North Carolina Initial Review

Data accessed December 1, 2021

CHIEFS
for CHANGE

Context for this document

This document is applicable to **any state-level agency hoping to leverage publicly available data diagnostics to understand how to better meet the wellbeing needs of students and catalyze change.**

The COVID-19 pandemic exacerbated several needs and challenges for K-12 students that involve student wellbeing; state agencies are using this opportunity to **rethink overall student wellbeing[1] support strategies.**

This document contains a set of analyses and questions to consider when conducting **a review of statewide student wellbeing.**

Please review the Tableau tool for additional analysis, as helpful.

1. This document focuses primarily on the mental health aspects of student wellness

Data accessed December 1, 2021

Overview of document purpose

What this document is

Inputs to a state-wide diagnostic 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

Relevant agencies may include counties, Governors' offices; state education agencies; state Medicaid agencies; and Departments of Health, Mental Health, and Children and Families

What this document 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 state-wide mental health 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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Prior to reviewing the analyses included in this tool, consider reflecting on the included data

This data review can:

- **Highlight trends** over time in key wellbeing metrics

- **Contextualize your state's** data relative to regional peer data sets

- Support **understanding key dimensions**, highlighted [here](#)

> There are **multiple valuable data sources in exploring student wellbeing**; this tool focuses on **publicly available data**.

> Your state agencies may have **different or more up-to-date internal data** that would be helpful to explore, in addition to **local and county-level internal data.**

> The pandemic has had an **unprecedented impact on student wellbeing**.

> The COVID-19 pandemic has impacted **both incidence and reporting** of student wellbeing data.

> At the same time, some researchers estimate that government responses to the pandemic could **reduce child poverty by over 50%**. **Child poverty is often [correlated with measures of wellbeing](#).**

> When considering available data, **it is important to be clear on what data is from before versus during the pandemic.**

Consider reflecting on the following questions before and as you review these analyses on student wellbeing in your state

You will have another chance to reflect on these questions in the Action Planning section of this tool

Before you review these analyses

What **agencies or community partners** have you worked with to date? Who else can you engage?

What **key actions** has your agency taken to support student wellbeing?

Where have you seen **success**?

Where do you expect to see areas of **opportunity**?

Where are you most excited to **learn more**?

As you review these analyses

Consider the **data source and likely sample size** – how might that impact how you interpret the data?

What are the **needs for child wellbeing services** in your state?

How do these **needs impact your students at school**?

Do your schools and health system have the **resources to meet this need**?

How does **the need for and access to resources vary across your state**?

After you review these analyses

What could your agency do to address the needs for child wellbeing services in your state?

How could you work with other state entities to advocate for change?

How could you set standards and improve local agency capacity to meet student wellbeing needs?

How could you work with non-governmental entities at the local / state levels to support student wellbeing?

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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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0. 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
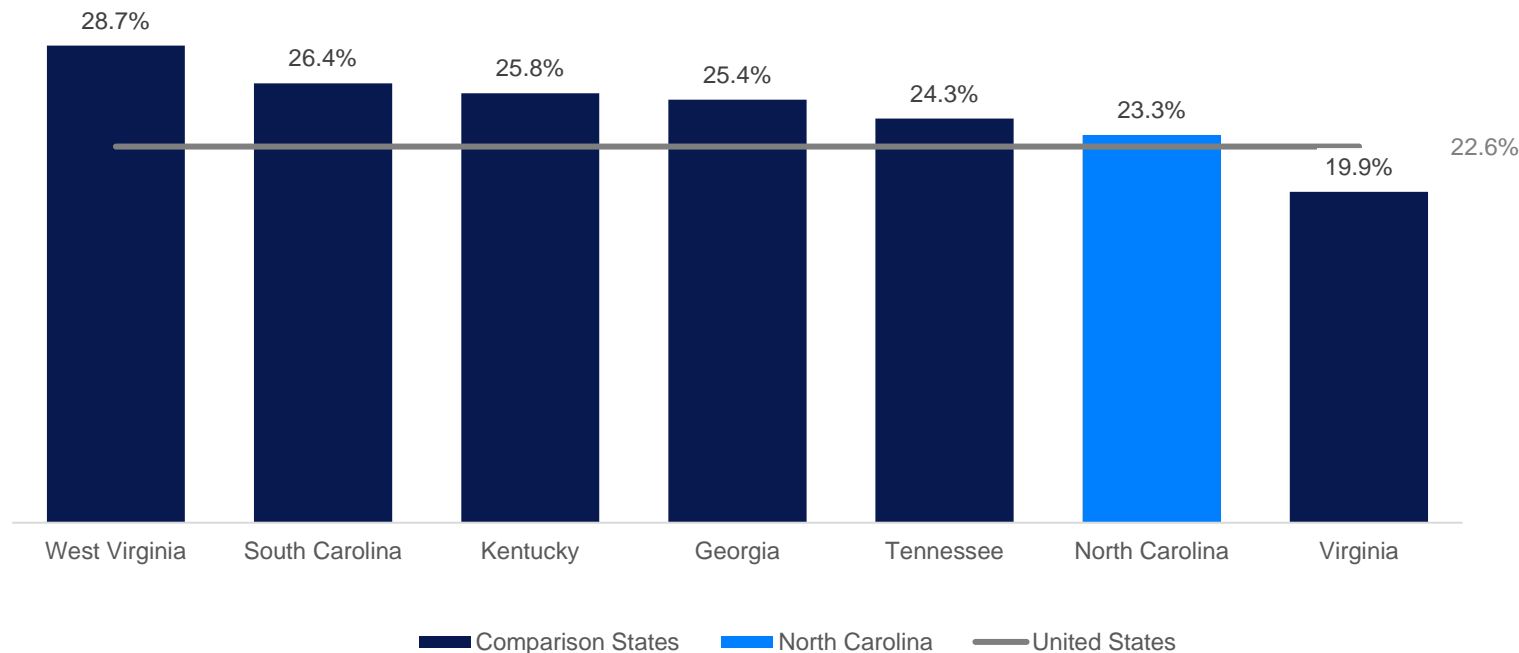
Child Health Data

State-level

Data accessed December 1, 2021

0. Children experiencing mental, emotional, developmental, or behavioral challenges

Children experiencing at least one mental, emotional, developmental, or behavioral challenge[1] (3-17 years)

% of children in North Carolina vs. comparison states (2019-2020)

Chart data:
- West Virginia: 28.7%
- South Carolina: 26.4%
- Kentucky: 25.8%
- Georgia: 25.4%
- Tennessee: 24.3%
- North Carolina: 23.3%
- Virginia: 19.9%
- United States: 22.6%

Legend: ■ Comparison States ■ North Carolina ▬ United States

Takeaways to consider

- Compare the state's rate to the US average and comparison states.
- Remember that although rates of some mental, emotional, developmental, or behavioral challenges (e.g., anxiety) captured in this measure can be decreased with prevention and/or treatment interventions, some challenges (e.g., autism) have rates that are more fixed.
- Think about how these data could be used, if appropriate, to strengthen a case for state and local agencies to take action to change the status quo.

1. Experiencing at least one of Tourette syndrome, anxiety, depression, behavioral and conduct issue, developmental delay, intellectual disability, speech or other language disorder, learning disability, autism/ASD, ADD/ADHD, or a positive screen on the CSHCN Screener
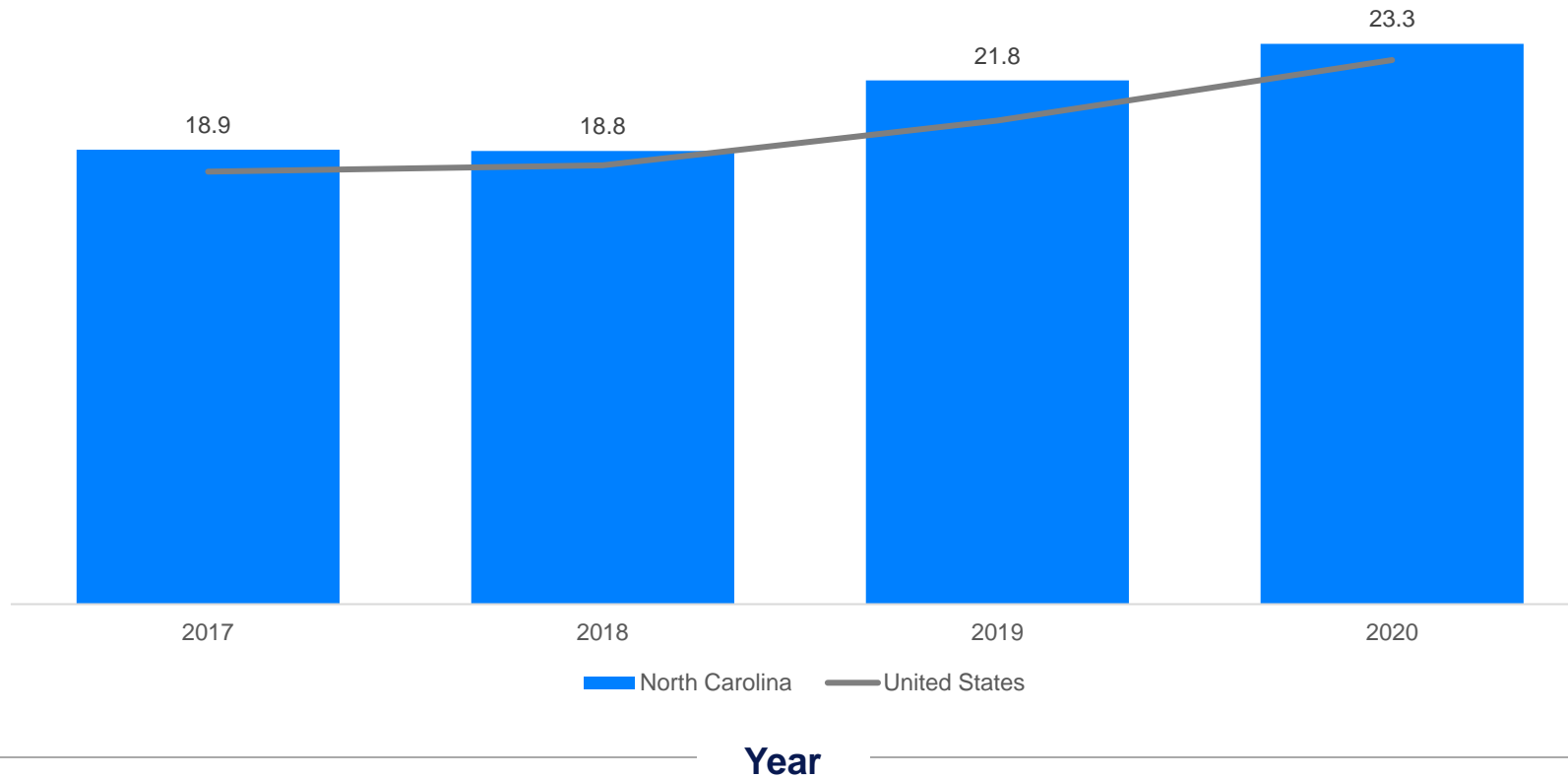
Source: Child Health Data

Data accessed December 1, 2021

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0. Children experiencing mental, emotional, developmental, or behavioral challenges over time

Children experiencing at least one mental, emotional, developmental, or behavioral challenge[1] (3-17 years)
% of children in North Carolina

Year

■ North Carolina ━ United States

Takeaways to consider

- Examine growth in rates of children experiencing at least one challenge across time and compared to the national average to contextualize the urgency of the challenge.

- Remember that although rates of some mental, emotional, developmental, or behavioral challenges (e.g., anxiety) captured in this measure can be decreased with prevention and/or treatment interventions, some challenges (e.g., autism) have rates that are more fixed.

1. Experiencing at least one of Tourette syndrome, anxiety, depression, behavioral and conduct issue, developmental delay, intellectual disability, speech or other language disorder, learning disability, autism/ASD, ADD/ADHD, or a positive screen on the CSHCN Screener

Source: Child Health Data

Data accessed December 1, 2021

0. Children experiencing mental, emotional, developmental, or behavioral challenges by race and ethnicity

Children experiencing mental, emotional, developmental, or behavioral challenge[1] by race/ethnicity (3-17 years)

% of children in North Carolina vs. comparison states (2019-2020)
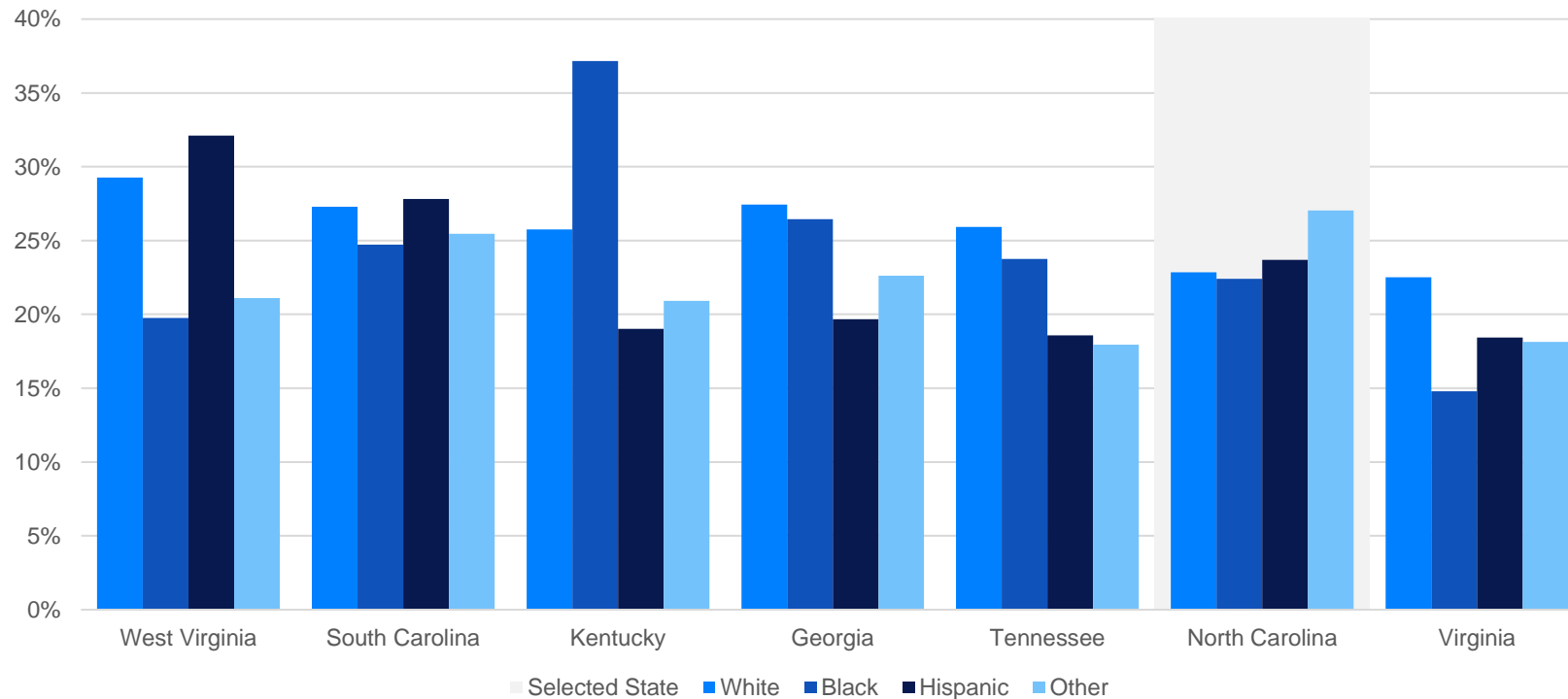
Selected State ■ **White** ■ **Black** ■ **Hispanic** ■ **Other**

Takeaways to consider

- Compare rates within the state by race/ethnicity. What subgroups are most affected?

- Compare the rates for each race/ethnicity to rates in other states. Keep in mind that lower numbers can increase the overall variability.

- Think about how these data could be used, as appropriate, to strengthen a case for state and local agencies to act.

1. Experiencing at least one of Tourette Syndrome, Anxiety, Depression, Behavioral and conduct issue, Developmental delay, Intellectual disability, Speech or other language disorder, Learning disability, Autism/ASD, ADD/ADHD, or a positive screen on the CSHCN Screener
Note: Not all states report data for all races/ethnicities
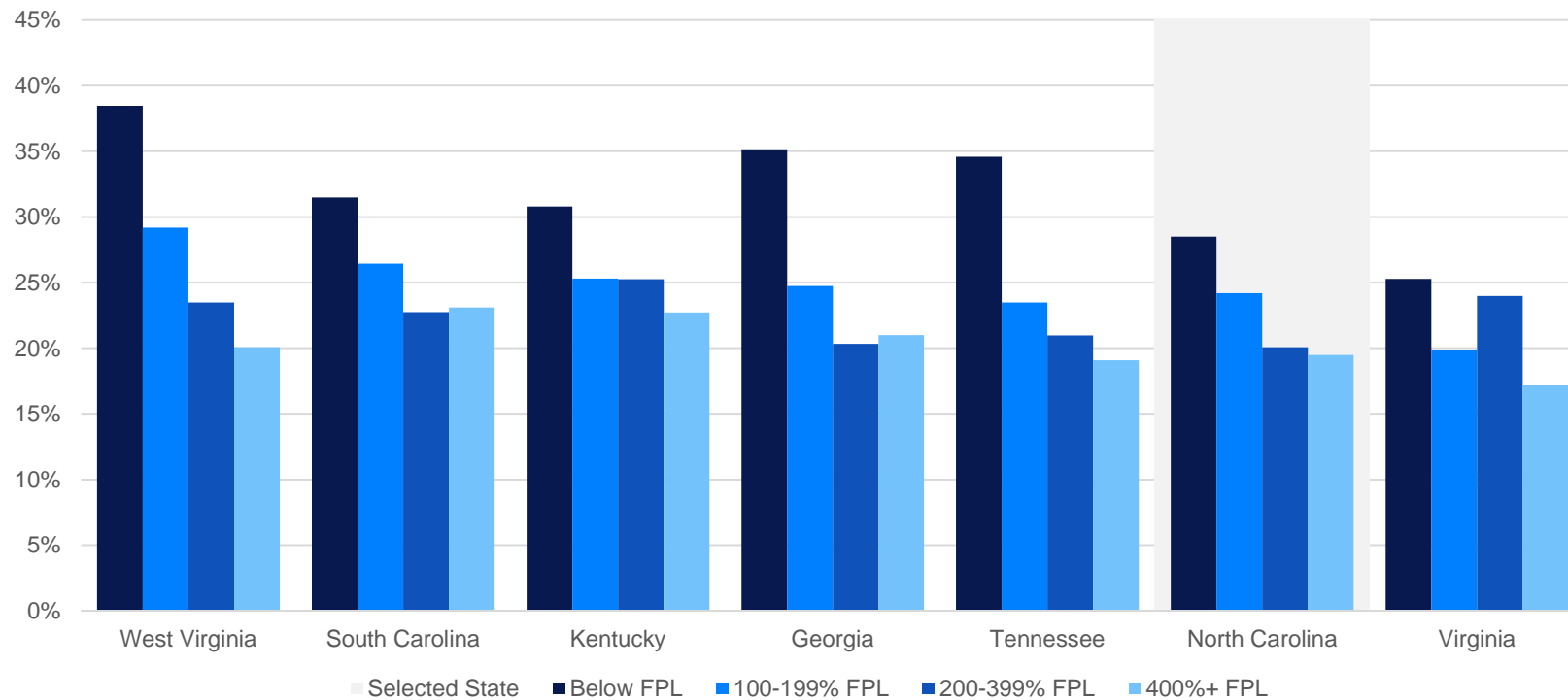
Source: Child Health Data

Data accessed December 1, 2021

0. Children experiencing mental, emotional, developmental, or behavioral challenges by income

Children experiencing mental, emotional, developmental, or behavioral challenge[1] by income level (3-17 years) <u>by household income level</u>

% of children in North Carolina vs. comparison states (2019-2020)

Legend: Selected State · Below FPL · 100-199% FPL · 200-399% FPL · 400%+ FPL

States: West Virginia, South Carolina, Kentucky, Georgia, Tennessee, North Carolina, Virginia

Takeaways to consider
- Compare rates within the state by income level. What subgroups are most affected?
- Compare the rates for each income level to rates in other states.
- Think about how these data could be used, where appropriate, to strengthen a case for state and local agencies to act.

1. Experiencing at least one of Tourette Syndrome, Anxiety, Depression, Behavioral and conduct issue, Developmental delay, Intellectual disability, Speech or other language disorder, Learning disability, Autism/ASD, ADD/ADHD, or a positive screen on the CSHCN Screener
FPL: Federal Poverty Line

Source: Child Health Data

Data accessed December 1, 2021

1. Promotion of positive outcomes

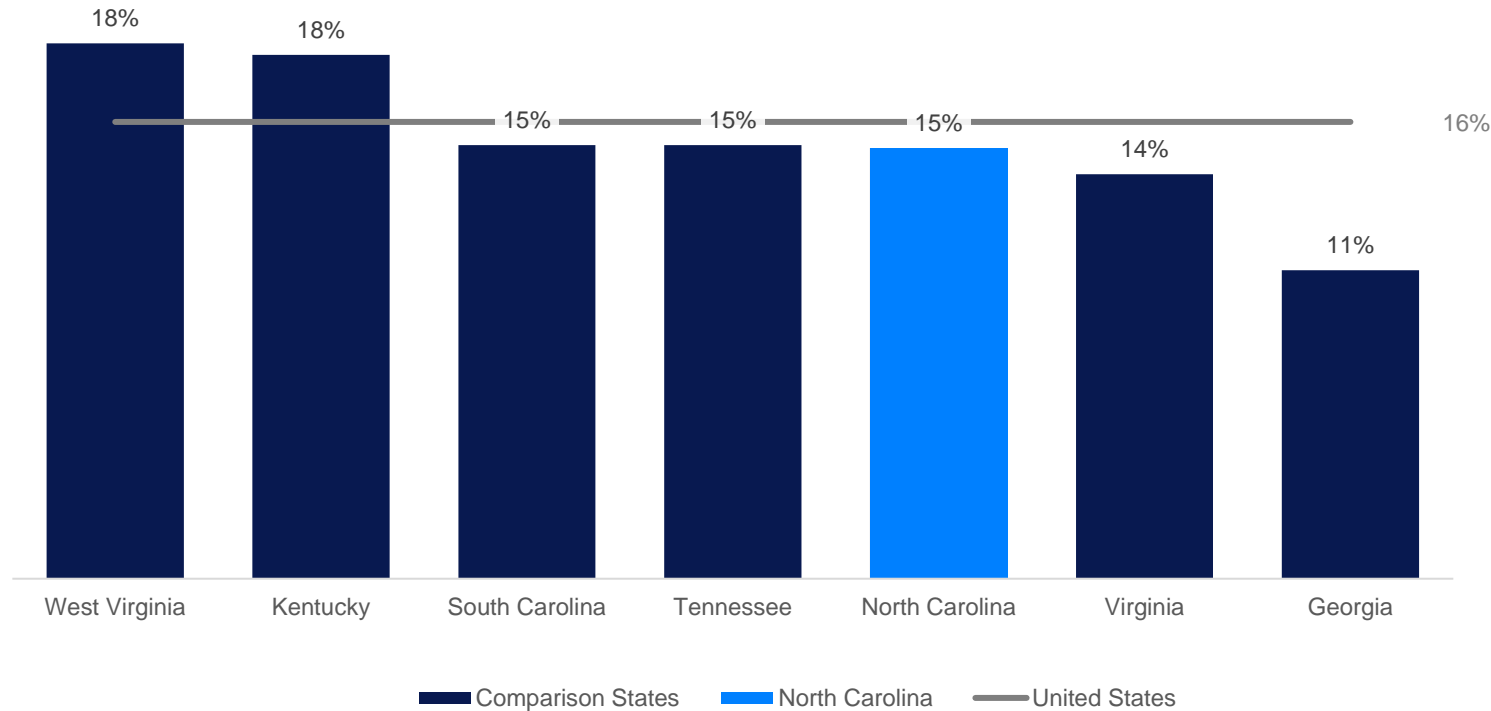| Questions to explore	Analyses to consider		Helpful data sources	Data granularity
How safe do students appear to be online?	1a	Benchmark share of students experiencing electronic bullying compared to states and national average	[CDC Youth Risk Behavior Surveillance System (YRBSS)](#)	State-level
Have 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[1]	[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

1. The National Survey of Children's Health defined a child as flourishing if they score as "always" or "usually" on all of the following indicators: (1) showing interest and curiosity in learning new things, (2) working to finish tasks he or she starts, and (3) staying calm and in control when faced with a challenge

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Data accessed December 1, 2021

1a. Benchmarking electronic bullying

Electronic bullying in North Carolina vs. comparison states
High school students experiencing electronic bullying through texting, Instagram, Facebook, or other social media, % (2018-19)

Chart values:
- West Virginia: 18% (Comparison States)
- Kentucky: 18% (Comparison States)
- South Carolina: 15% (Comparison States)
- Tennessee: 15% (Comparison States)
- North Carolina: 15% (North Carolina)
- Virginia: 14% (Comparison States)
- Georgia: 11% (Comparison States)
- United States: 16%

Legend: ■ Comparison States ■ North Carolina — United States

Takeaways to consider
- Assess the state's gap compared to the national average and to comparison states to contextualize urgency of the issue.
- Remember that "better than average" doesn't automatically mean "good" if on average bullying rates are unacceptably high.
- Consider anchoring on comparison states with similar maturity in anti-cyberbullying efforts and levels of social media penetration / broadband access.

Source: CDC Youth Risk Behavior Surveillance System (YRBSS)
Data accessed December 1, 2021

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1b. Benchmark of child / adolescent flourishing

Child / adolescent flourishing[1] in North Carolina vs. comparison states

% of children/adolescents flourishing (ages 6-17, 2019-20)

Legend: Comparison States · North Carolina · United States
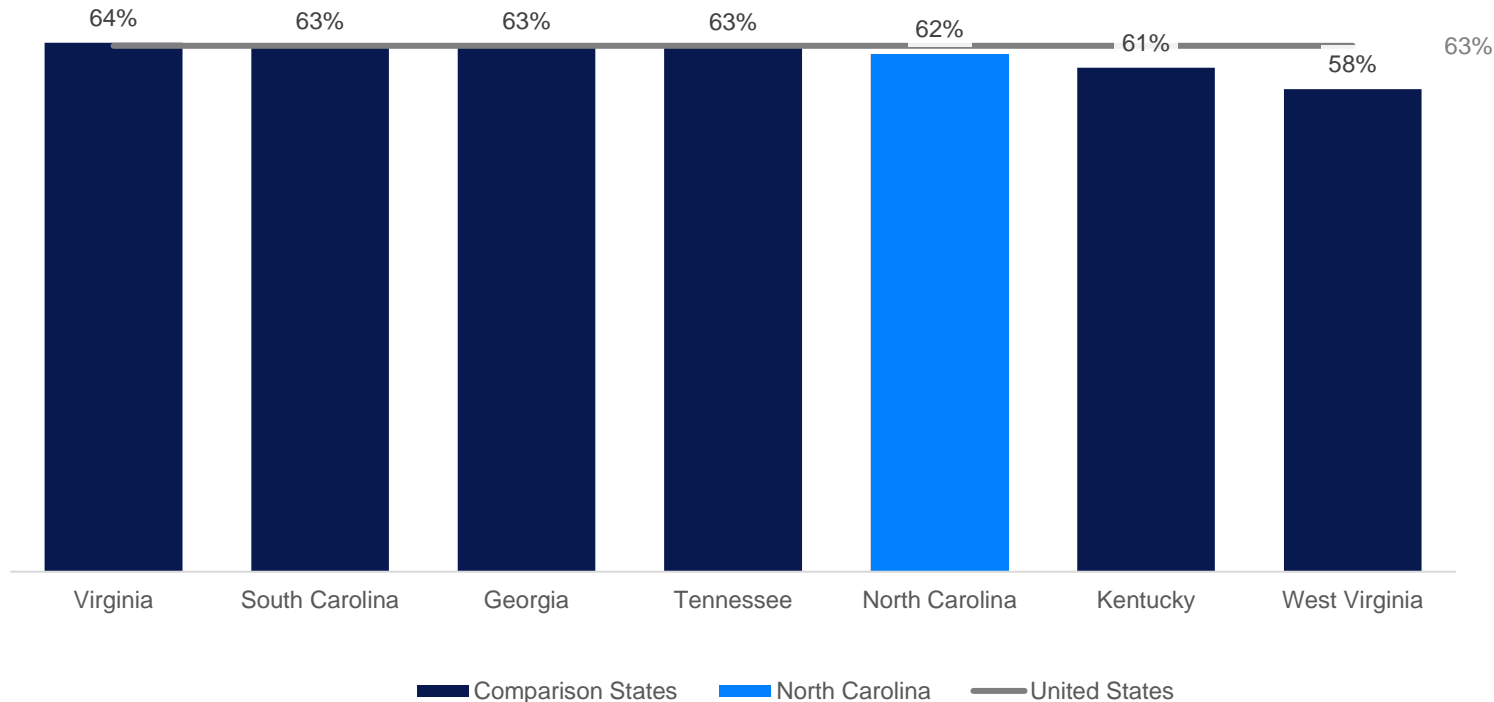
1. The National Survey of Children's Health defined a child / adolescent as flourishing if they score as "always" or "usually" on all of the following indicators: (1) showing interest and curiosity in learning new things, (2) working to finish tasks he or she starts, and (3) staying calm and in control when faced with a challenge

Source: National Survey of Children's Health
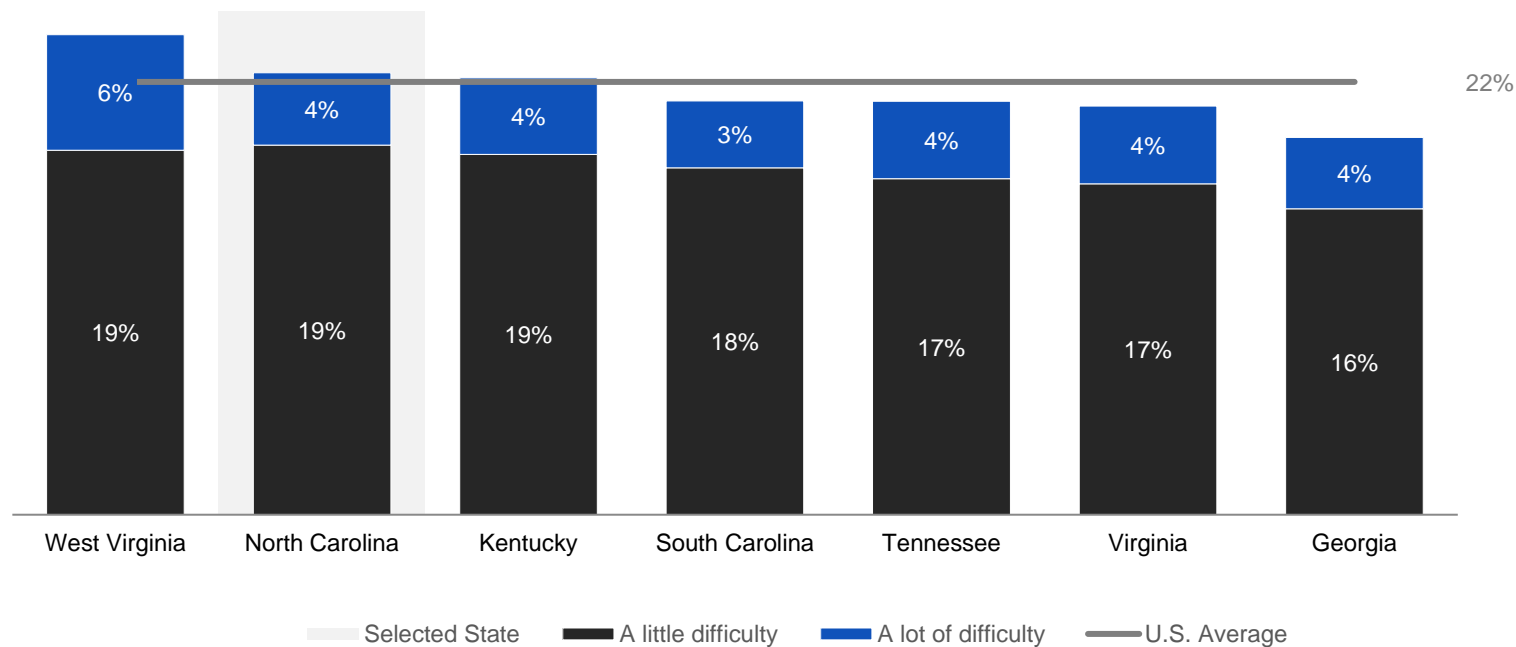
Data accessed December 1, 2021

Takeaways to consider

- Compare the state's rate to the rates of comparison states. Consider whether the state's rates are acceptable, regardless how they compare to comparison state rates.

- Reflect on what it means that in most states more than 1 in 3 students are NOT flourishing.

1c. Benchmark of child ability to make or keep friends

Child ability to make or keep friends[1] in North Carolina vs. comparison states

% of children ages 6-17 experiencing 'a little' to 'a lot' of difficulty making or keeping friends (2019-20)

Takeaways to consider

- Compare the state's rate to the rates of comparison states. Consider whether the state's rates are acceptably low, regardless of how they relate to comparison state rates.

- Reflect on what it means that in most states more than 1 in 5 students are having difficulty making and keeping friends.

1. "Compared to other children his or her age, how much difficulty does this child have making or keeping friends, age 6-17 years?"
2. Note: Students not experiencing any difficulty making or keeping friends have been omitted, and make up the remaining percentage of each stacked bar (adding to 100%)
Source: National Survey of Children's Health

Data accessed December 1, 2021

2. 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](#)	

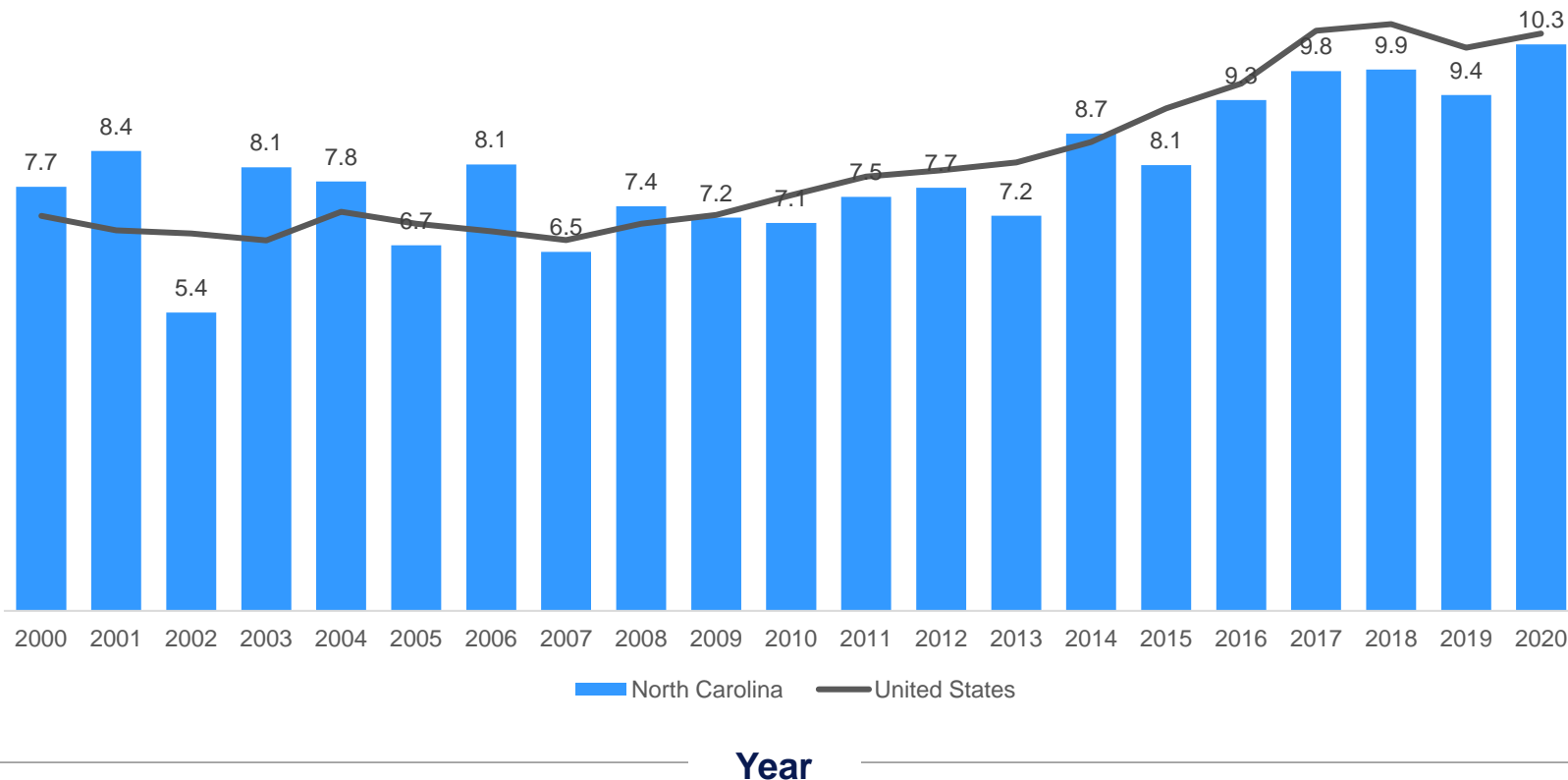**Visit this CCSSO resource to learn more about how to deploy the MTSS framework to promote positive health outcomes and prevent and address adverse mental health and substance misuse outcomes**

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2a. Adolescent and young adult suicide rate in North Carolina compared to national rate

Adolescent and young adult suicide rate (ages 10-24)
Deaths by suicide per 100,000 adolescents and young adults

North Carolina values: 7.7 (2000), 8.4 (2001), 5.4 (2002), 8.1 (2003), 7.8 (2004), 6.7 (2005), 8.1 (2006), 6.5 (2007), 7.4 (2008), 7.2 (2009), 7.1 (2010), 7.5 (2011), 7.7 (2012), 7.2 (2013), 8.7 (2014), 8.1 (2015), 9.3 (2016), 9.8 (2017), 9.9 (2018), 9.4 (2019), 10.3 (2020)

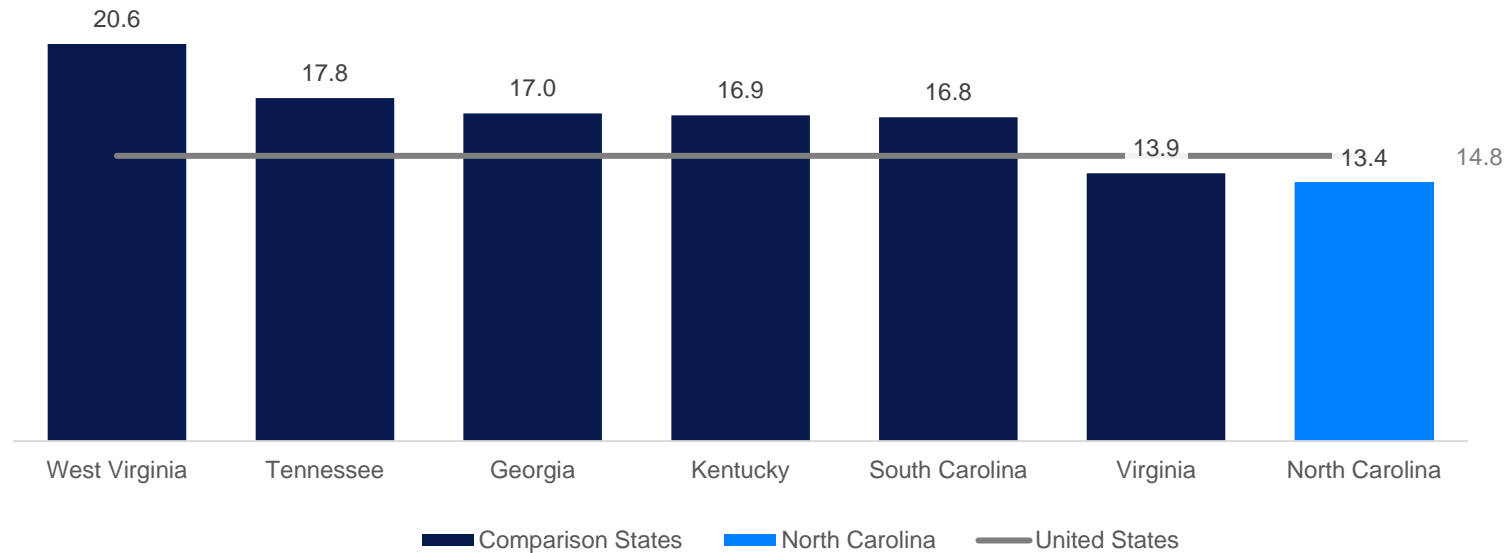Legend: North Carolina — United States

Year

Takeaways to consider

- Examine growth in rates of suicide across time and compared to the national average to contextualize urgency of the challenge.

- To view a state-by-state comparison, please visit the Tableau tool.

- Place in context of recent social or economic developments (e.g., job loss at state level, COVID-19, etc.).

Source: CDC National Vital Statistics
Data accessed December 1, 2021

2b. Children experiencing two or more adverse childhood experiences (ACEs) relative to comparison states, US average

Children experiencing two or more ACEs[1] (0-17 years)
% of children in North Carolina vs. comparison states (2018-2019)

Legend: ■ Comparison States ■ North Carolina — United States

Takeaways to consider

- Assess the state's gap compared to national average and comparison states to contextualize urgency of the challenge.
- Remember that "better than average" doesn't necessarily mean "good."

The CDC **links ACEs to increased risk of childhood mental illness** – and several negative student outcomes (e.g., school failure, substance misuse, high-risk behavior, and mental illness)

1. 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 (2-year estimate)

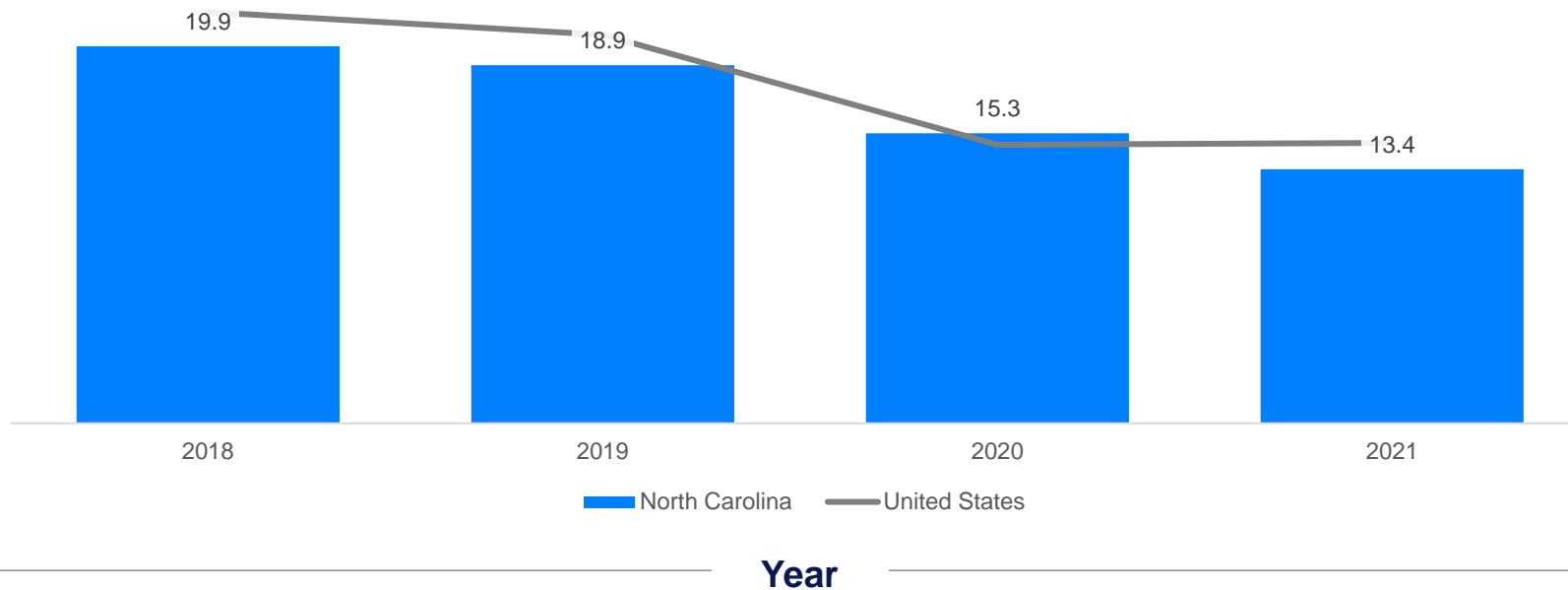Source: United Health Foundation ACEs data by state

Data accessed December 1, 2021

2b. Children experiencing two or more adverse childhood experiences (ACEs) over time

Children experiencing two or more ACEs[1] (0-17 years)
% of children in North Carolina

The CDC **links ACEs to increased risk of childhood mental illness** – and several negative student outcomes (e.g., school failure, substance misuse, high-risk behavior, and mental illness)

Takeaways to consider
- Examine growth in rates of ACEs across time and compared to the national average to contextualize the urgency of the challenge.
- Place in context of recent social or economic developments (e.g., job loss at state level, COVID-19, etc.).

1. 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 (2-year estimate)
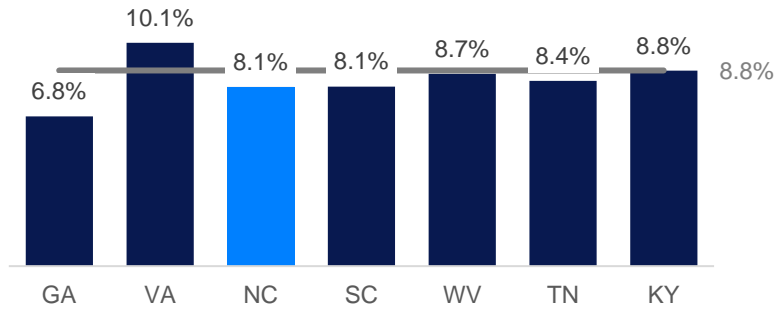
Source: United Health Foundation ACEs data by state

Data accessed December 1, 2021

2c. Youth substance use

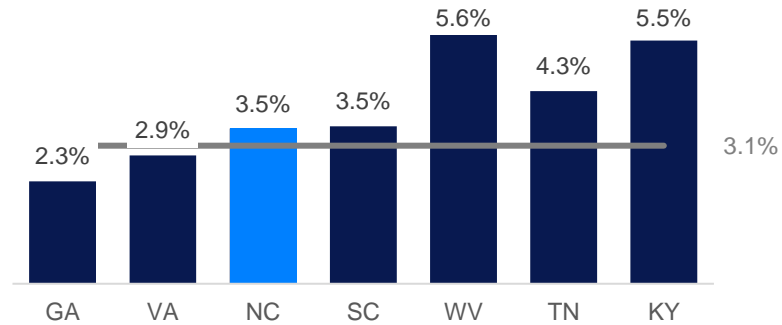**Legend:** ■ Comparison States ■ North Carolina ■ United States

Current alcohol use (ages 12-17)
(At least 1 drink of alcohol during the 30 days before the survey; 2018-19)

	GA	VA	NC	SC	WV	TN	KY
%	6.8%	10.1%	8.1%	8.1%	8.7%	8.4%	8.8%

US: 8.8%

## Current tobacco[1] use (ages 12-17)
(At least 1 use of tobacco during the 30 days before the survey; 2018-19)

	GA	VA	NC	SC	WV	TN	KY
%	2.3%	2.9%	3.5%	3.5%	5.6%	4.3%	5.5%

US: 3.1%

Current marijuana use (ages 12-17)
(At least 1 use of marijuana during the 30 days before the survey; 2018-19)

	GA	VA	NC	SC	WV	TN	KY
%	4.2%	5.0%	5.1%	4.6%	6.2%	5.5%	5.7%

US: 6.6%
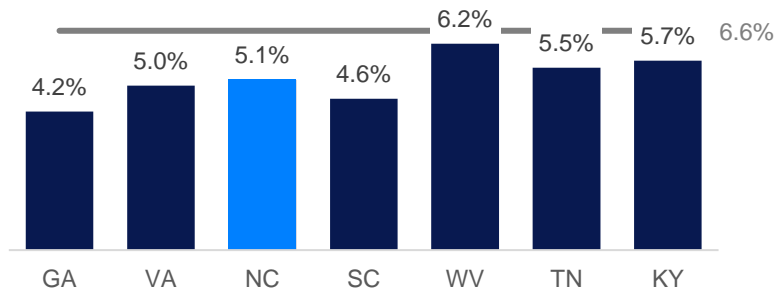
Current illicit drug use (ages 12-17)
(At least 1 use of an illicit drug (not marijuana) during the 30 days before the survey; 2018-19)

	GA	VA	NC	SC	WV	TN	KY
%	1.7%	1.5%	1.8%	2.5%	1.5%	2.0%	1.7%

US: 1.8%
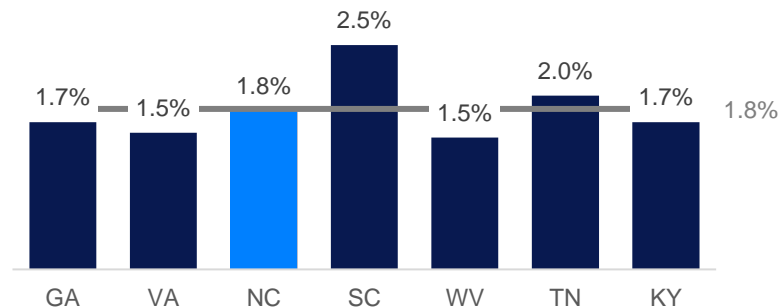
Takeaways to consider

- Compare the state's youth substance use rate to the US average. Consider whether the state's substance misuse rates are acceptably low, regardless how they compare to the US average.

1. Excludes nicotine vaping

Source: SAMHSA Data Archive

Data accessed December 1, 2021

3. School-based indicators

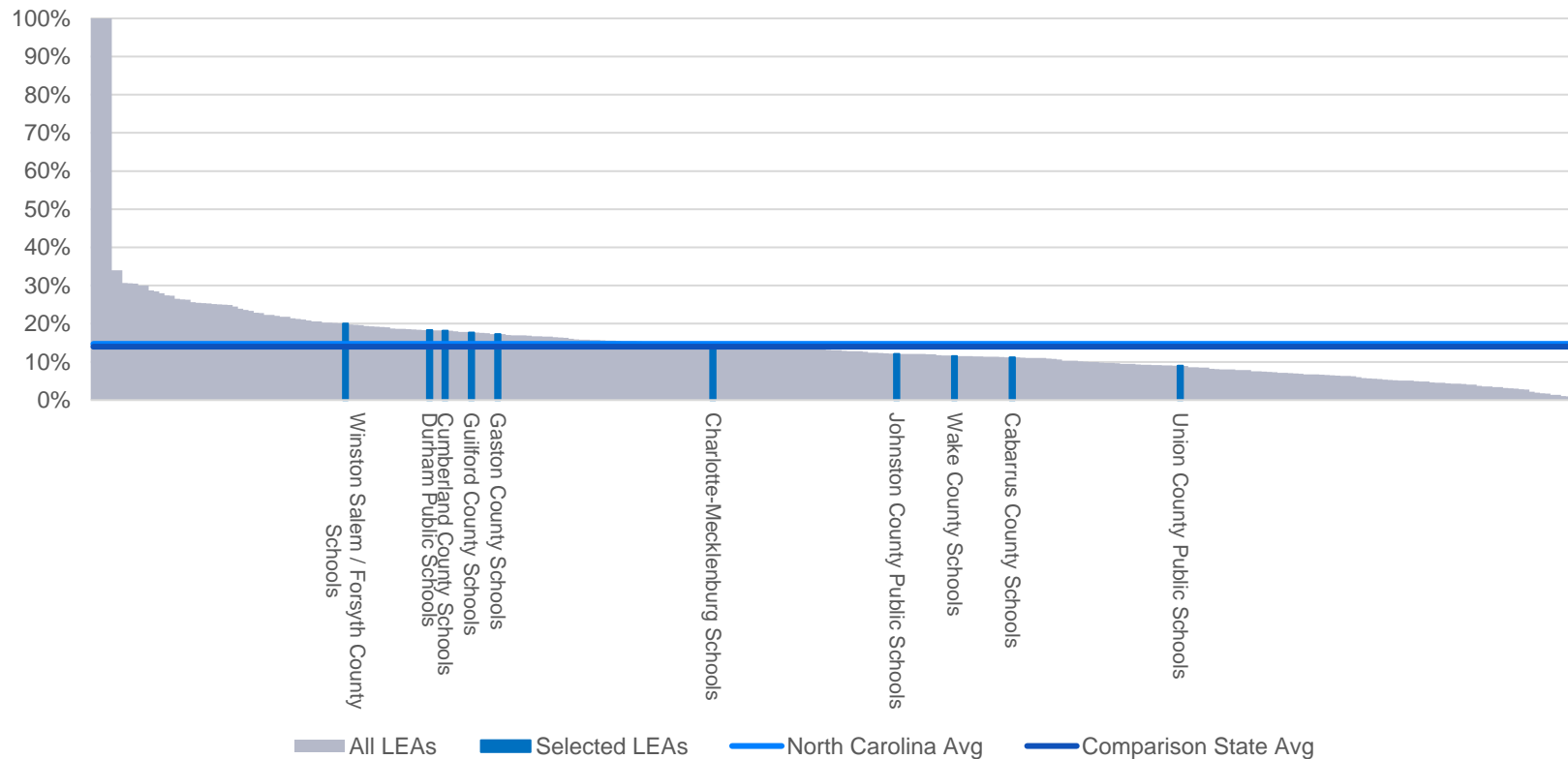| Questions to explore	Analyses to consider	Helpful data sources	Data granularity
What are the rates of key negative student outcomes (e.g., absenteeism)?	**3a** Counties with the highest absenteeism	U.S. DOE absenteeism data	State- and county-level

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

Data accessed December 1, 2021

3a. Students experiencing chronic absenteeism by LEA

Students experiencing chronic absenteeism
(% by LEA; 2017-18)

Legend: All LEAs | Selected LEAs | North Carolina Avg | Comparison State Avg

LEAs labeled: Winston Salem / Forsyth County Schools, Cumberland County Schools, Durham Public Schools, Guilford County Schools, Gaston County Schools, Charlotte-Mecklenburg Schools, Johnston County Public Schools, Wake County Schools, Cabarrus County Schools, Union County Public Schools

Takeaways to consider
- Understand variation in absenteeism by LEA or region within the state.
- Identify common factors across LEAs with high absenteeism.
- Understand overall variation in absenteeism across LEAs.
- Identify overperforming LEAs from which best practices might be adopted elsewhere.
- Investigate LEAs with a large spike in absenteeism to understand reason for the high rates, and to see if extra support is required.
- NOTE: this graph may appear to include a long tail with no data. These indicate LEAs with either no absenteeism or no reported data.

Source: Office of Civil Rights Data Collection

Data accessed December 1, 2021

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4. Understanding current inputs / supports for child health statewide

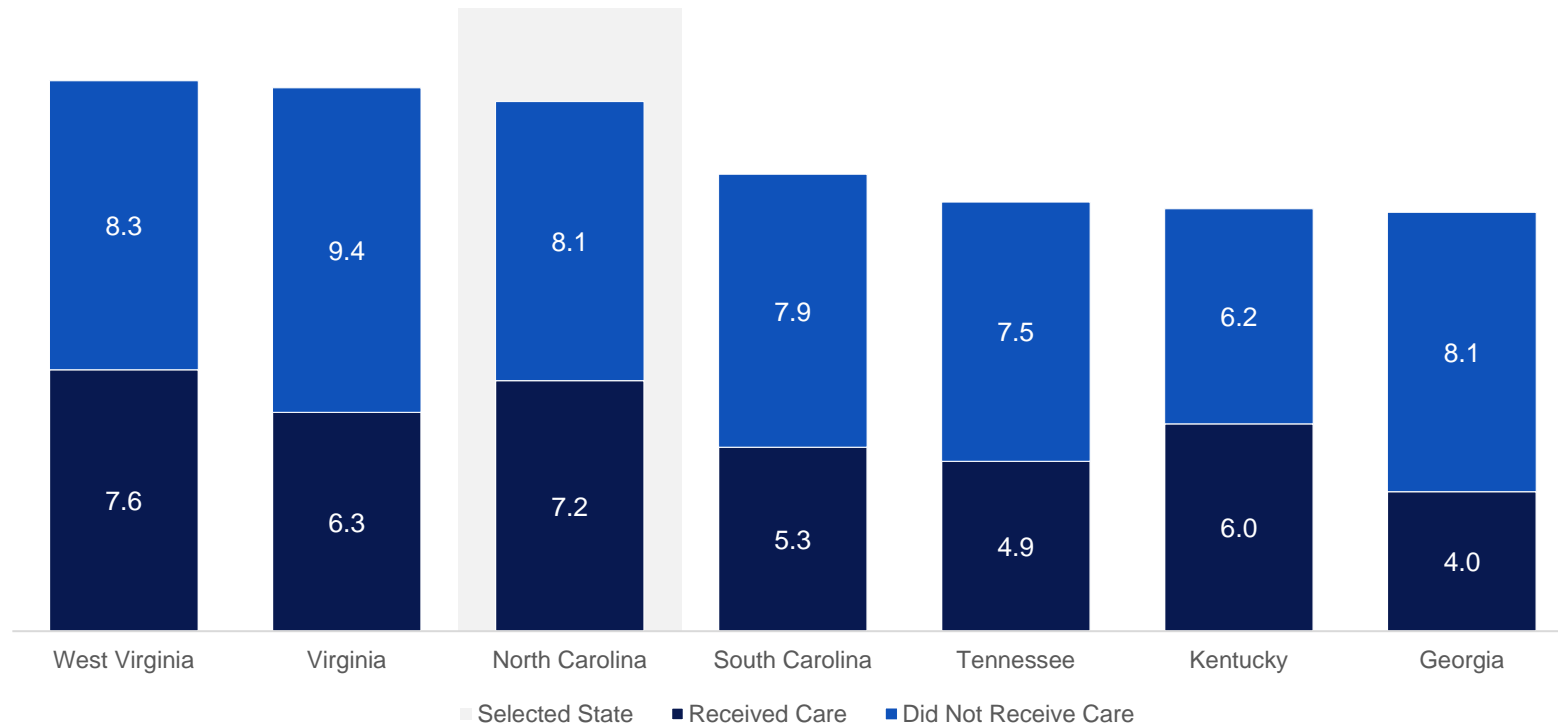| Questions to explore	Analyses to consider	Helpful data sources	Data granularity
Is identification and referral occurring before students reach a point of academic or behavioral health crisis?	**4a** % of children who need but are not receiving care, including by morbidity and subgroup	[SAMHSA National Survey on Drug Use and Health](#) [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

4a. Incidence of Major Depressive Episodes (MDE) and lack of access to depression care among adolescents relative to other states

Average annual percentage of adolescents age 12-17 experiencing at least one Major Depressive Episode, by whether or not they received care

% of adolescents in North Carolina vs. comparison states (2016-2019)

Legend: Selected State | Received Care | Did Not Receive Care

State	Received Care	Did Not Receive Care
West Virginia	7.6	8.3
Virginia	6.3	9.4
North Carolina	7.2	8.1
South Carolina	5.3	7.9
Tennessee	4.9	7.5
Kentucky	6.0	6.2
Georgia	4.0	8.1

Takeaways to consider

- Compare rates of MDE and rates of care access to those in other states. Consider whether the state's rates are acceptable, regardless how they compare to the US average and comparison states.
- If you are in a state with high levels of unmet need, what efforts do you have in place to increase identification, referral and treatment for highest need populations?
- Consider immediate steps an agency could take to lower the number of in-need children not receiving services.
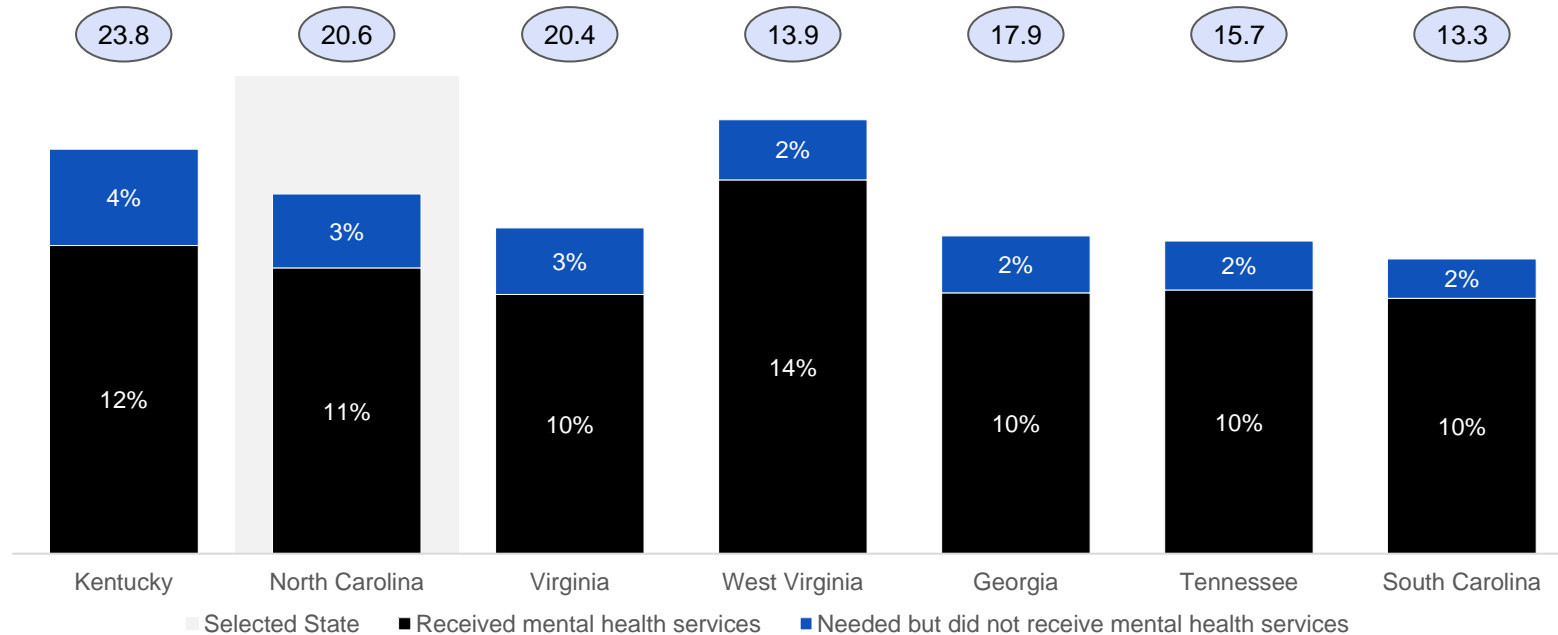
NOTE: these data are clinically specific (only regard major depressive episodes). Their collection methodology (grounded in specific symptom reporting) is relatively accurate

Source: SAMHSA National Survey on Drug Use and Health, 2012-2019

Data accessed December 1, 2021

4a. In-need children who did NOT receive mental health care relative to other states

$$\text{(oval)} = \frac{x\%}{(x\% + y\%)}$$

% of children (ages 3-17 years) who needed treatment or counseling from a mental health professional and did not receive treatment or counseling,[1] according to parent surveys

% of children in North Carolina vs. comparison states (2019-2020)

	Kentucky	North Carolina	Virginia	West Virginia	Georgia	Tennessee	South Carolina
Oval	23.8	20.6	20.4	13.9	17.9	15.7	13.3
Needed but did not receive	4%	3%	3%	2%	2%	2%	2%
Received	12%	11%	10%	14%	10%	10%	10%

Selected State ■ Received mental health services ■ Needed but did not receive mental health services
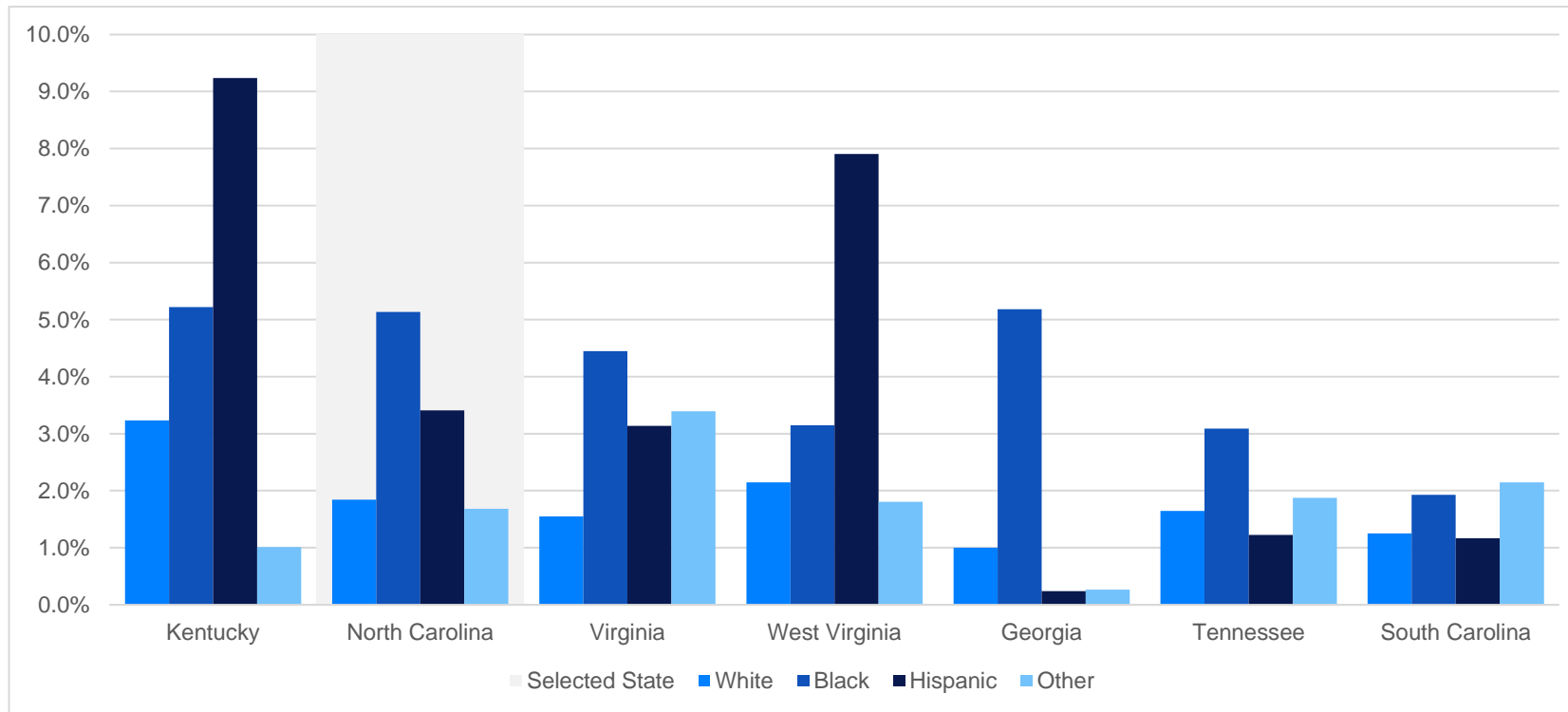
Takeaways to consider

- Compare the rates to those in other states. Consider whether the state's rates are acceptably low, regardless how they compare to the US average and comparison states.

- If you are in a high unmet need state, what efforts do you have in place to increase identification, referral and treatment for highest need populations?

- Consider immediate steps an agency could take to lower the number of in-need children not receiving services.

1. From the National Survey of Children's Health: "During the past 12 months, has this child received any treatment or counseling from a mental health professional, age 3-17 years?" Options: Yes; No, but needed to see a professional; No, did not need to see a professional

Source: Child Health Data

Data accessed December 1, 2021

4a. In-need children who did NOT receive mental health care relative to other states

% of children (ages 3-17 years) who needed but did NOT receive treatment or counseling[1] from a mental health professional, according to parent surveys, by race/ethnicity[2]

% of children in North Carolina vs. comparison states (2019-2020)

Legend: Selected State | White | Black | Hispanic | Other

States (x-axis): Kentucky, North Carolina, Virginia, West Virginia, Georgia, Tennessee, South Carolina

1. From the National Survey of Children's Health: "During the past 12 months, has this child received any treatment or counseling from a mental health professional, age 3-17 years?" Options: Yes; No, but needed to see a professional; No, did not need to see a professional | 2. Data not available for all races/ethnicities in all states

Source: Child Health Data
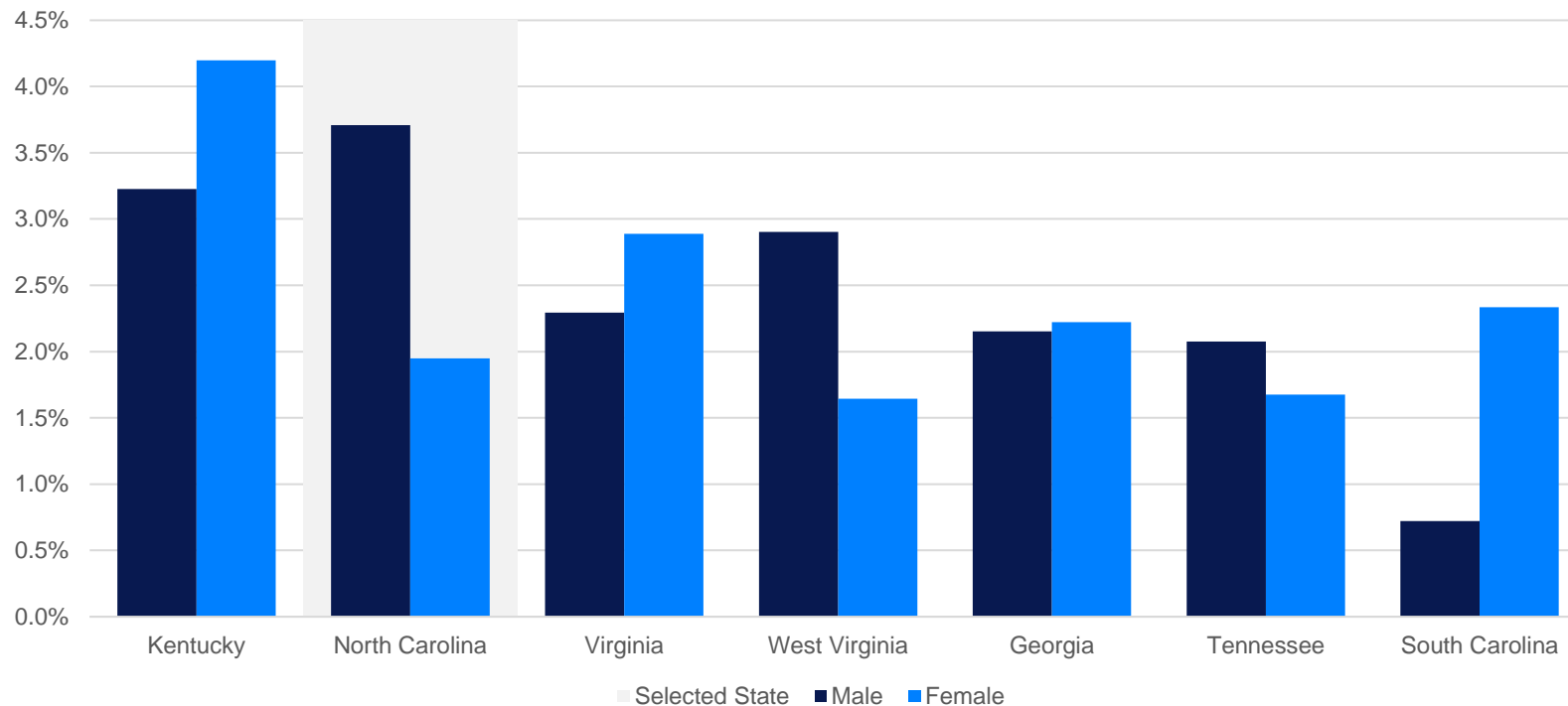
Data accessed December 1, 2021

Takeaways to consider

- Compare the rates for each subgroup to those in other states. Consider whether the state's rates are acceptably low, regardless of how they compare to the US average and comparison states.

- Given that the data reflected comes from parent surveys, reflect on other factors that may be driving results displayed.

- If you are in a high unmet need state, what efforts do you have in place to increase identification, referral and treatment for highest need subpopulations?

- Consider immediate steps an agency could take to lower the number of in-need children not receiving services for highly impacted subgroups.

CHIEFS for CHANGE

4a. In-need children who did NOT receive mental health care relative to other states

% of children (ages 3-17 years) who needed but did NOT receive treatment or counseling[1] from a mental health professional, according to parent surveys, by sex of child

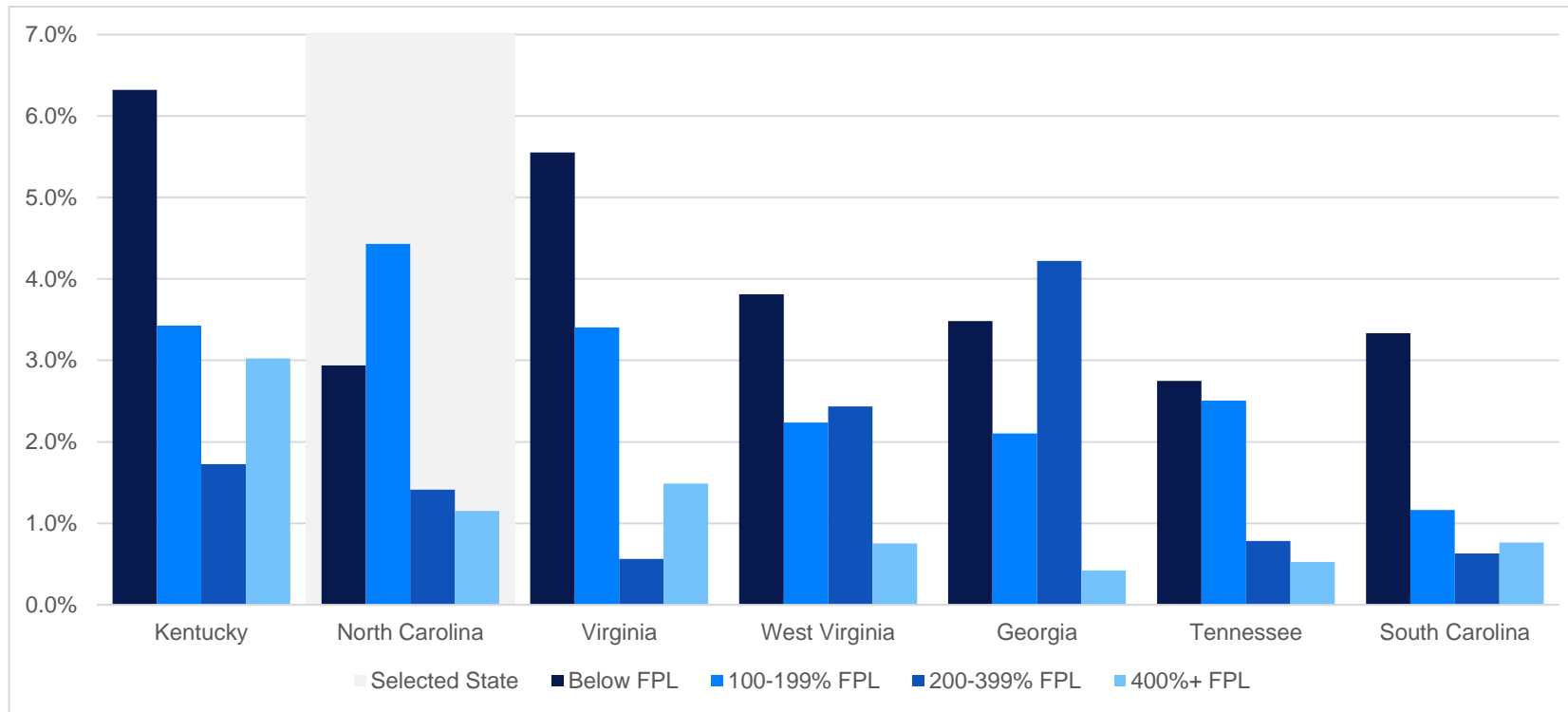% of children in North Carolina vs. comparison states (2019-2020)

Takeaways to consider

- Compare the rates for each subgroup to those in other states. Consider whether the state's rates are acceptably low, regardless of how they compare to the US average and comparison states.

- Given that the data reflected comes from parent surveys, reflect on other factors that may be driving results displayed.

- If you are in a high unmet need state, what efforts do you have in place to increase identification, referral and treatment for highest need subpopulations?

- Consider immediate steps an agency could take to lower the number of in-need children not receiving services for highly impacted subgroups.

1. From the National Survey of Children's Health: "During the past 12 months, has this child received any treatment or counseling from a mental health professional, age 3-17 years?" Options: Yes; No, but needed to see a professional; No, did not need to see a professional

Source: Child Health Data

Data accessed December 1, 2021

4a. In-need children who did NOT receive mental health care relative to other states

% of children (ages 3-17 years) who needed but did NOT receive treatment or counseling[1] from a mental health professional, according to parent surveys, <u>by household income level</u>

% of children in North Carolina vs. comparison states (2019-2020)

Takeaways to consider

- Compare the rates for each subgroup to those in other states. Consider whether the state's rates are acceptably low, regardless of how they compare to the US average and comparison states.

- Given that the data reflected comes from parent surveys, reflect on other factors that may be driving results displayed.

- If you are in a high unmet need state, what efforts do you have in place to increase identification, referral and treatment for highest need subpopulations?

- Consider immediate steps an agency could take to lower the number of in-need children not receiving services for highly impacted subgroups.

1. From the National Survey of Children's Health: "During the past 12 months, has this child received any treatment or counseling from a mental health professional, age 3-17 years?" Options: Yes; No, but needed to see a professional; No, did not need to see a professional
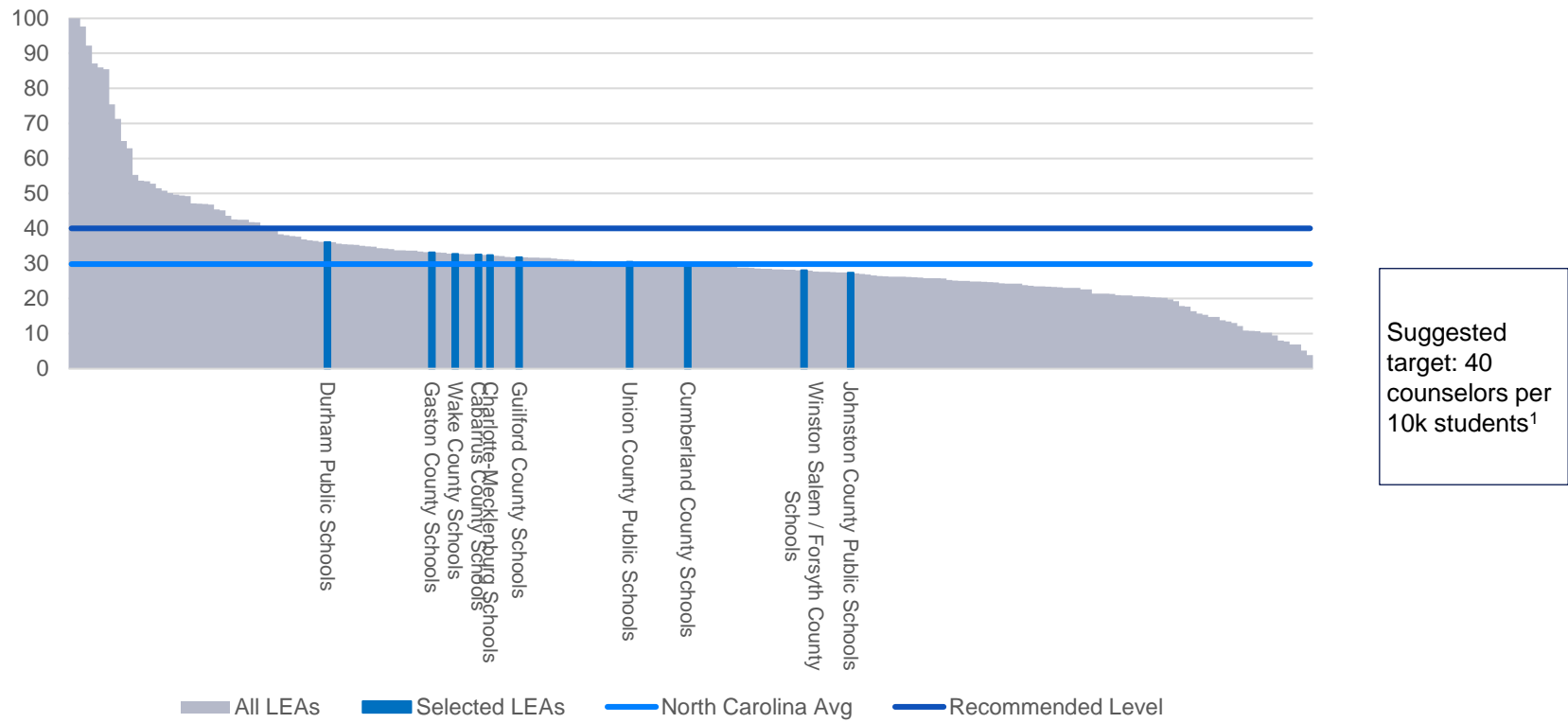
Source: Child Health Data

Data accessed December 1, 2021

4b. Access to school counselors, by LEA

Number of school counselors per 10k students, by LEA (2020-21)

Suggested target: 40 counselors per 10k students[1]

Legend: All LEAs | Selected LEAs | North Carolina Avg | Recommended Level

LEA labels: Durham Public Schools, Gaston County Schools, Wake County Schools, Charlotte-Mecklenburg Schools, Cabarrus County Schools, Guilford County Schools, Union County Public Schools, Cumberland County Schools, Winston Salem / Forsyth County Schools, Johnston County Public Schools
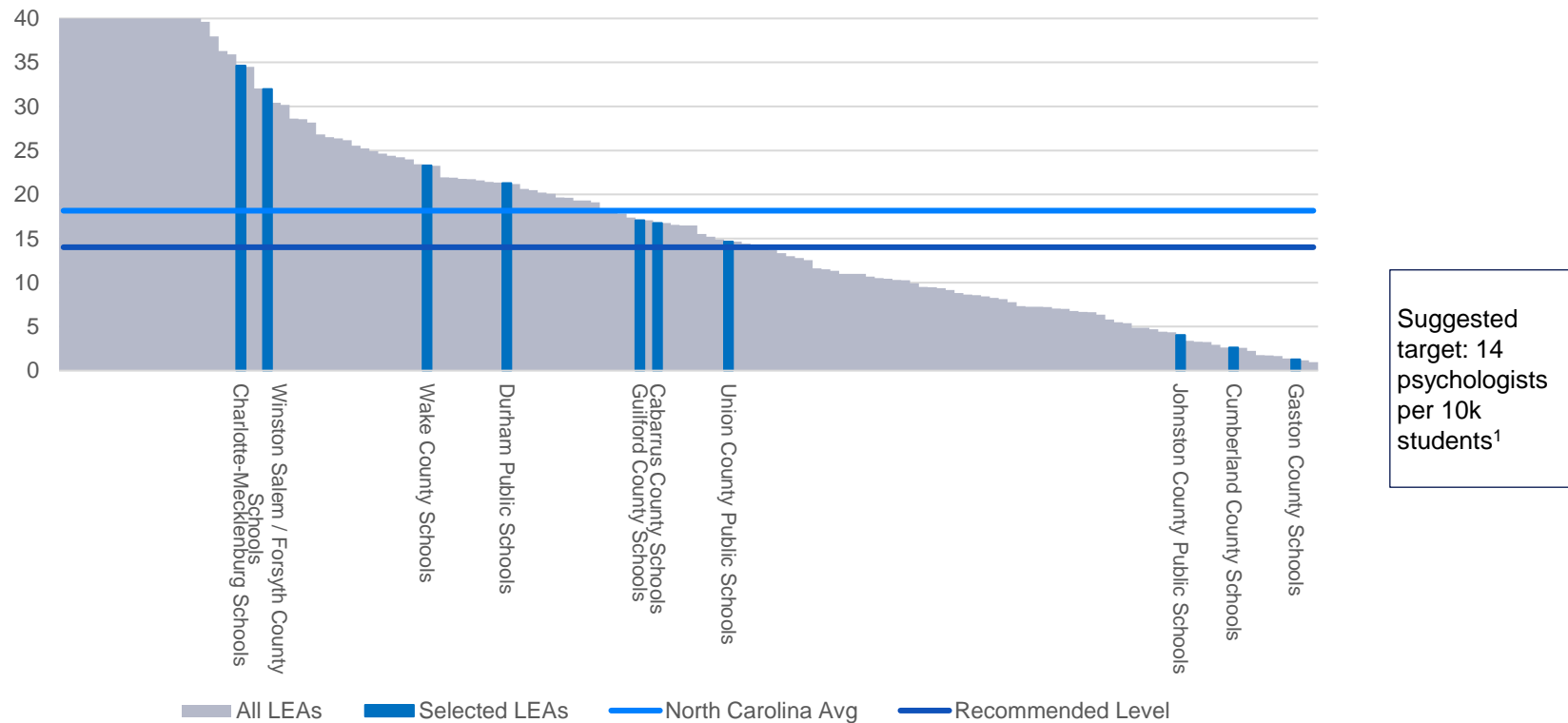
Takeaways to consider

- Compare availability across LEAs to state-wide goals / targets.
- Identify common factors across LEAs with low availability.
- Consider why a small number of LEAs have very high staff-to-student ratios (often, these are special needs LEAs affiliated with e.g., the incarceration system).
- If certain LEAs have sufficient school counselor coverage, consider the opportunity to promote more equitable access to care in the most underserved LEAs or regions (e.g., through telehealth).
- NOTE: this graph may appear to include a long tail and/or with no data. These indicate LEAs with either no counselors or no reported data.

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1. American School Counselor Association (ASCA) recommended number of school counselors per 10k students

Source: NCES (Common Core of Data; School District Survey)

Data accessed December 1, 2021

4b. Access to school psychologists, by LEA

Number of school psychologists per 10k students, by LEA (2020-21)

Suggested target: 14 psychologists per 10k students[1]

Legend: All LEAs — Selected LEAs — North Carolina Avg — Recommended Level

X-axis labels: Charlotte-Mecklenburg Schools, Winston Salem / Forsyth County Schools, Wake County Schools, Durham Public Schools, Cabarrus County Schools Guilford County Schools, Union County Public Schools, Johnston County Public Schools, Cumberland County Schools, Gaston County Schools
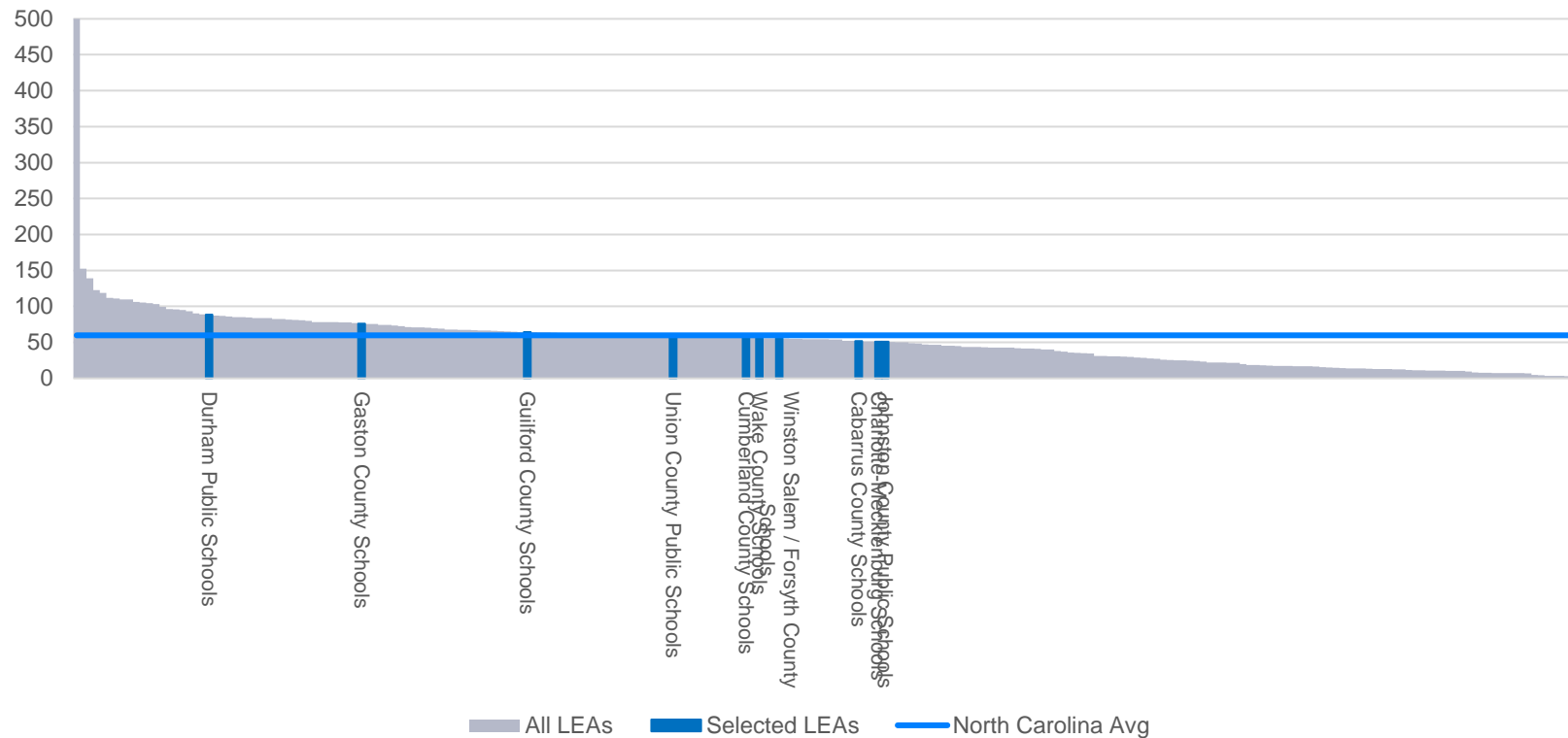
Takeaways to consider

- Compare availability across LEAs to state-wide goals / targets.
- Identify common factors across LEAs with low availability.
- Consider why a small number of LEAs have very high staff-to-student ratios (often, these are special needs LEAs affiliated with e.g., the incarceration system).
- If sufficient care coverage in some LEAs, consider opportunity to promote more equitable access to care in the most underserved LEAs or regions (e.g., through telehealth).
- NOTE: this graph may appear to include a long tail and/or with no data. These indicate LEAs with either no psychologists or no reported data.

1. National Association of Student Psychologists (NASP) recommended number of school psychologists per 1k students

Source: NCES (Common Core of Data; School District Survey)

Data accessed December 1, 2021

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4b. Access to other student support staff, by LEA

Number of other student support staff per 10k students, by LEA (2020-21)

Legend: All LEAs | Selected LEAs | North Carolina Avg

Labeled LEAs: Durham Public Schools, Gaston County Schools, Guilford County Schools, Union County Public Schools, Wake County Schools, Cumberland County Schools, Winston Salem / Forsyth County Schools, Cabarrus County Schools, Charlotte-Mecklenburg Schools, Johnston County Public Schools

Takeaways to consider

- Compare availability across LEAs to state-wide goals / targets.
- Identify common factors across LEAs with low availability.
- Consider why a small number of LEAs have very high staff-to-student ratios (often, these are special needs LEAs affiliated with e.g., the incarceration system).
- If sufficient support coverage in some LEAs, consider opportunity to promote more equitable access to care in the most underserved LEAs or regions (e.g., through telehealth).
- NOTE: this graph may appear to include a long tail and/or with no data. These indicate LEAs with either no other support staff or no reported data.

Source: NCES (Common Core of Data; School District Survey)
Data accessed December 1, 2021

4c. School counselors, psychologists, and other support staff relative to recommended levels

■ Comparison States ■ North Carolina ——United States ——Industry recommendation

School counselors
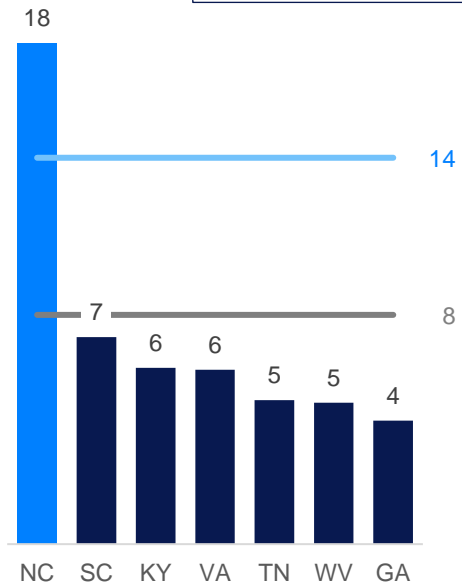Per 10k students (2020-21)

NOTE: ASCA recommends **~40**

VA	NC	SC	WV	KY	GA	TN
30	30	30	30	26	23	21

Industry recommendation: 40
United States: 24
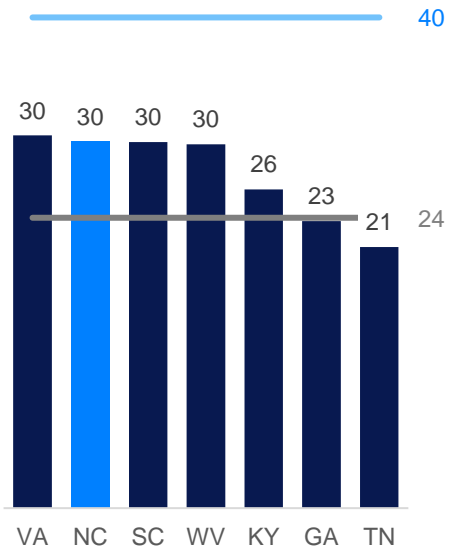
Note: Counselors' responsibilities generally include college and career planning (in HS) – and other elements beyond MH care

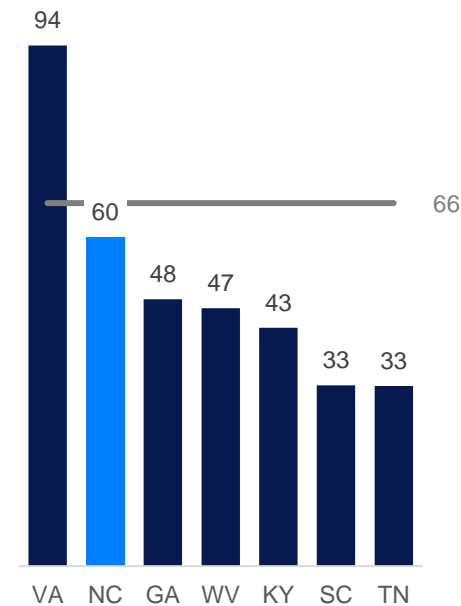**School psychologists**
Per 10k students (2020-21)

NOTE: NASP recommends **~14**

NC	SC	KY	VA	TN	WV	GA
18	7	6	6	5	5	4

Industry recommendation: 14
United States: 8

Note: Psychologists' responsibilities generally include disability testing – and other elements beyond MH care

Other student support staff
Per 10k students (2020-21)

VA	NC	GA	WV	KY	SC	TN
94	60	48	47	43	33	33

United States: 66

Note: Includes all staff defined as student support (e.g., paraprofessionals, aides, social workers), less psychologists and counselors

Takeaways to consider
- Gap between availability of staff and national recommendation could inform the type and scale of talent initiatives an agency might consider (i.e., initiatives to reallocate, upskill, and/or hire additional resources).
- National recommendations to not account for the variation in need among local populations.

Source: NCES (Common Core of Data; School District Survey); ASCA (American School Counselor Association); NASP (National Association of School Psychologists)
Data accessed December 1, 2021

CHIEFS for CHANGE

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Appendix

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.

The recipient remains solely responsible for all decisions, use of these materials, and compliance with applicable laws, rules, regulations, and standards. Consider seeking advice of legal and other relevant certified/licensed experts prior to taking any specific steps.

To follow is a list of additional potential analyses to further explore the state of student wellbeing in the system

ILLUSTRATIVE ONLY - POTENTIAL ANALYSIS TO COMPLETE WITH ADDITIONAL STATE DATA

	Questions to explore	Analyses to consider	Helpful data sources	Data granularity
1 Positive wellbeing outcomes	To what degree do students report a sense of belonging / connection to school?	Measure YOY improvement in student responses to school climate questions	SEA-administered statewide school climate surveys	LEA-level
3 School-based indicators	What are the rates of key academic success indicators (e.g., graduation rates, postsecondary success)?	Graduation rates over time, including by LEA and demographic subgroup	Internal SEA data	LEA-level
		Measures of postsecondary success over time, including by LEA and demographic subgroup	Internal SEA data	LEA-level
	What are the rates of key negative student outcomes?	Chronic absenteeism over time (incl. economically disadvantaged students)	Internal SEA data	State- and county-level
		Outcomes (e.g., suspension, expulsion, dropout, crime rates) by LEA and school	Internal SEA data U.S. DOE Civil Rights Data	State- and LEA-level
4 Inputs / supports for student wellbeing	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, PBIS)?	Landscape of current state-level programming	Internal SEA data (e.g., PD training module participation rate)	State-level
	What is the shortage of key roles *outside schools* relative to recommended levels? Is there variance by locality?	Counties with <1 child psychiatrist per 10K people	AACAP Workforce factsheet (2019)	State- and county-level
		Variation in access to mental health services (nationally, by county)	Center for Societal Benefit Through Healthcare	State- and county-level
	At what rate are students accessing overall health care (e.g., PCP visits)?	Medicaid enrollment, access to physician care vs. well-child visits	State Medicaid enrollment data State well-child visit data	County-level