Youth Mental Health in New Jersey

Current Status and Opportunities for Improved Services

Authors:

Karen Lowrie, Ph.D.
Rutgers University - New Brunswick

Brooke Schwartzman
Rutgers University - New Brunswick

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June 2023

Suggested Citation:

Executive Summary

Teens of today have faced major shifts in the societal, environmental, community, familial, and individual spheres, heightened by the ongoing pandemic, creating challenges and pressures that negatively impact mental health and well-being. The combined experiences of COVID and racial trauma have led to increases in mental health symptoms among youth nationwide, including stress, anxiety, depression, and suicide attempts (Lee, 2020; Golberstein, Wen, and Miller, 2020; Yard et al., 2021). New Jersey has not been immune to the impacts of deteriorating youth mental health, as the state has declared a youth mental health crisis (Burney, 2022).

Because youth aged 12-18 spend much of their time in a school setting, schools can play a critical role, both in identifying students' mental health needs and providing and connecting students with appropriate services and supports. Services located in school buildings could be especially critical for students from families that already face financial or familial hardships, and thus important to addressing equity in access to programs and treatment. In the wake of rising mental health concerns, the New Jersey Department of Children and Families (DCF) seeks to reform New Jersey's current School Linked Services (SLS) program, a support structure that links schools and social services and includes School-Based Youth Services Programs (SBYSP) in about 90 host schools. A new initiative entitled the NJ Statewide Student Support Services Network (NJ4S) has been designed to serve as SLS's replacement. It would function as a hub-and-spoke model in which 15 regional hubs will receive requests for services and then direct them to local sites.

To inform the discussions around the reform of SLS and the adoption of the NJ4S model, this study summarized the most recent available data on youth mental health and performed high-level case studies of successful youth mental health service infrastructure in Washington D.C., Wisconsin, and Maryland to conclude with a set of research-informed policy recommendations:

1. **Support and enhance current mental health programs.** If a hub model is considered, clearly outline how the 15 regional hubs will be used to bolster the current SLS system and reassure the permanence of this decision.

2. **Implement creative options to improve access to SBYSP.** The pre-existing SBYSP can be expanded to more fully service all schools in the districts that are already enrolled, as well as in neighboring school districts. To address equity, it would be important to focus this expansion on districts with higher percentages of low-income, Black, and Hispanic students, or on districts that can receive children from other schools with free transportation services offered.

3. **Expand School-Based Health Center (SBHC) network both geographically and functionally to broaden the reach of low-cost mental health services.** New Jersey's SBHC program should be expanded beyond just Newark to other cities where youth struggle to access primary care.

4. **Standardize school-linked mental health services and require Multi-Tiered Systems of Support (MTSS) for intervention and referral services.** Require MTSS as the standard for all schools to ensure that schools are following an evidence-backed delivery system. This includes the use of social-emotional learning that can train students on managing emotions and stress and building healthy habits.

5. **Pilot a hub model in one or two regions (if a shift to a regional service delivery model is considered).** School-linked-services would remain in all schools, while the hubs are developed to expand upon and coordinate current services.

6. **Use Child Study Teams (CST) more extensively in mental health framework.** CSTs should be intimately linked to New Jersey Tiered Systems of Support (NJTSS) and explicitly named in the state's guidance on school-based mental healthcare.

7. **Improve access and clarity of outreach materials on available youth mental health services.** Electronic information should be more easily available and better organized across agencies and programs for parents to understand the mental health services offered in schools for the state and should always be translated into Spanish.

The report concludes with some suggestions for enhanced data collections and opportunities for expanded research to improve understanding of the nature of the problem and of the best options for successfully addressing the problem, so that all New Jersey youth, regardless of race, gender, or geography, have the best opportunity to thrive as healthy adults.

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Introduction

The teen and adolescent years have always been marked by challenges, as youth learn to navigate the world. But times are changing; youth of today have faced major shifts in the societal, environmental, community, familial, and individual spheres, creating challenges and pressures that negatively impact mental health and well-being. Youth mental health problems often go unrecognized and untreated. Early intervention is important for youth mental health. Research has shown that early intervention can prevent the development of more severe mental health problems and improve outcomes for youth (Mei et al, 2020). Youth mental health problems can have long-term consequences. Mental health problems in youth can lead to social and academic difficulties and can increase the risk of substance abuse, self-harm, and suicide. (NJDOE, 2022). Poor mental health is also associated with increased risk of school discipline and police contact (Prin et al. 2021).

Young people nationwide battle a mental health crisis, heightened by the ongoing pandemic, that is left insufficiently addressed by a shortage of counselors and other professionals in many areas. According to a recent survey, 70% of elementary and middle school principals reported that they didn't have enough mental health professionals on staff to meet students' needs. (Wall, 2021). The CDC's 2021 Youth Risk Behavior Survey (YRBS) data, which is only available at the national level as of now, has demonstrated disturbing trends among youth. Fifty-five percent of youth experienced emotional abuse by a parent or another adult in the home and 11% experienced physical abuse by a parent or another adult in the home (CDC Newsroom, 2022). Clear disparities have also risen in the data between demographic groups. In the past year, 20% of female students experienced sexual violence at least once, 60% reported feelings of sadness or hopelessness, and nearly 25% created a suicide plan. Fifty percent of LGBTQ students reported having poor mental health and 25% attempted suicide in the past year (CDC, 2022). During the past three years, the combined experiences of COVID and racial trauma have led to increases in mental health symptoms among youth nationwide, including stress, anxiety, depression, and suicide attempts (Lee, 2020; Golberstein, Wen, and Miller, 2020; Yard et al., 2021).

While horrific outcomes and outgrowths such as suicide and school shootings are alarming and visible, many experts say that the crisis in youth mental health is broad and deep in almost every community in the country. Youth mental health is shaped by a combination of factors close to home. Because youth aged 12-18 spend much of their time in a school setting, schools can play a critical role, both in identifying students' mental health needs and providing and connecting students with appropriate services and supports. Schools can offer an accessible and comfortable setting for youth in need of services if trained staff and resources are there to match the needs. For many youth, school-based services

are their primary means of accessing mental health care (NAS, 2021). There is evidence that when mental health services are present in a school, youth have fewer suicidal ideations and attempts compared with youth at schools that don't have these services (NAS, 2021).

Mental and behavioral health needs are particularly acute for families of color who are already underserved, more likely to live in poverty, and less likely to access basic mental health care for their kids (Derrow, 2023). These families, particularly those already burdened by poverty, lack of transportation, insufficient insurance, or language difficulties, may encounter barriers in seeking the treatment their children's need in the larger community (Burney, 2022). For this reason, services located in school buildings could be especially critical for students from families that already face financial or familial hardships, and thus important to addressing equity in access to programs and treatment. Some evidence suggests that Black and Latinx students report more anxiety and depression, and also that their access to mental health staff in schools is decreasing over the past decade (Wall, 2021; Neito-Munoz, 2022).

New Jersey has not been immune to the impacts of deteriorating youth mental health, as the state has declared a youth mental health a crisis (Burney, 2022). In a January 2021 New Jersey School Boards Association (NJSBA) report, roughly 47% of the 264 board of education members, superintendents, and business administrators surveyed reported that students were generally more anxious and depressed (NJSBA, 2021). Hospitalizations for anxiety for children aged 12-17 rose by 54% between 2019 and 2021, and the proportion of self-harm hospitalizations almost doubled (NJHA, 2022).

In the wake of rising mental health concerns, the New Jersey Department of Children and Families (DCF) seeks to reform New Jersey's current School Linked Services (SLS) program, a support structure that links schools and social services. These current supports include student academic achievement and mental wellness initiatives in 90 school districts, health centers, family success centers, juvenile delinquency prevention programs, and adolescent pregnancy prevention programs. A new initiative entitled the NJ Statewide Student Support Services Network (NJ4S) has been designed to serve as SLS's replacement. It would function as a hub-and-spoke model in which 15 regional hubs will receive requests for services and then direct them to local sites. These "spokes" include schools, libraries, community centers, faith-based organizations, and more. The services provided in schools would be targeted towards specific communities and age groups and would function as tiers of increasingly more involved initiatives.

NJ4S Policy Update

Due to strong opposition, plans to implement the NJ4S program were put on hold in November 2022 while the state continued to build out the hub-and-spoke model. In May 2023, Governor Murphy announced that New Jersey has completely abandoned cutting school-based mental health programs. The 15 regional hubs that are part of NJ4S will still be set in place by September 2023, but rather than replace school-based mental health care, these hubs will reinforce and expand upon the pre-existing continuum of supports in schools (Briar 2023).

Purpose and Organization of this Report:

The purpose of this report is to inform the discussions around the reform of SLS and the adoption of the NJ4S model, or other near-term policy and program options that impact the identification, treatment, and support of students' mental health and well-being in New Jersey's middle school and high school settings. The report first summarizes the most recent available direct and indirect measures of youth mental health in the state from federal and state data sources, along with a discussion of data limitations. The next section provides a background on school-based mental health services, and then specifically describes the state's current youth mental health service delivery system as well as the proposed new model. After that, the report highlights lessons learned from successful mental health infrastructure serving youth elsewhere in the United States. The report concludes with a set of research-informed policy recommendations related to providing resources, support, and services to address youth mental health and wellbeing needs, emphasizing considerations of equity.

The report asks the following research questions:

- What is the prevalence of mental health problems among middle-school- and high-school-aged youth in New Jersey? How do mental health problems vary by gender and race/ethnicity among youth in New Jersey?

- How do youth in New Jersey access school-based mental health services, and what are the barriers to accessing care?

- How does the availability and utilization of mental health services for youth in other states serve as a model or application for New Jersey?

Current State of Youth Mental Health in New Jersey: Data and Trends

When attempting to paint a picture of the status of youth mental health, there are at least two general categories of data available. One is direct measures of mental health conditions or cases, such as clinical diagnoses, treatment, or self-reported or observational information. A second is measures of the various factors that can be determinants of mental health or be influenced by mental health conditions. Youth mental health is impacted by a combination of both risk and protective factors (US HHS, 2009). A risk factor (also called a determinant of health) is "a characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcome" (US HHS, 2009). A protective factor, on the other hand, is "a characteristic at the biological, psychological, family, or community (including peers and culture) level that is associated with a lower likelihood of problem outcomes or that reduces the negative impact of a risk factor on problem outcomes" (US HHS, 2009).

Risk and protective factors can be divided across three scales or domains; individual, family, and school-neighborhood-community, as shown below.

Table 1: Risk and Protective Factors for Mental Health

Risk and Protective Factors for Mental Health		
Domain	**Risk Factors**	**Protective Factors**
Individual	Poor concentration Low-self esteem Anxiety Depression Poor Social Skills Emotional problems in childhood Conduct issues Favorable attitudes towards drugs and/or alcohol Antisocial behavior	Academic achievement High self-esteem Emotional regulation Coping skills Connection with school, peers, culture, athletics, employment, or religion
Family	Poor parental mental health Parent-child conflict Family dysfunction Child abuse Parental unemployment Poor parental supervision	Family with structure and rules Supportive relationships Clear expectations for behavior
School-Neighborhood Community	Poor academic achievement Poverty Community-level trauma or stress Community violence School violence Low commitment to school Aggression towards peers Loss of close friendships	Presence of mentors School engagement Clear expectations for behavior Physical and psychological safety

Source: US HHS, 2009

Ideally, a full picture of youth mental health will include accurate measures of all or most of these factors, along with detail on actual mental health and well-being outcomes in individuals. It would also include breakdowns by categories of geography, race, income, immigrant status, and other important economic, political, and socioeconomic characteristics with an eye toward assessing equity issues. In this study, due to time constraints and relative inaccessibility of many of these data, only a limited number of the above categories are presented and only from a limited number of sources.

Data Sources: How to Measure

The majority of the data referenced in this report is sourced from surveys. They generally measure frequency and intensity of feelings as well as behaviors associated with mental well-being. A smaller proportion of our data is sourced directly from facilities or providers that treat mental health conditions. These data measure numbers of diagnoses, patients under treatment, services provided, etc.

Each of these sources, in terms of their use in this report, are described in the next subsection.

Surveys

The surveys consulted for this study are described below. If data were not available at the state level, the survey was not considered for this study. Ideally, to examine gender and racial disparities, data that had demographic characteristics were preferred.

Due to institutional protections surrounding the vulnerability of youth as research subjects, many of the surveys that were considered used adult caregivers, or educators as respondents instead. They are able to provide insightful second-hand and observational information about young people in their care. Other surveys directly survey youth respondents, providing arguably a more valid but often less robust measure.

Selected Surveys:

Youth Risk Behavioral Survey (YRBS): The YRBS is a biennial survey overseen by the CDC that collects data on the behaviors and risks of high school students in each state. The survey asks students about their mental health and substance use habits. The data can be used to understand the prevalence of mental health issues among young people in the state. The most recently published data was collected in 2021 but not all of the data is available at the state level yet. For measures not available at the state level, the 2019 YRBS data was used instead.

2019 New Jersey YRBS - Youth Respondents Sample Size	
Demographics of Survey Respondents	Number of Youth
All	1,393
Male	652
Female	733
Unknown*	8
White - Non Hispanic	608
Black - Non Hispanic	146
Hispanic	377
Asian	162
Other - Non Hispanic**	77
Unknown*	23

* "Unknown" results were not included in the data tables.
** This includes Native American, Pacific Islander, and Multiple Races. This data was not included for many of the survey questions because the sample size was so small that the CDC did not make it publicly available in their online data query tool.

2021 New Jersey YRBS - Youth Respondents Sample Size	
Demographics of Survey Respondents	Number of Youth
All	695
Male	313
Female	382
White - non-Hispanic	320
Black - non-Hispanic	90
Hispanic	194
Asian	<91*

*The 2021 YRBS data has not been completely released so it is not yet clear what the sample size is of surveyed Asian students.

New Jersey Middle School Risk and Protective Factors Survey: This survey is similar to the YRBS but asks middle school students about their mental health and substance use habits rather than high school students. This data can serve as a complement to the YRBS and provide a more up-to-date picture on the state of adolescent mental health. The most recent year for this data is 2021.

New Jersey Middle School Risk and Protective Factors Survey - Youth Respondents Sample Size	
Demographics of Survey Respondents	**Number of Youth**
All	6,490
Male	2,875
Female	3,459
Non-Binary*	156
Hispanic**	1,895
White	3,167
Black	539
Native American, and Pacific Islander *	155
Other	1,227
Two or More Races	941
Asian	461

*This number is so small that the results were not included in the data tables.
**This survey did not separate ethnicity from race. The "White", "Black", "Other" and "Asian" categories include both Hispanic and non-Hispanic members of that race.
*** This data was not included because of the small sample size. "Other" and "Two or More Races" were separated because of how the data was provided in the survey report.

National Survey on Childrens' Health (NSCH): Administered by the U.S. Census Bureau, the NSCH is a national survey of parents in households with children aged 17 and under about the physical and emotional health of the child. Each parent selected to participate in the study fills out the survey based on just one of their children. The combination of 2020-2021 data is the most recent version of the survey for which state-level data is available.

New Jersey NSCH - Youth Sample Size Reported by Parent Respondents	
Demographics of Survey Respondent's Child	Number of Youth
All	917
Male	501
Female	416
White - Non Hispanic	478
Black - Non Hispanic	63
Hispanic	169
Other - Non Hispanic*	207

*This includes Asian, Native American, Pacific Islander, and Multi-Race.

Survey Data Limitations:

During the data collection process for this report, some key constraints emerged concerning the accessibility or availability of other potentially useful and relevant datasets, as described below:

- **Adolescent Behaviors and Experiences Survey (ABES):** ABES functions as an expanded version of the YRBS and was completed in 2021 to capture the impact of the COVID-19 pandemic on youth mental health. This data was not available at the state level.

- **School Survey on Crime and Safety (SSOCS):** SSOCS measures crime and safety, but also measures mental health outcomes as it strongly influences disciplinary issues. The data is available at the state level only with the completion of an extensive approval process that was not possible in the time of this study.

- **School Pulse Panel Survey:** The school pulse panel collects data on how the COVID-19 pandemic has impacted schools, from student mental health to teacher and parent experiences. This data is not available at the state level.

- **The National Survey on Drug Use and Health (NSDUH):** The NSDUH is a nationally representative survey that collects data on substance use, mental health, and other health-related behaviors among individuals aged 12 and older. The combination of 2018-2019 is the most recent version of the survey for which state-level data is available and responses cannot be broken down by demographics.

- **Youth Risk Behavioral Survey (YRBS):** The most recent data available was collected in 2021, but the CDC is still in the process of publishing state-level data. Consequently, some YRBS measures in this report revert back to using 2019 data where 2021 data was not yet available for New Jersey.

- **Race and Ethnicity:** Surveys used different methods for collecting race and ethnicity data. The NSCH and YRBS broke responses out into 4 categories; White, Black, Hispanic, and Other (including Asian). The New Jersey Middle School Risk and Protective Factors Survey counts Hispanic as an ethnicity rather than race. For the sake of consistency, we included counts of Hispanic students. Note, however, that when results from this survey are being presented, the White, Black, and Asian student counts include Hispanic and non-Hispanic students.

- **Large Confidence Intervals:** Some data from the NSCH have been marked with a * symbol. This indicates that the statistic's 95% confidence interval is larger than 20 percentage points. The decision to mark confidence intervals larger than 20 percentage points is modeled after how NSCH presents its own data in its online data query tool. Such data should be treated with caution.

Hospital and Treatment Facility Data

New Jersey Hospital Association's (NJHA's) Center for Health Analytics, Research, and Transformation (CHART): CHART examines trends in mental and behavioral health diagnoses among New Jersey's emergency department (ED) patients and inpatient hospitalizations.

Mental Health Client-Level Data (MHC-LD): MH-CLD uses data from state mental health systems to show trends in mental health, diagnoses, treatments, demographics, and substance use. The data presented in this report has been filtered by age so that only values for patients under the age of 18 are presented. The most recent version of the survey was published in 2020.

New Jersey MHC-LD - Youth Sample Size Reported by Facility Administrators	
Demographics of Survey Respondent's Child	**Number of Youth**
All	60,367
Male	34,668
Female	25,688
Unknown*	11
White - Non Hispanic	16,989
Black - Non Hispanic	10,232
Hispanic	18,495
Other - Non Hispanic**	4,857
Unknown*	9,794

*"Unknown" results were not included in the data tables
**This includes Asian, American Indian, Pacific Islander, and Two or More Races

Measures of Youth Mental Health

The following section includes both NJ survey data and hospital/facility data relating first to direct measures of mental health-related conditions, and secondly to other associated behavioral outcomes and influencing risk or protective factors.

Overall Mental Health

Close to 40% of youth do not meet all three (3) parameters of "flourishing" in their socioemotional development based on parent responses. Hispanic children were two times as likely as White, non-Hispanic children to demonstrate one (1) or less flourishing parameters. Close to 25% of children are reported to have at least one mental, emotional, developmental, or behavioral problem. Approximately 10% of youth have serious difficulty concentrating, remembering, or making decisions due to a physical, mental, or emotional condition (NSCH, 2020-2021).

MHC-LD data from psychiatric facilities demonstrates that 78% of youth being served at those facilities struggle with a serious emotional disturbance. Hispanic and Black, non-Hispanic youth were particularly likely be diagnosed with a serious emotional disturbance whereas Other, non-Hispanic youth were far less likely to experience such an outcome. Female patients were more likely than their male counterparts to be diagnosed with a trauma/stressor disorder, an anxiety disorder, or a depressive disorder (MHC-LD, 2020).

Looking at Emergency Department (ED) discharge data from CHART, the prevalence of mental, behavioral, or substance use disorder has increased dramatically among children under 18. In a recent analysis, CHART found that the prevalence of anxiety and depression – as well as self-harm and eating disorders – remained elevated in 2021 compared to pre-COVID-19 levels (NJHA, 2022).

Table 2: Is this child or adolescent flourishing, age 6-17 years?

Is this child or adolescent flourishing, age 6-17 years?			
Demographic	**0-1 Flourishing Items**	**2 Flourishing Items**	**3 Flourishing Items**
All (n = 917)	16%	21%	63%
Male (n = 501)	19%	21%	60%
Female (n = 416)	14%	20%	66%
White - Non Hispanic (n = 478)	13%	23%	65%
Black - Non Hispanic (n = 63)	15%*	70%	68%*
Hispanic (n = 169)	24%	24%	52%
Other Race - Non Hispanic (n = 207)	15%	12%	74%

Source: NSCH, 2020-2021 (The 3 flourishing items measured were children showing interest and curiosity in learning new things, children staying calm and in control when faced with challenges, and children working to finish the tasks that they start).
* Indicates a confidence interval larger than 20 percentage points.

Table 3: Does this child have a mental, emotional, developmental, or behavioral (MEDB) problem, age 3-17 years?

Does this child have a mental, emotional, developmental, or behavioral (MEDB) problem, age 3-17 years?		
Demographic	**1 or More MEDB Items**	**No MEDB Items**
All (n = 917)	23%	77%
Male (n = 501)	25%	75%
Female (n = 416)	21%	79%
White - Non Hispanic (n = 478)	24%	76%
Black - Non Hispanic (n = 63)	25%	75%
Hispanic (n = 169)	24%	76%
Other Race - Non Hispanic (n = 207)	13%	87%

Source: NSCH, 2020-2021.

Table 4: Does the child have serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition, age 6-17 years?

Does the child have serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition, age 6-17 years?		
Demographic	**Yes**	**No**
All (n = 917)	9%	91%
Male (n = 501)	10%	90%
Female (n = 416)	8%	92%
White - Non Hispanic (n = 478)	10%	90%
Black - Non Hispanic (n = 63)	5%*	95%
Hispanic (n = 169)	10%	90%
Other Race - Non Hispanic (n = 207)	6%	94%

Source: NSCH, 2020-2021.
* Indicates a confidence interval larger than 20 percentage points.

Table 5: Youth in Psychiatric Treatment Facilities by Diagnosis

Youth in Psychiatric Treatment Facilities by Diagnosis				
Demographic	**Trauma or Stressor Disorder**	**Anxiety Disorder**	**Depressive Disorder**	**Serious Emotional Disturbance**
All (n = 60,367)	23%	8%	7%	78%
Male (n = 34,668)	20%	7%	4%	78%
Female (n = 25,688)	26%	11%	10%	78%
White - Non Hispanic (n = 16,989)	23%	14%	8%	71%
Black - Non Hispanic (n = 10,232)	22%	4%	5%	83%
Hispanic (n = 18,495)	24%	7%	7%	82%
Other - Non Hispanic (n = 4,857)	19%	7%	5%	66%

Source: MHC-LD, 2020.

Figure 1: Percentage of NJ Emergency Department Visits Among Children)17 Years and Under) by Mental and Behavioral Health Diagnosis (2017-2020)

*From Apr. through Dec. only (all years)

■ 2017   ■ 2018   ■ 2019   ■ 2020
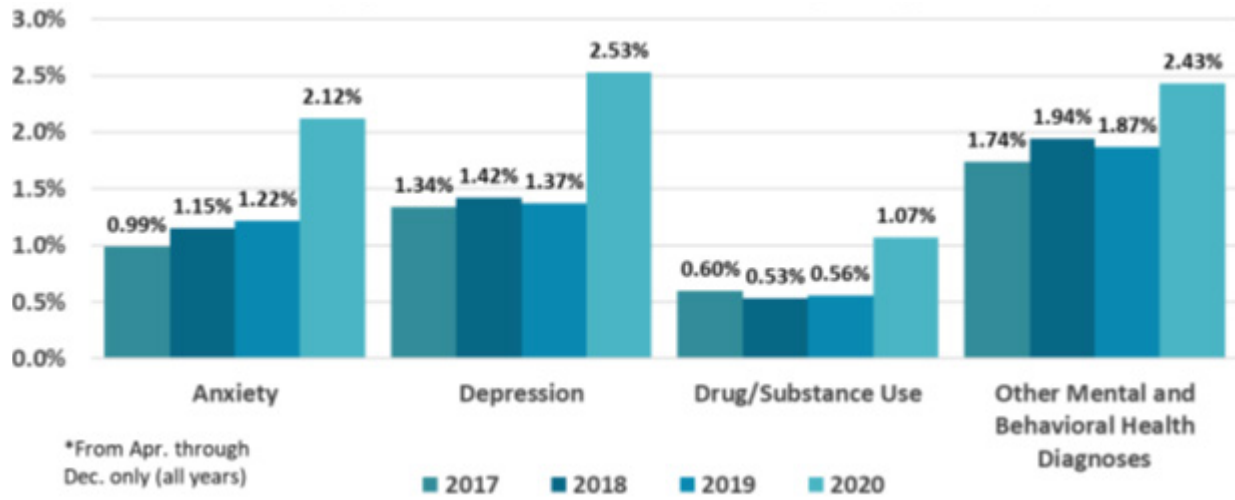
Source: New Jersey Hospital Discharge Data.
Notes: 1) Anxiety-related diagnoses include phobic anxiety disorders; 2) Other mental and behavioral health-related diagnoses include behavioral syndromes, and dissociative, stress-related, adjustment-related, somatoform, other nonpsychotic, manic, bipolar, persistent mood, and other mood disorders. They exclude adult personality disorders; and 3) Drug/substance use-related diagnoses include abuse and dependence disorders. They exclude undetermined and assault-related diagnoses, as well as subsequent and sequential encounters.

Anxiety

According to parents, 8% of children currently struggle with anxiety problems while an additional 3% have struggled in the past but not now. Interestingly, NSCH data shows that White, non-Hispanic children were the most likely to have anxiety problems and that Black, non-Hispanic children were the least likely to have anxiety problems. This is in direct contrast to several other studies which have demonstrated the opposite. One possible explanation for this is that the data is based on parents' reporting rather than asking their children directly. There may have been barriers or cultural differences influencing the response patterns of parents as they filled out the survey. Another explanation could be the low sample size of parents with Black children who completed the survey (NSCH, 2020-2021).

The NJHA CHART data (pg. 23) shows that in 2021, the proportion of emergency department visits among 12- to 17-year-olds in New Jersey with a diagnosis for anxiety increased to 49 per 1,000 – an approximately 36% increase from 2019, which was 36 per 1,000. For inpatient hospitalizations, these proportions for the same periods were 169 and 260 per 1,000 – an increase of roughly 54% (Figures 2 and 3, pg. 23) (NJHA, 2022).

Table 6: Does this child currently have anxiety problems, age 3-17 years?

Does this child currently have anxiety problems, age 3-17 years?			
Demographic	No	In the past, but not now	Yes
All (n = 917)	89%	3%	8%
Male (n = 501)	90.5%	1.5%*	8%
Female (n = 416)	88%	3%*	9%
White - Non Hispanic (n = 478)	86.5%	3%*	10.5%
Black - Non Hispanic (n = 63)	93%	3%*	4%*
Hispanic (n = 169)	89%	3%*	8%
Other Race - Non Hispanic (n = 207)	95%	0%*	5%

Source: NSCH, 2020-2021.
* Indicates a confidence interval larger than 20 percentage points.

Figure 2: Proportion of Anxiety-Related ED Visits (Children 12-17), Per 1,000

Figure 3: Proportion of Anxiety-Related IP Hospitalizations (Children 12-17), Per 1,000
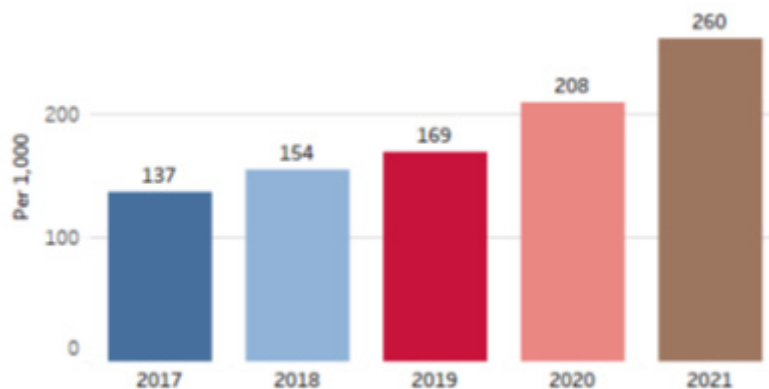
Source for Figures: New Jersey Hospital Discharge Data.
Diagnoses for anxiety included ICD-10 codes F40-F419.

Depression

Parents reported that 3% of children are currently struggling with depression and another 2% have struggled with depression in the past, but not now. Parents of Black children were the least likely to report their child as never having struggled with depression. This is dramatically different from the responses sourced from youth directly (NSCH, 2020-2021). As with the data regarding anxiety problems, there may be a number of possible factors that influenced this disparity, including parents' reporting, cultural differences, and/or low sample size of survey respondents.

Forty-two percent of high school students reported feeling so sad or hopeless every day for a period of at least two (2) weeks that they stopped doing some of their usual activities. Female students were nearly twice as likely to report struggling with these depressive emotions than male students. White, non-Hispanic students were the least likely to report this issue (YRBS, 2021).

Half of middle school students reported experiencing several days or longer when they spent the majority of the day feeling sad, empty, or depressed. Again, female students were 60% more likely to struggle with this than male students, and Hispanic students were more likely than other ethnic/racial groups to indicate these depressive emotions (NJ Middle School Risk and Protective Factors Survey, 2021).

The proportion of depression-related emergency department (ED) visits among teens increased by approximately 38% from 2019 to 2021, and the proportion of depression-related hospitalizations increased by 25% (Figures 4 and 5, pg. 26) (NJHA, 2022).

Table 7: Does this child currently have depression, age 3-17 years?

Does this child currently have depression, age 3-17 years?			
Demographic	No	In the past, but not now	Yes
All (n = 917)	95%	2%*	3%
Male (n = 501)	96%	1%*	3%
Female (n = 416)	95%	2%*	3%
White - Non Hispanic (n = 478)	96%	1%*	3%
Black - Non Hispanic (n = 63)	93%	3.5%*	3.5%*
Hispanic (n = 169)	94%	3%*	3%*
Other Race - Non Hispanic (n = 207)	97%	1%*	2%*

Source: NSCH, 2020-2021.
* Indicates a confidence interval larger than 20 percentage points.

Table 8: High school students felt sad or hopeless almost every day for 2 or more weeks in a row so that they stopped doing some usual activities, during the 12 months before the survey

High school students felt sad or hopeless almost every day for 2 or more weeks in a row so that they stopped doing some usual activities, during the 12 months before the survey		
Demographic	Yes	No
All (n = 695)	42%	58%
Male (n = 313)	28%	72%
Female (n = 382)	53%	47%
White - non-Hispanic (n = 320)	37%	63%
Black - non-Hispanic (n = 90)	49%	51%
Hispanic (n = 194)	47%	53%
Asian (n = <91)*	38%	62%

Source: YRBS, 2021.
* The 2021 YRBS data has not been completely released so it is not yet clear what the sample size is of surveyed Asian students.

Table 9: Middle School Students that had a period of time lasting several days or longer when most of the day [they] felt sad, empty, or depressed in the past year

Middle School Students that had a period of time lasting several days or longer when most of the day [they] felt sad, empty or depressed in the past year		
Demographic	Yes	No
All (n = 6,490)	50%	50%
Male (n = 2,875)	38%	62%
Female (n = 3,459)	59%	41%
Hispanic (n = 1,895)	56%	44%
White (n = 3,167)	49%	51%
Black (n = 539)	46%	54%
Other (n = 1,227)	55%	45%
Two or More Races (n = 941)	55%	45%
Asian (n = 461)	47%	53%

NJ Middle School Risk and Protective Factors Survey, 2021.

Figure 4: Proportion of Depression-Related ED Visits (Children 12-17), Per 1,000
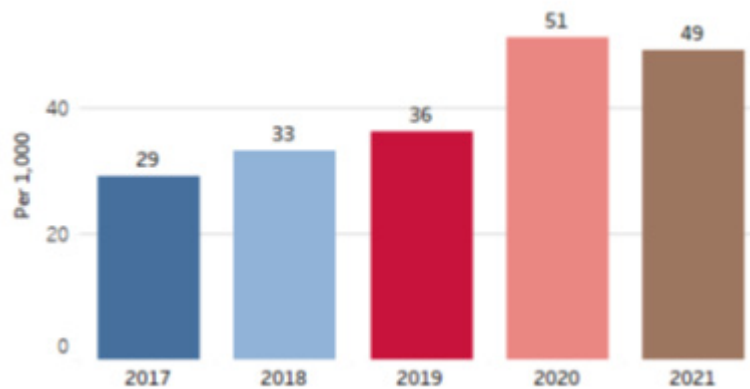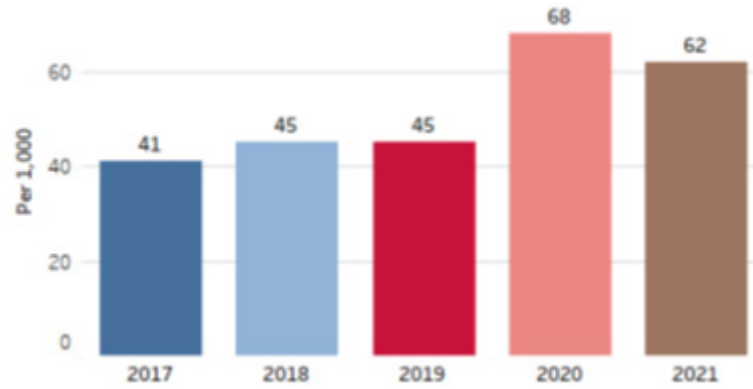

Figure 5: Proportion of Depression-Related IP Hospitalizations (Children 12-17), Per 1,000
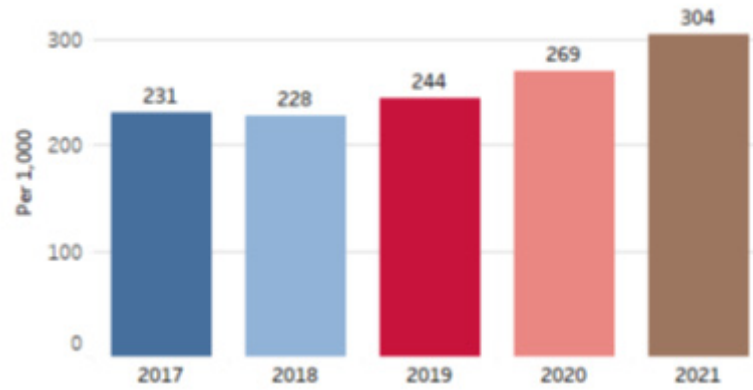
Source for Figures: New Jersey Hospital Discharge Data Diagnoses for depression include ICD-10 codes F320-F339.

Suicide

In the 12 months leading up to the survey, 20% of high school students seriously considered suicide and 10% actually attempted it. Female students were twice as likely as their male counterparts to seriously consider attempting suicide. Black students are the most likely of racial/ethnic groups to actually attempt suicide (YRBS, 2021).

The NJHA CHART data shows that the proportion of ED visits among 12- to 17-year-olds who had either a primary or secondary diagnosis for self-harm was approximately 68% higher in 2021 compared to 2019, while the corresponding increase for inpatient hospitalizations was 95% (Figures 6 and 7, pg. 28) (NJHA, 2022).

Along with self-harm related emergency department visits and inpatient hospitalizations, adolescent suicide has also increased in New Jersey. A JAMA Pediatrics study found that in 2020 5.8% of teens committed suicide. From 2015 to 2019, the average annual percentage of teens that committed suicide was 4.6%.

Table 10: High School Students Who Engaged in Suicidal Behavior During the 12 months before the survey

High School Students Who Engaged in Suicidal Behavior During the 12 months before the survey		
Demographic	Seriously Considered Attempting Suicide	Actually Attempted Suicide
All (n = 695)	20%	10%
Male (n = 313)	12%	8%
Female (n = 382)	26%	11%
White - non-Hispanic (n = 320)	20%	7%
Black - non-Hispanic (n = 90)	21%	13%
Hispanic (n = 194)	17%	11%
Asian (n = <91)*	24%	11%

Source: YRBS, 2021.
* The 2021 YRBS data has not been completely released so it is not yet clear what the sample size is of surveyed Asian students.

Figure 6: Proportion of Self-Harm-Related IP Hospitalizations (Children 12-17), Per 1,000
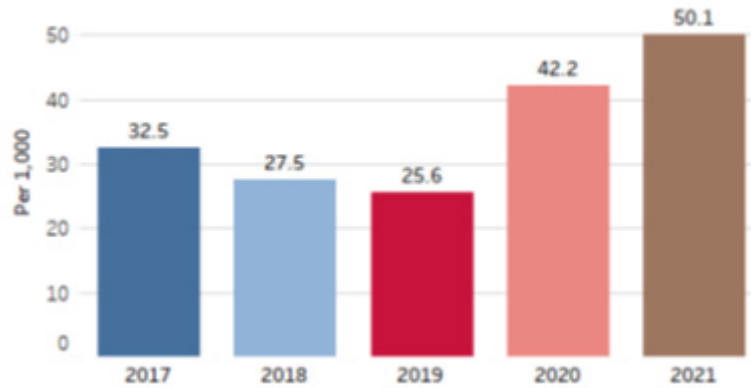
Figure 7: Proportion of Self-Harm-Related ED Visits (Children 12-17), Per 1,000
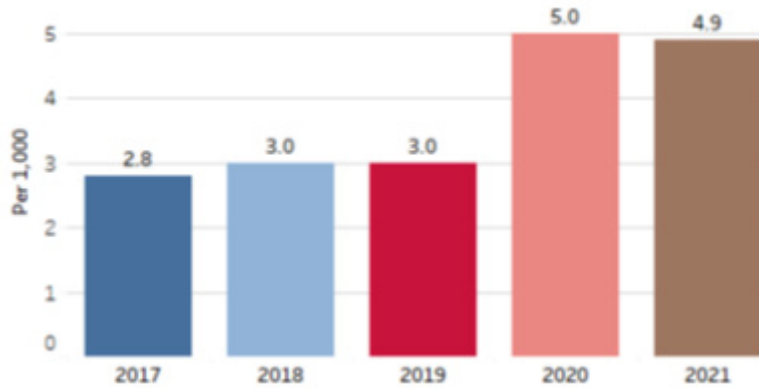
Source for Figures: New Jersey Hospital Discharge Data.

Diagnoses for self-harm include intentional self-harm poisonings from drugs, medicaments, biological substances, and nonmedical substances (ICD-10 codes T30-T65); self-inflicted injuries (X71-X83); and suicide attempts (T149).

Table 11: Adolescent Suicides in New Jersey

Adolescent Suicides in New Jersey		
	Number of Adolescent Suicides	**Proportion of Suicides Among Adolescents**
2015-2019 Annual Mean	32.4	4.6%
2020	37	5.8%

Source: Charpignon et al., 2022)

Behaviors Connected with Youth Mental Health

It is known that behavioral issues are linked with poor mental health outcomes in children. Parents reported in the most recent NSCH survey that 8% of youth either currently or used to struggle with behavioral or conduct problems. This number has steadily been increasing since the 2018-2019 NSCH data (NSCH 2018-2019, 2019-2020, 2020-2021). Even though there are an array of factors impacting children and adolescent behavior, it is likely that the COVID-19 pandemic has influenced these statistics, especially after hearing testimony from educators concerning student behavior in the classroom (Chatterjee, 2022).

Table 12: Does this child currently have behavioral or conduct problems, age 3-17 years?

Does this child currently have behavioral or conduct problems, age 3-17 years?			
Demographic	No	In the past, but not now	Yes
All (n = 917)	92%	3%	5%
Male (n = 501)	89%	3%*	8%
Female (n = 416)	94%	3%*	3%
White - Non Hispanic (n = 478)	92%	2%*	6%
Black - Non Hispanic (n = 63)	88.5%	4%*	7.5%*
Hispanic (n = 169)	91.5%	5%*	3.5%
Other Race - Non Hispanic (n = 207)	93%	1%*	6%*

Source: NSCH, 2020-2021.
* Indicates a confidence interval larger than 20 percentage points.

Table 13: Children that either currently or used to have behavioral or conduct problems, age 3-17 years

Children that either currently or used to have behavioral or conduct problems, age 3-17 years		
2018-2019	2019-2020	2020-2021
5%	7%	8%

Source: NSCH, 2020-2021; NSCH, 2019-2020; NSCH, 2018-2019.

Marijuana & Tobacco Use

Tobacco use in youth is linked to both be a side effect of struggling with mental illness and an aggravator of mental illness (NJ Middle School Risk and Protective Factors Survey, 2021). Close to 20% of high schoolers used electronic vapor products in the month before the survey. White, non-Hispanic students are most likely to consume electronic vapor products, especially compared to their Asian counterparts (YRBS, 2021). Results from the 2018 New Jersey Youth Tobacco Survey indicate that cigarette use has been steadily declining while electronic vapor product use has been consistently climbing. There is a particularly stark contrast between the 2018 NJYTS estimate that 18% of high school students use electronic vapor products and the 2019 YRBS estimate of 28%. The YRBS data corroborates this dramatic increase between 2018 and 2019 in vaping behavior nationally, but also indicates a drop in vaping nationally between 2019 and 2021. Middle school students reported very low levels of cigarette use but higher levels of e-cigarette use (NJ Middle School Risk and Protective Factors Survey, 2021).

Seventeen percent of high school students have smoked at least one (1) day in the 30 days before the survey and close to a third have tried it at least once in their life. Compared to 2013 and 2019 rates, high school students have become slightly less likely to consume marijuana. Asian, non-Hispanic students are 50% less likely to consume marijuana than their peers of other ethnic/racial groups (YRBS 2013, 2021).

Table 14: High School Students Who Consumed Tobacco Products On at least 1 day during the 30 days before the survey

High School Students Who Consumed Tobacco Products On at least 1 day during the 30 days before the survey		
Demographic	Cigarettes	Electronic Vapor Products
All (n = 695)	3.7%	18%
Male (n = 313)	5%	15%
Female (n = 382)	2.8%	21%
White - non-Hispanic (n = 320)	6.3%	20%
Black - non-Hispanic (n = 90)	0%	14%
Hispanic (n = 194)	2.7%	18%
Asian (n = <91)*	0%	5.5%

Source: YRBS, 2021.
* The 2021 YRBS data has not been completely released so it is not yet clear what the sample size is of surveyed Asian students.

Table 15: High School Students Who Consumed Tobacco Products On at least 1 day during the 30 days before the survey

High School Students Who Consumed Tobacco Products On at least 1 day during the 30 days before the survey		
Year	Cigarettes	Electronic Vapor Products
2018	3%	18%
2016	5%	10%
2014	8%	12%
2012	9%	6%

Source: NJYTS, 2018.

Table 16: Middle School Students Who Consumed Tobacco in the Past Year

Middle School Students Who Consumed Tobacco in the Past Year		
Demographic	Cigarettes	E-Cigarettes
All (n = 6,490)	1%	7%
Male (n = 2,875)	1%	5%
Female (n = 3,459)	1%	8%
Hispanic (n = 1,895)	1.5%	10%
White (n = 3,167)	1%	6%
Black (n = 539)	1%	4%
Other (n = 1,227)	1.7%	9%
Two or More Races (n = 941)	1.8%	9%
Asian (n = 461)	0%	2%

Source: NJ Middle School Risk and Protective Factors Survey, 2021.

Table 17: High School Students Who Have Used Marijuana

High School Students Who Have Used Marijuana		
Demographic	At Least One Day During the 30 Days Before the Survey	At Least Once in Their Life
All (n = 695)	17%	30%
Male (n = 313)	14%	26%
Female (n = 382)	20%	32%
White - non-Hispanic (n = 320)	20%	32%
Black - non-Hispanic (n = 90)	18%	25%
Hispanic (n = 194)	17%	34%
Asian (n = <91)*	6.5%	15%

Source: YRBS, 2021.
* The 2021 YRBS data has not been completely released so it is not yet clear what the sample size is of surveyed Asian students.

Table 18: High School Students Who Have Used Marijuana

High School Students Who Have Used Marijuana		
Year	At Least One Day During the 30 Days Before the Survey	At Least Once in Their Life
2021	17%	30%
2019	20%	33%
2013	21%	39%

Source: YRBS, 2021; YRBS, 2019; YRBS, 2013.

Alcohol Use

In the 30 days before the survey, 26% of high school students had at least one (1) drink and 15% engaged in binge drinking. White, non-Hispanic and Hispanic students are 2-3 times more likely than their peers to have participated in either of these activities (YRBS, 2021). Female students in middle were more likely to consume alcohol than male students but this difference is absent amongst the high school population. Overall, in the 30 days before the survey 10% of middle school students reported having at least one (1) drink and 3% engaged in binge drinking (NJ Middle School Risk and Protective Factors Survey, 2021).

Table 19: High School Students Who Consumed Alcohol on at least 1 day during the 30 days before the survey

High School Students Who Consumed Alcohol on at least 1 day during the 30 days before the survey		
Demographic	At Least 1 Drink	Binge Drinking
All (n = 695)	26%	15%
Male (n = 313)	26%	16%
Female (n = 382)	26%	14%
White - non-Hispanic (n = 320)	36%	24%
Black - non-Hispanic (n = 90)	9%	1.2%
Hispanic (n = 194)	22%	8.7%
Asian (n = <91)*	10%	11%

Source: YRBS, 2021.
* The 2021 YRBS data has not been completely released so it is not yet clear what the sample size is of surveyed Asian students.

Table 20: Middle School Students Who Consumed Alcohol in the Past Year

Middle School Students Who Consumed Alcohol in the Past Year		
Demographic	**At Least 1 Drink**	**Binge Drinking**
All (n = 6,490)	10%	3%
Male (n = 2,875)	8%	2%
Female (n = 3,459)	12%	3%
Hispanic (n = 1,895)	12%	3%
White (n = 3,167)	10%	3%
Black (n = 539)	7%	2%
Other (n = 1,227)	12%	3%
Two or More Races (n = 941)	12%	2%
Asian (n = 461)	5%	1%

Source: NJ Middle School Risk and Protective Factors Survey, 2021.

Academic Performance

When parents were asked about the frequency that their child engages in school, 13% reported that the student was only sometimes or never engaged. Double the number of male students were reported at the lowest level of engagement compared to female students. Almost two times the number of Black, non-Hispanic youth were categorized as only sometimes or never engaged compared to White, non-Hispanic students (YRBS, 2019).

Table 21: How often does this child engage in school: cares about doing well in school and does required homework, age 6-17 years?

How often does this child engage in school: cares about doing well in school and does required homework, age 6-17 years?			
Demographic	**Always Engaged**	**Usually Engaged**	**Sometimes or Never Engaged**
All (n = 917)	47%	40%	13%
Male (n = 501)	37.5%	46.5%	16%
Female (n = 416)	56.5%	34%	9.5%
White - Non Hispanic (n = 478)	45%	44.5%	10.5%
Black - Non Hispanic (n = 63)	54%*	28%*	18%
Hispanic (n = 169)	45%	40.5%	14.5%
Other Race - Non Hispanic (n = 207)	53.5%	36%	10.5%

Source: NSCH, 2020-2021.

Influencing Social and Environmental Factors

Relationships with Peers

Youth who feel connected to adults and peers at school are less likely than those who do not feel connected to report persistent feelings of sadness or hopelessness (CDC, 2022). The following tables attempt to measure other aspects of peer relationships.

Close to 25% of parents reported that their children had some amount of difficulty in making and keeping friends. Six percent of parents also indicated that their child was bullied, picked on, or excluded by their peers at least once a month. Only 64% of White, non-Hispanic children were never bullied, picked on, or excluded in the year before the survey. This is in stark contrast to the higher proportion (82%) of Black, non-Hispanic children who report no bullying (NSCH, 2020-2021). Fifteen percent of students in high school were electronically bullied in the year prior to the survey. Double the number of female students experienced electronic bullying compared to male students, and Bsian youth are half as likely to be electronically bullied than White, non-Hispanic youth (YRBS, 2021).

The NJ Middle School Risk and Protective Factors Survey rated various peer-related factors with a factor score that ranges between 0 and 1. The closer to 1 the factor score is, the more likely that group of students is to experience the factor. The factor score for the single protective factor presented, interaction with prosocial peers, is 0.57. Of the three risk factors presented, the one students were most likely to be exposed to was the use of drugs by friends. Black and Hispanic middle school students are most likely to experience the three risk factors while White and Asian middle school students are most likely to experience the one single protective factor (NJ Middle School Risk and Protective Factors Survey, 2021).

Table 22: Compared to other children their age, how much difficulty does this child have making or keeping friends, age 6-17 years?

Compared to other children their age, how much difficulty does this child have making or keeping friends, age 6-17 years?			
Demographic	**No Difficulty**	**A Little Difficulty**	**A Lot of Difficulty**
All (n = 917)	77%	19%	4%
Male (n = 501)	76.5%	18%	5.5%
Female (n = 416)	78%	20%	2%
White - Non Hispanic (n = 478)	76%	19%	5%
Black - Non Hispanic (n = 63)	82%*	17%*	1%*
Hispanic (n = 169)	75%	21%	4%*
Other Race - Non Hispanic (n = 207)	81.5%	15%	3.5%*

Source: NSCH, 2020-2021.
* Indicates a confidence interval larger than 20 percentage points.

Table 23: During the past 12 months, how often was this child bullied, picked on, or excluded by other children, age 6-17 years?

During the past 12 months, how often was this child bullied, picked on, or excluded by other children, age 6-17 years?					
Demographic	Never	1-2 Times	1-2 Times per Month	1-2 Times per Week	Almost Every Day
All (n = 917)	70%	24%	4%	1%	1%*
Male (n = 501)	69%	25.5%	3.5%	1%*	1%*
Female (n = 416)	71%	23%	4%	1%*	1%*
White - Non Hispanic (n = 478)	63.5%	29%	4%	1.5%*	2%*
Black - Non Hispanic (n = 63)	82%	11.5%*	5%*	1.5%*	0%*
Hispanic (n = 169)	70%	25%	3.5%*	1%*	0.5%*
Other Race - Non Hispanic (n = 207)	78.5%	19%	1.5%*	1%*	0%

Source: NSCH, 2020-2021.
* Indicates a confidence interval larger than 20 percentage points.

Table 24: High School Students Who Were Electronically Bullied during the 12 months before the survey

High School Students Who Were Electronically Bullied during the 12 months before the survey		
Demographic	Yes	No
All (n = 695)	15%	85%
Male (n = 313)	11%	89%
Female (n = 382)	19%	81%
White - non-Hispanic (n = 320)	17%	83%
Black - non-Hispanic (n = 90)	8%	92%
Hispanic (n = 194)	12%	88%
Asian (n = <91)*	16%	84%

Source: YRBS, 2021.
* The 2021 YRBS data has not been completely released so it is not yet clear what the sample size is of surveyed Asian students.

Table 25: Middle School Student Peer Risk and Protective Factors – Factor Scores

Middle School Student Peer Risk and Protective Factors – Factor Scores				
Demographic	Friend's Use of Drugs	Gang Involvement	Interaction with Antisocial Peers	Interaction with Prosocial Peers
All (n = 6,490)	0.5	0.2	0.3	0.57
Male (n = 2,875)	0.4	0.2	0.4	0.56
Female (n = 3,459)	0.6	0.2	0.3	0.59
Hispanic (n = 1,895)	0.06	0.02	0.04	0.52
White (n = 3,167)	0.04	0.01	0.02	0.6
Black (n = 539)	0.06	0.02	0.06	0.54
Other (n = 1,227)	0.06	0.03	0.04	0.51
Two or More Races (n = 941)	0.07	0.02	0.05	0.58
Asian (n = 461)	0.02	0.01	0.01	0.63

Source: NJ Middle School Risk and Protective Factors Survey, 2021.

Neighborhood Conditions

Only 70% of parents definitely agree that the neighborhood their child lives in is safe. The parents of female students are 50% more likely to somewhat or definitely disagree with the sentiment of the neighborhood being safe. There are stark disparities between the experiences of White children and children of color. Hispanic students are almost 300% more likely and Black, non-Hispanic students are 600% more likely to reside in neighborhood where the parent disagrees with it being safe when compare to White, non-Hispanic students. These disparities continue through other community measures as well. White, non-Hispanic youth are almost 50% more likely to live in a supportive neighborhood than Hispanic or Black, non-Hispanic youth. Female children were also more likely to live in a supportive neighborhood than male children. Around 65% of Black, non-Hispanic and Hispanic youth lived in communities with zero detracting elements while that statistic spikes to 85% for White, non-Hispanic children (NSCH, 2020-2021).

Table 26: Does this child live in a safe neighborhood?

Does this child live in a safe neighborhood?			
Demographic	Definitely Agree	Somewhat Agree	Somewhat or Definitely Disagree
All (n = 917)	71%	25%	4%
Male (n = 501)	68.5%	29%	2.5%*
Female (n = 416)	74%	21%	5%
White - Non Hispanic (n = 478)	81%	17%	2%*
Black - Non Hispanic (n = 63)	60%*	28.5%*	11.5%*
Hispanic (n = 169)	55.5%	39%	5.5%*
Other Race - Non Hispanic (n = 207)	78%	21%	1%*

Source: NSCH, 2020-2021.
* Indicates a confidence interval larger than 20 percentage points.

Table 27: Does this child live in a supportive neighborhood?

Does this child live in a supportive neighborhood?		
Demographic	Yes	No
All (n = 917)	60%	40%
Male (n = 501)	57%	43%
Female (n = 416)	63.5%	36.5%
White - Non Hispanic (n = 478)	72%	28%
Black - Non Hispanic (n = 63)	49%*	51%*
Hispanic (n = 169)	44%	56%
Other Race - Non Hispanic (n = 207)	62%	38%

Source: NSCH, 2020-2021.
* Indicates a confidence interval larger than 20 percentage points.

Table 28: Does this child live in a neighborhood where there is litter or garbage on the street or sidewalk, poorly kept or rundown housing, or vandalism such as broken windows and graffiti?

Does this child live in a neighborhood where there is litter or garbage on the street or sidewalk, poorly kept or rundown housing, or vandalism such as broken windows and graffiti?			
Demographic	**0 Detracting Elements**	**1 Detracting Elements**	**2 Detracting Elements**	**3 Detracting Elements**
All (n = 917)	75.5%	15%	6%	3.5%
Male (n = 501)	74%	17.5%	5%	3.5%
Female (n = 416)	77%	13%	6.5%	3.5%*
White - Non Hispanic (n = 478)	84.5%	11%	3.5%	1%*
Black - Non Hispanic (n = 63)	66%*	14%	10%*	10%*
Hispanic (n = 169)	65%	23%	8%*	4%*
Other Race - Non Hispanic (n = 207)	73%	16%	6%*	5%*

Source: NSCH, 2020-2021.
* Indicates a confidence interval larger than 20 percentage points.

Home Environment

When parents were asked about their own mental health status, 80% of fathers reported they had excellent mental health while only 73% of mothers reported the same. Mothers of Black, non-Hispanic and Hispanic children were significantly less likely to report excellent mental health. For fathers, only those of Black, non-Hispanic children were noticeably less likely to report excellent mental health than those of other racial/ethnic groups (NSCH, 2020-2021).

Poor relationships between children and their parents, as well as low engagement levels from parents in their child's life, can act as risk factors for mental health. The survey reports that 19% of all parents only sometimes or never attend child activities or events, but that parents of Black, non-Hispanic children were more than twice as likely to report this low level of activity engagement (NSCH, 2020-2021).

Table 29: If this child's mother is a primary caregiver and lives in the household, in general, what is the status of mother's mental and emotional health?

If this child's mother is a primary caregiver and lives in the household, in general, what is the status of mother's mental and emotional health?			
Demographic	Excellent	Good	Fair or Poor
All (n = 917)	73%	23%	4%
Male (n = 501)	73%	23%	4%
Female (n = 416)	73%	23%	4%
White - Non Hispanic (n = 478)	79%	18%	3%
Black - Non Hispanic (n = 63)	55.5%*	37.5%*	7%*
Hispanic (n = 169)	66%	29%	5%*
Other Race - Non Hispanic (n = 207)	79.5%	16.5%	4%

Source: NSCH, 2020-2021.
* Indicates a confidence interval larger than 20 percentage points.

Table 30: If this child's father is a primary caregiver and lives in the household, in general, what is the status of father's mental and emotional health?

If this child's father is a primary caregiver and lives in the household, in general, what is the status of father's mental and emotional health?			
Demographic	Excellent	Good	Fair or Poor
All (n = 917)	80%	16%	4%
Male (n = 501)	80%	16.5%	3.5%
Female (n = 416)	80%	16%	4%
White - Non Hispanic (n = 478)	81%	15%	4%
Black - Non Hispanic (n = 63)	71.5%*	23%*	5.5%*
Hispanic (n = 169)	80%	18%	2%*
Other Race - Non Hispanic (n = 207)	82%	13%	5%*

Source: NSCH, 2020-2021.
* Indicates a confidence interval larger than 20 percentage points.

Table 31: During the past 12 months, how often did you (the parent/guardian) attend events or activities that this child participated in, age 6-17 years?

During the past 12 months, how often did you (the parent/guardian) attend events or activities that this child participated in, age 6-17 years?				
Demographic	Always	Usually	Sometimes	Rarely/Never
All (n = 917)	60.5%	21%	11%	7.5%
Male (n = 501)	60%	22%	10%	7%
Female (n = 416)	61%	20.5%	11.5%	7%
White - Non Hispanic (n = 478)	67%	21.5%	8.5%	3%
Black - Non Hispanic (n = 63)	58%*	16.5%*	10%*	15.5%*
Hispanic (n = 169)	51%	23%	15%	11%
Other Race - Non Hispanic (n = 207)	58%	22.5%	12%*	7.5%

Source: NSCH, 2020-2021.
* Indicates a confidence interval larger than 20 percentage points.

Traumatic Experiences

The more adverse childhood experiences (ACE's) that a youth endures, the higher of a risk they face in developing mental health illnesses. Sixty-eight percent of parents report that their child has experienced no ACE's. There is a definite disparity between racial/ethnic groups in reported ACE experiences. Less than 20% of the group that identifies as "Other, non-Hispanic," which is composed mostly of Asian children, have experienced at least one ACE, while half of Black, non-Hispanic children have experienced at least one ACE (NSCH, 2020-2021).

The 2021 YRBS reports that 10% of high school students have experienced physical dating violence in the year before the survey and 11% have experienced sexual violence in that same time frame. Female students are are more than three times as likely to endure sexual violence as compared to their male counterparts who face slightly higher odds of experiencing physical dating violence (YRBS, 2021).

Table 32: Has this child experienced one or more adverse childhood experiences (ACE's)?

Has this child experienced one or more adverse childhood experiences (ACE's)?			
Demographic	No ACE's	One ACE	Two or More ACE's
All (n = 917)	68%	19%	13%
Male (n = 501)	68.5%	18%	13.5%
Female (n = 416)	67.5%	19.5%	13%
White - Non Hispanic (n = 478)	72.5%	18%	9.5%
Black - Non Hispanic (n = 63)	51.5%*	26.5%	22%
Hispanic (n = 169)	61.5%	20.5%	18%
Other Race - Non Hispanic (n = 207)	81.5%	10.5%	8%

Source: NSCH, 2020-2021.
*Indicates a confidence interval larger than 20 percentage points.

Table 33: High School Students Who Experienced Violence one or more times during the 12 months before the survey

High School Students Who Experienced Violence one or more times during the 12 months before the survey		
Demographic	Physical Dating Violence among students who dated or went out with someone during the 12 months before the survey	Sexual Violence by Anyone
All (n = 695)	10%	11%
Male (n = 313)	10%	5%
Female (n = 382)	8%	18%
White - non-Hispanic (n = 320)	10%	12%
Black - non-Hispanic (n = 90)	5%	7%
Hispanic (n = 194)	8%	11%
Asian (n = <91)*	-	6%

Source: YRBS, 2021.
* The 2021 YRBS data has not been completely released so it is not yet clear what the sample size is of surveyed Asian students.

COVID-19 Experiences

Middle school students shared their COVID-19 experiences from between March 2020, the date that schools closed, and the time at which the survey was taken. The survey showed that 50% of students felt nervous, anxious, or on-edge at least half of the time, and 50% felt little interest or pleasure in doing things at least half of the time. Forty percent of middle school students reported feeling down, depressed, hopeless, or being unable to control their worrying at least half of the time (NJ Middle School Risk and Protective Factors Survey, 2021).

Children whose parents' employment was impacted negatively during the pandemic have demonstrated higher levels of stress than their peers. The 2021 survey found that 14% of middle schoolers in the state had at least one parent lose their job. Black and Hispanic children were significantly more likely than their peers to experience the stressors of job loss or parents being essential workers who needed to work outside the home (NJ Middle School Risk and Protective Factors Survey, 2021).

Isolation is understood to be a risk factor for poor youth mental health outcomes. A quarter of children did not speak to their friends on most days and a third of children did not communicate with their family on most days (NJ Middle School Risk and Protective Factors Survey, 2021).

Table 34: Middle School Student Mental Health Outcomes since March 2020 when Schools Closed

Middle School Student Mental Health Outcomes since March 2020 when Schools Closed			
Feeling	Never or Rarely	About Half of the Time	Most Days or Every Day
Nervous, Anxious, On-Edge	51%	23%	26%
Little Interest/Pleasure in Doing Things	51%	23%	26%
Feeling Down, Depressed, Hopeless	58%	19%	23%
Not Being Able to Stop/ Control Worrying	60%	17%	23%

Source: NJ Middle School Risk and Protective Factors Survey, 2021.

Table 35: Middle School Students whose Parents or Guardians' Employment was Impacted by COVID-19

Middle School Students whose Parents or Guardians' Employment was Impacted by COVID-19		
Demographic	Parents or Guardians Served as Essential Workers since March 2020	Parents or Guardians Losing their Job Since March 2020
All (n = 6,490)	51%	14%
Male (n = 2,875)	51%	13%
Female (n = 3,459)	51%	16%
Hispanic (n = 1,895)	58%	22%
White (n = 3,167)	48%	10%
Black (n = 539)	63%	18%
Other (n = 1,227)	58%	24%
Two or More Races (n = 941)	54%	18%
Asian (n = 461)	40%	12%

Source: NJ Middle School Risk and Protective Factors Survey, 2021.

Table 36: Middle School Communication Networks during the Pandemic

Middle School Student Communication Networks during the Pandemic			
People or Groups	**Never or Rarely**	**About Half of the Time**	**Most Days or Every Day**
Friends	12%	11%	77%
Family	14%	21%	65%

Source: NJ Middle School Risk and Protective Factors Survey, 2021.

School Conditions

Overall, about 80% of all parents surveyed definitely agree that their child is safe at school. A lower proportion of parents of Hispanic children (64%) definitely agree that their child is safe (NSCH, 2020-2021). Ten percent of high school students report carrying a weapon at least once in the 30 days before the survey and 2% report doing so on school property. Male students are significantly more likely than female students to carry a weapon in general but this difference evens out when asked specifically about doing so on school property. Nine percent of high school students who got involved in a physical fight at least once in the 12 months before the survey did so on school property; male students were significantly more likely than female students to be involved in a physical fight. Black, non-Hispanic and Hispanic students were 50% more likely to report being involved in a physical fight than White, non-Hispanic youth (YRBS, 2019).

Data on several other negative school climate conditions were collected. At school, 8% of high school students were threatened or injured with a weapon, 16% were bullied, and 26% were either offered, sold, or given an illegal drug. Female students were more likely to be bullied at school while male students were more likely to have interactions involving weapons or illegal drugs. Asian, non-Hispanic students were the least likely to experience any of these conditions (YRBS, 2019).

Table 37: Is this child safe at school, age 6-17 years?

Is this child safe at school, age 6-17 years?			
Demographic	**Definitely Agree**	**Somewhat Agree**	**Somewhat or Definitely Disagree**
All (n = 917)	78.5%	19.5%	2%*
Male (n = 501)	77%	21%	2%*
Female (n = 416)	80%	18%	2%*
White - Non Hispanic (n = 478)	85.5%	13.5%	1%*
Black - Non Hispanic (n = 63)	80%*	18.5%*	1.5%*
Hispanic (n = 169)	64%	31.5%	4.5%*
Other Race - Non Hispanic (n = 207)	82%	18%	0%*

Source: NSCH, 2020-2021.
* Indicates a confidence interval larger than 20 percentage points.

Table 38: High School Students Who Carried A Weapon on at least 1 day during the 30 days before the survey

High School Students Who Carried A Weapon on at least 1 day during the 30 days before the survey		
Demographic	Carried a Weapon Anywhere	Carried a Weapon on School Property
All (n = 1,393)	10%	2%
Male (n = 652)	17%	2.5%
Female (n = 733)	4%	1.5%
White - Non Hispanic (n = 608)	10%	2%
Black - Non Hispanic (n = 146)	13%	1.5%
Hispanic (n = 377)	12%	3%
Asian - Non Hispanic (n = 162)	7%	1%

Source: YRBS, 2019.

Table 39: High School Students Who Experienced a Negative School Climate Condition One or More Times in the 12 Months before the Survey

High School Students Who Experienced a Negative School Climate Condition One or More Times in the 12 Months before the Survey				
Demographic	Threatened or Injured with a Weapon on School Property	Bullied on School Property	In a Physical Fight on School Property	Offered, Sold, or Given an Illegal Drug on School Property
All (n = 1,393)	8%	16%	9%	26%
Male (n = 652)	9%	14%	13%	27%
Female (n = 733)	6%	19%	5%	25%
White - Non Hispanic (n = 608)	8%	18%	8%	26%
Black - Non Hispanic (n = 146)	6%	16%	12%	24%
Hispanic (n = 377)	8%	15%	12%	29%
Asian - Non Hispanic (n = 162)	5%	11%	1%	19%

Source: YRBS, 2019.

Youth Mental Healthcare in New Jersey

Current Coverage

Overall, 96% of children are currently covered by health insurance or a health coverage plan. The only noteworthy disparity is Hispanic children whose coverage rate is 4 to 5 percentage points lower than other racial/ethnic groups. Only 56% of parents, however, claim that their child's health insurance always covers the child's mental or behavioral health needs. Male children were 17% more likely to always have access to mental or behavioral health coverage than female children. Hispanic children were the least likely to always have coverage. Interestingly, Black, non-Hispanic children were more likely than White, non-Hispanic children to have health coverage. Large confidence intervals around the data on Black, non-Hispanic children do exist, so these numbers should be approached with caution (NSCH, 2020-2021).

Table 40: Is this child currently covered by health insurance or health coverage plans?

Is this child currently covered by health insurance or health coverage plans?		
Demographic	Yes	No
All (n = 917)	95.5%	4.5%
Male (n = 501)	96%	4%*
Female (n = 416)	95%	5%
White - Non Hispanic (n = 478)	97%	3%*
Black - Non Hispanic (n = 63)	97%	3%*
Hispanic (n = 169)	91.5%	8.5%
Other Race - Non Hispanic (n = 207)	96%	4%*

Source: NSCH, 2020-2021.
* Indicates a confidence interval larger than 20 percentage points.

Table 41: Thinking specifically about this child's mental or behavioral health needs, how often does this child's health insurance offer benefits or cover services that meet these needs, age 3-17 years?

Thinking specifically about this child's mental or behavioral health needs, how often does this child's health insurance offer benefits or cover services that meet these needs, age 3-17 years?			
Demographic	Always	Usually	Sometimes/Never
All (n = 917)	56%	28%	16%
Male (n = 501)	61%	23%	16%
Female (n = 416)	52%	33%	15%
White - Non Hispanic (n = 478)	56.5%	27%	16.5%
Black - Non Hispanic (n = 63)	58%*	37%*	5%*
Hispanic (n = 169)	54%*	24%*	22%*
Other Race - Non Hispanic (n = 207)	61%*	27%	12%

Source: NSCH, 2020-2021.
* Indicates a confidence interval larger than 20 percentage points.

Youth Mental Health Treatment

In the 12 months before the survey, 12% of children received treatment or counseling from a mental health professional. Only 2% of parents reported that their child was in need of this support but did not receive it. While the children may have received services, it is interesting to note that only about 50% of parents who sought out mental health treatment or counseling for their child found that doing so was not difficult. Even more concerning, 22% of parents felt that it was very difficult or impossible. Parents of female children found it less difficult to access services than those of male children (NSCH, 2020-2021).

Table 42: During the past 12 months, has this child received any treatment or counseling from a mental health professional, age 3-17 years?

During the past 12 months, has this child received any treatment or counseling from a mental health professional, age 3-17 years?			
Demographic	Yes	No, But Needed To	No, Didn't Need To
All (n = 917)	12%	2%	86%
Male (n = 501)	12%	2%	86%
Female (n = 416)	11%	3%	86%
White - Non Hispanic (n = 478)	12%	2%	86%
Black - Non Hispanic (n = 63)	10%*	2%*	88%
Hispanic (n = 169)	14%	4%*	82%
Other Race - Non Hispanic (n = 207)	6%	2%*	92%

Source: NSCH, 2020-2021.
* Indicates a confidence interval larger than 20 percentage points.

Table 43: How difficult was it to get the mental health treatment or counseling that this child needed?

How difficult was it to get the mental health treatment or counseling that this child needed?				
Demographic	Not Difficult	Somewhat Difficult	Very Difficult	Impossible
All (n = 917)	51%	27%	12%	10%*
Male (n = 501)	48%*	28%*	12%	11%
Female (n = 416)	54%*	26%*	12%*	8%*
White - Non Hispanic (n = 478)	53%*	28%	13%	6%*
Black - Non Hispanic (n = 63)	-	-	-	-
Hispanic (n = 169)	49%*	19%*	11%*	21%*
Other Race - Non Hispanic (n = 207)	-	-	-	-

Source: NSCH, 2020-2021.
* Indicates a confidence interval larger than 20 percentage points.

Youth Mental Health in New Jersey - Key Take-aways:

Looking as a whole at the survey and facility data presented here, a few highlighted themes emerge:

- From a quarter to a half of New Jersey youth are experiencing poor mental health in the form of emotional or depressive problems, sadness, or hopelessness for extended periods of time.

- About a third of New Jersey youth have experienced an Adverse Childhood Experience (ACE), with the proportion about 50% for Black students, and one in six females have experienced sexual violence.

- Female students are up to 50% more likely to experience anxiety, sadness, or suicide ideations than male students.

- Hispanic youth are more likely to feel unsafe at school than White or Black students, and suffer more emotional disturbances.

- White youth suffer anxiety in higher proportions than Black, Hispanic, or Asian youth.

- White and Hispanic youth engage in more binge drinking and are more likely to be victims of bullying than Black youth.

- The proportion of poor neighborhood and familial determinants of mental health is higher in Hispanic and Black populations.

- Asian students are less likely than other racial/ethnic groups to experience risk factors for developing poor mental health outcomes.

- One in six families reports no insurance for mental health and about half found difficulty getting adequate counseling.

Understanding School-Based Mental Health Services

Basics of School-Based Mental Healthcare

Comprehensive School Mental Health Systems (CSMHS) are school-based infrastructures of services designed to encourage positive school climates, **Social-Emotional Learning (SEL)**, mental health, and wellbeing. At the same time, CSMHS decreases the prevalence and severity of mental illness while influencing the social and environmental factors that shape student mental health (Hoover et al., 2019).

Offering such services in schools can be efficient and effective. Staff are in the prime position to identify mental health concerns and provide early interventions. This is particularly true when schools implement universal screening to assess mental health determinants. Research outcomes have clearly demonstrated positive long-term impacts on students from school-based social, emotional, and behavioral interventions. Unlike traditional community-based mental health services, schools offer a more accessible, less stigmatizing setting to all students, including those that would otherwise face barriers to receiving aid. The ease of access shows; nationwide, between 70% and 80% of children and adolescents utilizing mental health services are doing so at school. These interventions positively impact students' psychosocial and academic performances in areas such as decision making, social skills, standardized testing, and graduation rates (Hoover et al., 2019).

More generally, schools can support student mental health through cultivating a positive school climate which fosters safety, a supportive academic and disciplinary environment, and respectful relationships between members of the school community. When positive school climates and the successful integration of SEL into the curriculum are achieved, schools are more likely to see decreased bullying, improved peer-to-peer relationships, and fewer instances of weapon threats. Partnerships between schools and student caregivers are more easily achieved than with traditional community-based services. Parents and guardians are familiar with the school, can access services in a way that is convenient for both them and their child's schedules, and are less inhibited by insufficient health insurance coverage (Hoover et al., 2019).

Primary Features of a Comprehensive School Mental Health System

A CSMHS cannot thrive without specialized support staffing and well-trained educators. These individuals are at the forefront of fostering positive school climates, educating students on mental health literacy, and endowing them with social-emotional skills, identifying at-risk youth, and delivering mental

health interventions. This includes teachers, administrators, school counselors, school nurses, social workers, and school psychologists. However, school staff alone cannot address the mental health needs of students. Collaborative partnerships must be established with families, policy makers, and community partners capable of augmenting school services. This should be done so seamlessly that mental health services are continuous and tightly coordinated (Hoover et al., 2019).

Building out a CSMHS requires first conducting a **needs assessment** to identify current system needs and, more specifically, which are to be prioritized. Complementary to this, **resource mapping** results in a comprehensive list of all mental health supports offered to students and families. Together these two deliverables will highlight the strengths and weaknesses of a school's mental health services system (Hoover et al., 2019).

Mental health interventions within a CSMHS are delivered in a framework of varying intensities commensurate to each student's level of need, also known as a **Multi-Tiered System of Support (MTSS).** Services are organized into three tiers. **Tier 1** is designed to promote mental health and strengthen social, emotional, and behavioral skills for all students regardless of their personal circumstances. They are generally implemented school-wide or grade-wide. The other tiers are only applied to youth that are identified as needing them by way of needs assessments, student screening, referrals, or other school identification processes. **Tier 2** is comprised of early interventions targeted towards students that have been pinpointed as either experiencing mild distress, mild functional impairment, or are at-risk for developing mental health concerns. These usually take the form of small group interventions for students with similar struggles or through brief individualized sessions. The final tier, **Tier 3,** offers treatment services. Students in need of Tier 3 have been identified as experiencing severe distress or functional impairment. The supports administered are highly individualized and may involve an official diagnosis (Hoover et al., 2019).

CSMHS interventions should be comprised of **evidence-based practices (EBP)** which are backed by research and rigorously tested to increase the likelihood of students receiving truly effective care. Evidence-based practices exist at every tier of MTSS and, in addition to improving mental health outcomes for individual students, can be used to cultivate positive school climates and staff wellness as well. The **What Works Clearinghouse (WWC)** is a database built and maintained by the U.S. Department of Education that contains an array of EBP's for schools to use (Hoover et al., 2019).

Data plays a critical role in a properly functioning comprehensive school mental health system. The provision and impact of services must be tracked in order to assess outcomes at the student-level, school-level, and district-level. The ease of collecting such data can be significantly dependent on the data system at use. Upon accruing comprehensive data, said information is used for **data-driven decision making (DDDM)** around further structuring of mental health services (Hoover et al., 2019).

As many schools do not receive a large enough budget to cover the entirety of their mental health programming, sustainable CSMHS's rely on diversification of funding. The U.S. Department of Education offers several legislative earmarks and grant programs. Almost every state takes

advantage of funds from the **Every Student Succeeds Act (ESSA),** particularly the Student Support and Academic Enrichment program through which states can disperse grants to schools. A portion of the grant must be used for improving upon school climate, school safety, or mental and behavioral health. There are four additional competitive grant programs available to states thanks to the U.S. Department of Education (Rafa et. Al., 2021):

- School-Based Mental Health Services Grant Program
- Trauma Recovery Demonstration Grant Program
- Mental Health Service Professional Demonstration Grant Program
- School Climate Transformation Grant-State Education Agency Program

The U.S. Department of Health and Human Services also hosts several large funding sources for school mental health programs. Each state has its own Medicaid program and is able to use the associated funding in various ways. Some states reimburse schools for the mental health services provided or encourage schools to partner with mental healthcare providers that accept Medicaid (Rafa et. Al., 2021). The reimbursement process is particularly crucial to the funding of CSMHS's. Until 2014, Medicaid programs were not allowed to reimburse schools for providing services to Medicaid youth unless they had an **individualized education plan (IEP).** This meant that schools were treating children on Medicaid without IEP's and not then being reimbursed for doing so, which would place significant strain on school budgets. A 2014 change in federal guidance was passed to allow state Medicaid programs to be altered so that schools could be reimbursed for servicing Medicaid children without IEP's, thereby increasing funding for mental health supports. As it currently stands though, many states have failed to incorporate this change into their state Medicaid programming (Aurrera Health Groups, 2021). Additional funding opportunities include Project AWARE of the **Substance Abuse and Mental Health Services Administration (SAMHSA)** and Healthy Schools Program of the **Centers for Disease Control and Prevention (CDC)** (Rafa et. Al., 2021).

State-level funding opportunities can also originate from several sources. Some states allocate funding for mental health services directly through their school funding models. Many states appropriate funds for supporting student mental health outside of the school funding model but within the state budget. A few states earmark tax revenue to be invested in student mental health efforts (Rafa et. Al., 2021).

A related but still important component of some school-based mental health systems are **school-based health centers (SBHC).** These are born of partnerships between school districts and healthcare organizations to provide students more accessible forms of preventative, early intervention, and treatment services. Traditional SBHC's are brick-and-mortar locations on school campuses while those labeled as "school-linked" are fixed sites near, but not on, school campuses. Mobile and virtual SBHC's are available as well. All SBHC's provide primary care, and between 70% to 80% of fixed location variations offer behavioral health services as well. The majority of SBHC's are located in areas with higher numbers of low-income families, higher percentages of enrolled students of color, and are designated for grades 6 and up, a reflection of adolescents' unique developmental needs (Love et. al., 2018).

## New Jersey School-Linked Services Model and Proposed NJ4S Model

Current Service Delivery Systems:

Every school in New Jersey is required to have a system of intervention and referral services (I&RS) in place. I&RS is a coordinated system for delivering intervention and referral services to students experiencing difficulties with learning, behavior, or health, as well as to teachers who are struggling to address such needs (NJDOE, 2019). Every school's IR&S must have a Child Study Team (CST) comprised of a school psychologist, a learning disabilities teacher-consultant, and a school social worker (ESCNJ, n.d.). Exactly how the I&RS system and the CST are operated in relation to each other and to the overall functioning of the school varies from location to location as there is no standardized framework that all schools must use.

The New Jersey Department of Education (NJDOE) recommends, but does not require, that schools organize their I&RS and CST using the New Jersey Tiered System of Supports (NJTSS). NJTSS is a rebranding of the MTSS concept commonly found in other state's school systems and as described in the earlier section of this report. NJDOE has structured the NJTSS framework to include the core principles of MTSS including a 3-tiered system of service delivery, universal mental health screening, data-based decision making, family and community engagement, and staff professional development (NJDOE, 2019).

In response to the COVID-19 pandemic, Governor Murphy called for a youth mental health working group to create resources for school staff to address the mental health crisis, which resulted in a Comprehensive School-Based Mental Health Resource Guide which outlines what a CSMHS is and how schools can create one. Previous resources published by the state on school-based student mental health services have only mentioned elements of the CSMHS model, but this report explicitly calls out the framework as a whole. Note that the CSMHS framework is a suggestion and not a mandate from NJDOE. The principles outlined in the Comprehensive School-Based Mental Health Resource Guide match that of the CSMHS principles discussed in the above section of this report.

Figure 8: School-Based Mental Health Practices Within an MTSS Framework
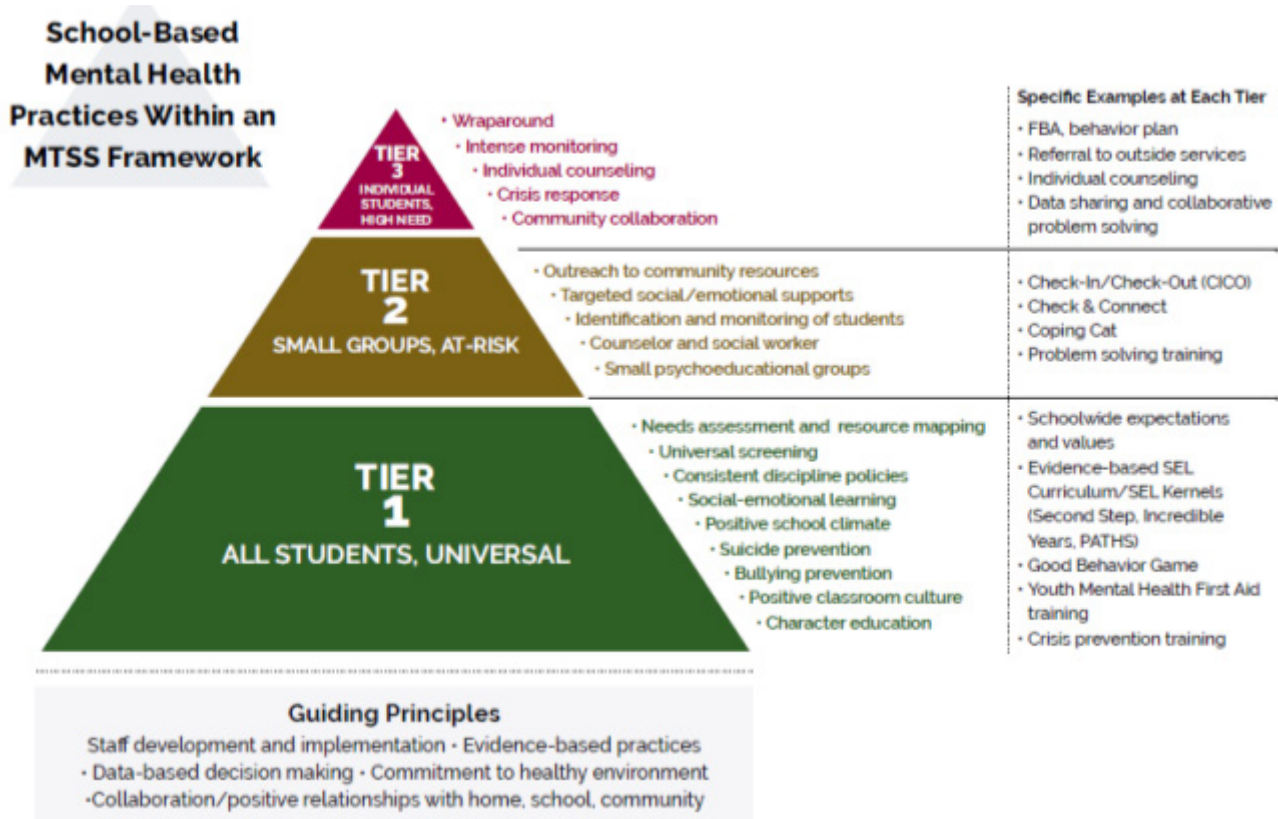
Source: NJDOE, 2022.

In addition to the aforementioned components, the Department of Children and Families (DCF) heads the Office of School Linked Services and the School Linked Services (SLS) program. SLS was created 35 years ago and contracts with schools and non-profit organizations to offer additional services and supports in middle and high schools beyond what the I&RSs and CSTs offer. SLS oversees a portfolio of several initiatives, some of which are currently housed within 136 schools (NJDCF, 2022). All students attending those schools can participate in the programs, and services are provided before, during, and after school. SLS is estimated to serve between 25,000 and 30,000 students, and costs $32 million annually (Burney, 2022). Below are the SLS programs currently located within participating schools (NJDCF, 2022):

- School Based Youth Services Program (SBYSP) - SBYSP is intended to link schools with social service providers to provide a variety of supportive programs.

- Prevention of Juvenile Delinquency - This program focuses on juvenile delinquency prevention strategies and self-regulation skills to prevent behaviors that can impede the student's achievement of their education and life goals.

- Adolescent Pregnancy Prevention - This program is intended to provide pregnancy prevention skills and knowledge to support the student's ability to achieve their educational goals.

- Family Friendly Centers - FFC is intended to encourage youth development, encourage parental engagement in their child's life, and create partnerships between schools and parents.

- Parent Linking Program - This initiative provides support to expecting and parenting teen mothers and fathers.

- Newark School Based Health Center - Newark SBHC offers not just primary care for students, but behavioral care as well.

As a byproduct of the COVID-19 related mental health crisis, the State of New Jersey proposed reorganizing SLS into the proposed NJ4S program. NJDCF's reasoning for such a move is that SLS is only operating in 136 out of the state's 2,493 schools and, according to DCF, serves less than 3% of New Jersey's 1.4 million K-12 students, therefore failing to provide enough support (NJDCF, 2022). While NJDCF cites mental health concerns as evidence that the current SLS system is not working, SLS programs address more than just mental health topics. In its white paper on the topic, the state does not mention the efficacy of the non-mental health related programs in its reasoning for altering SLS nor what will be happening to these programs. There is some research showing that some children prefer accessing services outside of school settings (NJDCF, 2022) although other research has indicated that children prefer accessing services in school (Hoover et al., 2019).

Of the SLS portfolio, SBYSP is the program that most directly provides student mental health services. DCF reports that there are now 90 schools hosting it. For the following analysis however, we were limited to referencing the 2015 DCF directory of partners (DCF, 2015) which lists 86 schools across 65 school districts. A copy of this list is located in the Appendix. The tables on page 57 (indicated as **TOTAL**) summarize data at the state, district, and school level with a focus on schools and school districts engaging in the SBYSP program (NJDOE, 2021-2022).

Table 44: Racial-Ethnic Demographics of Students in New Jersey

Racial-Ethnic Demographics of Students in New Jersey						
	Total K-12 Students	% White- Non Hispanic	% Black- Non Hispanic	% Hispanic	% Asian- Non Hispanic	% Other- Non Hispanic
Students in **Schools with SBYSP**	103,003	26%	21%	45%	5%	3%
Students in **School Districts with SBYSP**	395,390	29%	20%	43%	5%	3%
TOTAL	**1,360,916**	**40%**	**15%**	**32%**	**10%**	**3%**

Source: NJDOE, 2021-2022.

Table 45: Grade-Level Demographics of Students in New Jersey

Grade-Level Demographics of Students in New Jersey							
	Total K-12 Students	7th Grade Students	8th Grade Students	9th Grade Students	10th Grade Students	11th Grade Students	12th Grade Students
Students in **Schools with SBYSP**	103,003	3,992	4,001	23,157	21,572	20,781	19,930
% of Students in **Schools with SBYSP**	7.5%	4%	4%	21.5%	21.5%	21%	20%
Students in **School Districts with SBYSP**	395,390	26,005	26,368	32,803	28,792	27,761	26,637
% of Students in **School Districts with SBYSP**	29%	26%	26%	31%	29%	28%	27%
TOTAL	**1,360,916**	**98,753**	**100,143**	**107,255**	**99,989**	**98,320**	**98,410**

Source: NJDOE, 2021-2022.

Table 46: Demographic Risk Factors of Students in New Jersey

Demographic Risk Factors of Students in New Jersey					
	Total K-12 Students	% Receiving Free or Reduced Lunch	% English Learners	% Migrants	% Homeless
Students in **Schools with SBYSP**	103,000	50%	10%	0.08%	0.75%
Students in **School Districts with SBYSP**	395,390	48%	10%	0.06%	0.7%
TOTAL	**1,360,916**	**34%**	**7%**	**0.04%**	**0.5%**

Source: NJDOE, 2021-2022.

School districts and schools hosting the SBYSP program are more likely, in comparison to statewide averages, to serve students of color, students receiving free or reduced cost lunches, students learning English as a second language, students that are migrants, and students that are homeless. This suggests that the current locations of SBYSP programs are successfully sited within the most at-risk youth populations.

There is a disparity between the number of students served by SLS as reported by DCF and our analysis. DCF states that only 3% of students have access to SLS services. We analyzed just SBYSP, which is one of many SLS programs, and found that 7.5% of all K-12 NJ students are located in schools with SBYSP. Had all SLS programs been included in the analysis, that number would be even higher. Furthermore, an average of 21% of 9th – 12th grade students attend a school with SBYSP. At the district level the statistics are higher. Our analysis shows that 29% of all K-12 NJ students attend a school district where at least one school hosts SBYSP. Since some SBYSP services reach outside the host school (teacher training, educational outreach, etc.), there are district-wide benefits.

Proposed Reform: NJ Statewide Student Support Services Network (NJ4S)

In Fall 2021, DCF launched a re-engineering effort for School-Linked Services with the purpose of providing comprehensive, universal, and sustainable supports. The NJ Statewide Student Support Services Network (NJ4S), called a "first in the nation" by the Administration, would use a hub and spoke model (HSM) to "build a network that provides support for all school-aged youth and their families, expanding support beyond the 2% that are served currently" (Kiefer, 2022). HSM was designed to increase the effective and efficient use of resources by offering a centralized, regional location (hub) that is set up to receive requests for an array of services. From the hub, services are provided at local sites (spokes). Each of 15 regional hubs would be administered by a social services agency (some currently provide the School-Based Youth Services) and guided by an Advisory Council (Kiefer, 2022). Under the proposed system, hubs will deliver, manage, or coordinate the delivery of tiered services to specific school communities based on identified needs and eligibility, with those with greatest need receiving greater intensity of services. The spokes are sites where programming will be delivered, and sites will include school buildings but also could include additional spaces utilized by the community, such as Family Success Centers, community centers, libraries, or other locations that are accessible and conducive to the programming offered.

Figure 9: NJ4S Hub and Spoke Diagram

Source: NJDCF, 2022.

In addition to the expanded reach of the program, proponents point to the HSM's lowering of costs and efficiencies achieved through reducing duplicative work and being better positioned to access and utilize a variety of federal funding opportunities.

Critics countered by pointing out that schools currently housing SLS would lose their well-established mental health programming. They note that the current system has proven effective in the schools where it is hosted, and that trust has been established between counselors and students. When accessing school-based mental health care, students do not need a diagnosis to seek help and can receive treatment without needing an outside provider or facility, which is a more daunting task for some families with limited car access or lacking insurance. (Elias, 2023; Langberg, 2023). Opponents to NJ4S also highlighted that to lose funding for current programs would be disruptive of continued service and would put schools at risk of losing their mental health programming altogether (Biryukov, 2022). It was unclear if prevention and larger systems-thinking was well-integrated into the hub model, and there was concern that hub-and-spoke models have not yet been demonstrated to work at scale (Elias, 2023).

During the time that this report was being prepared, the state Department of Children and Families announced the extension of SBYSP beyond the intended June 2023 end date after the state heard significant opposition during the Fall of 2022 (Gagis, 2022). In his 2023 budget address, Governor Phil Murphy announced "This budget will launch the New Jersey Statewide Student Support Services Network to help countless more students focus on mental health wellness." (Brier, 2023). The budget set aside $43 million to establish the 15 regional centers and the "hub and

spokes" model." Later in May 2023, Governor Murphy announced that New Jersey completely abandoned cutting school-based mental health programs. The 15 regional hubs that are part of NJ4S will still be set in place by September 2023, but rather than replace school-based mental health care with "spokes", these hubs will reinforce and expand upon the pre-existing continuum of supports in schools (Briar 2023).

Other State Models

High Level Case Study Comparisons

There exist exemplary school-based mental health systems in other parts of the country that can serve as case studies for the reformation of New Jersey's own system. This part of the report will highlight case studies of school-linked or school-based mental health services in Washington D.C., Maryland, and Wisconsin. Washington D.C. and Maryland were selected for their strong performance in youth mental health outcomes, school-based mental health service policies, and SBHC's. Wisconsin was chosen for its strong performance in youth mental health outcomes and references to CSMHS in spite of its lacking mental health policies and SBHC infrastructure.

There are several shared attributes across the case studies. All three ranked in the top 15 states for youth mental health outcomes according to Mental Health America's 2023 State of Mental Health in America reporting (Ranking the States, 2023). They also performed well in Mental Health America's 2020 assessment, indicating stability, especially in the face of the COVID-19 pandemic (Hopeful Futures Campaign, 2022). All three also require by law that schools provide school-based mental health services and structure these services in an MTSS format (NASBE, n.d.).

Differences between case studies are more apparent in other measures. Hopeful Futures Campaign's report card on school mental health services in the United States studied the progress being made by states in relation to their school-based mental health policies. Washington D.C. and Maryland ranked ahead of most states, while Wisconsin, on the other hand, was in the lower range of average (Hopeful Futures Campaign, 2022). Additionally, Wisconsin does not have policy promoting an SBHC system in place while Washington D.C. and Maryland do (NASBE, n.d.). School-Based Health Alliance's 2016-2017 national census on school-based health care in the United States assessed the number of SBHC's by state. Washington D.C. offers one 1.01 SBHC's per 10,000 students and Maryland offers a lower, but still encouraging, 0.84 SBHC's per 10,000 students (Love et. al., 2018). Wisconsin did not have any SBHC's as of 2017 (Love et. al., 2018), but its school-based mental healthcare system references CSMHS principles in its design (Wisconsin Department of Public Instruction, 2021). Neither Washington D.C. nor Maryland explicitly call out CSMHS in their publications or online materials when outlining their school-linked mental health services (DCPS, 2020, Maryland State Department of Education, 2017).

The table on page 62 summarizes the aforementioned similarities and differences between case studies. It also includes New Jersey measures for the sake of comparison.

Table 47: Comparison of State-Level School-Based Mental Health Services Across Case Studies

Comparison of State-Level School-Based Mental Health Services Across Case Studies								
	School-Based Mental Health Services[4]	SBHC Policy[4]	Number of SBHC's per 10,000 students[1]	Mental Health Policy Progress[2]	MHA 2023 Ranking[3]	MHA 2020 Ranking[2]	Refers to MTSS	Refers to CSMHS[5]
New Jersey	Required	Addresses but no formalized policy	0.11	10	6	6	Yes, suggested	Recent mention
Washington D.C.	Required	Formalized policy	1.01	11	1	1	Yes, required	No
Maryland	Required	Formalized policy	0.84	12	14	9	Yes, required	No
Wisconsin	Required	Addresses but no formalized policy	0	6	3	6	Yes, required	Yes

1: Love et. al., 2018.
2: Hopeful Futures Campaign, 2022.
3: Mental Health America, 2023.
4: NASBE, n.d., 2023.
5: DCPS, 2020, Maryland State Department of Education, 2017, Wisconsin Department of Public Instruction, 2021, NJDOE, 2019.

Washington D.C.

Washington D.C. may not be a state, but it arguably has the most robust school-based mental health system in the country. The region boasts the best youth mental health outcomes in the nation, the most SBHC's per 10,000 students, and the strongest ratios of school mental health staff to students. Its public school system is run by the District of Columbia State Board of Education (SBOE) which oversees the only school district, the District of Columbia Public Schools (DCPS) (DCPS, 2020).

Table 48: Washington D.C. Staff to Student Ratios

Washington D.C. Staff to Student Ratios			
	School Psychologist	School Social Worker	School Counselor
Washington D.C.	1:410	1:365	1:511
Recommended	1:500	1:250	1:250

Source: Hopeful Futures Campaign, 2022.

Every school has located within it a DCPS School Mental Health (SMH) Team and a School Counseling Team. The SMH Team includes school-based psychologists and licensed independent clinical social workers who are responsible for administering mental health services through an MTSS framework. The School Counseling Teams, while separate from the SMH Teams, offer support services in an MTSS framework that can be coupled with mental health interventions if need be (DCPS, 2020).

Outside of these two main pillars, the additional mental health services provided at schools depend on that location's specific partnerships. The School Mental Health Expansion Initiative assists SMH Teams in partnering with local youth mental health nonprofits and community agencies in order to provide students additional services. The Department of Behavioral Health (DBH) operates its own School Behavioral Health Program designed to offer preventative, early intervention, and clinical services in schools. The initiative is not currently offered district-wide but is in the process of being expanded to all schools. Lastly, the Wendt Center of Loss and Healing leads the charge on its Resilient Scholars Project-School Based Services in select schools by offering trauma-focused cognitive behavioral therapy, play therapy, and mindfulness skills (DCPS, 2020).

The table below outlines how the DCPS School Mental Health Teams and the School Counseling Teams offer students support at each of the three MTSS tiers. Note that the School Counseling Team cannot offer supports at the Tier 3 level. Some students who are assigned Tier 3 interventions receive direct clinical services from the SMH Team staff. For this, DCPS has a menu of 19 EBT's to call on, all of which can be found in SAMHSA's National Registry of Evidence-Based Programs and Practices. If a student's challenges persist over time, the school-based team may pursue disability classification for the student which then increases the number and intensity of supports available to them (DCPS, 2020).

Table 49: Washington D.C. Tiered System of Supports

Washington D.C. Tiered System of Supports		
Tiers	**Team**	**Services**
Tier 1	DCPS School Mental Health Team	- Social-emotional learning - Prevention programming - Staff professional development - Parent workshops
	School Counseling Team	- District classroom lessons - Individual student planning - Districtwide/schoolwide activities
Tier 2	DCPS School Mental Health Team	- Mental health & educational consultation - Mental health screening - Support groups - Skill-building groups - Functional Behavior Assessment (Level I) & Behavior Intervention Plan (Level I)
	School Counseling Team	- Small group instruction - Individual supportive services - Education & behavioral consultation
Tier 3	DCPS School Mental Health Team	- Individual & group psychotherapy using EBP's - Crisis intervention - Functional Behavior Assessment (Level I) & Behavior Intervention Plan (Level I)
	School Counseling Team	None offered

Source: DCPS, 2020.

For a student to receive Tier 2 or Tier 3 services, they must be referred for such assistance. DCPS uses a universal referral form that can be completed by peers, parents, teachers, or the students themselves as self-referrals. **School Based Health Coordinators (SBHC)** are responsible for processing any submitted forms. Once a referral has been accepted, the school-based mental health team will review the material and assign their most appropriate clinician to address the student's needs. Within ten (10) days of this step, the clinician will reach out to the student and their caregivers to begin next steps. The exact interventions provided depend on the results of school psychologists and social workers screening the referred student using early warning indicators and standardized tools (DCPS, 2020).

The DCPS Office of Engagement and Partnerships plays a crucial role in building relationships between schools, families, and the community. Its Family Engagement Division trains teachers on **Academic Parent Teacher Teams (APTT),** a new type of parent-teacher conferences that emphasize the importance of parents supporting academics at home, and on conducting home visits. At the school level, staff and parents are taught how to improve overall communication and teamwork with one another. The Community Engagement Division leads district level engagement with a **Cluster Support Model.** Schools are broken into clusters and each cluster has a dedicated team of Central Office staff. Doing so ensures that initiatives are targeted and aligned (Family and Community, 2023).

All teachers, principals, and staff are required to complete behavioral health training biannually so that they are able to recognize students with unfulfilled behavioral needs and implement suicide prevention, intervention, and postvention. Washington D.C.'s health education standards also require K-12 health education programs to include material on mental health. There are no policies in place though for teaching students lifelong mental health management skills (NASBE, n.d.).

Washington D.C. has a wide range of policies in place for ensuring positive school climates. In 2021, legislation was put in place to require an annual school climate survey be administered to collect student, staff, and parent experiences. There are also policies in place explicitly addressing anti-bullying, inclusive environments, suicide prevention, and alternatives to exclusionary discipline (NASBE, n.d.).

Washington D.C. receives funding for its school-based through several programs. For services provided by the DCPS School Mental Health Teams or the School Counseling Teams, Telehealth services for all Medicaid students are reimbursed, but in-person services are only reimbursed for Medicaid-enrolled students with IEP's (Hopeful Futures Campaign, 2022). Services provided by CBO's are only available to students with insurance and upon administering said services, their insurance policies will be billed (DCPS, 2020). Washington D.C. has funding set aside for youth mental health services in addition to its school funding and receives assistance from ESSA and SAMHSA's Project AWARE (Rafa et. Al., 2021).

Illustrated on page 65 are the overarching metrics of success for Washington D.C. as identified by Hopeful Futures Campaign's report card on school mental health services.

Table 50: Washington D.C. Youth Mental Health Outcomes

Washington D.C. Youth Mental Health Outcomes		
Source	**Variable**	**Result**
NSDUH 2018-2019	At least one Major Depressive Episode (MDE) in the past year	11%
	At least one Major Depressive Episode (MDE) in the past year but did not receive treatment	41%
	Substance use disorder in the past year	6%
YRBS 2019	Considered suicide in the past year	18%
	Felt sad or hopeless every day for a period of at least 2 weeks in the past year	36%
NSCH 2020-2021	Parents reported their child having at least one mental, emotional, developmental, or behavioral problem	20%

Source: Hopeful Futures Campaign, 2022.

Key Take-aways:

- Washington D.C. has the strongest ratios of school mental health staff to students and the most SBHC's per 10,000 students in the nation.

- All schools deliver mental health services through an MTSS framework.

- Every school has a DCPS School Mental Health Team and a School Counseling Team that work together to offer interventions at all 3 tiers.

- The Department of Behavioral Health is in the process of installing additional behavioral health programming in all schools.

- Local mental health non-profits partner with select schools to offer additional services.

- Washington D.C. uses the Cluster Support Model in which schools are broken into clusters and each cluster has a dedicated team of Central Office staff.

Maryland

The state of Maryland has impressive youth mental health outcomes, coupled with a high ratio of SBHC's per 10,000 students and strong mental health policies in place. Its public school system is run by the Maryland State Department of Education which oversees 25 school districts.

Table 51: Maryland Staff to Student Ratios

Maryland Staff to Student Ratios			
	School Psychologist	**School Social Worker**	**School Counselor**
Maryland	1:1,198	1:2,324	1:352
Recommended	1:500	1:250	1:250

Source: Hopeful Futures Campaign, 2022.

Every school is mandated to host a coordinated program of student services led by a Maryland School Mental Health Team including, at a minimum, the following staff: school counselors, pupil personnel, school psychologists, school nurses, and school social workers. Pupil personnel fill the unique role of acting as student advocates, consultants for parents and school staff, liaisons between departments of education agencies, and referral sources to outside agencies (Maryland State Department of Education, n.d.) All school-based mental health services provided to students come from the set of five (5) intervention practices listed below (Maryland State Department of Education, 2017).

Table 52: Maryland Mental Health Interventions

Maryland Mental Health Interventions	
Practice	**Location**
Integrated Tiered System of Supports	All schools
Mind Up Curriculum	Select schools
Positive Behavioral Interventions and Supports (PBIS Maryland)	All schools
Social Emotional Foundations (SEL) for Early Learners	All schools
School-wide Integrated Framework for Transformation (SWIFT)	Select schools

Source: Maryland State Department of Education, 2017.

The Integrated Tiered System of Supports is an MTSS framework of behavioral and emotional interventions organized across three tiers. The Mind Up Curriculum imparts strategies on students for focusing attention, self-regulation, resilience to stress, and adopting a positive mindset. SEL for Early Learners is an umbrella of SEL programming that encourages supportive learning environments and social-emotional development among students. PBIS Maryland enacts PBIS principles in public schools, trains school staff on how to carry out such an initiative, and helps transition young children from the SEL for Early Learners program conducted in early education settings to the PBIS supports conducted for older students. Finally, SWIFT aims to eradicate silos in education by integrating general and specialized education infrastructure to ensure that every child feels like a valued member of the school community (Maryland State Department of Education, 2017).

In response to the heightened mental healthcare needs of students as a byproduct of the COVID-19 pandemic, Maryland Public Schools have launched the **Maryland School Mental Health Response Program.** It is comprised of six (6) elements: 1) the Maryland School Mental Health Team, 2) an expansion of current programs, 3) an electronic/web-based hub, 4) research and evaluation, 5) sustainability strategies, and 6) partnerships with community health agencies. Imperative to this work is that the Maryland School Mental Health Response Program will not replace any already existing on-site work, but rather, will support and enhance the services already in place (Maryland State Department of Education, n.d.).

Maryland Public Schools heads two family engagement programs, both of which are available in all school districts. The Early Childhood Family Engagement Framework recognizes the importance of family engagement, implements a common set of goals across the early childhood education system for family engagement, and offers education providers strategies and resources for such engagement. The state's other program is its Pre-K-12 Family Engagement Framework with the overall goal of maximizing educators' ability to partner with families (Maryland State Department of Education, 2017).

All staff who are regularly in direct contact with students are required to partake in annual trainings on suicide, mental health, and trauma. Maryland public schools also administer the Teacher SEL Self-Assessment Survey. This tool allows teachers to determine how well they incorporate a set of ten (10) SEL teaching practices into their classroom (Maryland State Department of Education, 2017). For students, health education is required to include the topics of mental and emotional health. Additionally, early education curriculums are mandated to teach students lifelong mental health management skills (NASBE, n.d.).

Maryland has a few key policies in place for maintaining a positive school environment. This includes directives for anti-bullying, suicide prevention, and statewide school climate surveys.

Maryland receives funding for its school-based through several programs. Telehealth services for all Medicaid students are reimbursed, but in-person services are only reimbursed for Medicaid-enrolled students with IEP's (Hopeful Futures Campaign, 2022). Maryland has funding set aside for youth mental health services in addition to its school funding and receives assistance from ESSA and SAMHSA's Project AWARE (Rafa et. Al., 2021).

Below are the overarching metrics of success for Maryland as identified by Hopeful Futures Campaign's report card on school mental health services.

Table 53: Maryland Youth Mental Health Outcomes

Maryland Youth Mental Health Outcomes		
Source	Variable	Result
NSDUH 2018-2019	At least one Major Depressive Episode (MDE) in the past year	15%
	At least one Major Depressive Episode (MDE) in the past year but did not receive treatment	45%
	Substance use disorder in the past year	4%
YRBS 2019	Considered suicide in the past year	18%
	Felt sad or hopeless every day for a period of at least 2 weeks in the past year	32%
NSCH 2020-2021	Parents reported their child having at least one mental, emotional, developmental, or behavioral problem	24%

Source: Hopeful Futures Campaign, 2022.

Key Take-aways:

- Maryland has a high ratio of SBHC's per 10,000 students.

- Every school is required to have a School Mental Health Team which includes not just mental health staff but also pupil personnel who function as student advocates.

- All schools, at a minimum, offer services in an MTSS format, engage in Positive Behavioral Intervention Supports, and incorporate Social-Emotional Learning Foundational programming.

- Maryland launched the Maryland School Mental Health Response program in order to address the increased mental health crisis fueled by the COVID-19 pandemic. The program includes expanding current programs, creating an electronic resource hub, researching effective strategies, and partnering with more community-based organizations.

Wisconsin

Wisconsin explicitly incorporates the concept of CSMHS into its vision for school-based mental health services. Wisconsin schools already have MTSS systems in place. It is now expected that they will incorporate six (6) components of CSMHS into their pre-existing infrastructure (Wisconsin Department of Public Instruction, 2021).

Schools must offer a continuum of mental health supports including services for prevention, early intervention, and treatment. Additionally, students will have access to crisis intervention and systems of care, a range of community-based services that create wraparound support for children and their families.

Collaboration must take place between schools, community partners, Out-of-School Time providers, students, and families. Every school will have a school mental health team which is defined as a group of stakeholders whom meet regularly to make decisions on supporting student mental health. Note that these teams are not limited to just 'pupil services staff,' which is how Wisconsin refers to school psychologists, school social workers, school nurses, and school counselors. Other staff engaged in these partnerships include school administrators, coaches, and teachers (Wisconsin Department of Public Instruction, 2021).

School mental health teams regularly assess the state of CSMHS at their school through needs assessments and resource mapping. This should result in a determination of how well the continuum of supports meets the school community's needs and leverages its strengths.

Strong mental health referral pathways are instituted in order to identify students that need additional support when the current level they are being served is insufficient. Traditional methods of referral, like through discipline or teacher referrals, exist but have been found to be insufficient. Wisconsin encourages more forward-thinking pathways such as universal mental health screenings, mental health literacy promotion, and mental health awareness campaigns.

School mental health teams must establish sustainability by using strategies that optimize financial and non-financial assets. Other factors that encourage sustainability are retention of well-trained staff, stakeholder buy-in, integration with current MTSS features, and advocation for school mental health policies (Wisconsin Department of Public Instruction, 2021).

The final component of CSMHS that schools are expected to adopt is the use of quantitative and qualitative data to inform priorities and next steps. Doing so will allow schools to identify gaps in their programming, students at higher risk of mental health complications, aggregate student resilience, and both the short- and long-term outcomes on students due to implementation.

Wisconsin places a special focus on building out CSMHS with a trauma-sensitive lens. Doing so means incorporating and prioritizing the principles of cultural responsiveness, safety, trustworthiness, choice, collaboration, and empowerment. The intention is that students of all backgrounds will be able to successfully access mental health services and reap as many benefits as possible (Wisconsin Department of Public Instruction, 2021).

Key Take-aways:

- Wisconsin explicitly calls out CSMHS in their school mental health framework.
- Every school has a mental health team including mental health staff, administrators, coaches, and teachers.
- Wisconsin frames its CSMHS with a trauma-sensitive lens.

Findings and Policy Recommendations

Most experts and observers agree that positive youth mental health requires a comprehensive approach that is firmly rooted in prevention first, and that requires a systems-approach of cooperation and coordination among schools, providers, parents, and the community. Most would also agree that there are inequities related to care access that can lead to worse mental health outcomes for young people. Similarly, the impacts of pandemic-related social isolation and school closures, housing instability, racial trauma, and loss of employment may be felt more strongly by young people in communities with fewer adequate social and economic resources (NAS, 2021).

Recommendations for New Jersey

The policy and planning recommendations below follow from the findings of the case studies and informed by the analysis of the data presented in this report:

1. **Support and enhance current mental health programs.** If the hub model is considered, clearly outline how the 15 regional hubs will be used to bolster the current SLS system and reassure the permanence of this decision. This may look like Washington D.C.'s Cluster Support Model where groupings of schools are assigned to select central office staff to better align and target initiatives. It could also replicate Maryland's COVID-19 inspired School Mental Health Response Program by bolstering the pre-existing SLS services with expanded programming, research, community partnerships, and an electronic hub.

2. **Implement creative options to improve equitable access to School-Based Youth Services Program (SYSBP).** Almost one-third of NJ students attend a school district where at least one school hosts a SYSBP. Proposed structural modifications should take advantage of this fact. The pre-existing SBYSP can be expanded to more fully service all schools in the districts that are already enrolled, as well as in neighboring school districts. To address equity, it would be important to focus this expansion on districts with higher percentages of low-income, Black, and Hispanic students, or on districts that can receive children from other schools with free transportation services offered.

3. **Expand School-Based Health Center (SBHC) network both geographically and functionally to broaden the reach of low-cost mental health services.** SBHCs play a vital role in other states' school-based mental health services not only because these facilities offer additional behavioral health services, but also because they address physical health concerns which can impact a child's mental well-being.

New Jersey's SBHC program should be expanded beyond just Newark to other cities where youth struggle to access primary care.

4. **Standardize school-linked mental health services and require MTSS for intervention and referral services.** Instead of suggesting that schools use an MTSS framework for their I&RS, require MTSS as the standard for all schools. Doing so would standardize the state's services and also ensure that schools are following an evidence-backed delivery system. In addition to I&RS being standardized, mental health curriculums and preventative care should be as well. This includes the use of social-emotional learning that can train students on managing emotions and stress and building healthy habits (Wall, 202;, NSBA, 2019).

5. **Pilot a hub model in one or two regions (if a shift to a regional service delivery model is considered).** School-linked-services would remain in all schools, while the hubs are developed to expand upon and coordinate current services (Sitrin, 2022; Elias, 2023). After a period of testing and modifying the model, it could then be re-designed based on evidence and comparisons from the pilot so that current SBYS benefits are retained, and then expanded to the rest of the regions.

6. **Use Child Study Teams (CST) more extensively in a mental health framework.** As of right now, New Jersey has siloed its NJTSS framework from the Child Study Teams that are already implemented in all schools. Considering how CSTs include psychologists and social workers, staff that are absolutely crucial to well-functioning school-based mental health services, CSTs should be intimately linked to NJTSS and explicitly named in the state's guidance on school-based mental healthcare.

7. **Improve access and clarity of outreach materials on available youth mental health services.** There is no single electronic source of information for parents to understand the mental health services offered in schools for the state. DCF's programs, NJTSS, and information on CSTs are all kept on different websites and are difficult to find. Crucial information resources for students and parents should always be translated into Spanish, as well as into other languages that might be prominent in minority or immigrant populations in certain geographies.

Opportunities for Expanded Data Collection and Research

In the course of this study, ideas for areas that would benefit from expanded data collections and research efforts emerged. These efforts would then continue to inform policy-makers, program managers, administrators, providers, counselors, parents and all in the community who share great concern for improved mental health and well-being for New Jersey's middle and high-school aged children. Some of these areas for research and enhanced monitoring/evaluation are:

- **Data collection:** If more data about student diagnoses, services, and treatments, ideally broken out by student characteristics and demographics, and including all levels of service (school, physician, hospital, treatment facility, counseling center, etc.), could be

systematically collected, it would enhance overall understanding of the severity and the disparate impacts of the problem. Additional survey instruments that query students directly (such as the emotional climate survey offered by Search Institute of Minneapolis, MN or other tested tools) would also add validity and depth to understanding the issue. Making the data open and available would facilitate efforts by wider circles of researchers to examine the issues.

- **Best practices and lessons learned:** Research should continue looking at where outcomes are improving and assess how programs, service infrastructure, or interventions are making a difference in those outcomes. More evidence-based lessons learned on improving outcomes can then be incorporated into future policies and programs.

- **Trends in mental health:** With the best available data, researchers should continue to examine how mental health indicators and measures are changing over time.

- **Associated factors:** Given the apparently strong connections between numerous social and environmental determinants and mental health, as well as connections between mental health and future behaviors, more research is needed to examine more closely and clearly these connections.

Continually deepened understanding of the nature of the problem and of the best options for successfully addressing the problem will help to ensure a brighter future and the best opportunities for all New Jersey youth, regardless of race, gender, or geography, to thrive as adults.

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Appendix

County	District	Municipality	School
Atlantic	Atlantic City School District	Atlantic City	Atlantic City High School
	Buena Regional School District	Buena	Buena Regional High School
	Buena Regional School District	Buena	Buena Regional Middle School
	Egg Harbor Township School District	Egg Harbor	Egg Harbor Township Highschool
	Hamilton Township School District	Hamilton Township	Oakcrest Highschool
Bergen	Englewood Public School District	Englewood	Dwight Morrow/ Academies @ Englewood
	Hackensack School District	Hackensack	Hackensack High School
	Teaneck School District	Teaneck	Teaneck High School
Burlington	Pemberton Township School District	Pemberton	Pemberton High School
	Willingboro Public School District	Willingboro	Willingboro High School
Camden	Camden City School District	Camden City	Camden City High School
	Camden City School District	Camden City	Creative Arts Morgan Village Academy
	Camden City School District	Camden City	Veterans Memorial Family School
	Camden City School District	Camden City	Woodrow Wilson High School
	Winslow Township School District	Winslow Township	Winslow Township High School
Cape May	Cape May County Technical High School District	Cape May Court House	Cape May County Technical School
	Lower Cape May Regional School District	Cape May	Lower Cape May Regional High School
Cumberland	Bridgeton City School District	Bridgeton	Bridgeton Broad Street School
	Bridgeton City School District	Bridgeton	Bridgeton High School
	Cumberland Regional School District	Seabrook	Cumberland Regional High School
	Downe Township School District	Newport	Downe Township Elementary School
	Millville School District	Millville	Millville High School
	Vineland Public School District	Vineland	Vineland High School South
	Vineland Public School District	Vineland	Thomas W. Wallace Middle School

Essex	Newark Public School District	Newark	Barringer High School
	Essex County Schools Of Technology	Newark	Newark Vocational Technical School
	Irvington Public School District	Irvington	University Middle School
	Irvington Public School District	Irvington	Irvington High School
	South Orange-Maplewood School District	Maplewood	Columbia High School
	South Orange-Maplewood School District	Maplewood	Maplewood Middle School
	Orange Board Of Education School District	Orange	Orange High School
	Bloomfield Township School District	Bloomfield	Bloomfield High School
Gloucester	Clayton Public School District	Clayton	Clayton Jr./Sr. High School
	Gloucester County Vocational-Technical School District	Sewell	Gloucester County Institute of Technology
Hudson	Bayonne School District	Bayonne	Bayonne High School
	Hudson County Schools Of Technology School District	Jersey City	County Preparatory High School
	Jersey City Public Schools	Jersey City	Henry Snyder High School
	Union City School District	Union City	Union City High School
	Union City School District	Union City	Union Hill Middle School
	Harrison Public Schools	Harrison	Harrison High School
	Hoboken Public School District	Hoboken	Hoboken High School
	Kearny School District	Kearny	Kearny High School
Hunterdon	Hunterdon Central Regional High School District	Flemington	Hunterdon Central Regional High School
Mercer	Trenton Public School District	Trenton	Trenton Central High School
	Ewing Township School District	Ewing	Ewing High School
Middlesex	South Brunswick School District	Monmouth Junction	Crossroads North Middle School
	South Brunswick School District	Monmouth Junction	South Brunswick High School
	Carteret Public School District	Carteret	Carteret High School
	Highland Park Boro School District	Highland Park	Highland Park High/ Middle School
	Perth Amboy Public School District	Perth Amboy	Perth Amboy High School
	New Brunswick School District	New Brunswick	Lord Stirling Community School
	New Brunswick School District	New Brunswick	McKinley Community School
	New Brunswick School District	New Brunswick	New Brunswick High School

Monmouth	Asbury Park School District	Asbury Park	Asbury Park High School
	Keansburg School District	Keansburg	Keansburg High School
	Long Branch Public School District	Long Branch	Long Branch High School
	Red Bank Regional School District	Little Silver	Red Bank Regional High School
Morris	Dover Public School District	Dover	Dover High School
Ocean	Brick Township Public School District	Brick	Brick Memorial High School
	Brick Township Public School District	Brick	Brick Township High School
	Brick Township Public School District	Brick	Veterans Memorial Middle School
	Lakewood Township School District	Lakewood	Lakewood High School
	Pinelands Regional School District	Little Egg Harbor	Pinelands Junior High School
	Pinelands Regional School District	Little Egg Harbor	Pinelands Regional High School
Passaic	Clifton Public School District	Clifton	Clifton High School
	Paterson Public School District	Paterson	East Side High School
	Paterson Public School District	Paterson	John F. Kennedy High School
	Hawthorne Public School District	Passaic	Lincoln Middle School
	Passaic City School District	Passaic	Passaic High School
	Passaic County Manchester Regional High School District	Haledon	Manchester High School
	Passaic County Technical-Vocational School District	Wayne	Passaic County Vo-Tech
	Passaic Valley Regional High School District #1	Little Falls	Passaic Valley High School
Salem	Penns Grove-Carneys Point Regional School District	Pennsgrove	Pennsgrove High School
	Salem City School District	Salem City	Salem City High School
Somerset	Somerset County Vocational And Technical School District	Bridgewater	Somerset County Vocational
Sussex	Sussex County Technical School District	Sparta	Sussex County Technical School
Union	Roselle Public School District	Roselle	Abraham Clark High School
	Elizabeth Public Schools	Elizabeth	Admiral William F. Halsey Jr. Health & Public Safety Academy
	Elizabeth Public Schools	Elizabeth	Thomas Jefferson Arts Academy
	Plainfield Public School District	Plainfield	Hubbard Middle School
	Plainfield Public School District	Plainfield	Maxson Middle School
	Plainfield Public School District	Plainfield	Plainfield High School

Warren	Phillipsburg School District	Phillipsburg	Phillipsburg Middle School
	Phillipsburg School District	Phillipsburg	Phillipsburg High School
	Warren Hills Regional School District	Washington	Warren Hills Regional High School
	Warren Hills Regional School District	Washington	Warren Hills Regional Middle School

Source: DCF, 2015

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