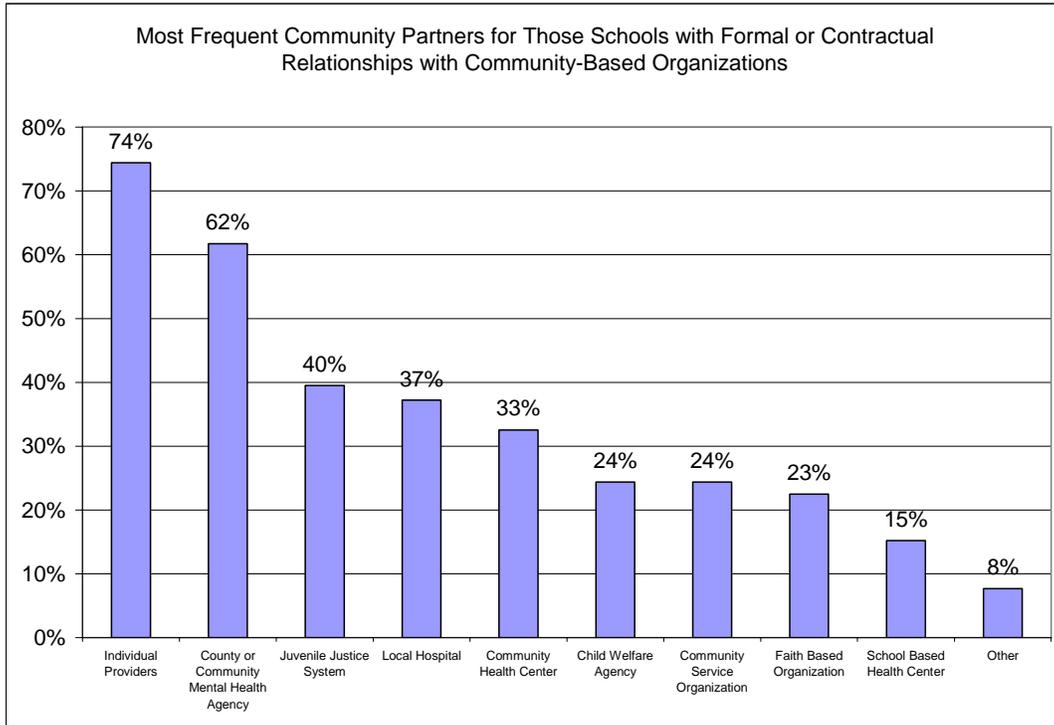
## *Data Collection on Mental Health and Schools*

Increasingly, health care practitioners across the spectrum of providers are recognizing the value of having access to timely data on the services that patients are receiving.   Mental health is no different. Timely data can be used by administrators to understand the mental health and well-being of the student body, as well as specifically identifying the needs of individual students, and perhaps most importantly, to track how the mental health resources are improving the mental health of students. Despite the clear value of such data, almost one-third of the schools do not provide any data on either mental health services or mental health services provided to special education students.   Of those that collect data on mental health services provided to students, almost one-third collect data for special education students only (Figure 22).

Figure 22
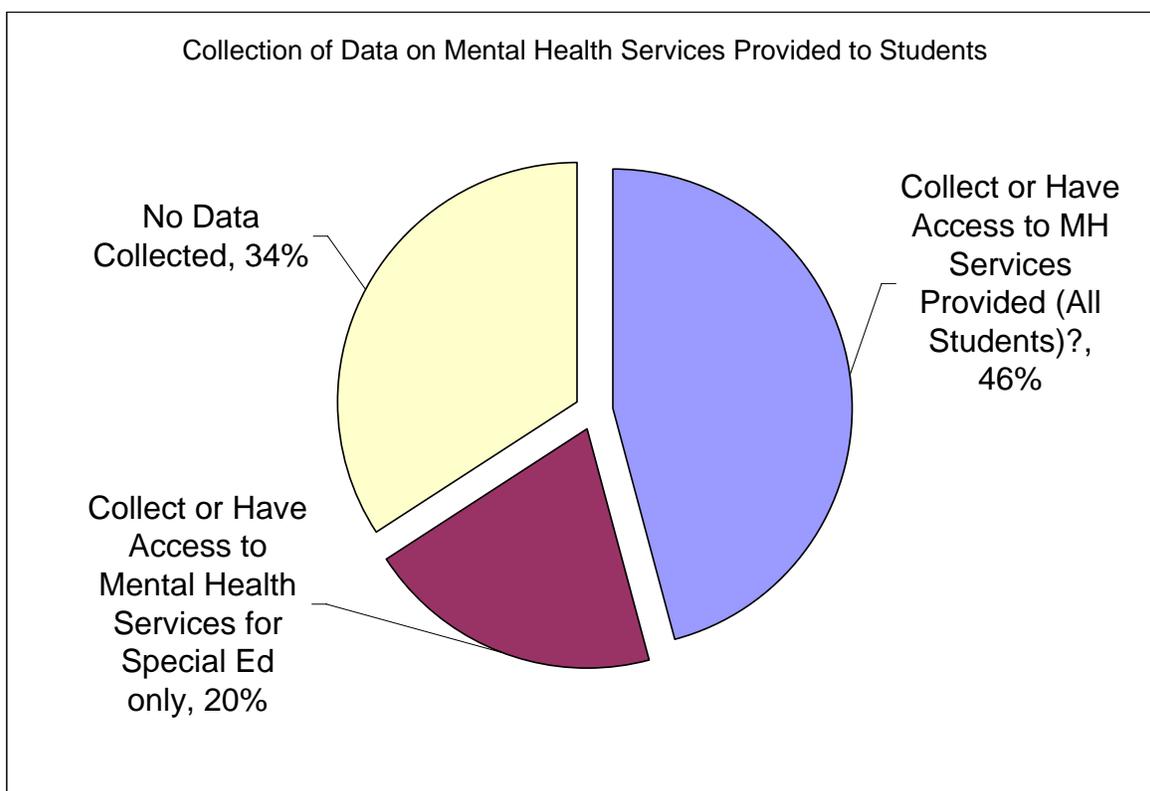
Although two-thirds of the schools reported collecting data on mental health services, less than half are collecting data that would help a school evaluate and assess who is receiving what services, at what costs, and with what outcomes. Only 40% of those that collect data collect data on the types of mental health problems they are experiencing in the school. Only 40% of those that collect data collect data on the types of school based services that are provided and the referrals to community mental health systems (Figure 23). Thus, most schools in the state do not have the information necessary to strategically guide school-based mental health programs, let alone evaluate its effectiveness.

Figure 23

Share of Schools that Collect Data on ....
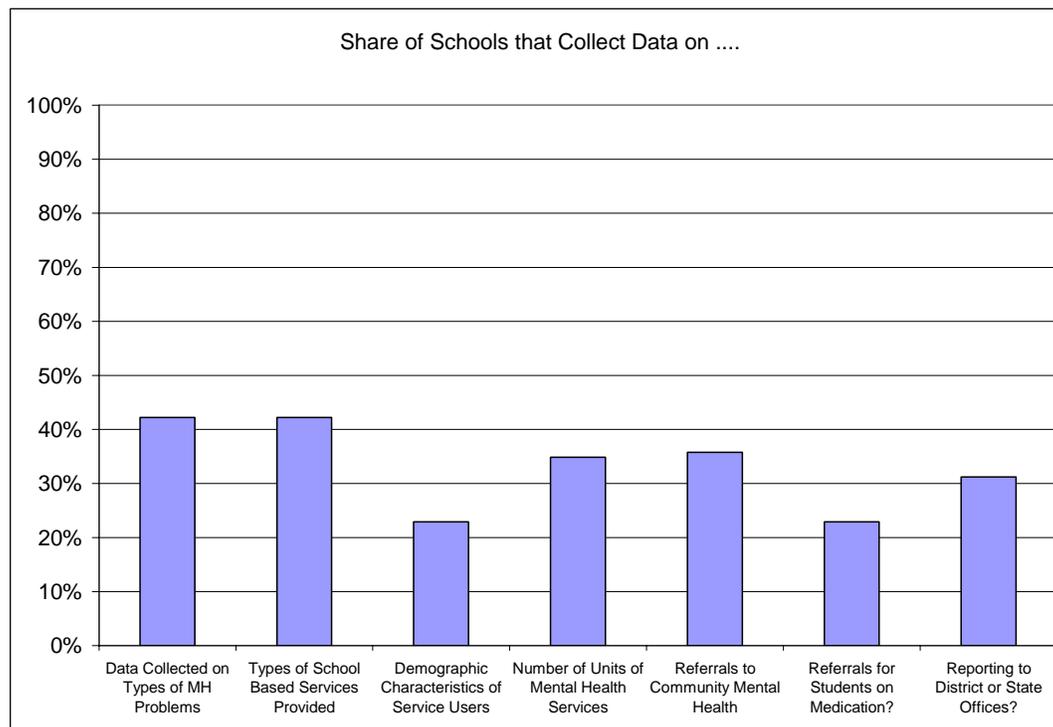
Schools and the Community Mental Health Centers

As discussed previously (Figure 5), 80% of school districts responding reported Medicaid as a source of funding for mental health services in schools. Like school mental health services, the Community Mental Health Centers (CMHC) are significantly supported by Medicaid to provide services to children. This suggests that potential partnerships between the two could maximize the benefit of Medicaid resources. In fact, a prior ad-hoc survey found that formal relationships between schools and the CMHCs exist across the state, but little was known about the administrative arrangements of these agreements.

Therefore, we assumed that the CMHCs would be the most common agency providing mental health services in the school setting, so we targeted their Children's Directors as a source of information to further our understanding of the system of school-based mental health services. However, as discussed above, the CMHCs were not the most common provider of services. But, the conversations that stemmed from this piece revealed a depth of insight into school-based mental health services and children's mental health across New Hampshire important in understanding the current system of services.

For this study, we interviewed the children's directors from the CMHCs to explore how formal (and informal) agreements to provide mental health services in schools function, as well as what challenges and barriers exist that influence school-based programs and engagement in mental health care for children in New Hampshire.

Our conversations with the children's directors of community mental health centers revealed that about 13% of New Hampshire's public schools have a school-based mental health service provided by a CMHC. As discussed above, schools are most likely to contract with an individual provider. And, although this figure seems contradictory to the data previously discussed, it is possible that, given the low response rate of the school survey, those schools that responded represent that vast majority of schools with formal relationships with a CMHC. Despite the low frequency of formal school-based services provided by a CMHC, every Community Mental Health Center reported ongoing informal relationships in almost all of the schools within their catchment area, particularly when referring children in need of services.

Schools are often a catalyst for initiating mental health services

Regardless of the presence of a school-based mental health services program, most interviewees reported that schools often initiate the process to engage a child in services and are a major source of potential referrals for children's mental health services. This is not surprising. Children spend a significant portion of their time at school, working closely with teachers and other school staff. As a natural result, the staff comes to know the children who attend their school and can, potentially, be the first to identify a behavioral issue.

Views on whether schools demonstrate adequate competency in the early identification of mental health problems were largely conflicted; a few feel that they may still not try to make a referral until a situation reached a crisis point. Some noted that the schools participating in a PBIS[7] program were better at identifying children with mental health needs earlier on. While often schools are not looking at the full spectrum of mental health issues because they are focused on educational functioning, schools often do, in fact, refer students with issues that fall outside those parameters.

Outside of special education students with services mandated by an IEP, schools do not directly refer children to CMHCs; rather, they will recommend to the family that their child would benefit from these services and will then call the clinic to provide a "heads up" and offer some perspective. Still, it is the parents' responsibility to enlist a CMHCs' services. Oftentimes, parental follow-up is lacking; a problem that remains a key source of frustration for schools.

Schools have had varying levels of effectiveness as a referral source ─ relationships and outreach by the CMHCs to schools and parents have been found to improve that effectiveness. For example, some CMHCs are working with schools on a facilitated referral process where the schools are more closely involved with the parents in hopes of improving follow-up in the treatment engagement process.

---

[7] Positive Behavioral Interventions and Supports (PBIS) is a program implemented in NH schools defined as "the systematic organization of school environments and routines that enable educators to increase the capacity to adopt, use, and sustain effective behavioral practices and processes for all students." From, Muscott et al., "PBIS in NH: Preliminary Results of a Statewide System for Implementing Schoolwide Discipline Practices." Education and Treatment of Children. 27:4. Nov 2004.

The types of school-based services provided and the agreements that govern them vary greatly across the state

The types of agreements and services provided vary greatly across CMHCs and the schools they work with. The most common arrangement, about two-thirds of schools with services provided by a CMHC, is for a therapist to be based in the school where children receive services just as the child would if they went to the clinic directly. The child remains a client of the CMHC and insurance is billed directly for services. The school generally provides only space (and sometimes phone, office supplies, internet access, etc.) for the clinician to see clients.

Half of the schools with CMHC-provided services have a Memorandum of Understanding (or other contract) for these arrangements that states the CMHC will provide an in-school therapist in exchange for space and other provisions; just as often though, these arrangements operate without any formal agreements. It was reported that many schools do not understand the structure of, or the need for, these agreements. Some principals, as reported by the CMHCs, prefer to forego such agreements to minimize potential red-tape at the district level; nonetheless, most CMHCs feel they are necessary.

Often, a school will contract with CMHC to provide only a specific service that is supported by grants or by funding reserved for students with an IEP or who require special education services. Group therapy, psycho-educational classes and/or consultation services to guidance counselors, or special education staff, are the most common. In very few cases will schools pay for services directly to the CMHC, and these rare occasions generally exist when they must provide a mandated service under a student's IEP.

Although there may not be a formal agreement between a school and its local CMHC, as noted above, schools are often the initiator for connecting children with services. And, as reported, many case managers or therapists working with a family will attend IEP meetings for their clients, often pro-bono, demonstrating that collaboration between community mental health and schools exists outside of formal arrangements.

Many challenges and barriers to care exist for school-based mental health programs

Several challenges and barriers to successful school-based services were reported in working with schools to provide services. In particular, insurance coverage and geography are the most prevalent issues that prevent children from receiving sufficient care for mental health issues ─ school-based or otherwise.

Managing Expectations

One of the challenges reported most often when working with schools concerned their expectations of mental health services and treatment. Although the schools and mental health providers share a common goal, there is a feeling that the school system lacks a sufficient understanding of the mental health system and the treatment process.

This situation is often most evident once a child is engaged in treatment. The CMHCs reported that schools, as well as the child's family, often take the stance that once a child has begun

treatment the responsibility of correcting behavioral issues lies completely within the role of the therapist. This is starkly inconsistent with the collaborative model the CMHC staff is used to working with.

This issue is also evident when it comes to the issue of confidentiality. Interviewees reported that obtaining permission from a parent enabling a clinician to share information with school staff tended not to be a barrier, and the survey results concurred – less than 10% of schools reported that confidentiality was a barrier to providing services. However, clinicians have reservations due to ethical issues with sharing information with the school, as they are not bound by the same privacy standards. While confidentiality waivers are common practice, the clinicians are still able to use their judgment when discussing a case with school staff. This presents a challenge for the therapists, as they must determine what information should be disclosed to school staff in order to best help the child's treatment, and what should be withheld because of privacy concerns. Interviewees report that often the school does not understand the dynamic, insomuch that clinicians works for the family – not the school – and as such, they must comply with parental wishes regarding treatment and the disclosure of information.

Logistics can also be an issue for providing services within a school. Even if space is available – which often proves difficult for a school to provide – tools to aid in treatment, such as a phone, computer, and internet access, are not always available to a clinician working in a school. Given the amount of administrative work required by Medicaid and many insurers, this can be a substantial hindrance to productivity.

Parental Engagement

One of the greatest challenges posed by children's directors was engagement with the family. In some cases, families of children referred through the schools may feel that the schools were interfering, which reduces parental buy-in of treatment. It is more often the case that the school experiences difficulty trying to connect a child in need of services due to the lack of parental follow through; forty percent of schools surveyed reported that "gaining parental cooperation and consent" was a barrier to providing mental health treatment. This increases frustration on the part of schools and the CMHC since there is only so much they can do because treatment requires parental consent.

Once a child in receiving treatment in a school setting, the parents do not typically accompany the child to their treatment session, reducing a clinician's opportunity to connect with the parents, in contrast to situations where treatment occurs at a clinic.

Furthermore, there are often mental health issues with other members of the family exacerbating the behavioral issues of the child. If that family member does not have access to appropriate mental health services (most often due to lack of coverage, which will be discussed later), it becomes a key challenge for treating the child. It is reported that schools do not appreciate the difficulty in treating a child in this particular situation due to a systemic misapprehension that the therapist can treat a child fully and quickly.

Resource Challenges

According to the CMHCs children's directors, many schools do not have the funding to hire internal mental health staff, and thus must turn to a community provider to obtain access to these services. Additionally, school funding is often inconsistent; with funding levels changing year-over-year, rendering the maintenance of a sustainable in-school program a significant challenge. In some cases, grants can bridge the gap between budget cuts; however, they are unsuitable as a long-term solution.

While our conversations found that training school staff about mental health, and the identification of potential mental health issues in particular, was an essential activity, such training programs lacked the necessary funding. Formal training was found to be relatively uncommon – more often, clinicians reported that informal training and clinical supervision with guidance counselors and other school staff was the norm. It is important to note, however, that MAST-NH has filled in some of these gaps in training for participating schools.[8]

Funding is not the only challenge faced by school-based mental health service programs. One of the most daunting challenges that exist is staffing these programs. Turnover, particularly in rural parts of the state, proves a daunting issue. Often, new school years can mean a new school-based provider. Staff turnover can create a perception of program instability or call into question the commitment level of the CMHC, subsequently presenting challenges for receiving referrals. Mental health professionals are often in short supply in general, with private practices and other organizations competing for the same limited resources. As long as the shortage of qualified mental health personnel remains a systemic issue, staff turnover will continue to be a significant challenge among school-based services as well.

These findings are supported by the results of the school survey. Half of the schools surveyed reported that community mental health resources were inadequate and 40% reported that resources for mental health services in general were inadequate.

Coverage and geography are not only significant barriers to mental health in schools, but to children's mental health services in every setting

The Community Mental Health Centers, as noted above, receive a substantial part of their financial support from Medicaid. Private coverage is also common, but self-pay is a rarity. Coverage is not a panacea; all of these payment options create barriers to initiating, engaging, and completing a successful treatment regimen for children with behavioral health issues, whether in the school setting or at the clinic.

Medicaid is the source of funding for the vast majority of children seen at the CMHCs, which will pay for case management and other support services. However, parents of children with Medicaid often do not have insurance coverage of their own, and, therefore, are not able to

---

[8] Mental Health and Schools Together – New Hampshire (MAST-NH), a "demonstration project in eight communities statewide is designed to integrate school and community mental health services for students needing comprehensive support for social, emotional, and behavioral challenges. The goal of the project will be to streamline the process and increase access to mental health and other community-based services to children and families in need." Definition from http://www.nhcebis.seresc.net/mast_nh. Accessed March 13, 2009.

engage in the treatment they require for themselves if they also have a mental illness. Interviewees agreed that the child is often a reflection of the mental health of the family, both due to heredity and because a parent's mental health issues can influence the mental health of the child. If the parent's mental health problems are not treated, it becomes increasing difficult for the child to improve with treatment. In some cases, this can also raise ethical issues regarding treating a child knowing that the problems could be exacerbated in his or her home life.

Among the privately insured with mental health coverage, parents generally are also insured and could receive services, but barriers to successful care still exist. First, private insurance often pays only for individual treatment and may not pay for family therapy. This is beneficial if a parent with mental health issues does engage in treatment. But, as noted above, the mental health of all family members has an influence on a child and family therapy may be the best treatment option.

Second, private insurance does not pay for support services. Even children with private coverage need some level of case management, the cost of which has to be built into the cost of providing treatment or done on a pro-bono basis. From the perspective of school-based services, this significantly impacts the level of involvement a clinician can have with consulting and collaborating with school staff, since these activities would not be paid for by private coverage

Third, private insurance often has a limit on the number of treatment sessions it will cover. Many children's directors reported that treatment plans, school-based or not, are altered to reflect these limits as parents would be unable to pay for services once insurance coverage was used up.

It is important to note that not all of the most serious cases occur with children who are covered by Medicaid. These children still require intensive services, but often lack sufficient coverage for the mental health services they need through private payers. In cases where students are privately insured, case management and many other non-billable services are often performed on a pro-bono basis by the clinician. This is certainly an area where additional resources could be beneficial to improve services for children who lack sufficient coverage.

And, children who are uninsured, covered under plans without mental health coverage, or covered under high-deductable plans experience heightened barriers to receiving sufficient services for behavioral health issues. In fact, 65% of schools reported that the financial constraints of the family were a significant barrier to providing mental health services for their children. This shifts the financial burden of providing funding to the CMHCs and/or to the schools they attend.

Beyond insurance coverage, transportation was reported as another barrier to receiving care across the state – a problem that is especially acute in rural areas, which makes geography an important factor in service provision. This problem was also reported by schools as well; half of schools cited transportation as a barrier to care. Factors such as work schedules and other family obligations create difficulties in treatment attendance at the clinic. In rural parts of the state, a family may live quite a distance from the CMHC and must not only make the time for the treatment appointment, but also the travel time. Additionally, the appointment time would be after school hours, posing a significant burden on a family and making it difficult to consistently

attend treatment. Several children's directors commented that treatment plans may be altered to try to accommodate family's travel burden; however, this comes at the sacrifice of a recommended treatment schedule. For example, a child who may benefit greatly from weekly sessions may only be able to commit to monthly sessions due to the burden of traveling to the clinic. On the other hand, that same child may be able to have those weekly sessions in a school-based setting, where transportation already has been provided and regular attendance is more likely.

Many factors influence whether a school has mental health services available

From the perspective of the CMHCs, several reasons impact a school's ability to support a mental health services program. Differences in funding, priorities and resources create a degree of variability in feasibility from district to district to supply these services to students. For example, the CMHCs in areas with the largest populations currently do not provide school-based services. It is assumed that these districts have the resources to hire a provider on staff or that these areas have a more ample availability of private practitioners to provide child services. However, Nashua is currently working with their local CMHC to coordinate school-based services for their schools.

Also, several conversations alluded to the idea that schools in the more affluent districts in the state had the least interaction with the staff at the CMHCs. The reasons for this are unclear; it is possible that those areas have wider access to private providers or hire their own mental health staff.

School administrations and school boards can be resistant to a school-based mental health program, according to several CMHC Children's Directors. The hesitation, it seems, stems from the idea that providing mental health services takes away from the school's mission of education. Children often must miss class time to attend treatment, which potentially detracts from their education. Experts in the mental health field counter that children with behavioral health issues have trouble learning; therefore, any mental health problems with a child should be addressed in order to maximize educational functioning. Reports from Children's Directors of CMHCs operating school-based services also cite that programs are more successful when the school administration shows leadership and commitment to providing mental health services for their students.

Furthermore, interviewees report that increasingly teachers feel pressured to perform the role of a social worker, which detracts from their duties as an educator. Again, those in the field assert that teachers can serve as an integral front line source for prevention and early detection of mental health problems among their students.

Finally, all children's directors reported that stigma still plays a role in mental health treatment and can influence the existence of school-based programs. However, as will be discussed later, school-based mental health services can also reduce the stigma associated with seeking care.

Open communication is seen as the greatest avenue to successful school/mental health collaborations

Many clinicians working in the schools highlighted several factors that have led to successful collaborations between CMHCs and schools. Buy-in from the administration and understanding from teachers and other staff was seen as the most important factor. Moreover, a close working relationship and open lines of communication with the special education staff tends to improve the success of service integration, as well as coordination for the children who need the most services. Their belief is that mental health can be a strong influence on educational performance and schools should realize the importance of that relationship.

Many children's directors cited the clinician's temperament and work-style as another factor that highly influenced successful school-based services programs. Schools tend to follow a team approach where many professionals work with a child to improve his or her educational performance. A clinician who is not only trained to work with children, but also one that can work within this team-driven atmosphere will tend to experience greater success with the in-school model.

Overall, among interviewees who reported programs that worked well, it was found that ongoing, open communication with all stakeholders – school staff, clinicians, and parents as well as other social service agencies – was essential to the success of a school-based program. And, this is viewed as essential to the success of any treatment engagement for children. In more than one instance, especially in rural parts of the state, collaboration among agencies was reported to be critical to maximizing the impact of scare resources.

Even with many challenges, school-based mental health services has the potential to increase access and improve treatment

Respondents noted that school-based mental health services have several benefits. They increase access and improve treatment for the children they serve. And, they create community partnerships with organizations that share the vision of improving the lives of children.

Children receiving care in schools are far more likely to have consistent attendance to treatment since children are legally required to attend school. Increasing attendance is critical in improving treatment outcomes. Given the burden of transportation to the clinic, school-based sessions have a significant advantage.

Another advantage to providing services in the school setting is the ability to consult with teachers and other school staff. As discussed previously, children spend a significant amount of time at school under the close observation of teachers and staff. Clinicians have the advantage of gaining the perspective of these educators in evaluating a child's behavior and subsequent progress rather than relying solely on the perspective of the family.

Even with its benefits, the school is not necessarily the best setting for delivering services. The seriousness and type of mental health issues influences the appropriateness of school-based mental health services. The treatment for some issues does not render a school setting ideal. In cases such as trauma, it is possible that a child could be emotionally disturbed during treatment

and would experience difficulty when they are expected to return to class and focus. This is reported to be a concern from school administration as well as clinicians.

Overall, and most importantly, the vast majority of the Children's Directors interviewed felt that school-based mental health services increased the access to care for children who otherwise would not receive it. Many of the children treated in the school setting would not engage in services in a clinical setting. The willingness reported among all the CMHCs to provide services in the school setting is an opportunity for collaboration to increase access to and improve mental health treatment for children statewide.

Appendix 1: Interpretation of Results and Statistical Precision

Source of error in the survey methodology can be introduced through a variety of different factors. Two of the primary sources of error in conducting surveys are sampling error and response bias. Most surveys introduce potential sampling error into the study by selecting a sub-set of the full population to which to send the survey. In our case, we sent the survey to all schools and all districts. Therefore, there is no sampling bias.

There is, however, the possibility of response bias – that is, those that responded to the survey are different in ways that would be important to understanding mental health services in New Hampshire schools. If the schools that responded are significantly different in terms of size and geography, and size and geography are closely related to the issue under study – mental health services – then we should be concerned about whether our results are generalizable to the broader community of schools being studied.

In order to assess whether the respondents in our survey were similar to those in the broader population, we compared our survey respondents to the broader group of schools on three dimensions: the share of total enrollment that was enrolled in free and reduced lunch programs, the size of the schools, and the geographic location of the schools. This provides us with answers to the question of whether or not we have a group of respondents that are similar in terms of the economic status of the communities (using the share of enrollment that is eligible for free and reduce lunch), the geography and the size.

Figure Appendix 1-A shows the distribution of schools by school size for our survey respondents and for schools generally in the state. Our survey respondents are slightly more likely to be from the smaller schools in the state.
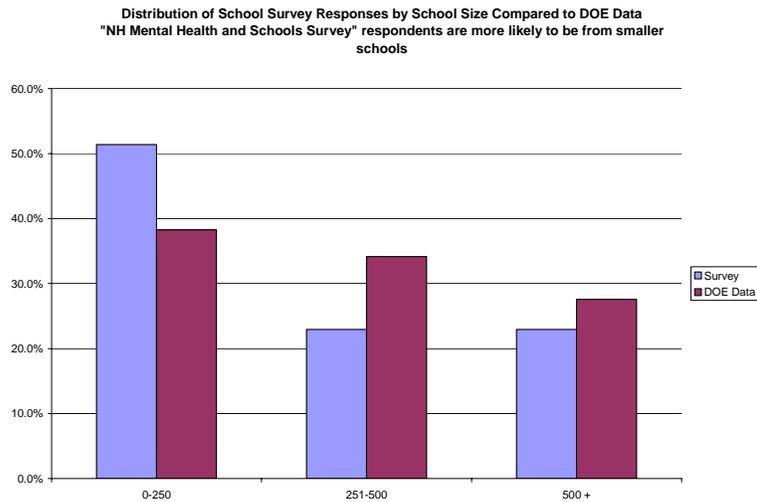
Figure Appendix 1-A

Figure Appendix 1-B shows the distribution of schools by the county in which the school resides. The distribution of schools is roughly similar across the state with two exceptions. The survey under-represents schools in Hillsborough County and over-represents respondents in Rockingham County. This would make geographic comparisons difficult, but would not be problematic unless either Hillsborough County or Rockingham County were significantly different in terms of the underlying characteristics of school mental health provision.

Figure Appendix 1-B

Distribution of Survey Respondents in Survey Compared to DOE Data
Under-represents Hillsborough; Over-represents Rockingham
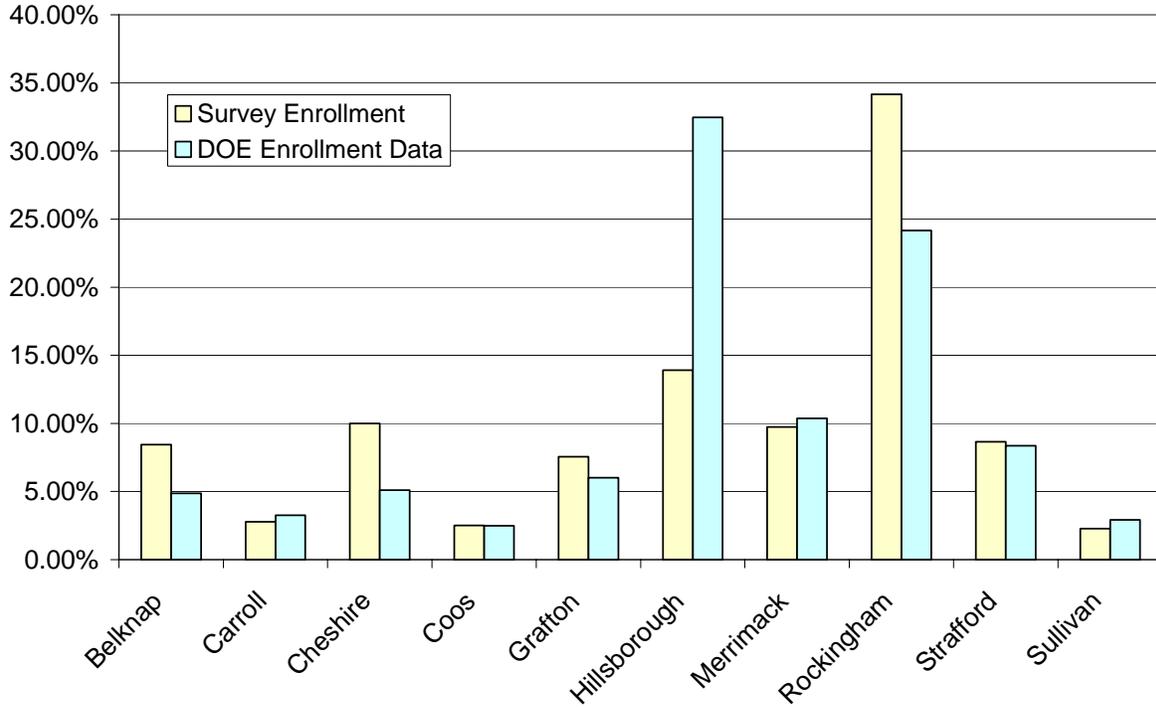
Potentially more important, if the schools that responded to the survey were more likely to be providing mental health services than those that did not, then the results are not generalizable to the community of schools at large. Assessing this is difficult, because the point of this survey was to understand this very issue. That is, there is not great information against which we could assess our survey results. As part of the survey, however, we built in a question regarding the school's use of positive behavioral interventions and supports. Moreover, from the New Hampshire Center for Effective Behavioral Interventions and Supports (NH CEBIS) – we have a good understanding of the number of schools that have worked with NH CEBIS on the implementation of PBIS. Thus, if the share of the survey respondents reporting PBIS in their schools was similar to that in the data reported by PBIS, our results are likely representative of the provision of mental health services generally across the state. Figure Appendix 1-C shows the share of survey respondents reporting PBIS in their schools compared to the data provided by NH CEBIS. This data suggests that survey respondents were slightly more likely to report PBIS services than the NH CEBIS data would suggest.

Figure Appendix 1-C

Share of Schools Claiming PBIS through NHCEBIS
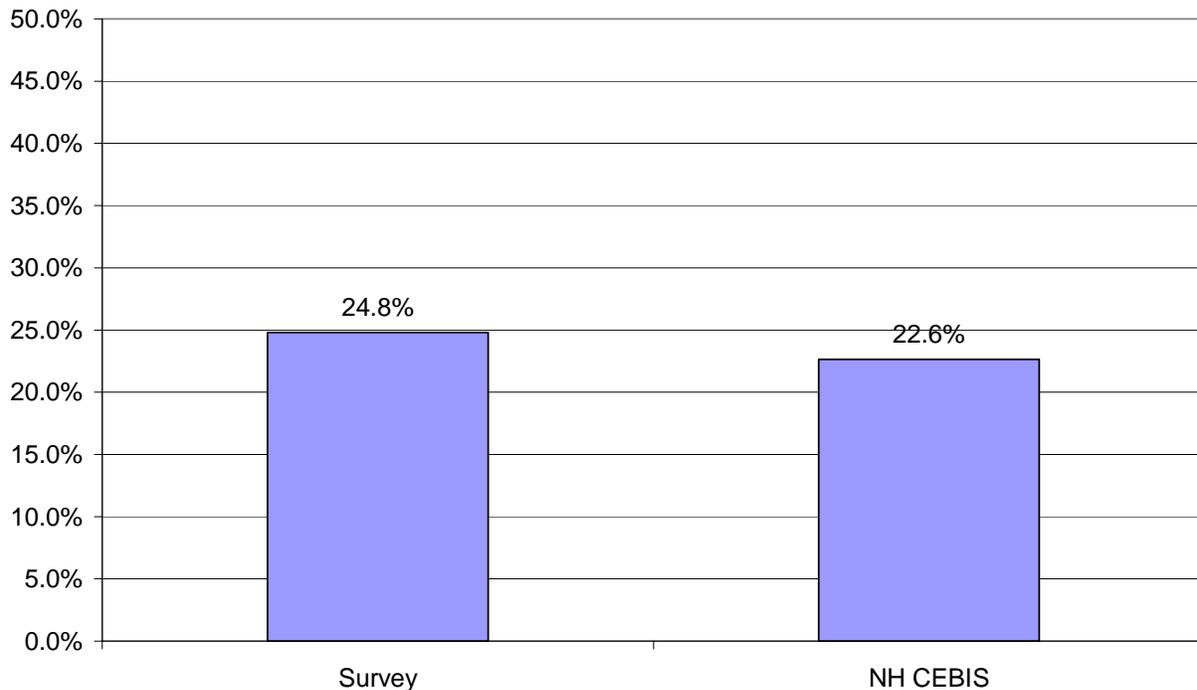
Appendix 2: Survey to Schools

Survey of the Characteristics and Funding of School Mental Health Services 2007-2008

School Questionnaire

This survey was originally sponsored by the Substance Abuse and Mental Health Services Administration as part of a national evaluation of mental health and schools.   The Endowment for Health and the New Hampshire Center for Public Policy Studies are conducting this survey to enhance the state's understanding of mental health service provision and schools. <u>Results for individual schools will be kept confidential.</u> Aggregate results will be used to enhance the Endowment for Health's funding of projects in support of mental health services in schools and to better understand the current policy environment.

Should you have questions about the content of the survey, please contact the NH Center for Public Policy Studies at 603-226-2500.
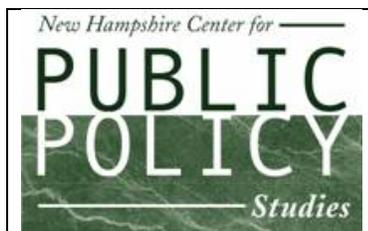
Definitions

The focus of this survey is on mental health interventions for students in your school.

Mental health interventions are defined as:

Those mental health services and supports delivered to individual students who have been referred and identified as having psychosocial or mental health problems.

When answering questions about these mental health services include:

Mental health services for all students, both special education and general education students;

All mental health services supported by your district or school, both those provided directly by the school or district and those provided by community-based organizations with which your school or district has a contractual or formal agreement;

Mental health services delivered in district/school settings and in community settings if provided through contract or formal agreements;

Mental health services delivered by mental health staff whether they are school-based, district-based, or community-based if provided by organizations or providers with which the school or district has a formal agreement for services.

We realize that many schools also have **preventive mental health programs** for the broader student body. You will have an opportunity to tell us about those programs in item 28. For the purpose of that item please use the following definition:

Preventive mental health programs are those programs, activities and curricula provided to the general student population for the purpose of preventing social, emotional and adjustment problems.

If you have any questions about this questionnaire,

please call the NH Center for Public Policy Studies at 603-226-2500.

Basic School Characteristics
Before we ask you questions specifically about mental health services in your school, we would like some information about basic characteristics of your school. **You may have to ask someone in the school office for some of this information**.
On or about the first of October of this school year, what was the total enrollment in your school?

[_____] students

Students identified as limited English proficient or English language-learners .... _____

Students with an Individualized Education Program (IEP) as defined by the Individuals with Disabilities Education Act (IDEA) .... _____

Students eligible for free or reduced-price lunch .... _____

For the current school year (2007-2008), please check the box for each grade offered at your school.

☐ Pre-kindergarten

☐ Kindergarten

☐ 1 st

☐ 2 nd

☐ 3 rd

☐ 4 th

☐ 5 th

☐ 6 th

☐ 7 th

☐ 8 th

☐ 9 th

☐ 10 th

☐ 11 th

☐ 12 th

Of the total number of students enrolled in your school as reported in item 1, how many are:

American Indian or Alaska Native____
Black, not Hispanic   _____
Hispanic   _____
White, not Hispanic   _____

Of the total number of students enrolled in your school as reported in item 1, how many are:

Delivery of Mental Health Services
The next questions ask about delivery of mental health services in your school and relationships with the school district.
Mental health services are defined as: **Those services and supports delivered to individual students who have been referred and identified as having psychosocial or mental health problems.**
5. Which students may receive these mental health services?

☐   a. All students

☐   b. Special education students only

6. How are mental health services managed in your school?
(Check all that apply)

☐   a. One person or team manages mental health services for all students (both general education and special education).

☐   b. One person or team manages mental health services for special education students only.

☐   c. One person or team manages mental health services for general education students only.

☐   d. No one manages mental health services at this school.

☐   e. Other _____
(please describe)

7. Does your district operate a mental health unit or clinic?

☐   Yes

☐   No [SKIP to Item 9].

8. Where is this MH unit or clinic located?

☐   In this school

☐   Outside this school

9. Does your school work with community agencies to provide mental health services for students in your school?

☐   Yes

☐   No

Who has responsibility for each of the following functions for mental health services provided to GENERAL EDUCATION students in your school?

Check all that apply

	NA	School	District	Collaborative/ Intermediate Unit
Allocating funds for MH services	☐	☐	☐	☐
Establishing policies, guidelines or standards on MH service delivery	☐	☐	☐	☐
Determining the number and types of MH staff needed in your school	☐	☐	☐	☐

Hiring mental health staff	☐	☐	☐	☐
Supervising MH staff	☐	☐	☐	☐
Planning in-service training and professional development for MH staff	☐	☐	☐	☐
Administering contracts or agreements with outside organizations or agencies providing MH services	☐	☐	☐	☐

11. Who has responsibility for each of the following functions for the mental health services provided to SPECIAL EDUCATION students in your school?

		Check all that apply		
	NA	**School**	**District**	**Collaborative/ Intermediate Unit**
Allocating funds for MH services	☐	☐	☐	☐
Establishing policies, guidelines or standards on MH service delivery	☐	☐	☐	☐
Determining the number and types of MH staff needed in your school	☐	☐	☐	☐
Hiring mental health staff	☐	☐	☐	☐
Supervising MH staff	☐	☐	☐	☐
Planning in-service training and professional development for MH staff	☐	☐	☐	☐
Administering contracts or agreements with outside organizations or agencies providing MH services	☐	☐	☐	☐

<u>Mental Health Staff in School</u>
The next questions ask about the types of staff providing mental health services to students enrolled in your school.

12. How are MH services staffed in your school?
(Check all that apply)

☐   Mental health staff are school-based. (i.e. employees of the district or school who are assigned to this school and work only in this school).

☐   Mental health staff are district-based. (i.e. employees of the district who are assigned to the district and travel to different schools, spending only part of their time in this school).

☐   A collaborative or intermediate unit provides the MH staff.

☐   A community provider or organization provides the MH staff.

☐   Other (please describe) _____

13. On average, circle how frequently your school staff uses the following strategies to coordinate activities and services for students in your school.

	(1)	(2)	(3)	(4)
Interdisciplinary team meetings among MH staff	**Weekly**	**Monthly**	**Quarterly**	Rarely **or never**
Joint planning sessions between MH staff and regular classroom teachers	**Weekly**	**Monthly**	**Quarterly**	Rarely **or never**
Joint planning sessions between MH staff and special education teachers	**Weekly**	**Monthly**	**Quarterly**	Rarely **or never**
Professional development on MH topics for regular school staff	**Weekly**	**Monthly**	**Quarterly**	**Rarely or never**
Sharing of MH resources among school staff (e.g. printed materials, videos, exchange of referral info.)	**Weekly**	**Monthly**	**Quarterly**	**Rarely or never**
Informal communication about MH issues or services (phone, e-mail) among school staff	**Weekly**	**Monthly**	**Quarterly**	**Rarely or never**

14. How many of the following staff provide mental health services to students in your school? Include both school-based and district-based staff.
In **column 1** indicate the total number for each type of staff that your school has. Put in '0' for none. Of the total, indicate the number who are fulltime **(column 2)** or part-time **(column 3)**. In **column 4** indicate the percent of time (on average) each type of staff spends providing mental health services to students.

School Staff	(1) Number of positions	(2) Number Full-time	(3) Number Part-time	(4) Percent Time
School counselor ………………………	____	____	____	_____%
Mental health counselor ………………	____	____	____	_____%
	____	____	____	_____%
School social worker …………………..				
School psychologist ……………………	____	____	____	_____%
PhD-level clinical psychologist or counseling psychologist ………………	____	____	____	_____%
Alcohol/substance abuse counselor ….	____	____	____	_____%
School nurse …………………………..	____	____	____	_____%
Psychiatrist …………………………...	____	____	____	_____%
Other staff positions (e.g. outreach worker, behavioral aide, peer counselor)	____	____	____	_____%

15. Of the total staff in each category reported in column 1 of item 14, indicate in column 1 the number with a master's degree or higher in their field. In column 2 indicate the number with licensure or certification in their field.

School Staff	(1) Number with Master's degree or higher in their field	(2) Number with inlicense or certificate in their field
School counselor	____	____
Mental health counselor	____	____
School social worker	____	____
School psychologist	____	____
PhD-level clinical psychologist or counseling psychologist		____
Alcohol/substance abuse counselor ...	____	____
School nurse	____	____
Psychiatrist	____	____
Other staff positions (e.g. outreach worker, behavioral aides, peer counselor)	____	____

Arrangements with Community Organizations and Individual Providers

16. Does your school or district have formal or contractual agreements with any community-based organizations or individual providers to provide mental health services to students enrolled in your school?

☐ Yes

☐ No **[Skip to item 18]**

17. For each of the following community-based organizations or individual providers, indicate in column 1 whether or not your school has an agreement, in column 2 where the service is provided, and column 3 who pays for the service.

Community-based organizations	(1) YES	NO	(2) If YES, where provided (Check one or both) In school	In community	(3) If YES, paid by (Check all that apply) School or district	Community (e.g. agency or county)	3rd party payment (Medicaid, private)	Grant funds
School-based health center operated by a community-based organization	☐	☐	☐	☐	☐	☐	☐	☐
Community health center or clinic (public or private)	☐	☐	☐	☐	☐	☐	☐	☐
County or community mental health agency or center ………......	☐	☐	☐	☐	☐	☐	☐	☐
Local hospital …….......................	☐	☐	☐	☐	☐	☐	☐	☐
Child welfare agency …...............	☐	☐	☐	☐	☐	☐	☐	☐
Juvenile justice system or court	☐	☐	☐	☐	☐	☐	☐	☐
Faith-based organizations	☐	☐	☐	☐	☐	☐	☐	☐
Community service organization (e.g. YMCA, Boys & Girls Club)…	☐	☐	☐	☐	☐	☐	☐	☐
Other, describe _____ ….	☐	☐	☐	☐	☐	☐	☐	☐
Individual Providers Psychologist, psychiatrist, social worker, or mental health counselor.	☐	☐	☐	☐	☐	☐	☐	☐

18. What are your general practices for routine referrals to and coordination with community-based organizations or providers?

☐ Staff make passive referrals (e.g. give brochures, lists, phone numbers of providers)

☐ Staff make active referrals (e.g. staff complete form with family, make calls or appointments, assist with transportation.)

☐ Staff follow-up with student/family (e.g. calls to ensure appointment kept, assess satisfaction with referral, need for follow-up)

☐ Staff follow-up with provider (via phone, e-mail, mail)

Staff attend team meetings with staff of community providers

☐

    Other _____ (please describe)

☐

<u>Psychosocial or Mental Health Problems</u>
The next questions ask about the types of psychosocial or mental health problems that are seen in your school.
19. Using the code list below, rank the 3 most frequent problems for each group:
(Use the letter codes a. to n. to indicate the problem.)

Female students   **Male students**

1 st _____   1 st _____
2 nd _____   2 nd _____
3 rd _____   3 rd _____

20. Overall, which problem uses most of your school's mental health resources (e.g. staff time, materials)?
(Use letter code to indicate the problem.)
_____
Code list of psychosocial or mental health problems for questions 19 and 20.
Use the letter code to indicate the problem.
Adjustment issues (e.g. difficulty managing transition to new school, new grade or class)
Social, interpersonal or family problems
Anxiety, stress, school phobia
Depression, grief reactions
Aggressive/disruptive behavior, bullying
Behavior problems associated with neurological disorders (e.g., attention deficit disorder with or without hyperactivity, epilepsy, Tourette's syndrome)
Delinquency and gang-related problems
Suicidal or homicidal thoughts or behavior
Alcohol/drug problems
Eating disorders
Concerns about gender or sexuality
Experience of physical or sexual abuse
Sexual aggression, including harassment
Major psychiatric or developmental disorders (e.g., psychosis, bipolar disorder, Autism)

<u>**Mental Health Services Provided to Students in your School**</u>
21. Does your school provide the following services, either directly or through a community based organization with which you have a formal arrangement? If YES, also indicate who provides the service.

	YES	NO	**If YES, check all that apply** Provided by school or district staff	Provided by community staff
Assessment for emotional or behavioral problems or disorders (including behavioral observation, psychosocial assessment, and psychological testing)	☐	☐	☐	☐
Behavior management consultation (with teachers, students, family)	☐	☐	☐	☐
Case management (monitoring and coordination of services)	☐	☐	☐	☐
Referral to specialized programs or services for emotional or behavioral problems or disorders (e.g. eating disorders) ……………………………	☐	☐	☐	☐
Crisis intervention .... ……..	☐	☐	☐	☐
Individual counseling/therapy …….	☐	☐	☐	☐
Group counseling/therapy	☐	☐	☐	☐
Substance abuse counseling …..	☐	☐	☐	☐
Medication for emotional or behavioral problems ……………	☐	☐	☐	☐
Referral for medication management	☐	☐	☐	☐
Family support services (e.g. child/family advocacy, counseling)	☐	☐	☐	☐

22. How many students in your school received one or more of the above mental health services during the last school year (2001-2002)?
_____ (number) OR _____ (%)

23. Using the following scale from 1 to 4 where "1" is "not difficult" and 4 is "very difficult", circle the degree of difficulty that your school has in providing the following mental health services for your students. (Check NA if service is not available in your school).

	Not Difficult — > — > — > — >			Very Difficult	NA
assessment for emotional or behavioral problems or disorders (including behavioral observation, psychosocial assessment, and psychological testing)	1	2	3	4	☐
Behavior management consultation (with teachers, students, family)..................	1	2	3	4	☐
Case management (monitoring, coordination of services)	1	2	3	4	☐

Referral to specialized programs or services for emotional or behavioral problems or disorders (e.g. eating disorders.......................   **1**   **2**   **3**   **4**   ☐

Crisis intervention ....   **1**   **2**   **3**   **4**   ☐

Individual counseling/therapy ....   **1**   **2**   **3**   **4**   ☐

Group counseling/therapy ....   **1**   **2**   **3**   **4**   ☐

Substance abuse counseling ....   **1**   **2**   **3**   **4**   ☐

Medication for emotional or behavioral problems ......   **1**   **2**   **3**   **4**   ☐

Referral for medication management ....   **1**   **2**   **3**   **4**   ☐

Family support services (child/family advocacy, counseling) ....   **1**   **2**   **3**   **4**   ☐

24. Using the following scale from 1 to 4 where "1" is "not a barrier" and "4" is a " serious barrier", circle the extent to which each of the following is a barrier in delivering mental health services to your students.

	Not a —> —> —> Serious barrier			barrier
School mental health resources are inadequate to meet student needs (e.g. waiting lists, limited space or staff availability)	1	2	3	4
Competing priorities take precedence over mental health services	1	2	3	4
Protecting student confidentiality	1	2	3	4
Gaining parental cooperation and consent	1	2	3	4
Financial constraints of families (can't afford services or lack of insurance)	1	2	3	4
Stigma associated with student receiving mental health services	1	2	3	4
Language and cultural barriers of students or families	1	2	3	4
Community mental health resources inadequate to meet student needs	1	2	3	4
Inadequate coordination/collaboration between school staff and community providers	1	2	3	4
Transportation difficulties for students to travel to service providers………………………………………………….	1	2	3	4

Data Collection and Reporting

The next questions ask about data your school collects and reports on mental health services for students.

25. Does your school collect or have access to data on mental health services provided to students in your school?

____   Yes, for all students

___   Yes, for special education students only

___   No data collected **[SKIP to 28]**

26. What data are collected? (Check all that apply)

☐   Types of mental health problems presented by students

☐   Types of school-based mental health services provided

☐   Demographic characteristics of students who receive services

☐   Number of units of mental health services delivered

☐   Referrals to community mental health providers

☐   Referrals for students on medication

27. How does your school use these data? (Check all that apply)

☐   Reporting to district or state offices

☐   Developing training and professional development programs for various school staff

☐   Planning and evaluation of school-based mental health services and resources

☐   Planning and evaluation of arrangements with community-based mental health providers

☐   Other uses for the data (please describe)
          _____

Preventive and Early Intervention Programs

28. Does your school provide any of the following prevention and early intervention programs or services?

School-wide screening for behavioral or emotional problems	Yes	No
Kindergarten screening for social-emotional problems	___	___
Health class inventory	___	___
if so at what grade level(s)_____		
Columbia Teen Screen Survey	___	___
My Voice Student Aspirations Survey	___	___
Systematic Screening for Behavioral Disorders/BASC-2	___	___
Youth Risk Behavior Survey	___	___
Other _____	___	___

Please tell us how your school responds if concerns about an individual student are raised through any of the above screening processes.

_____

_____

_____

_____

Curriculum-based programs to enhance social and emotional functioning and reduce barriers to learning	**Yes**	**No**
PBIS through NH CEBIS	___	___
(Positive Behavioral Interventions and Supports through NH Center for Effective Behavioral Interventions and Supports)		
Responsive Classroom	___	___
Other _____		

School-wide strategies to promote safe, drug-free schools
Safe Schools/Healthy Students Initiative (please describe)

Alcohol/tobacco/drug use prevention (please describe)

Prevention and pre-referral interventions for mild problems (please describe)

Outreach to parents regarding student mental health (please describe)

Peer counseling/mediation, support groups

29. Please tell us what you think is the most successful approach or strategy that your school is using to improve the mental health of students.

_____
_____
_____
_____
_____

Please provide the name, title and contact information of the person who completed this survey. This information will be used only for following up with questions regarding this survey.
Name: _____

Title: _____

Phone: _____

E-mail: _____

If more than one person was involved in completing this survey, please indicate who.

☐ Principal

☐ Assistant Principal

☐ Director of Mental Health Services (or Student Support Services)

☐ School secretary _____

☐ School counselor, school psychologist, school social worker or other mental health staff

☐ Other (Please provide title)_____

If you have any comments you would like to make about this survey or about funding mental health services, please use the space below.

Appendix 3: Survey to Districts

Survey of the Characteristics and Funding of School Mental Health Services 2007-2008 District Questionnaire

---

This survey was originally sponsored by the Substance Abuse and Mental Health Services Administration as part of a national evaluation of mental health and schools.   The Endowment for Health and the New Hampshire Center for Public Policy Studies are conducting this survey to enhance the state's understanding of mental health service provision and schools. Results for individual school districts will be kept confidential. Aggregate results will be used to enhance the Endowment for Health's funding of projects in support of mental health services in schools and to better understand the current policy environment. Should you have questions about the content of the survey, please contact the NH Center for Public Policy Studies at 603-226-2500.
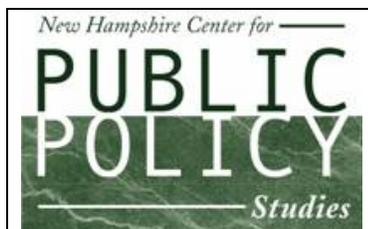
The focus of this survey is on mental health interventions for students in your district. The following definitions are furnished for your convenience:

Mental health interventions are defined as services and supports delivered to individual students who have been referred and identified as having psychosocial or mental health problems.

When answering questions about these mental health services, please include:

Mental health services for all students, both special education and general education students.

Mental health services supported by your district, both those provided directly by the district or schools, and those provided by community-based organizations with which your district or schools have a contractual or formal agreement;

Mental health services delivered in district/school settings and in community settings, if provided through contract or formal agreements;

Mental health services delivered by mental health staff (whether they are school-based, district-based, or community-based staff) if provided by organizations or providers with which the school or district has a formal agreement for services.

Instructions:
- ❑ All questions refer to the current school year, unless otherwise specified.
- ❑ Return your questionnaire in the envelope provided to:
***

If you have any questions about this questionnaire, please call the NH Center for Public Policy Studies at 603-226-2500.

We would like to know how your district is organized to deliver mental health services to students. In particular, we are interested in whether your system for providing mental health services includes services for all students, both general education and special education students, or whether you have separate systems, one for general education students and one for special education students.

1.   Which students receive district-supported mental health services?

❑₁   All Students

❑₂   Special Education students only

2.   Where is administrative responsibility for district-supported student mental health services located? [Check all that apply].

❑₁   At the school district

❑₂   At an Intermediate Unit, or Collaborative or Cooperative - An administrative unit smaller than the state which exists primarily to provide consultative, advisory, administrative, or statistical services to local education agencies, or to exercise regulatory functions over local education agencies. It may operate schools contract for school services. Where there is a supervisory union board, the union is included as an intermediate unit.

❑₃   Each school administers its own mental health services

❑₄   No unit has administrative responsibility

❑₉₅ Other (Please describe) _____

3.   Are services for general education and special education students administered together by one unit or staff or separately by different units or staff?

❑₁   Together

❑₂   Separately

❑₃   No unit has administrative responsibility

4.   Which of the following statement(s) describe the arrangement for staffing mental health services for students in your district? [Check all that apply].

❑₁   Mental health staff are **school-based** (i.e. each staff person is   assigned to an individual school and works only in that school).

❑₂   Mental health staff are **district-based** (i.e. each staff person is assigned to the district and travels to different schools to provide mental health services).

❑₃   Schools or clusters of schools determine what combination of staff meet their needs and assign staff accordingly.

❑₄   District operates a mental health unit or clinic that serves multiple schools.

❑₅   Mental health staff are provided through contracts with outside providers.

❑₉₅   Other arrangements. Please describe*:*

 Are mental health services in your district budgeted separately from other education expenditures?

❑₁   Yes

    ❑₂   No

 6.   Are mental health services for special education students budgeted separately from those for other students?

            ❑₁ Yes

❑₂   No

❑₃   Not Applicable

7.   **The next series of questions ask about the sources of funding used to support mental health services for the students in your district.**
     In the first column please check either "YES" or "NO" to indicate whether or not your district uses the source for mental health services. For each funding source <u>used</u>, check if used for prevention activities, intervention activities or both.

		Is source used for mental health services?		If Yes - Check if source used for…	
		Yes	**No**	**Prevention Activities?**	**Intervention Activities?**
Federal sources	a. Individuals with Disabilities Education Act (IDEA)	❑₁	❑₂	❑₁	❑₂
	b. Title I	❑₁	❑₂	❑₁	❑₂
	c. Community Mental Health Services Block Grant	❑₁	❑₂	❑₁	❑₂
	d. Title IV - Safe & Drug-Free Schools and Communities	❑₁	❑₂	❑₁	❑₂
	e. Safe Schools, Healthy Students Initiative	❑₁	❑₂	❑₁	❑₂
State sources	f. State Special Education Funds	❑₁	❑₂	❑₁	❑₂
	g. State General Fund	❑₁	❑₂	❑₁	❑₂
Local sources	j. Local funds (taxes)	❑₁	❑₂	❑₁	❑₂
Service Reimbursement	k. Medicaid reimbursement	❑₁	❑₂	❑₁	❑₂
	l. Third party payments (e.g. private health insurance, Tri-care)	❑₁	❑₂	❑₁	❑₂
	m. SCHIP	❑₁	❑₂	❑₁	❑₂
	n. Self-pay	❑₁	❑₂	❑₁	❑₂
Private revenue sources	o. Private foundation grants (e.g. Robert Wood Johnson Foundation, Casey Grant, Endowment for Health)	❑₁	❑₂	❑₁	❑₂
Other	p. Other source of funding (Please describe) _____ _____	❑₁	❑₂	❑₁	❑₂

8.   Of the sources listed below, please check which <u>5</u> are the <u>top</u> <u>sources</u> used for funding mental health services.

❑1   Individuals with Disabilities Education Act (IDEA

❑2   Title I

❑3   Community Mental Health Services Block Grant

❑4   Title IV - Safe & Drug-Free Schools and Communities

❑5   Safe Schools, Healthy Students Initiative

❑6   State Special Education Funds

❑7   State General Fund

❑10   Local funds (taxes)

❑11   Medicaid reimbursement

❑12   Third party payments (e.g. private health insurance, Tri-care)

❑13   Healthy Kids Silver

❑14   Self-pay

❑15   Private foundation grants (e.g. Robert Wood Johnson Foundation, Casey Grant, NH Endowment for Health)

❑95   Other sources of funding (Please describe) _____

9.   Of your total expenditures for mental health services for all students, please estimate what percentage is allocated to each of the following. For each category not funded, enter a '0'. All sources combined should total 100%.

a. Administrative overhead	_____%
b. Salaries for mental health staff	_____%
c. Contracts with community organizations or providers to provide MH services	_____%
d. Technical assistance, professional development and training	_____%
e. Other (Please <u>list</u> major categories)	_____%
Total =	**100%**

10.   How are mental health resources directed to students in your district? [Check all that apply]

❑1   On a per pupil basis (based on student enrollment)

❑2   Targeted to schools based on mental health needs of students

❑3   Resources are equally distributed to schools (regardless of size)

❑95   Other (Please describe)_____

11.   To what extent do the following restrictions impede the delivery and coordination of mental health services for students in your district?
(Check only one box on each line)

<u>Restrictions imposed by funding sources</u>	Not at all	Minor extent	Moderate extent	Major extent
a. Restrictions on the location in which mental health services can be provided (on-site vs. in the community)	❑1	❑2	❑3	❑4
b. Restrictions on types of mental health services provided	❑1	❑2	❑3	❑4
c. Restrictions on types of staff who can provide services	❑1	❑2	❑3	❑4
d. Limitations on the providers considered eligible to provide service	❑1	❑2	❑3	❑4

e. Limitations on the number of sessions or duration of mental health services	$\square_1$	$\square_2$	$\square_3$	$\square_4$

Other obstacles

f. Complexities of using multiple funding sources to fund mental health positions or programs	$\square_1$	$\square_2$	$\square_3$	$\square_4$
g. Lack of administrative support for 3rd party billing for third party reimbursement	$\square_1$	$\square_2$	$\square_3$	$\square_4$
h. Insufficient community mental health resources	$\square_1$	$\square_2$	$\square_3$	$\square_4$
i. Competing priorities for use of funds (e.g. focus on improving academic achievement)	$\square_1$	$\square_2$	$\square_3$	$\square_4$
j. Restrictions with insurance and HMOs	$\square_1$	$\square_2$	$\square_3$	$\square_4$

12.   Since the beginning of the 2000-2001 school year, what has happened to the level of funding for mental health services for general education students in your district? (Check only one box)

       ❑₁   Decreased

❑₂   Remained the Same

❑₃   Increased

❑₄   Not Applicable

13.   Since the beginning of the 2000-2001 school year, what has happened to <u>the need</u> of general education students for mental health services in your district? (Check only one box)

❑₁   Decreased

❑₂   Remained the Same

❑₃   Increased

❑₄   Not Applicable

14.   Since the beginning of the 2000-2001 school year, how has the provision of mental health services for <u>general education students</u> in your district changed in each of the following areas? (Check only one box on each line)

	Decreased	Remained the same	Increased	Not applicable
a. Number of mental health staff has:	❑₁	❑₂	❑₃	❑₄
b. Number of general education students served has:	❑₁	❑₂	❑₃	❑₄
c. Range of mental health services offered has:	❑₁	❑₂	❑₃	❑₄
d. Professional development and training have:	❑₁	❑₂	❑₃	❑₄
e. Referrals to community-based providers have:	❑₁	❑₂	❑₃	❑₄
f. Availability of community-based providers to deliver services to students has:	❑₁	❑₂	❑₃	❑₄
g. Outreach to parents has:	❑₁	❑₂	❑₃	❑₄
h. Other (Please describe) _____	❑₁	❑₂	❑₃	❑₄

15.   Please provide the name, title and contact information of the person who completed this survey.

a. Name: _____

b. Title: _____

c. Phone: _____

d. E-mail: _____

16.   If more than one person helped to complete this survey, please indicate who did.

      ❑₁   Superintendent

❑₂   Assistant Superintendent

❑₃   Director of Psychological, Mental Health Services or Student Support Services

❑₉₅   Other, please provide title_____

17.   If you have any comments you would like to make about this survey or about funding mental health services, please use the space below.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Appendix 4: Interviewees from New Hampshire's Community Mental Health Centers

The Center would like to thank everyone interviewed for their time to speak with us and for their candor in answering our questions.

- Janet Salisbury   Community Partners, Dover
- Doug Iosue   Monadnock Family Services, Keene
- Chris Cummings   Riverbend Community Mental Health, Concord
- Steve Press   Community Counsel of Nashua
- Julie Golkowski   Seacoast Mental Health Center, Portsmouth
- Glenn Quinney   The Mental Health Center of Greater Manchester
- Ray Barrett   Genesis Behavioral Health, Laconia
- Nancy Nowell   West Central Behavioral Health, Lebanon
- Michelle Parsons   West Central Behavioral Health, Lebanon
- Amy Beston   West Central Behavioral Health, Lebanon
- Laurie White   West Central Behavioral Health, Newport
- William Valentine   Claremont Child and Family Center
- Eve Klotz   Northern Human Services, Ossipee
- Suzzane Gaetjens-Oleson   Northern Human Services, Littleton
- Nancy Martin   Northern Human Services, Conway
- Cathy Brings   Northern Human Services, Conway
- Steven Arnold   Northern Human Services, Colebrook/Groveton
- Jennifer McCarthy   Northern Human Services, Berlin

Our Supporters

The Center's continued service to New Hampshire is possible because the following individuals, organizations, and corporations have made generous unrestricted donations to the Center 2004-2006. The Center's supporters do not necessarily endorse, nor has the Center asked them to endorse, any of the findings or recommendations in our reports.

Corporate Donors

Anthem Blue Cross/Blue Shield
Dartmouth Hitchcock Medical Center*
First Colebrook Bank*
Granite State Electric dba National Grid
Harvard Pilgrim Health Care of NE
High Point Communications Group, Inc.
Hitchiner Manufacturing Co., Inc.*
J.A. Wright & Co.
Jameson French- Northland Forest Products Inc.
Laconia Savings Bank
Lavallee/Brensinger Architects Fund of NHCF-Manchester*
Ledyard National Bank

Lincoln Financial Foundation
New England Life Care, Inc.
New England Wire Technology Corp.
NH Hospital Association
New London Hospital
Northeast Delta Dental
Northland Forest Products, Inc.
Ocean Bank*
Public Service of NH*
Southern NH University
Story Land/Heritage NH
Unitil*

Sustaining Partners (*gifts of $100,000 or more since 1996*)

The NH Charitable Foundation
Harold Janeway*

The Putnam Foundation*

Sustaining Benefactors (*gifts totaling $25,000 or more in any three-year period*)

Whit & Closey Dickey
Endowment for Health

John Morison
William Welsh

Major Donors (*annual gifts of $5,000 to $25,000*)

Anonymous
Bruce & Jane Keough*

Lovett-Woodsum Family Charitable Foundation
Betty Tamposi

Donors (*annual gifts of $2,000 to $5,000*)

Harvey & Christina Hill

Subscribers (*annual gifts of $1,000*)

James & Ellen Adams Bassett
Cotton Cleveland & John Garvey*
Geoffrey E. Clark & Martha Fuller Clark Fund of NHCF-Piscataqua Region
James A. Coburn
Feldstein Family Fund of NHCF
Gov. Wesley Powell Fund of NHCF- Northern Region
Martin L. Gross*
Andrew E. Lietz
John & Susan Lynch*

Walter & Dorothy Peterson*
Joseph & Augusta Petrone
James Putnam*

Mike & Judith Smith
John & Marjory Swope*
Georgie & John Thomas
John F. Jr. & Patricia Weeks Fund*
Beverly & Dan Wolf*
Kimon & Anne Zachos*

Friends of the Center (*annual gifts up to $1,000*)

Anonymous* (two donors)
Paul & Mary Avery Charitable Fund of the Greater Piscataqua Community Foundation
John & Pam Blackford
Thomas & Emilie Burack
Alice L. DeSouza*
Child and Family Services
John & Judith Crosier*
Charles A. DeGrandpre
First Parish Church
Morton E. Goulder Foundation*
William G. & Erika Johnson

Ann McLane Kuster & Brad Kuster
Joseph & Theresa Marcille

Douglas & Nancy McIninch*
Mt. Washington Valley Chamber of Commerce
NH Farm Bureau Federation
John & Alice Pepper
Mary & John Rauh*
Jay & Barbara Rosenfield
David & Mary Ruedig
Frederic K. Upton
Brian Walsh & Linda Patchett

* indicates a pledge to repeat a gift over three or more years*

Become a Subscriber!

The Center's essential independence and objectivity are made possible by philanthropic donations. Donors, through the support of our operations and our independent projects, ensure our non-partisan credibility. The Center's continued independent voice is only possible because of the generosity of donors like *you*.

Your generosity will help the Center continue its work to inform and improve public policy in New Hampshire. A three year pledge would greatly help the Center to maintain the flexibility and independence necessary to help New Hampshire make better policy decisions. Unrestricted donations from supporters like you make it possible for the Center to conduct analyses on a broad range of issues such as health care, education, corrections, and state budget trends. Multi-year commitments allow us to plan for longer term projects that yield information with the potential for great impact.

Annual donation amount	Donor level
$1,000	Subscriber
Up to $5,000	Donor
Up to $20,000	Major Donor
More than $20,000	Sustaining Benefactor

Today's date: _____

My pledge total: $_____ will be fulfilled as follows:

Year 1: $ _____   Year 2: $ _____   Year 3: $ _____
I have enclosed a donation of $_____

Signature: _____
In the Center's listing of supporters, please acknowledge   **I wish to remain anonymous ☐**
this donation as follows:
(name) _____
(address) _____

My e-mail address: _____

As a sponsor of the Center's work, I would like:

☐   E-mail notices on the Center's work

☐   E-mail notification when the Center releases a new report

☐   Mailed copy of each report when published

☐   Invitations to Center- sponsored presentations & events

Please make checks payable to New Hampshire Center for Public Policy Studies and mail them to: One Eagle Square, Suite 510, Concord NH 03301. All contributions are 100 percent tax deductible. Contact us if you have any questions, special requests, or suggestions.