# System-Level Student Wellbeing Data Review Tool

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# STATES HAVE AN OPPORTUNITY TO MEANINGFULLY SUPPORT STUDENT WELLNESS

## The nation is facing a crisis in child wellbeing; the COVID-19 pandemic has exacerbated this challenge

- Leading experts continue to sound the alarm on our nation's youth mental health crisis following the Surgeon General's "rare public advisory" on protecting youth mental health in late 2021.
- The mental, emotional, and physical wellbeing of students is essential for overall child wellness and for academic acceleration in response to the pandemic.

## This tool supports state agencies as they seek to understand and address this challenge

- Using publicly available data, state agencies may better understand the current wellbeing needs of students and how to better meet those needs.
- This tool also allows users to compare their data to other states and localities to understand bright spots and opportunities for learning.

### This tool will support users to:
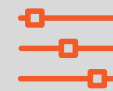
- Understand your state's child wellbeing metrics and better use your internal data
- Partner with other state and local agencies including health departments to address child wellbeing
- Identify and consider opportunities for state-level action such as procurement to support local needs and address gaps
- Identify potential issues where federal funding sources (e.g., American Rescue Plan) can support solutions
- Support school districts to understand their LEA or county's data by putting it into the broader state and national context to inform their strategy

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# SYSTEM-LEVEL STUDENT WELLBEING DATA REVIEW TOOL (1/2)

This document can support any state-level agency hoping to leverage publicly available data to understand and consider options to better meet the wellbeing needs of students. While there is also a need to understand and support adult wellbeing, this tool focuses on students. The System-Level Student Wellbeing Data Review Tool is grounded in the 10-point framework developed by The Coalition to Advance Future Student Success, a group of 12 leading education organizations committed to working together to reopen, recover, and rebuild schools.

**This tool allows states to complete key data reviews to glean insights on:**

Positive wellbeing outcomes (e.g., measures of student flourishing)

Adverse mental health and substance misuse outcomes (e.g., benchmark share of children experiencing ACEs relative to peer states and national average)

School-based indicators (e.g., rates of chronic absenteeism)

Supports that exist in your state (e.g., availability of psychologists)

**SYSTEMS CAN CUSTOMIZE THE TOOL TO SUIT THEIR NEEDS**

**Districts interested in leveraging this tool's data for their LEA should reach out to cfcta@ilogroup.com.**
**For our district-focused Student Wellbeing tool, click here.**

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## System-Level Student Wellbeing Data Review Tool

**1** **INITIAL REVIEW:** A state-specific, system-level document which includes key wellbeing data benchmarked against regional peers and questions for discussion

**2** **DATA DEEP DIVE:** A Tableau tool that allows systems to dive into data and create additional data views by time or demographic factors

**3** **ACTION PLANNING:** Tools to translate the data review into potential action, including:

- Guided exercises for developing a statewide student wellbeing strategy
- Guidance for developing an outreach plan to communicate the statewide case for change, if appropriate based on data review
- Opportunities for further analysis and exploration

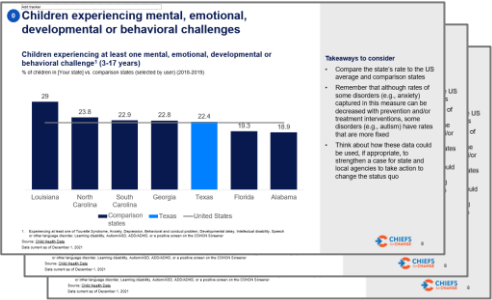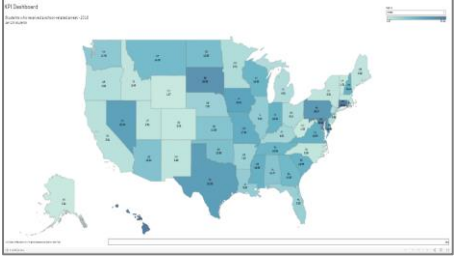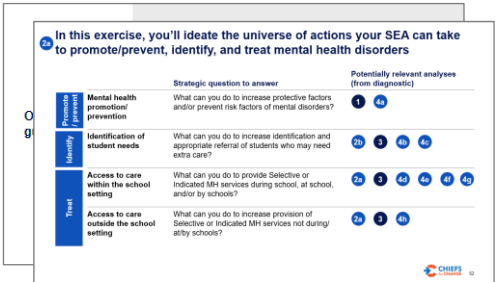## Elements Include
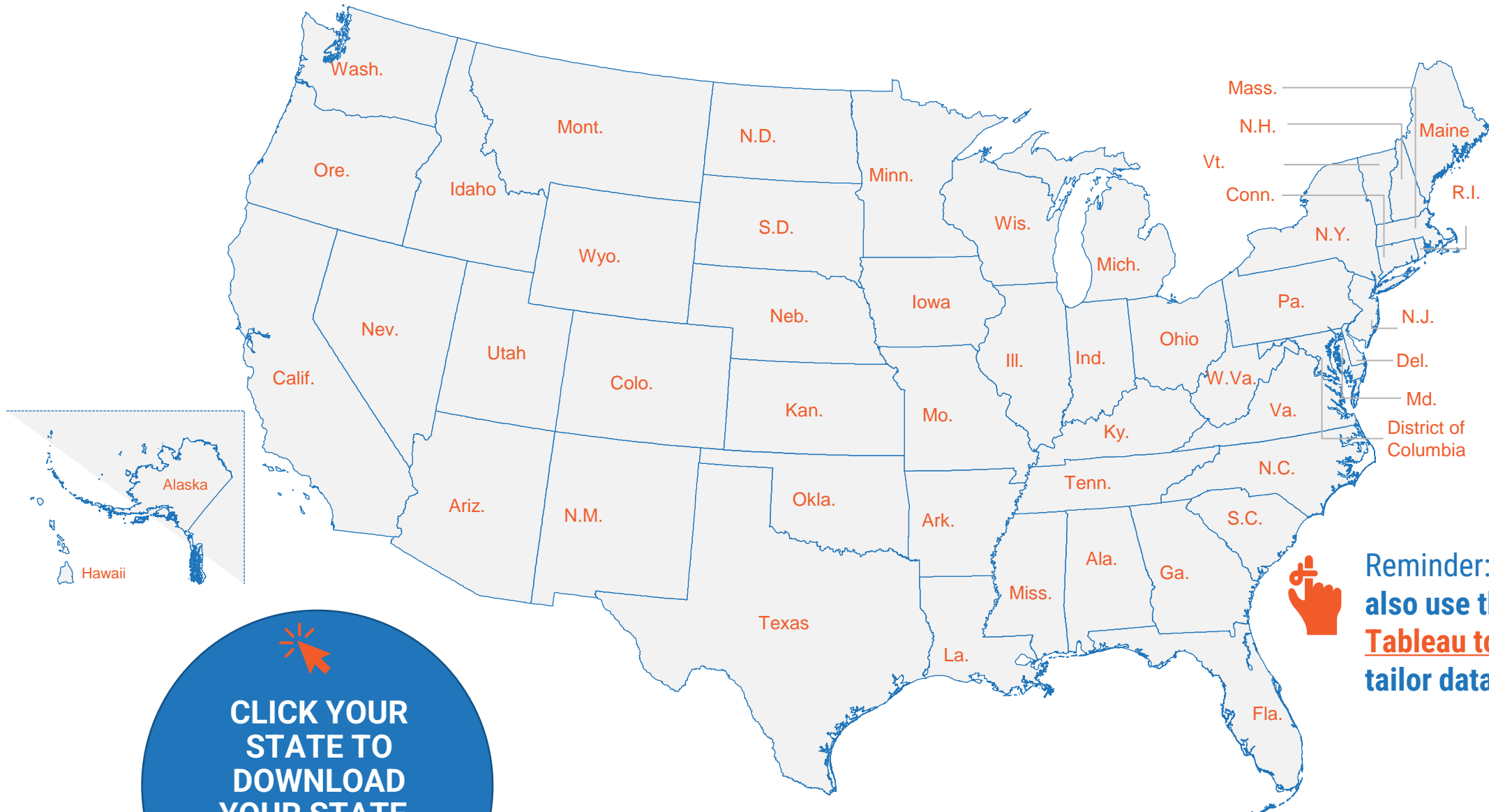
Data review

Tableau tool

Templates to create a case for change

Guided exercises for strategy development

These components can be used individually or together based on your state's needs. For an Excel version of data or personalized comparisons, please contact CFCTA@ilogroup.com.

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# THIS TOOL CAN SUPPORT STATES TO DRIVE CROSS-AGENCY ACTION AND SUPPORT LOCAL DISTRICTS

## Collaboration between agencies can be critical...

**ACTIONS MAY INCLUDE:**

- Raising awareness of key opportunities to support student wellbeing
- Determining where agencies have complementary priorities and initiatives; align efforts to work in the same direction
- Developing programs to recruit and retain mental health workers in underserved geographies

## ...and can be done in conjunction with additional state initiatives to support local agencies

**ACTIONS MAY INCLUDE:**

- Establishing statewide framework and supports for districts for child wellbeing services
- Securing funding for child wellbeing initiatives (from SEA budget, grants, Medicaid, ESSER, etc.)
- Monitoring statewide and local child wellbeing initiatives and reallocating resources from ineffective to evidence-based programs, where applicable
- Identifying gaps in local capacity in meeting state standards (e.g., via needs assessments) and providing targeted support to address gaps
- Assisting districts in building partnerships with state, regional, and local organizations supporting child wellbeing

For more examples of how states can take action to support student wellbeing, read CCSSO's recent publication: Advancing Comprehensive School Mental Health Systems

## Collaboration in action

Colorado agencies and partnerships came together to develop the Colorado Framework for School Behavioral Health Services which melds a system of care within an MTSS.

It was developed by the Colorado Education Initiative in partnership with a diverse group of stakeholders, including the Colorado Department of Education, Colorado Department of Human Services and the Colorado Association of Family and Children's Agencies.

Note: Actions on this page are illustrative and non-exhaustive

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# TOOL IN ACTION: A CASE STUDY USING DATA TO INCREASE CROSS-AGENCY COLLABORATION FOR CHILD WELLBEING

## Situation

A large, midwestern state wanted to set a statewide, cross-agency mental health and wellbeing strategic plan. In order to do so, the state **needed solid data** to guide thinking.

The state Department of Education had established partnerships with other agencies, and stakeholders were motivated to develop a plan; however, **they needed a clear consensus on priorities.**

The state had increased its efforts to track mental health and outcomes, but **data sources could be better connected.**

## Approach

The state Department of Education and Department of Mental Health **used data from this tool to conduct a gap analysis.**

**From there, they convened a team to review the gap analysis and discuss what steps have already been taken** in order to prevent duplication.

The team also **focused on how to use the data effectively**, one component at a time, from data protocol to dissemination.

## Impact

The Department of Education and Department of Mental Health went **from a general partnership to specific objectives with a shared workplan.**

**Three priorities were identified** based on the data: (1) school-based tools to identify student needs (2) mental health services coordination (3) family and school capability building.

The departments agreed to **specific steps with a timeline** to address each of the priorities.

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# STEPS CAN BE INFORMED BY COALITION-BUILDING AND STAKEHOLDER ENGAGEMENT: SAMPLE SET OF ACTIONS

| Timing | Potential actions |
|---|---|
| **Months 1 and 2:**<br><br>Understand context and convene partners | ✓ **Understand existing data**, using the Initial Review document and <u>Tableau tool</u> |
| | ✓ Gather a **cross-agency team; listen to their experiences and perspectives, and share data.** Partners could include Governors' Offices, state education agencies, state Medicaid agencies, and Departments of Health, Mental Health, Human Services, and Children and Families, higher education institutions, and community organizations |
| **Months 3+:**<br><br>Engage a broader set of stakeholders to chart a path forward | ✓ Where appropriate, **consider developing a** <u>case for change</u> **to build support and buy-in** |
| | ✓ Work with a broad set of stakeholders--including families, students, trusted community-based organizations, and school leaders--to further **understand areas of strength and opportunity, and begin to create a** <u>set of potential actions</u> |
| | ✓ **Finalize set of actions with agency leadership, and begin planning** |

Note: <u>Detailed set of actions found here</u>

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# CONTENT

Data accessed December 1, 2021

# OVERVIEW OF PURPOSE

## What this is

Inputs to a statewide data review on child and youth wellbeing utilizing publicly available data

Templates on specific analyses to understand the current state of student wellbeing supports/inputs as well as various wellbeing and academic outcomes

Tools to support partnerships, analyses, and planning

## What this is not

Definitive guidelines for using data to inform a current or newly developing comprehensive state-level student wellbeing strategy

Comprehensive set of data sources that pinpoint specific needs within a state

All-inclusive list of stakeholders to engage when building a statewide mental health and wellbeing strategy for K-12 students

Assessment of a causal relationship between the availability of student wellbeing supports and student outcomes

Data accessed December 1, 2021

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# THIS TOOL WAS DEVELOPED LEVERAGING SEVERAL SOURCES OF KNOWLEDGE

## Federal and non-profit data sources

Data sources include:

- SAMHSA National Survey on Drug Use and Health (NSDUH)
- CDC Youth Risk Behavior Surveillance System (YRBSS)
- National Center for Education Statistics (NCES)
- Office of Civil Rights
- Child and Adolescent Health Measurement Initiative
- United Health Foundation

## Experts in psychology, education, and public health

Experts included former Substance Abuse and Mental Health Services Administration (SAMHSA) senior leadership, academics, and school administrators.
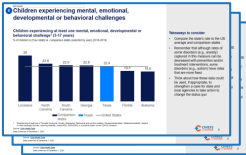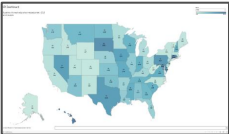
In particular, we would like to acknowledge Sharon Hoover, PhD.; Janice K. Jackson, EdD.;  Bryan Johnson, EdD.; Jennifer Kitson, EdS., NCSP; Art McCoy, PhD.; Mark Weber, MBA; Paolo DeMaria; and Marleen Wong, PhD. for their review and input.

## Pilots and guided input from partner SEAs and LEAs

This tool was developed through conversations with Tennessee, Mississippi, Colorado, and Ohio's Departments of Education as well as school districts across the Chiefs for Change network.

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# CONSIDERATIONS FOR WHICH TOOLS TO USE AND WHO TO ENGAGE

| | Purpose | Time to conduct | Content | Why to use this |
|---|---|---|---|---|
| **Phase 1:**<br><br>Initial System-Level Student Wellbeing Data Review | Obtain a high-level understanding of current student wellbeing and service offerings at the state level<br><br>Each state's document comes pre-populated with regional states as a comparison set. For a personalized comparison, email CFCTA@ilogroup.com | About three hours | <br>Data review | Understand the current state of student wellbeing supports and outcomes at the state level |
| **Phase 2:**<br><br>State-level planning and further review of student wellbeing data | Dive deeper into select areas, reviewing data by time series, various demographic cuts, etc.<br><br>Compose a data-supported narrative for why change is needed, grounded in current youth and child outcomes and adaptable for different audiences<br><br>See sample roadmap for a more detailed set of actions | Multiple sessions over several weeks | <br>Templates to create a case for change<br><br><br>Guided exercises for strategy development<br><br><br>Tableau tool | Develop a robust understanding of student wellbeing supports<br><br>Brainstorm potential solutions<br><br>Develop a case for change, if appropriate |

# THE INITIAL REVIEW DOCUMENT CONTAINS SELECT, NON-COMPREHENSIVE ANALYSES (USING PUBLICLY AVAILABLE DATA) ON KEY COMPONENTS OF WELLBEING

| Components | Description | Example questions to answer for each component |
|---|---|---|
| **0** **Understanding current diagnoses** | Measures of current diagnoses of mental health conditions and neurological disorders in children and youths | • What is the prevalence of diagnosed mental health conditions and neurological disorders (e.g., anxiety, depression, ADD/ADHD), including by demographic subgroups? |
| **1** Positive wellbeing outcomes | Measures of student connectedness and safety, as well as attainment of a healthy mental state (e.g., social skills, coping, self-regulation, self-esteem, resilience) | • To what degree do students report a sense of belonging / connection to school? <br> • How safe do students feel? <br> • Have students attained a healthy mental state (e.g., social skills, coping, self-regulation, self-esteem, resilience)? |
| **2** **Adverse mental health and substance misuse outcomes** | Measures of effects of adverse mental health outcomes, including student distress and significant changes in thinking, emotion, or behavior | • What is the current rate of suicide (and suicidal ideation) among students? <br> • How many students are at risk of mental illness (proxied by e.g., prevalence of ACEs across students)? <br> • What is the rate of student substance misuse (e.g., rate of underage drinking)? |
| **3** **School-based indicators** | Measures of academic and other school-based successes that may be affected by student wellbeing | • What are the rates of key negative student outcomes (e.g., absenteeism)? |
| **4** **Inputs / supports for student wellbeing** | Measures of current implementation of positive practices in schools | • What is the availability and adoption of professional development and other school training / programming for teachers and staff to promote student wellbeing (e.g., trauma-informed training, Positive Behavioral Interventions and Supports (PBIS))? |
| | Assessment of ability to identify in-need students | • Is identification and referral occurring before students reach a point of academic or behavioral health crisis? |
| | Indicators of access to care inside schools | • What is the shortage of key roles in schools relative to recommended levels (identified and sourced later in the document)? Is there variance by locality and/or by demographic subgroups? |
| | Indicators of access to care outside schools, including to overall health care (including primary and specialty care) | • What is the shortage of key roles outside schools relative to recommended levels? Is there variance by locality and/or by demographic subgroups? <br> • At what rate are students accessing overall health care (e.g., PCP visits)? |

1. Flourishing is defined as children who show affection, resilience, interest and curiosity in learning, and smile and laugh a lot; data sourced from National Survey of Children's Health, U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB)
Data accessed December 1, 2021

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# THE INCLUDED DATA ANALYSES ARE LARGELY PRE-PANDEMIC DUE TO DATA AVAILABILITY; THE COVID-19 PANDEMIC HAS EXACERBATED MANY EXISTING WELLBEING TRENDS

## Pre-pandemic, students faced growing challenges:

**18%** of children had a diagnosed mental illness; 22% of children living below the poverty line had a diagnosed mental illness[1]

**49%** of children with a mental health disorder do not receive needed care[2]

**~50%** Hispanic and Black adolescents had ~50% fewer visits to mental health professionals[3]

**1.5x** Black adolescents attempt suicide >1.5x more often than white adolescents, but receive care less often[4]

## Challenges have intensified during the pandemic:

**35%** of parents said they were very or extremely concerned about their child's mental health[5]

**31%** increase in the number of mental health-related ER visits for youth ages 12 to 17[6]

**2.6x** increase in the number of visits to emergency rooms nationwide by individuals younger than 18 due to suicide attempt[7]

HHS has identified several groups at higher risk of mental health challenges during the pandemic including **racial and ethnic minority youth, low-income youth, and youth in rural areas.**[8]

1. CDC.gov
2. JAMA Pediatrics
3. Georgetown University Health Policy Institute
4. Mental Health America
5. McKinsey.com, COVID-19 and education: the lingering effects of unfinished learning
6. CDC.gov
7. CDC.gov
8. HHS

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# WITH THE TABLEAU DATA TOOL, USERS CAN COMPARE ACROSS STATES ON A NUMBER OF CHILDHOOD WELLBEING METRICS…

Use state heat maps to compare childhood wellbeing metrics across states (this map shows rate of child flourishing)

Select among 20+ childhood wellbeing metrics for state heat map comparisons
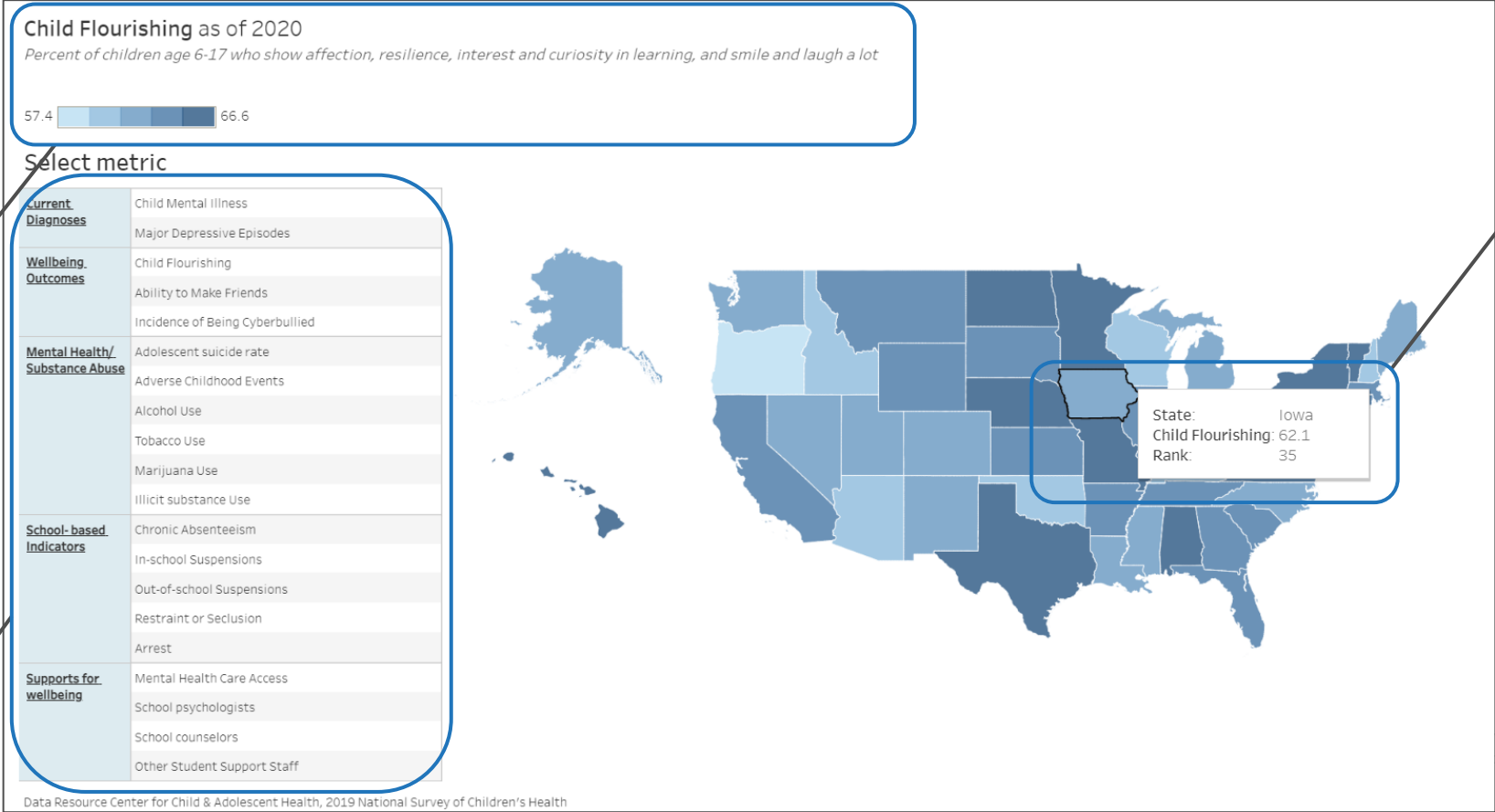
Hover over a specific state to show details on its value and ranking for the childhood wellbeing metric you've selected



**Child Flourishing** as of 2020
*Percent of children age 6-17 who show affection, resilience, interest and curiosity in learning, and smile and laugh a lot*

57.4 ▢▢▢▢▢ 66.6

Select metric

| | |
|---|---|
| Current Diagnoses | Child Mental Illness |
| | Major Depressive Episodes |
| Wellbeing Outcomes | Child Flourishing |
| | Ability to Make Friends |
| | Incidence of Being Cyberbullied |
| Mental Health/ Substance Abuse | Adolescent suicide rate |
| | Adverse Childhood Events |
| | Alcohol Use |
| | Tobacco Use |
| | Marijuana Use |
| | Illicit substance Use |
| School- based Indicators | Chronic Absenteeism |
| | In-school Suspensions |
| | Out-of-school Suspensions |
| | Restraint or Seclusion |
| | Arrest |
| Supports for wellbeing | Mental Health Care Access |
| | School psychologists |
| | School counselors |
| | Other Student Support Staff |

State:               Iowa
Child Flourishing: 62.1
Rank:                35

Data Resource Center for Child & Adolescent Health, 2019 National Survey of Children's Health

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# ...AND EXPLORE DEEP DIVES OF EACH CHILDHOOD WELLBEING METRIC WITHIN EVERY STATE
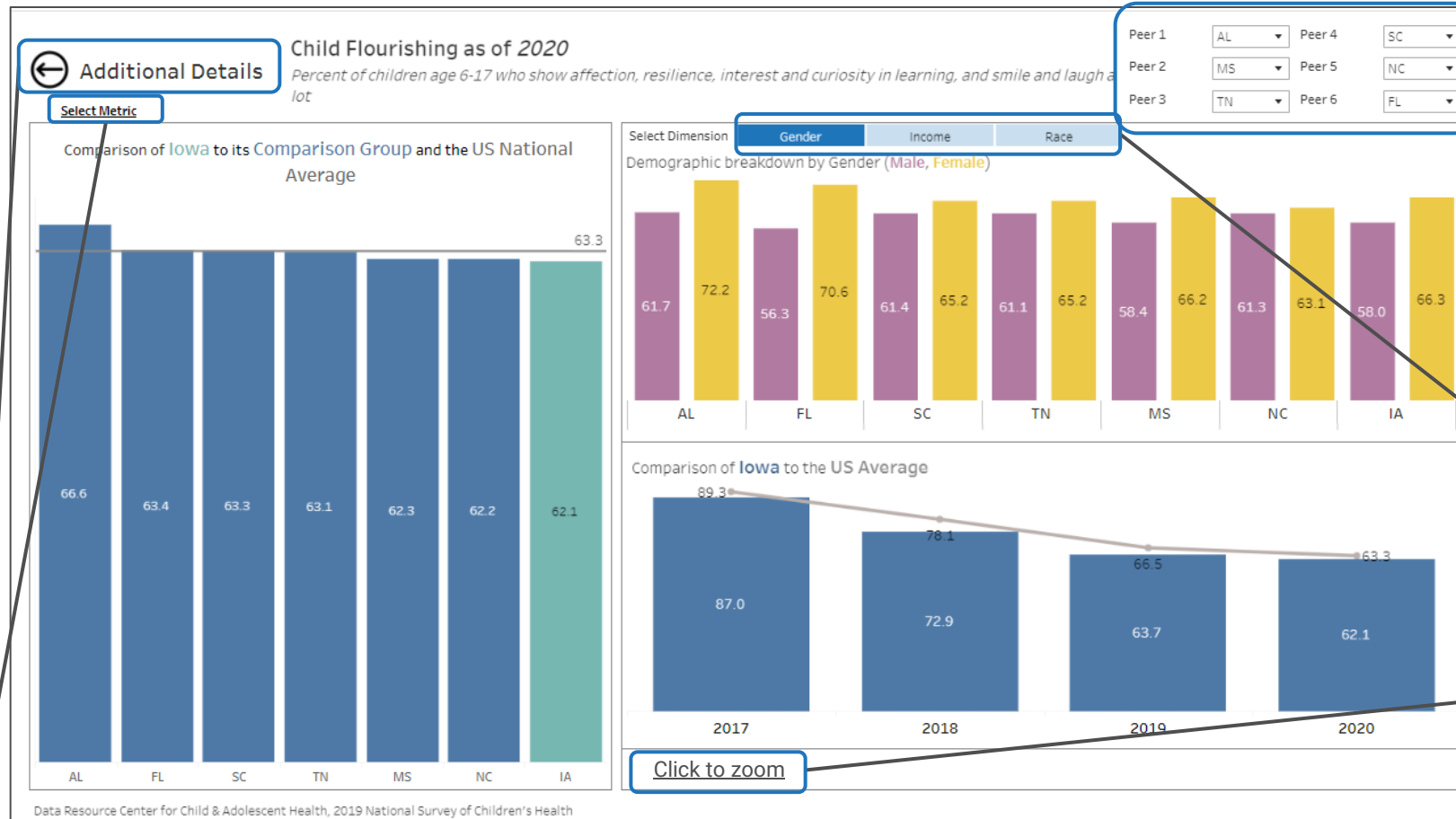
These graphs compare Iowa and peer states' child flourishing data

Access this view by double clicking on the desired state in the map view

Click here to return to the map view

Click here to select a different metric

Use these dropdown menus to select different peer states for comparison

Click here to toggle between data splits by gender, income, and race

Click on instructions like these to see a full-screen view of the associated graph



**Additional Details**

Child Flourishing as of *2020*

*Percent of children age 6-17 who show affection, resilience, interest and curiosity in learning, and smile and laugh a lot*

Select Metric

Comparison of Iowa to its Comparison Group and the US National Average

63.3

| | | | | | | |
|---|---|---|---|---|---|---|
| 66.6 | 63.4 | 63.3 | 63.1 | 62.3 | 62.2 | 62.1 |
| AL | FL | SC | TN | MS | NC | IA |

Select Dimension — Gender | Income | Race

Peer 1 AL   Peer 4 SC
Peer 2 MS   Peer 5 NC
Peer 3 TN   Peer 6 FL

Demographic breakdown by Gender (Male, Female)

| AL | | FL | | SC | | TN | | MS | | NC | | IA | |
|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| 61.7 | 72.2 | 56.3 | 70.6 | 61.4 | 65.2 | 61.1 | 65.2 | 58.4 | 66.2 | 61.3 | 63.1 | 58.0 | 66.3 |

Comparison of **Iowa** to the US Average

| 2017 | 2018 | 2019 | 2020 |
|------|------|------|------|
| 87.0 | 72.9 | 63.7 | 62.1 |

89.3 — 78.1 — 66.5 — 63.3

Click to zoom

Data Resource Center for Child & Adolescent Health, 2019 National Survey of Children's Health

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# TRANSLATING REFLECTION TO ACTION: DETAILED POTENTIAL ROADMAP FOR SYSTEMS FOLLOWING A DATA REVIEW

## Collaboration and partnership with other agencies, health partners, and stakeholders can be critical

| TIMING | POTENTIAL ACTIONS TO COMPLETE | RESOURCES |
|---|---|---|
| **Before data is reviewed** | ✓ Agency lead determines what other agencies and health partners are open to collaboration and assigns an initiative lead to drive collaboration | |
| **Month 1:**<br><br>Review data and begin building consensus | ✓ Agency initiative lead schedules meetings with other agency partners to listen to and understand their perspectives and introduce wellness tool; determines who from each agency will join an in-depth data review<br><br>✓ Agency initiative lead hosts first meeting for a cross-agency listening session and in-depth data review of the data tool<br><br>✓ Cross-agency team reflects on learnings and opportunities; determines best path to build understanding and consensus between agencies | Initial Review document<br><br>Tableau tool<br><br>Case for change template |
| **Months 2-3:**<br><br>Engage a broader set of stakeholders to chart path forward | ✓ Cross-agency team develops a case for change using this tool as a resource; presents to a broader group of agency leaders<br><br>✓ Cross-agency team creates a stakeholder engagement plan, including health partners, school leaders, families, and students to develop a set of proposed actions<br><br>✓ Cross-agency team tests hypotheses for action and finalizes the set of next steps to bring to more senior agency leaders | Case for change template<br><br>Reflection and action planning tools |
| **Ongoing:**<br>**Execute plans** | ✓ After set of actions are aligned on, each agency begins to act on plans<br><br>✓ Cross-agency team meets periodically to report progress against initiative goals, problem solve, and identify emergent opportunities for collaboration | |

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# CONTENT

# EXAMPLE CASE-FOR-CHANGE, IF APPROPRIATE FROM DATA (1/2)[1]

## Current student wellbeing needs in [Your state]

There is significant need for wellbeing services in the state

- Up to Xk children have a diagnosed condition (e.g., mental, emotional, developmental, or behavioral challenges), including X% of black children, X% of Hispanic children, and X% of low-income children
- The adolescent and young adult[2] suicide rate [increased/decreased] X% from 2001-2018. The national rate increased 55.1% in the same time period[3] [users may also consider listing rates in 1-2 key compared states' systems]
- ~X% of children have experienced two or more Adverse Childhood Experiences[4] between 2019-2020. Nationwide, 14.7% of students experienced an ACE between 2019-2020[5] [users may also consider listing rates in 1-2 compared states]
- Student perceptions of school connections were [positive/negative] [and/but] [improving/declining/constant] over time before the pandemic

These student wellbeing challenges impact students' academic experience

- X% of all students experienced chronic absenteeism in 2019-20; in X districts, more than 15% of students experience chronic absenteeism[6]
- X% of high schoolers experienced electronic bullying in 2019. Nationwide, 15.7% of students experienced electronic bullying in 2019 [users may also consider listing rates in 1-2 compared states][7]

**Consider adding additional insights or updating these insights with any data accessible to your agency/agencies**

Users should populate text in red with their own state's data, and consider adding data of their own

1. Note to user: This exercise is identical to the 'key learnings' page in the 'Guided exercise to develop a statewide strategy' section of this document
2. Suicide rate among individuals ages 10-24
3. CDC National Vital Statistics
4. Children ages 0-17 who experienced two or more of the following: parental divorce or separation; living with someone who had an alcohol or drug problem; neighborhood violence victim or witness; living with someone who was mentally ill, suicidal or severely depressed; domestic violence witness; parent served jail time; being treated or judged unfairly due to race/ethnicity; or death of parent
5. United Health Foundation ACEs data by state
6. U.S. Dept. of Ed Absenteeism data (2016)
7. Youth Risk Behavior Survey (2019)

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**Users should populate text in red with their own state's data, and consider adding data of their own**

## Current student wellbeing resources and programs available to students in [Your state]

Our schools and health system [do/do not] have resources to meet student wellbeing demand

- X% of children need but did NOT receive treatment in 2019 (compared to a nationwide average of 2.3%),[2] including X% of black children, X% of Hispanic children, X% of girls, and X% of low-income children
- Schools employ X counselors per 1k students, vs. NASP-recommended ratio of 4.[3] X% of districts employ less than that ratio [users may also consider listing rates in 1-2 compared states]
- X% of children covered by Medicaid (which enrolls X% of children) visited a physician last year. X% had an annual physical

Access to resources varies across the state

- X% of counties have less than one pediatrician and less than one student wellbeing provider[4] per 10k people. X% of counties did not meet the recommended ratio of 3.3 student wellbeing providers per 10k people[5] [users could indicate that rural counties tend to have fewer resources, if true]
- X% of counties have zero child and adolescent psychiatrists [users could indicate that rural counties tend to have fewer resources, if true]
- Districts staff X psychologists per 1k students; X% of districts did not meet the recommended ratio of 1.4 psychologists per 1k students[6] [users could indicate that urban/rural districts fare worse than suburban districts, if true]

**Consider adding additional insights or updating these insights with any data accessible to your agency/agencies**

1. Note to user: This exercise is identical to the 'key learnings' page in the 'Guided exercise to develop a statewide strategy' section of this document
2. Child Health Data
3. National Center for Education Statistics
4. Psychologists, psychiatrists, and LCSWs
5. McKinsey Center for Societal Benefit Through Healthcare Vulnerable Populations Dashboard
6. National Association of Student Psychologists (NASP) recommended number of school psychologists per 1k students

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# DATA CAN HELP MAKE THE "CASE FOR CHANGE" TO DIFFERENT AUDIENCES

## Four sample use cases

| | Activate interagency action | Mobilize LEA commitment and investment | Enlist community-based organizations | Strengthen alignment and understanding within the agency itself |
|---|---|---|---|---|
| **Potential use cases** | | | | |
| **Examples of how data could be used** | Show how child wellbeing indicators are interconnected between agencies, and could be improved if addressed through a coordinated state-level response | Demonstrate the impact of local decision-making and ability to move the needle (e.g., LEA spending in certain areas on relative to others within a state) | Ensure all stakeholders – from families to community-based orgs – are aware of the need for change and scale of the need and are compelled to act (e.g., better cost mgmt., better outcomes) | Ensure workforce buy-in for agreed upon goals and initiatives; support a change story that inspires internal teams |
| **Potential priority audience** | Governor's office, state board members, and other state-level agencies | LEAs (district leaders and school boards); Teachers and other school professionals | Broader community stakeholders | Internal teams |

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# Content

Introduction and instructions

Developing a case for change

**Developing a statewide strategy**

Appendix

Overview of state data review tool and analyses

# OVERVIEW OF THIS GUIDED EXERCISE

This section provides several thought exercises that can help cross-agency and stakeholder teams begin to develop a statewide strategy for supporting student wellbeing. See here for a sample set of actions to create change in a state.

## These exercises can help teams to:

**1** Summarize key learnings from the Initial Review document and reflect on the implications, including:

- What students in the state need
- What gaps currently exist
- How to improve the data for stronger insights

**2** Take stock of existing actions and priorities across agencies

**3** Brainstorm actions the state could take to improve school and district capacity to promote/prevent, identify, and treat student wellbeing

**4** Prioritize actions based on estimated feasibility and impact; develop a timeline for implementing these actions

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# **1** EXERCISE 1: SUMMARIZE KEY LEARNINGS FROM THE DATA

Summarize key learnings from the Initial Review document and reflect on the implications of those key learnings, including what students in the state need / what gaps currently exist in meeting those challenges, and how to improve the collected data for stronger insights. This will build on reflections from the Initial Review using your state-specific document. This should be completed after reviewing your state-specific document.

**IN THIS EXERCISE, PARTICIPANTS WILL:**

**1a** Capture key learnings from the data review into a single factsheet that can be consulted throughout all remaining exercises

**1b** Evaluate the quality of the data gathered / analyzed, describe additional or updated data that is already available, and decide whether any additional data should be collected

**1c** Reflect on the implications of those learnings

**Participants will reflect on four key questions:**

Whether there is need for increased student wellbeing supports

How wellbeing impacts academic outcomes

Whether schools and health systems have the resources to meet student wellbeing demand

How access to resources varies across the state

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## Current student wellbeing needs in [Your state]

Users should populate text in red with their own state's data, and consider adding data of their own

There is significant need for wellbeing services in the state

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25

Note to user: This is identical to the 'key learnings' page in the Case for Change section of this document

1. Note to user: This exercise is identical to the 'key learnings' page in the 'Guided exercise to develop a statewide strategy' section of this document
2. Suicide rate among individuals ages 10-24
3. CDC National Vital Statistics
4. Children ages 0-17 who experienced two or more of the following: parental divorce or separation; living with someone who had an alcohol or drug problem; neighborhood violence victim or witness; living with someone who was mentally ill, suicidal or severely depressed; domestic violence witness; parent served jail time; being treated or judged unfairly due to race/ethnicity; or death of parent
5. United Health Foundation ACEs data by state
6. U.S. Dept. of Ed Absenteeism data (2016)
7. Youth Risk Behavior Survey (2019)

CHIEFS for CHANGE

## Current student wellbeing resources and programs available to students in [Your state]

Our schools and health system [do/do not] have resources to meet student wellbeing demand

- X% of children need but did NOT receive treatment in 2019 (compared to a nationwide average of 2.3%),[2] including X% of black children, X% of Hispanic children, X% of girls, and X% of low-income children
- Schools employ X counselors per 1k students, vs. NASP-recommended ratio of 4.[3] X% of districts employ less than that ratio [users may also consider listing rates in 1-2 compared states]
- X% of children covered by Medicaid (which enrolls X% of children) visited a physician last year. X% had an annual physical

Access to resources varies across the state

- X% of counties have less than one pediatrician and less than one student wellbeing provider[4] per 10k people. X% of counties did not meet the recommended ratio of 3.3 student wellbeing providers per 10k people[5] [users could indicate that rural counties tend to have fewer resources, if true]
- X% of counties have zero child and adolescent psychiatrists [users could indicate that rural counties tend to have fewer resources, if true]
- Districts staff X psychologists per 1k students; X% of districts did not meet the recommended ratio of 1.4 psychologists per 1k students[6] [users could indicate that urban/rural districts fare worse than suburban districts, if true]

**Users should populate text in red with their own state's data, and consider adding data of their own**

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**Note to user: This is identical to the 'key learnings' page in the Case for Change section of this document**

1. Note to user: This exercise is identical to the 'key learnings' page in the 'Guided exercise to develop a statewide strategy' section of this document
2. Child Health Data
3. National Center for Education Statistics
4. Psychologists, psychiatrists, and LCSWs
5. McKinsey Center for Societal Benefit Through Healthcare Vulnerable Populations Dashboard
6. National Association of Student Psychologists (NASP) recommended number of school psychologists per 1k students

CHIEFS for CHANGE

# 1b DATA QUALITY REFLECTION QUESTIONS

**Evaluate the quality of the data gathered / analyzed; decide whether any additional data should be collected**

| | | |
|---|---|---|
| Are there any questions or concerns about the timeliness, relevance, or accuracy of data (sourced publicly or internally) used in these analyses? How can these data be further investigated? | What additional data is available in our state that is relevant to our discussions? How do we get that data, and how can it be presented to add meaning to our conversation? | What data are not currently being gathered (either by the state or by LEAs) that seem promising/useful to begin gathering? What steps should be taken to collect them? |

CHIEFS for CHANGE

# INITIAL REVIEW REFLECTION QUESTIONS

## Questions about the information from exercise 1a, by theme

There [is/is not] significant need for student wellbeing services in the state
- What challenges jump out the most?
- Which compared states seem to be having more success? Why might this be?
- What are the root causes of the needs we have identified? Where can we gather more data?
- What disparities exist between different student groups (e.g., race, FPL, gender)?

These student wellbeing successes / challenges impact students' academic experience
- What school-based outcomes seem most urgent, if any (e.g., chronic absenteeism, exclusion rates)?
- How do these school-based outcomes vary by student group?
- What are the root causes of the outcomes we have identified? Where can we gather more data?

Our schools and health system [do/do not] have resources to meet student wellbeing demand
- What resource gaps seem most urgent, if any?
- Are the resource gaps evenly distributed by student group?
- Which compared states seem to be having more success? Why might this be?

Access to resources [does / does not] vary across the state
- What geographies (e.g., counties or districts) are most concerning, if any?

**Now, reflect across all the categories:** ?

What insights from this exercise seem most important, and why? What insights are most surprising?

What questions are still present that may need further investigation? How could they be answered?

What is the overall impression of current student wellbeing need and service provision in the state?

CHIEFS for CHANGE

# WHAT ARE THE IMPLICATIONS OF THE KEY LEARNINGS FROM THE DATA REVIEW?

## Questions to flesh out the implications of the exercise on the previous page

| What were some of the key reflections from the previous exercise? | From these reflections, what could the cross-agency and stakeholder team do to enhance student wellbeing? | What additional stakeholders will need to be mobilized to take these steps? |
|---|---|---|
| | | |

CHIEFS for CHANGE

# ② EXERCISE 2: TAKE STOCK OF EXISTING ACTIONS AND OPPORTUNITIES

*Leveraging reflections from Exercise 1, hold a meeting to take stock of what your and other agencies are already doing to promote/prevent, identify, and address issues related to student wellbeing.*

**IN THIS EXERCISE, USERS WILL:**

**2a** Hold a cross-team meeting to inventory existing actions each agency takes to support child wellbeing. A sample agenda could be:

- Share existing active and planned initiatives for each agency

- Group active and planned initiatives by priority; identify duplication and opportunities for collaboration

- Determine next steps, with the goal of ensuring actions are cohesive and aligned

- Set time and date for next meeting to begin brainstorming opportunities to meet other child wellbeing needs

CHIEFS for CHANGE

# ③ EXERCISE 3: BRAINSTORM ACTIONS TO IMPROVE CAPACITY TO ADDRESS STUDENT WELLBEING

*Leveraging reflections from Exercises 1 and 2, brainstorm actions that the agency could take to improve school and district capacity to promote/prevent, identify, and address issues related to student wellbeing.*

**IN THIS EXERCISE, USERS WILL:**

**3a** Brainstorm as many ideas as an individual can for actions that agencies can take to improve capacity to address student wellbeing challenges in the relevant state (an example output is provided). Think about these actions along 2 dimensions:

- Categorized by desired outcome: promotion/prevention, identification, or treatment of student mental health challenges (both in-school and out-of-school)

- Categorized by change agent: activating capacity within the organization, activating capacity from adjacent sources (e.g., through cross-agency collaboration), or building new capacity across the student wellbeing system

CHIEFS for CHANGE

**IN THIS EXERCISE, PARTICIPANTS WILL BRAINSTORM THE UNIVERSE OF ACTIONS THE AGENCY CAN TAKE TO PROMOTE/PREVENT, IDENTIFY, AND TREAT MENTAL HEALTH CHALLENGES**

| | | **Strategic question to answer** | **Potentially relevant analyses (from data review)** |
|---|---|---|---|
| **Promote / prevent** | Student wellbeing promotion/ prevention | What can one do to increase protective factors and/or prevent risk factors of mental health challenges? | 1   4a |
| **Identify** | Identification of student challenges | What can one do to increase identification and appropriate referral of students who may need extra care? | 2a   3   4b   4c |
| **Treat** | Access to care within the school setting | What can one do to provide selective or indicated student wellbeing services during school, at school, and/or by schools? | 0   3   4b   4c |
| | Access to care outside the school setting | What can one do to increase provision of selective or indicated student wellbeing services not during/at/by schools? | 0   3 |

**CHIEFS for CHANGE**

# THINK OF ALL THE ACTIONS THE AGENCY CAN TAKE TO IMPROVE STUDENT WELLBEING SERVICE PROVISION, AND DOCUMENT THEM IN THE APPROPRIATE PLACE BELOW

## POTENTIAL ACTIONS TO EXPLORE…

|  |  | **WITHIN THE AGENCY**<br>*What services can be provided directly by the agency?* | **ACROSS AGENCIES AND/OR WITH OTHER CURRENT PARTNERS**<br>What services can be provided through collaborating with others, such as state agencies or community organizations? | **BUILD NEW CAPACITY**<br>What services would require additional resources (e.g., more wellbeing workers) or state capacity to provide? |
|---|---|---|---|---|
| **Promote / prevent** | **Student wellbeing promotion / prevention** What can one do to increase protective factors and/or prevent risk factors of mental health challenges? |  |  |  |
| **Identify** | **Identification of student challenges** What can one do to increase identification and appropriate referral of students who may need extra care? |  |  |  |
| **Treat** | **Access to care within the school setting** What can one do to provide selective or indicated wellbeing services during school, at school, and/or by schools? |  |  |  |
| **Treat** | **Access to care outside the school setting** What can one do to increase provision of selective or indicated wellbeing services not during/ at/by schools? |  |  |  |

CHIEFS for CHANGE

# EXAMPLE OF HIGH POTENTIAL INITIATIVES TO CONSIDER ACROSS THESE THEMES

**POTENTIAL ACTIONS TO EXPLORE…**

| | | WITHIN THE AGENCY | ACROSS AGENCIES AND/OR WITH OTHER CURRENT PARTNERS | NEW CAPACITY |
|---|---|---|---|---|
| **Promote / prevent** | **1** STUDENT WELLBEING PROMOTION | • Provide statewide teacher PD that includes comprehensive student wellness and academic development programming or offer "approved" options for LEAs to select locally<br>• Fully-scale trauma-informed approaches programming to all schools / districts, through a district-driven model<br>• Scale programming for providing families resources on family engagement, parent support networks, and supporting their children non-academically | • Establish / expand and fund statewide partnerships with community-based organizations to deliver high-quality, accessible afterschool programming | |
| **Identify** | **2** IDENTIFICATION OF STUDENT CHALLENGES | • Comprehensively scale mental health triage courses for all school professionals<br>• Note: scaling trauma-informed approaches programming will also cover identification of a subset of challenges | | |
| **Treat** | **3** ACCESS TO CARE WITHIN THE SCHOOL SETTING | • Build capability (e.g., through professional development) among school nurses to respond to and provide care for Tier 2 challenges | • Utilize local social workers to provide in-school supports<br>• Facilitate 'shared services' model for regional groups of districts to deploy specialized in-school providers together | • Catalyze broader state government to increase the number of in-school specialists available to students (e.g., through increased compensation to drive at-scale recruitment) |
| | **4** ACCESS TO CARE OUTSIDE THE SCHOOL SETTING | • Maintain an active referral network of high-performing community partners for school professionals to leverage<br>• Create formal linkages with Dept. of student wellbeing programs for uninsured students (incl. through educating school-based professionals) | • Work to activate PCPs as providers to screen for and address low-acuity mental health challenges (incl. through formal linkages between districts and providers)<br>• Develop infrastructure / funding to increase availability of telehealth services, in coordination with Dept. of Health | • Scale state Systems of Care to provide effective wraparound services for children and families<br>• Advocate for vertical integration of student wellbeing services within broader health and education systems (funded by Medicaid or new funding source) |

CHIEFS for CHANGE

# 4 EXERCISE 4: BRAINSTORM ACTIONS TO IMPROVE CAPACITY TO ADDRESS STUDENT WELLBEING

*Prioritize actions for the agency based on estimated feasibility and impact; assign responsibilities and develop a timeline for implementing these actions.*
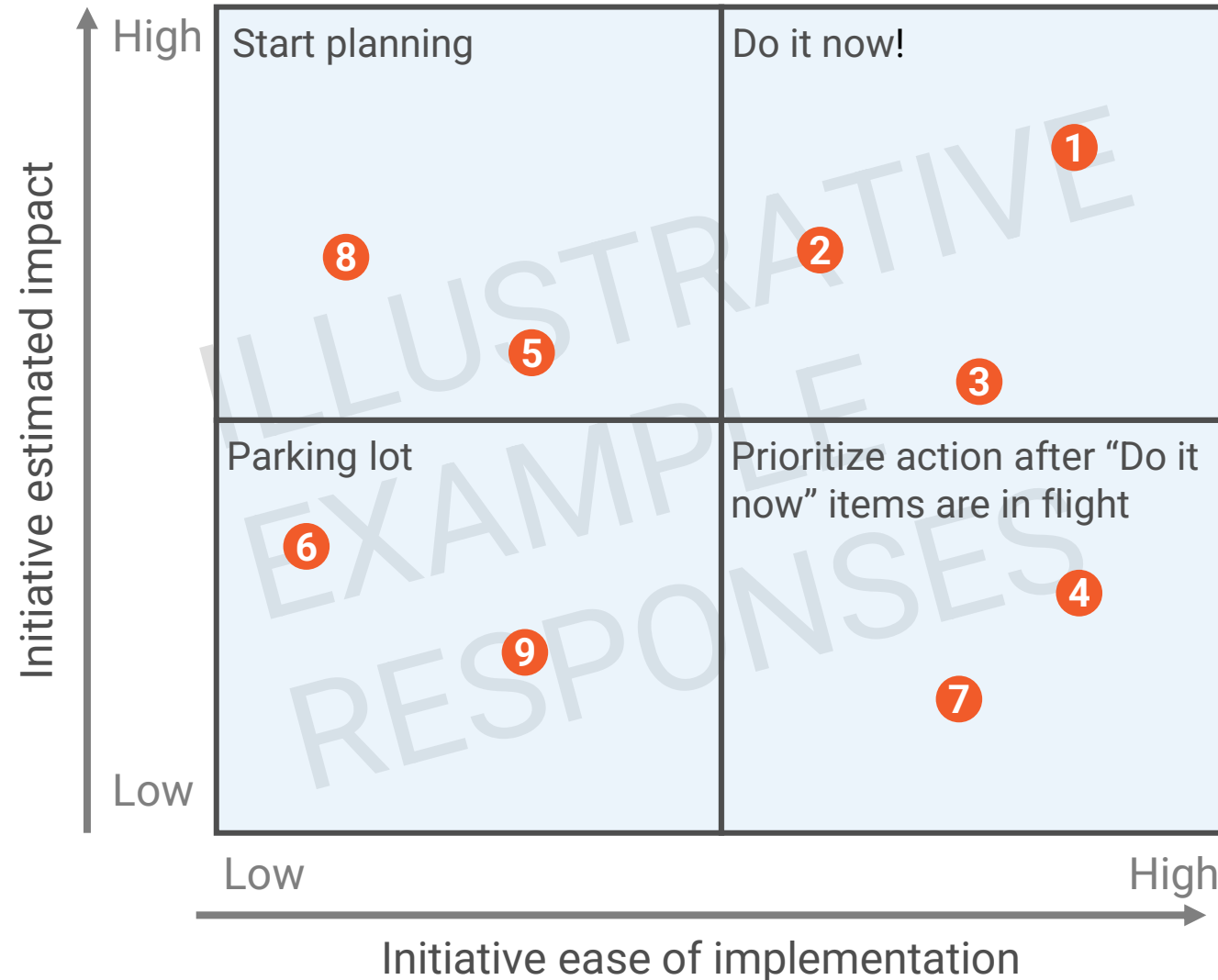
**IN THIS EXERCISE, PARTICIPANTS WILL:**

**4a** Estimate the ease of implementation and impact of each proposed action, and map the actions to identify top-priority actions that can be initiated immediately, and actions that will require longer-term planning

**4b** Align as a team on a complete, 1-2 sentence summary of the top priority actions (example output provided)

**4c** Assign responsibilities for completing each priority action, and develop a cadence of check-ins to coordinate team progress

**4d** Work with action leads to develop a 3-year roadmap for accomplishing the priority actions, including estimates of agency effort required for each action in each year (example output provided)

CHIEFS for CHANGE

# MAP THE INITIATIVES IDENTIFIED IN 2A BY FEASIBILITY AND IMPACT

## Key steps

- Plot ideas based on estimated impact and ease of implementation (quantified, where possible)
- Align the team on positioning of initiatives
- Dig deeper in cases where an initiative's position is in question

Initiative estimated impact →

**High**

| Start planning | Do it now! |
|---|---|
| ⑧  ⑤ | ① ② ③ |
| Parking lot | Prioritize action after "Do it now" items are in flight |
| ⑥  ⑨ | ④ ⑦ |

**Low**

Low      High

Initiative ease of implementation →

*ILLUSTRATIVE EXAMPLE RESPONSES*

## Initiative list

① ...
② ...
③ ...
④ ...
⑤ ...
⑥ ...
⑦ ...
⑧ ...
⑨ ...

CHIEFS for CHANGE

# LIST THE HIGH-PRIORITY ACTIONS AND PROVIDE A COMPLETE, SUCCINCT SUMMARY

**1** [Priority action here]: [provide summary here]

**2** [Priority action here]: [provide summary here]

**3** [Priority action here]: [provide summary here]

**4** [Priority action here]: [provide summary here]

**5** [Priority action here]: [provide summary here]

**6** [Priority action here]: [provide summary here]

CHIEFS for CHANGE

# EXAMPLE OF A COMPLETE, SUCCINCT SUMMARY OF PRIORITY ACTIONS

**1** **Improve support for teachers and staff to provide positive supports and basic screening for mental health challenges**: Expand current mental health programming to reach teachers in X%+ of schools by 202X using a district-led model; train nurses and school counselors to identify mental-health challenges and/or address lower-acuity challenges directly

**2** **Scale effective school climate practices:** Support districts in prioritizing in-classroom supports, establishing positive approaches to discipline, and enriching elective programming to improve student experience and engagement in order to significantly improve measures of student connection and sense of belonging. Monitor and track data disaggregated by race/ethnicity, gender, FPL, EL status, and IEP code

**3** **Increase the number of student wellbeing service providers available for school-based roles:** Launch statewide recruitment and retention effort, in partnership with districts and compared agencies, to help districts fill funded and open positions – and to add up to X school counselors, X school psychologists, and X social workers by 202X to ensure access for all students

**4** **Improve availability of family supports**: Expand resources to families – consider launching school-based centers providing resources for families in economically distressed or at-risk counties by 202X; in addition, standardize supports across resource centers to ensure all families have access to high-quality resources

**5** **Improve accessibility of existing out-of-school provider capacity:** Provide additional capacity (e.g., increased number of student wellbeing coordinators) and supports (e.g., technical assistance) for districts to build partnerships with high-performing community partners / providers, including PCPs; ensure that X% of key school staff know how to refer students for Tier III (indicative) care to the community by 202X

**6** **Activate mental-health workforce improvements to meet the challenges of students**: In service of student challenges, launch a medium- to longer-term multiagency effort to expand capacity of mental-health providers (by, e.g., increasing capacity of provider preparation programs); expand total provider capacity in counties with insufficient capacity by X%+ by 202X

CHIEFS for CHANGE

# IDENTIFY PRIMARY OWNERS AND EXTERNAL STAKEHOLDERS FOR EACH OF THE PRIORITY ACTIONS

| STRATEGY | Potential exec. sponsor | Potential action owner | Primary engagement channel | External stakeholders |
|---|---|---|---|---|
| **1** [Priority action here] | [First Last], [organization name] | [First Last], [organization name] | [e.g., districts, states, compared agencies] | [e.g., trainers, school/district leaders, community partners] |
| **2** [Priority action here] | [First Last], [organization name] | [First Last], [organization name] | [e.g., districts, states, compared agencies] | [e.g., trainers, school/district leaders, community partners] |
| **3** [Priority action here] | [First Last], [organization name] | [First Last], [organization name] | [e.g., districts, states, compared agencies] | [e.g., trainers, school/district leaders, community partners] |
| **4** [Priority action here] | [First Last], [organization name] | [First Last], [organization name] | [e.g., districts, states, compared agencies] | [e.g., trainers, school/district leaders, community partners] |
| **5** [Priority action here] | [First Last], [organization name] | [First Last], [organization name] | [e.g., districts, states, compared agencies] | [e.g., trainers, school/district leaders, community partners] |
| **6** [Priority action here] | [First Last], [organization name] | [First Last], [organization name] | [e.g., districts, states, compared agencies] | [e.g., trainers, school/district leaders, community partners] |

## Internal forums to manage progress could include:

- Effort-wide Steering Team:
  - Members: Owners of each strategy, plus Commissioner and other members of Cabinet as needed
  - Frequency: Quarterly
  - Mandate: Clear roadblocks, track key metrics, make pivots at the strategy level
- Content-area problem-solving groups:
  - Where helpful, organize groups across priority actions to regularly help each other problem solve challenges and coordinate actions

PRELIMINARY – to be further refined

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# 4d FOR EACH PRIORITY ACTION, THINK THROUGH WHAT (IF ANYTHING) NEEDS TO BE DONE EACH YEAR, AND ESTIMATE EFFORT REQUIRED

Agency effort required:

◯ Low    ◖ Medium    ● High

| STRATEGY | 1st school year | 2nd school year | 3rd school year |
|---|---|---|---|
| 1 [Priority action here] | | ● | | ● | | ● |
| 2 [Priority action here] | | ◖ | | ◖ | | ◖ |
| 3 [Priority action here] | | ◔ | | ◔ | | ◔ |
| 4 [Priority action here] | | ● | | ● | | ● |
| 5 [Priority action here] | | ◖ | | ◖ | | ◖ |
| 6 [Priority action here] | | ◔ | | ◔ | | ◔ |

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# 4d EXAMPLE 3-YEAR ROADMAP

Agency effort required:  ◗ Low  ◖ Medium  ● High

| STRATEGY | 2022-2023 school year | | 2023-2024 school year | | 2024-2025 school year | |
|---|---|---|---|---|---|---|
| **1** Improve support for teachers and staff to provide positive supports and basic screening for mental health needs | Deliver trauma pilot cohort; develop project plan for district model; pilot expanded PD | ● | Launch district trauma cohort; launch expanded PD (e.g., MH-TIPS[1] for nurses) | ◔ | Scale district trauma model statewide; refine expanded PD offerings based on uptake/effectiveness | ◖ |
| **2** Scale effective school climate practices | Support LEA planning of enrichment programming; promote climate survey (e.g., via incentive) | ● | Make funds available to (all or selected) districts to improve restorative practices or PBIS | ◔ | Monitor discipline and attendance data; provide additional supports to districts as needed | ◔ |
| **3** Increase the number of student wellbeing service providers available for school-based roles | Launch statewide recruitment effort; identify newly funded positions via district plans | ◖ | Monitor fill rate of new positions and determine system support model (e.g., signing bonuses) | ● | Continue to monitor progress toward targets and refine support model accordingly | ◔ |
| **4** Improve availability of family supports | Articulate 3-year family center expansion plan; conduct needs assessment; find funding source | ◖ | Launch new centers in 5+ counties; launch standardized supports informed by needs assessment | ◔ | Launch remaining new centers; conduct needs assessment "2.0" using standardized metrics | ◖ |
| **5** Improve accessibility of existing out-of-school provider capacity | Draft district-facing playbook; increase number of student wellbeing coordinators; open applications for new roles | ● | Test, refine, and launch playbook; hire any remaining new student wellbeing coordinators | ◔ | Monitor districts' responses re: referral and refine approach accordingly | ◔ |
| **6** Activate mental health workforce improvements to meet the needs of students | Share fact base and revised case for change with compared agencies (and sectors); convene (or join) multi-agency working group to expand student wellbeing provider capacity statewide | ◔ | Identify and launch priority actions for each agency/stakeholder; monitor progress toward goals | ◖ | Continue to monitor progress toward goals | ◔ |

1. Mental Health Training Intervention for Health Providers in Schools

CHIEFS for CHANGE

# CONTENT

Introduction and instructions

Developing a case for change

Developing a statewide strategy

**Appendix**

Overview of state data review tool and analyses

CHIEFS for CHANGE

# COVID-19 DISCLAIMER

These materials are being provided on an accelerated basis in response to the COVID-19 crisis. These materials reflect general insight based on currently available information, which has not been independently verified and is inherently uncertain. Future results may differ materially from any statements of expectation, forecasts, or projections. These materials are not a guarantee of results and cannot be relied upon. These materials do not constitute legal, medical, policy, or other regulated advice and do not contain all the information needed to determine a future course of action. Given the uncertainty surrounding COVID-19, these materials are provided "as is" solely for information purposes without any representation or warranty, and all liability is expressly disclaimed. References to specific products or organizations are solely for illustration and do not constitute any endorsement or recommendation.

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CHIEFS for CHANGE

# CONTENT

Introduction and instructions

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Developing a statewide strategy

Appendix

**Overview of state data review tool and analyses**

CHIEFS for CHANGE

# TYPES OF DATA AN AGENCY MIGHT CONSIDER USING IN CONDUCTING A DATA REVIEW

## Internal agency data (already available)

Agencies can access much of the data needed (e.g., absenteeism, available space) to define key needs and potential resources.

## Publicly available data sources

Existing public resources often have data on topics like prevalence of student wellbeing needs.

## Supplementary agency-collected data

Agencies can gather locally collected data from LEAs or obtain new data via surveys (e.g., survey key stakeholders, add questions to existing surveys).

Used for analyses created by this tool

CHIEFS for CHANGE

# THE INITIAL REVIEW DOCUMENT CONTAINS SELECT, NON-COMPREHENSIVE ANALYSES (USING PUBLICLY AVAILABLE DATA) ON KEY COMPONENTS OF WELLBEING

| | Components | Description | Example questions to answer for each component |
|---|---|---|---|
| 0 | Understanding current diagnoses | Measures of current diagnoses of mental health conditions and neurological disorders in children and youths | • What is the prevalence of diagnosed mental health conditions and neurological disorders (e.g., anxiety, depression, ADD/ADHD), including by demographic subgroups? |
| 1 | Positive wellbeing outcomes | Measures of student connectedness and safety, as well as attainment of a healthy mental state (e.g., social skills, coping, self-regulation, self-esteem, resilience) | • To what degree do students report a sense of belonging / connection to school?<br>• How safe do students feel?<br>• Have students attained a healthy mental state (e.g., social skills, coping, self-regulation, self-esteem, resilience)? |
| 2 | Adverse mental health and substance misuse outcomes | Measures of effects of adverse mental health outcomes, including student distress and significant changes in thinking, emotion, or behavior | • What is the current rate of suicide (and suicidal ideation) among students?<br>• How many students are at risk of mental illness (proxied by e.g., prevalence of ACEs across students)?<br>• What is the rate of student substance misuse (e.g., rate of underage drinking)? |
| 3 | School-based indicators | Measures of academic and other school-based successes that may be affected by student wellbeing | • What are the rates of key negative student outcomes (e.g., absenteeism)? |
| 4 | Inputs / supports for student wellbeing | Measures of current implementation of positive practices in schools | • What is the availability and adoption of professional development and other school training / programming for teachers and staff to promote student wellbeing (e.g., trauma-informed training, Positive Behavioral Interventions and Supports (PBIS))? |
| | | Assessment of ability to identify in-need students | • Is identification and referral occurring before students reach a point of academic or behavioral health crisis? |
| | | Indicators of access to care inside schools | • What is the shortage of key roles in schools relative to recommended levels (identified and sourced later in the document)? Is there variance by locality and/or by demographic subgroups? |
| | | Indicators of access to care outside schools, including to overall health care (including primary and specialty care) | • What is the shortage of key roles outside schools relative to recommended levels? Is there variance by locality and/or by demographic subgroups?<br>• At what rate are students accessing overall health care (e.g., PCP visits)? |

1. Flourishing is defined as children who show affection, resilience, interest and curiosity in learning, and smile and laugh a lot; data sourced from National Survey of Children's Health, U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB)

Data accessed December 1, 2021

CHIEFS for CHANGE

# INCLUDED IN THE INITIAL REVIEW DOCUMENT: UNDERSTANDING CURRENT DIAGNOSES

| Questions to explore | Analyses to consider | Helpful data sources | Data granularity |
|---|---|---|---|
| What is the prevalence of children experiencing mental, emotional, developmental, or behavioral challenges (e.g., anxiety, depression, ADD/ADHD), including by demographic subgroups? | 0 Current state share of children with a mental, emotional, developmental, or behavioral need against comparison states and national average, including by race/ethnicity and income level | Child Health Data | State-level |

Data accessed December 1, 2021

# INCLUDED IN THE INITIAL REVIEW DOCUMENT: PROMOTION OF POSITIVE OUTCOMES

| Questions to explore | Analyses to consider | | Helpful data sources | Data granularity |
|---|---|---|---|---|
| How safe do students appear to be online? | 1a | Benchmark share of students experiencing electronic bullying compared to states and national average | CDC Youth Risk Behavior Surveillance System (YRBSS) | State-level |
| Have students attained a healthy mental state (e.g., social skills, coping, self-regulation, self-esteem, resilience)? | 1b | Benchmark share of students aged 6 to 17 years who are flourishing | National Survey of Children's Health | State-level |
| | 1c | Benchmark share of students who are able to make or keep friends | National Survey of Children's Health | State-level |

Consider visiting statesleading.org to learn more about what states are doing to promote positive health outcomes in schools

Data accessed December 1, 2021

CHIEFS for CHANGE

# INCLUDED IN THE INITIAL REVIEW DOCUMENT: PREVENT AND / OR ADDRESS ADVERSE MENTAL HEALTH AND SUBSTANCE USE OUTCOMES

| **Questions to explore** | **Analyses to consider** | | **Helpful data sources** | **Data granularity** |
|---|---|---|---|---|
| **What is the current rate of suicide (and suicidal ideation) among students?** | 2a | Benchmark adolescent and young adult suicide rate to national rate | CDC National Vital Statistics | State-level |
| **How many students are at risk of mental illness (proxied by, e.g., prevalence of ACEs across students)?** | 2b | Benchmark share of children experiencing ACEs relative to compared states and national average | United Health Foundation ACEs data by state | State-level |
| | 2c | Adolescent substance misuse rates | SAMHSA Data Archive | |

Visit this CCSSO resource to learn more about how to deploy the MTSS framework to positive health outcomes and prevent and address adverse mental health and substance misuse outcomes

Data accessed December 1, 2021

CHIEFS for CHANGE

# INCLUDED IN THE INITIAL REVIEW DOCUMENT: SCHOOL-BASED OUTCOMES

| Questions to explore | Analyses to consider | Helpful data sources | Data granularity |
|---|---|---|---|
| What are the rates of key negative student outcomes (e.g., absenteeism)? | **3a** Counties with the highest absenteeism | U.S. DOE absenteeism data | State- and county-level |

Visit this CCSSO resource to learn more about the relationship between family engagement and student academic outcomes

CHIEFS for CHANGE

Data accessed December 1, 2021

# INCLUDED IN THE INITIAL REVIEW DOCUMENT: UNDERSTANDING CURRENT INPUTS / SUPPORTS FOR CHILD HEALTH STATEWIDE

| Questions to explore | | Analyses to consider | Helpful data sources | Data granularity |
|---|---|---|---|---|
| **Is identification and referral occurring before students reach a point of academic or behavioral health crisis?** | 4a | % of children who need but are not receiving care, including by subgroup | Child Health Data | State-level |
| **What is the shortage of key roles in schools relative to recommended levels? Is there variance by locality?** | 4b | Access to in-school providers by LEA | NCES | State- and LEA-level |
| | 4c | Counselors, psychologists, other support staff relative to recommended levels | NCES | State- and LEA-level |

Visit this CCSSO resource to learn more about what states are doing to support student wellbeing in response to COVID-19 and other stressors on student wellbeing

Data accessed December 1, 2021

CHIEFS for CHANGE