

POWER OF THE QUESTION

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? Six Questions State Boards Should Ask about Student Mental Health

By Megan Blanco

Throughout the pandemic, concerns about students' mental health have rightfully dominated many conversations on state boards of education. The U.S. Centers for Disease Control and Prevention (CDC) reported that emergency department visits related to mental health increased 24 percent for 5- to 11-year-olds and 31 percent for 12- to 17-year-olds during the pandemic.¹ Parents also expressed concerns, with 65 percent saying they worry about their child's emotional well-being, and 73 percent reporting they are at least somewhat likely to demand that their child's school provide better support for mental health and emotional well-being.²

In October 2021, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association declared a National State of Emergency in Children's Mental Health. In December 2021, the U.S. surgeon general issued an advisory on protecting youth mental health, calling for an all-of-society effort.

State boards have often considered actions to promote student mental health: improved mental health education, access to school psychologists, medical service referrals, screenings, educator training in mental health first aid, and suicide prevention plans. Other factors affecting students' mental wellness include school cultures where students feel safe, connected, and cared for; social and emotional skills such as resiliency, empathy, and ability to resist negative social pressures; student agency in their learning; and parent and caregiver knowledge of how to access relevant social services. Policies, attitudes, programs, and decision-making processes that embrace and respect the diversity of students' backgrounds and circumstances also contribute to students' well-being. State boards can ask the following six questions to foster student mental health.

1. WHAT EXISTING POLICIES, SERVICES, AND FUNDING STREAMS ADDRESS STUDENT MENTAL HEALTH IN OUR STATE?

State leaders should begin by reflecting on what has already occurred, assessing whether policies and services are having the intended

impact, and tallying the funding, training, and guidance that the state already provides to localities. By examining their asset base, state leaders will be better equipped to make decisions to improve the student mental health landscape and avoid creating duplicative or unnecessary programs. Such an examination may also reveal innovative ideas and local examples of successful implementation that can be brought to scale.

NASBE's State Policy Database on School Health, which catalogues policies on more than 200 school health variables coded by state, can help state boards map the state policy landscape. It may also prompt questions for evaluating the policies' reach. For instance, according to the database, 42 states require or encourage professional development for mental health. By examining this one policy, policymakers may uncover opportunities for improvement without adding a new policy to the books. Some subsidiary questions to explore:

- How is the state supporting districts in implementing the policy?
- Does the state curate research-based materials to help districts implement this requirement?
- If so, how many districts use the materials? If just a few, what more can be done to get these materials into the hands of district leaders and educators?
- Does our state collect teacher and staff input on the professional development they receive, and how do state officials use the feedback to improve their offerings?
- Since the policy was enacted, what change has there been in student outcomes?

To examine active programs and their funding, state leaders would benefit from starting a working group that comprises representatives of state agencies with programs that focus on student mental health: typically, the agencies for education, health, and children and families. These staff can curate a list of state and federally funded programs. The nonprofit research organization Child Trends lists federal programs in the student mental health space and thus can be used to support state-level asset mapping.³

Examining programs' mission, scope, timeline, and affiliated funding may reveal opportunities for enhanced collaboration, adjustments, and discussion on improving or combining programs to enhance their impact. With this knowledge, state boards may choose to include funding line items in their budget requests to state legislatures or partner with state agencies in advocating for increased federal funding during the annual appropriations cycle or open grant competitions.

2. WHAT IS THE STATE OF OUR STUDENTS' MENTAL HEALTH, AND ARE THERE SUBGROUP DIFFERENCES?

Depression, anxiety, attention-deficit hyperactivity disorder, and behavior problems are among the most commonly diagnosed mental health disorders in children.⁴ Suicide ideation can be but is not necessarily connected to a student's experience with depression, anxiety, and persistent feelings of loneliness and hopelessness. Other behavioral risk factors include alcohol and drug use, unsafe sexual behaviors, bullying, and poor sleeping and dietary habits.

CDC collects data on these metrics through the Youth Risk Behavior Survey (YRBS), an anonymous, voluntary survey administered biennially since 1991 in partnership with state education and health departments. Understanding the scope of external factors contributing to poor mental health as well as the scope of students medically diagnosed conditions can help state leaders direct resources to best meet the needs of students. To inform their decision making, state boards in Ohio and Hawaii have heard presentations on YRBS data. In its reopening guidance, the U.S. Department of Education (ED) suggested that state leaders also examine data pertaining to chronic absenteeism, school and campus climate surveys, student visits to school specialists, and calls to community crisis centers.⁵

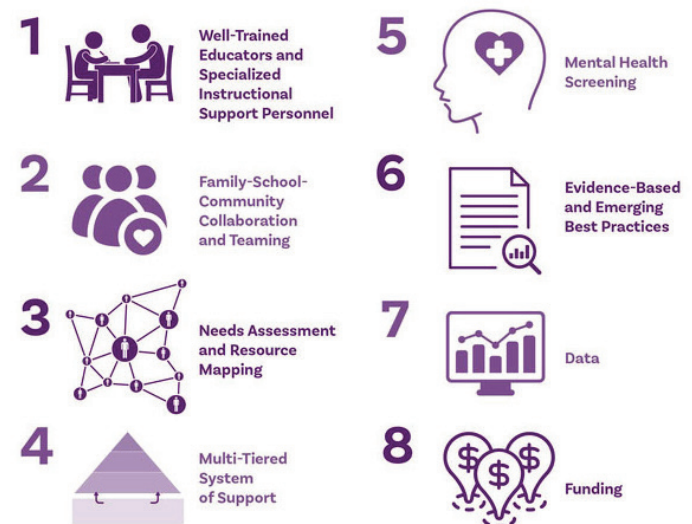
There are disparities in mental health metrics among certain populations that report higher rates of depression, bullying, and suicide ideation than others. National data show this to be the case for lesbian, gay, and bisexual students compared with their straight peers. Students of color and students in rural areas also report greater need for mental health services and support.⁶ Therefore, state leaders can promote mental wellness efforts that touch all students—antibullying policies, social and emotional skill building, school climate initiatives—while also targeting interventions to the unique context of communities with heightened need.

3. WHAT PARTNERSHIPS CAN OUR BOARD BUILD?

Building relationships with mental health experts in the state's department of health and institutions of higher education can ensure that state boards get unbiased, expert assessments of whether policies before them are medically sound and likely to improve student mental health. Opening these lines of communication may also reveal program models and initiatives in the health sector that can be tailored to a school setting or shed light on community-based initiatives that schools can join.

In such instances, the state board's greatest opportunity may be to raise awareness of potential solutions, educate the public, and cultivate enabling conditions for program models to scale rather than adopting new policies. Boards can show support for these programs through public statements, introductions between partners, invitations to present at board meetings, site visits, and working group meetings where partners share updates and lessons learned. In lieu of policy authority, state boards can leverage their power of convening stakeholders and of questioning to bring needed attention, coordination, and communication to an issue.

Core Features of a Comprehensive School Mental Health System



Source: Reprinted with permission from Sharon Hoover et al., "Advancing Comprehensive School Mental Health: Guidance from the Field" (Baltimore, MD: National Center for School Mental Health, University of Maryland School of Medicine, 2019).

Boards should also leverage standing committees such as student advisory councils, cross-agency children's cabinets, and suicide prevention taskforces to provide input on issues before the board and be a partner in developing and implementing solutions. Based on insights garnered through collaboration with its Child Well-Being Taskforce, **Connecticut** determined the need to establish—with the state's department of education, department of children and family services, and local providers—a care coordination system that included setting up school-based health centers and hiring or deploying more behavioral health staff in schools.⁷

4. WHAT MENTAL HEALTH EDUCATION DO STUDENTS RECEIVE?

Their policy authority over learning standards, graduation requirements, learning time requirements, and accountability metrics provides state boards opportunities to address mental health education. When reviewing and revising health education standards, for example, boards can include age-appropriate standards for mental health education, as New York, New Jersey, and Virginia have done. Boards may also require a minimum number of instructional minutes or graduation credit hours for mental health education to ensure that the subject receives adequate attention during the school day and does not lose out in competition with instructional time for core subjects that are tied to school accountability systems.

The National Center for School Mental Health advises embedding social and emotional learning competencies throughout all content areas, an effective approach to supporting the mental wellness of all students (see figure).⁸ More than 20 states already have comprehensive preK-12 social and emotional learning standards, according to the Collaborative for Academic, Social, and Emotional Learning.⁹ The Every Student Succeeds Act (ESSA) gives states greater flexibility to deliver a well-rounded education and to choose nonacademic measures of a school's effectiveness in their accountability systems. Thus state boards may consider student access to mental health programming, services, and education when refining their ESSA accountability metrics.

Because youth often turn to peers as trusted sources of information and support, research-based peer-to-peer suicide prevention training programs are another strategy to empower students with knowledge to seek help, detect at-risk behaviors, and offer friendship to peers in need.¹⁰

5. HOW IS OUR STATE BUILDING ADULT CAPACITY TO SUPPORT STUDENT MENTAL HEALTH?

In a 2020 survey, 68 percent of elementary school principals said they do not have enough mental health staff in their schools.¹¹ The National Association of School Psychologists recommends a ratio of one school psychologist per 500 students in order to provide comprehensive school psychological services. Current data estimate a national ratio of 1:1,211, with ratios varying greatly by state.¹²

To build adult capacity, states must attend to whether credentialed mental health professionals are equitably distributed across districts, the adequacy of preservice and in-service teacher training to support mental wellness in the classroom, and whether parents and caregivers have information to help them identify warning signs of mental distress and seek help. Many states have recently expanded their efforts in these areas.

Illinois, for instance, launched the Resilience Education to Advance Community Healing (REACH) Pilot Project in December 2020 to provide free, on-demand, virtual, asynchronous training to all educators in the state on trauma-informed and healing-centered practices. Beginning with the 2021–22 school year, REACH teams in 44 schools were set to develop and implement data-driven strategic plans to support students' social-emotional learning and mental health.

Oklahoma is directing \$35 million of its federal COVID relief funds toward launch of the Oklahoma School Counselor Corps, an application-based grants program that funds districts statewide to hire school counselors and school-based mental health professionals. To support the program's operation, the state will hire five regional coordinators to support professional development and training associated with the program.

Thirteen states have a policy requiring districts to implement parent education or support programs.¹³ **Utah's** policy, for example, requires that a district-led parent seminar include information on mental health, depression, suicide awareness, and suicide prevention.

The **North Carolina State Board of Education** adopted a School-Based Mental Health Policy in 2020. It requires each K-12 public school to have a Local School Mental Health Improvement Plan, which must be reviewed at least every five years and include at least six hours of mental health training for new school hires followed by two hours of training in subsequent years. To support schools with implementation, the policy requires the Department of Public Health to develop a model training that can be accessed in multiple formats and that the superintendent of public instruction will review every five

years.¹⁴ According to NASBE's database, 22 states require mental health first aid training for educators.¹⁵

In 2020, **Nevada** received more than \$10 million through the U.S. Department of Education's School-Based Mental Health Services Grant Program. One of the state board's priorities is to increase the number of counselors, psychologists, and social workers in schools. The state will also spend \$7.5 million of its federal COVID relief funds to hire a Multi-Tiered Systems of Support coach for every district. Alabama, Louisiana, and Alaska are using their COVID relief funds to place more social workers in schools so they can make appropriate referrals to community providers, including for mental health services.

State leaders should ask questions about the equitable distribution of trained mental health professionals in schools, with acute attention being given to areas where students face greater societal barriers to mental wellness (e.g., limited access to community health services, poor public transportation, high rates of homelessness and unemployment). If workforce shortages are discovered, schools would benefit from state boards including the issue in larger discussions around educator workforce shortages and when developing recruitment and preparation plans. Examining teacher preparation program requirements offers another opportunity to build educators' preservice knowledge and skills before they step into a classroom.

6. WHAT IS OUR BOARD DOING TO ELIMINATE STIGMA AND PUBLIC MISUNDERSTANDING ABOUT MENTAL HEALTH?

ED's guidance on reopening schools focused on supporting child and student social, emotional, behavioral, and mental health needs.¹⁶ It cited perceived stigma as a major challenge to mental health access and urged state leaders to work to overcome it.

While societal and cultural awareness of the importance of mental health to overall wellness is becoming increasingly accepted, individuals still have varying degrees of comfort with seeking and accepting services due to perceived fears of judgment, bullying, or discrimination. For youth to feel safe in discussing their mental health and to seek help with anxiety, feeling overwhelmed, depression, and thoughts of suicide, the topic must be normalized in schools. Just as a student would seek a dentist for a toothache or an optometrist for glasses, students must feel safe to seek mental health services.

Several states launch social media and traditional messaging campaigns to increase understanding of mental health. In 2018, the nation's largest school district, New York City, launched the "There's Help All Around You" campaign to share age-appropriate messaging, information on how to access services, and encouragement to seek help. In 2021, the city's education department launched "Let's Talk NYC" to connect high school students with school staff who have received mental health training.

In the 2021–22 school year, **Oregon** launched the "Care and Connection Campaign," encouraging its schools to use the first few weeks

of school to build relationships, create a welcoming climate, and give students a safe space to discuss their experiences during the pandemic. States can also provide sample social media toolkits, printable flyers, and text and email messages that schools can easily download to communicate information and activities to students, staff, and families, as did Texas's Department of Family and Protective Services, New York's Office of Mental Health, and Oregon's Department of Education.¹⁷

In addition, state board members should be thoughtful about language they use during board meetings to avoid perpetuating stereotypes or misinformation about mental health.

CONCLUSION

Student mental wellness mattered long before the pandemic. However, for many students whose lives and schooling were disrupted by COVID, there is an acute need for increased services, education, and supports. By grounding policy decisions in the school mental health landscape and data on student needs, boards can more efficiently and intentionally identify the policy adjustments needed to ensure that all students have what they need to be healthy and ready to learn.

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NOTES

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