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Governance Brief

Why Schools Hold the Promise for Adolescent Mental Health

By Deborah Anderluh

For schools looking to educate and nurture the latest generation of American children, the most recent data on adolescent mental health trends is reason for alarm. American youth are struggling with depression and anxiety in steeply rising numbers. The number of children and teens hospitalized for thoughts of suicide or self-harm more than doubled from 2008–15.[1] Suicide rates among teenage girls have hit a 40-year high.[2] According to the Centers for Disease Control and Prevention (CDC), middle schoolers are now as likely to die from suicide as from traffic accidents.[3]

But research also gives us cause for hope. The advances in recent decades in our understanding of mental health and well-being, and the role of treatment, education, and community in that equation, tell us this is not an intractable problem. These trends can be addressed and reversed. And schools have a central role in the solution.

As community leaders, school board members are in a unique position to influence the curriculum, policies, and community partnerships that shape the school environment. Board members' decisions can determine whether schools are helping, hurting, or having no impact when it comes to the mental health of our youth and their potential for resilience. It's a weighty responsibility, and the goal of this policy brief is to offer context on why schools have become a vital link in supporting adolescent mental health, guideposts for best practices, and key resources to help districts get there.

In this brief you will find:

- Trends in adolescent mental health
- Leading theories on the "why" behind those trends
- Why schools are an effective community hub for mental health services
- Best practices for providing those services
- Questions to help board members determine mental health services and needs in their LEAs

What the Numbers Tell Us

Let's start by going deeper into the statistical trends that have sparked serious concern among medical researchers in recent years.

It's not a new concept that mental illness tends to take root in childhood and adolescence. Longstanding research shows 50 percent of serious mental illnesses, such as schizophrenia and bipolar disorder, manifest by age 14, with an even higher rate of 75 percent by age 24.[4] The CDC estimates one in five American children ages 3-17 will have a diagnosable mental, emotional, or behavioral condition in any given year.[5]

But the last decade has brought a notable spike in diagnoses of depression and anxiety among children and teens, as well as a rise in fatal and destructive behavior associated with mental distress. Consider these findings:

- According to the CDC, the suicide rate for young people, ages 10-17, rose 70 percent from 2006 to 2016 and suicide is now the second-leading cause of death among U.S. teenagers, behind accidental death and ahead of homicide.[6]
- In the five years from 2010–15, the rate of teenage suicide attempts rose 23 percent, according to researcher Jean M. Twenge, a professor of psychology at San Diego State University. Twenge and her colleagues charted acute increases in depression, suicide, and attempted suicide

during that time frame that spanned income, race, ethnicity, and almost every region in the country.[7]

» The rate of adolescents reporting a recent bout of clinical depression rose 37 percent from 2005–14, according to the American Academy of Pediatrics.[8]

» A 2018 analysis by Blue Cross Blue Shield found diagnoses of major depression have jumped 65 percent since 2013 for girls ages 6-17, and 37 percent for boys in that age group.[9]

» According to the National Survey of Children's Health, from 2007–12, diagnoses of anxiety in youth ages 6-17 spiked 20 percent, and anxiety is now the leading cause of mental distress among American children.[10]

» A study of 10,000 youth found that two-thirds of adolescents who developed alcohol or substance use disorders had also experienced at least one mental health disorder.[11] There is a clear connection between several mental illnesses such as depression and anxiety, and substance use.

» Intentional nonsuicidal self-injury behaviors such as cutting, burning, pulling hair, and other physical self-harm can occur in the early grades, though it typically begins in middle-adolescence. While studies find that between 12–24 percent of young people have self-injured, about one in four report injuring themselves only once. About 6–8 percent of children and young adults experience it as a chronic issue.[12]

» Prior to 2009, American girls ages 10 to 14 sought emergency room treatment for self-inflicted injuries at a relatively stable rate. Since 2009, however, the rate has increased by 19 percent per year, surpassing the pace for any other group.[13]

Small Shoulders, Mounting Pressures

Why are so many young people in emotional crisis? Researchers cite a web of factors that contribute to a uniquely stressful environment for this tech-savvy generation.

For some children, the answer lies partly in genetics. Just as with many forms of physical illness, genetic factors can make a child more likely to develop a serious brain illness, and more susceptible to environmental triggers for that illness. Even then, genetics do not have to define the ultimate course of the illness. With early diagnosis and appropriate treatment, young people can learn to live with and manage a serious mental illness, much like many other serious physical conditions. But research also shows causal links that go beyond genetic predisposition. The following is a brief summary of the leading theories about the environmental and sociological factors contributing to the growing mental angst of young Americans.

ACEs: Research on Adverse Childhood Experiences, or ACEs, is a robust area of study that has found a direct correlation between chronic adversity in childhood and later onset of physical and mental illness.[14] Children raised amid violence, traumatic loss, abuse, neglect, domestic violence, and addiction—without a supportive adult buffer—can find their brains "rewired" by toxic stress. Chronic stress causes their young bodies to release a cascade of hormones and chemicals that, if sustained over time, can trigger changes in the brain and immune system.

Types of ACEs		
Abuse	**Neglect**	**Household challenges**
Emotional Physical Sexual	Emotional Physical	Mother treated violently Substance abuse Mental illness Separation/divorce Incarcerated household member

The more intense and prolonged a child's exposure to adversity under age 18, the greater the chances he or she will undergo physical changes that impede the ability to regulate behavior and emotion, triggering anxiety, depression, and cognitive impairment. Over time, these same changes can fuel development of serious physical ailments, including heart disease, asthma, and cancer.

Children growing up in urban neighborhoods plagued by crime and violence, as well as those raised in impoverished rural stretches, tend to face more ACEs, and the collective fallout can be more pervasive in schools serving those communities. These outcomes may range from behavioral challenges in the classroom to chronic absenteeism, which impacts student learning. A 2017 study of almost 60,000 children ages 6 to 17 found that having one or more ACE was significantly associated with chronic absence, and the association is stronger for those with two or more ACEs.[15] The good news? With early intervention and appropriate treatment, children exposed to toxic stress can heal. The damage can be reversed.

Rise of the smartphone: Jean M. Twenge, the noted San Diego State psychologist mentioned above, is among the researchers who see a clear link between the rise of the smartphone and a decline in adolescent mental health. Twenge for years has tracked national surveys that chart attitudes and behaviors of American youth, and was struck by a sudden and sustained uptick, starting in 2012, in the

percentage of teens whose responses reflected symptoms of depression: a sense of hopelessness, loss of purpose, and a belief they can't do anything right.[16]

Her deeper dive into the numbers uncovered parallel trends: A significant decline in teens who reported feeling happy and a significant rise in those who reported feeling lonely. A 50 percent increase from 2011–15 in teenagers who demonstrated signs of clinical depression; a 31 percent jump in suicides among 13- to 18-year-olds; and a 23 percent rise in attempted suicides.

Twenge and her colleagues dug into the "why," and believed the shift could not be attributed to the economy—which was improving—or a sudden increase in academic pressure. Instead, they settled on another pivotal statistic: 2012 was the year the percentage of Americans who owned smartphones crossed the 50 percent threshold.

Her subsequent analysis found teens who spent more time on screens were less happy, more depressed, and had more risk factors for suicide, results since echoed by other studies.

Twenge and others say the correlation isn't hard to understand.

"Teens are spending more time on screens but less time in real life with other people," said Jacob Towery, a child and adolescent psychiatrist in Palo Alto and author of *The Anti-Depressant Book; A Practical Guide for Teens and Young Adults to Overcome Depression and Stay Healthy.* "Connecting on screen is not nearly the same as being in real life with someone."

In addition, social media vastly expands the arena—and audience—for bullying. It plays on adolescent insecurities by creating a platform for communication measured in likes and shares—one that makes acutely clear who is being left out. Finally, the lure of 24/7 connection keeps some kids on screen and sleepless late into the night, a major risk factor for depression.

Twenge and other researchers are quick to note that smartphones also have opened children's worlds in positive ways and that not all screen time is bad. Research shows limiting phone use to about an hour a day is not associated with the unhealthy impacts cited in the studies.

Unrealistic expectations: A third broad body of reasoning for the rising tide of depression and anxiety is the recognition that today's children are being raised in hypercompetitive environments. Being on the college track increasingly means taking a heavy load of Advanced Placement courses and the hours of nightly homework that come with them. Excelling at sports means making both the school team and club team. What used to be unstructured downtime is now crowded with extracurricular activities.

And all that time on screen adds to the pressure: Social media can feed on students' insecurities by barraging them with updates on the activities and accomplishments of peers that often seem unrelentingly rosy when viewed from the outside.

The thinking here—similar to the ACEs research—is that the sustained accumulation of stress is having long-term effects on developing young brains. And that the impacts are exacerbated by the caffeinated drinks and other stimulants some high achievers are using to get through the day.

Here, too, researchers say lack of sleep—in this case associated with packed schedules and late nights of homework—is undermining student mental health.

"We know much more about sleep and its connection to mental illness than ever before," said Denise Pope, a senior lecturer at Stanford University and co-founder of Challenge Success, a research organization that works with schools and families to create a more balanced approach to learning. "We always knew if you had depression or anxiety, you had trouble sleeping. Now we can show a bilateral relationship. Students are more likely to have suicidal thoughts [with] sleep deprivation."

Further complicating the dynamic: Even as kids feel compelled to compete at higher levels, researchers say many teens today lack the coping skills to deal with setbacks.[17] Experts cite various reasons for the shift, from adults who do not adequately prepare children for how to handle setbacks to—yet again—the social media-fueled perception that one's peers are somehow happier and more successful. For this group, when setbacks do come, they can feel overwhelming.

Why Should Schools Get Involved in Mental Health?

So, where do schools fit into all this? And can they really take on mental health, given all the other responsibilities? These are natural questions for those dedicated to ensuring the education of a diverse and dynamic student body.

With the passage of Assembly Bill 114 (2011), school districts became solely responsible for ensuring that students with disabilities receive special education and related services, including mental health services. A student may qualify for special education services under the category of emotional disturbance when a student exhibits a general pervasive mood of unhappiness or depression over a long period of time and to a marked degree such that it adversely affects a child's performance (Cal. Ed. Code § 56026; Title 5, CCR § 3030). For Lisa Warhuus, interim director of Alameda County's Center for Healthy Schools and Communities, the answer is equally straightforward:

"Research shows that mental health, social-emotional health, and wellness impact learning. When youth are healthy and resilient, they are more prepared to access their education. They are able to learn," said Warhuus, whose county-run department partners with school districts throughout Alameda County to provide a full array of mental and physical health services on campus.

"The other thing positive mental health does is impact the school environment," she said. "When youth and families are in a good state of mental health, that gets reflected in the environment. Students are happier and healthier. Teachers are happier and healthier—because teachers struggle when their students have poor mental health."

That sentiment is echoed by researchers with the University of Maryland's Center for School Mental Health (CSMH). Students with unmet mental health needs often struggle with their schoolwork and negatively impact the classroom environment. With an estimated one in five students living with a mental illness and one in 10 experiencing challenges because of a mental health issue, the CSMH's researchers argue, schools have a real stake in ensuring their health needs are met.[18]

As it is, only a third of children and teens diagnosed with mental illness receive treatment, according to research compiled by the center. And 70 percent of youth who do receive treatment do so in a school setting.[19]

The CSMH, which works to identify and disseminate best practices in school mental health programs, cites reams of research findings that support the integration of mental health into education, as part of a broader community partnership. Among them:

» Mental wellness is a key factor in academic success;

» Educating staff, students, and parents in the signs and symptoms of mental illness is key to both early intervention and dismantling the stigma that still shrouds brain health;

» Students often spend more awake time at school than home, meaning staff are often in the best position to identify an emerging mental health issue;

» Students are more likely to follow through with mental health services in school settings;

» Bringing mental health services onto campus enables easier communication among providers, parents, and teachers; and

» Schools that put in place comprehensive mental health systems register improved academic performance, fewer special education placements, decreased disciplinary actions, and higher graduation rates.

Gustavo Loera is board chair of the California chapter of Health Occupations Students of America (HOSA), a national organization that aims to inspire students to pursue careers in health professions. This year, Cal-HOSA launched a pilot project in 10 schools around the state designed to educate students and staff about the risk factors for mental illness, strengthen partnerships with community mental health providers, and involve student leaders in combatting stigma. Schools serve as a natural hub for mental health education and services, Loera said, given the dominant role they play in family and community life.

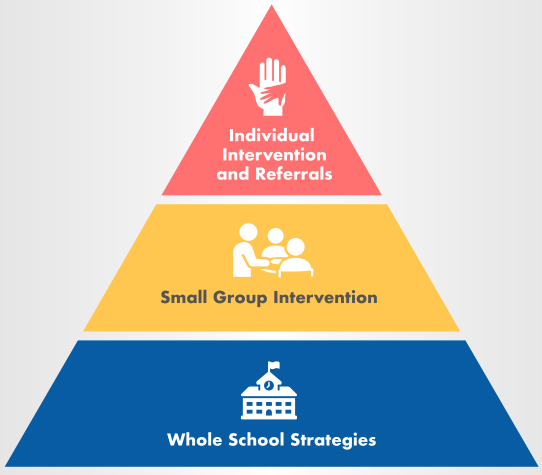
School leaders, he said, can "influence the curriculum to introduce mental health in ways that are not stigmatizing, that allow students to examine the societal and economic issues. And we are able to recognize potential risk factors and deal with them before they become a crisis that makes it more expensive to deal with."

Best Practices in Student Mental Health

Incorporating mental health education and services into schools takes planning and work—but not reinvention. There is a basic model that most experts point to as the gold standard for school-based care: using the "multi-tiered system of supports," or MTSS approach.

To get a sense of how MTSS works in the mental health context, picture a pyramid of care divided into three horizontal levels. The broad bottom base equates to strategies that benefit the whole school community. The middle tier is group intervention for at-risk students. And the top tier involves targeted intervention and referrals for individual students with urgent mental health needs.

Figure 1: Multi-Tiered Systems of Support in a Mental Health Context



So, what might that bottom tier look like? This can encompass a broad range of practices that shape the school climate. Among them:

» Staff training on the risks associated with childhood trauma and how that might affect classroom behavior;

» Infusing the curriculum with social-emotional learning—lessons that teach students to understand and manage emotions, as well as build empathy;

» An approach to discipline that focuses on personal growth and reparation rather than punishment;

» Training staff and students on the symptoms and risk factors of mental illness, as well as the terrific potential for recovery;

» Incorporating mental health into the health education curriculum throughout the grade span (The state is in the process of revising the 2009 health education framework to incorporate more mental health components.);

» Having an appropriate process for referrals for 504 plan and/or special education assessment;

» A strict anti-bullying policy that encompasses social media use;

» Adjusting school activities and homework loads to reflect the research that shows children need far more sleep than current schedules support;

» Ensuring every student has at least two adult staff regularly checking in with them; and

» Restricting cell phone and social media use during the school day.

The shape the two upper tiers take can vary, depending on a school's staffing and the nature of its community partnerships. Tier 2 might encompass group counseling sessions for grief support, building social skills and conflict resolution, as well as group interventions designed to build self-esteem and empowerment. Tier 3 involves intensive mental health interventions, often including assessments for 504 Plans and/or special education and/or outside referrals, tailored to an individual student.

Key to the model is a point person, or ideally a multidisciplinary team, that can regularly review and coordinate all referrals for service.

Though program details and staffing models may vary, the experts who design or operate school-based mental health programs point to two basic guiding principles as schools, county offices of education, and districts work to build that pyramid:

1. Don't try to do this alone. Partnerships with the county or community mental health organizations are key to the model's success. Educators are not therapists and don't have time to be. In addition, county and community mental health providers have access to diverse streams of government funding and grants that schools do not, and they can leverage that funding to hire key staff who specialize in mental health and casework.

2. Investing in Tier 1 (school-wide prevention) and Tier 2 (targeted group intervention) is just as important as investing in crisis mental health services. The first two tiers lay a foundation for prevention and early intervention, so schools are reaching kids before a situation escalates to crisis stage.

In the ideal models, schools with capacity provide the space for on-campus services and a supportive network of trained staff that includes a school social worker and counselors. They partner closely with county mental health or community service providers who can offer more specialized staff and services.

Lisa Eisenberg is policy director with the California School-Based Health Alliance, a nonprofit organization that works closely with school districts to develop health care programs. Her advice to school officials looking to launch a school-based partnership for mental health care: Do some homework up front and make an initial investment.

"If a school just goes to a county and asks, What can you provide?, that's not very collaborative", Eisenberg said. "A better approach: 'We have invested in training teachers; we have referral protocols; we've invested in these support groups. Here is the need we can't meet. What can you help us with?'"

Alameda County is widely considered a national model for what such community partnerships can look like. Over the past two decades, the county's Center for Healthy Schools and Communities (CHSC) has built a system of integrated mental and physical health care that now encompasses 18 school districts and 170 schools. The county contracts with community providers to operate on-campus wellness centers in 29 schools accessible to more than 35,000 students.

Of the more than 14,000 students who visited the campus health centers in 2014, about 30 percent were treated for behavioral health issues. And about a quarter of the students who came in for medical visits or health education took part in psycho-social screenings to identify young people in need of further support.

The partnership goes beyond medical services. The county provides regular workshops, training, and on-site support

to promote cultural understanding, family engagement, and other programs that help create a more nurturing environment from elementary school through high school.

"Districts like to be able to contain things within their own systems. It's always more attractive to do things yourself because partnerships can be challenging," said Warhuus, the program's interim director. "But none of our districts have resources to fund even basic education. School counseling is in crisis in this country, and counties and nonprofits have access to resources that districts don't have access to…We can leverage state and federal funding streams."

The CHSC's programs are informed by annual evaluations that aim to answer three core questions: How much did we do? How well did we do it? Is anyone better off?

Recent evaluations conducted by UC San Francisco researchers have found consistent benefits for children who take part in the Healthy Schools programs.[20] These include overwhelmingly positive reviews from young people who said the services made them feel they had an adult they could turn to for support, that they were better equipped to deal with stress, and that the services would keep them from using drugs and alcohol or engaging in fights.

The 2017 evaluation credits the centers with influencing gains on key measurements of school success: Improved academic performance, lower rates of suspensions and absenteeism, higher graduation rates, and greater participation in school activities.

The University of Maryland's CSMH has tracked similar results nationwide for schools that have put in place comprehensive mental health systems.

What are next steps for district and county office of education leaders interested in developing a coordinated mental health services program? Remember, there is no need for reinvention. There are multiple professional organizations and research institutions that specialize in helping schools design and implement mental health programs tailored to individual districts or schools.

Resources to Support Best Practices

ADAP, Johns Hopkins Medicine: The Adolescent Depression Awareness Program is designed to educate high school students, teachers, and parents about adolescent depression and associated risks for suicide. The program includes school-based curriculum, staff training, and community presentations. Training and materials are provided free of charge. bit.ly/2FE82uF

California School-Based Health Alliance: The Alliance is a statewide nonprofit organization that works closely with schools and districts to develop and implement health care services. The organization provides a full range of support, from consultation and program design to ongoing technical assistance and evaluation. www.schoolhealthcenters.org

Cal-HOSA: This is the California chapter of HOSA, a national organization that helps students develop leadership skills and encourages them to pursue careers in the health professions. The organization is working with 10 schools in California to develop programs that expand mental health awareness among staff, students, and community members, while growing access to services. The goal is to replicate successful models across 200 California schools. cal-hosa.org

Center for Healthy Schools and Communities, Alameda County: The Center for Healthy Schools and Communities, a division of the Alameda County Health Care Services Agency, is regarded as a national model. The center is partnering with 18 districts and 170 schools in Alameda County to provide a full continuum of physical and mental health care services, accessible to students on school campuses. Leveraging a range of funding streams, the center contracts for professional health care services, as well as providing technical support, staff training, and community programs that promote cultural understanding and engagement. achealthyschools.org

Center for Youth Wellness: The Center for Youth Wellness has played a leading role in drawing attention to ACEs research and recovery. The center's website is a rich repository of research and video explaining the science behind ACEs, potential impacts, and treatments. Center staff are available for consultation and presentations. centerforyouthwellness.org

Challenge Success: Challenge Success partners with schools to develop strategies that promote student well-being and engagement. The team, based in Stanford, California, has worked with hundreds of schools across the nation to design curriculum, class schedules, homework policies, and assessment strategies that help students and families find a healthy school–life balance. www.challengesuccess.org

Child Mind Institute: The Child Mind Institute is a national nonprofit dedicated to research and care that advances the science of brain illness in children and youth. The organization's website offers a wealth of data, research, and treatment options related to child mental health, including strategies for educators. Its 2018 mental health report focuses on the rising incidence of anxiety in children and teens. childmind.org

Mental Health America: Mental Health America is a national nonprofit that advocates on behalf of people living with mental illness and promotes prevention and early intervention, services, and education. Each August, it publishes an annual Back-to-School toolkit to guide educators in raising awareness about mental illness. www.mentalhealthamerica.net/back-school

Palix Foundation: The Palix Foundation is the driving force behind the Alberta Family Wellness Initiative in Canada. The initiative has produced a host of training materials, online courses, and engaging videos to explain brain science and dispel myths around mental illness. The materials aim to both raise awareness about mental health risks and treatment and promote strategies for prevention and early intervention. www.albertafamilywellness.org

University of Maryland Center for School Mental Health: The Center for School Mental Health is a nationally recognized leader in the evaluation and development of effective school mental health programs. The center houses extensive online resources for schools and parents and offers intensive professional development through online courses and conferences. csmh.umaryland.edu

Youth Mental Health First Aid: This is a widely acclaimed, evidence-based training in recognizing and responding to signs of mental illness in children and teens. The eight-hour training is geared toward adults who work with children, as well as family members. www.mentalhealthfirstaid.org/take-a-course/course-types/youth

Questions for Board Members

1. What professional learning to help teachers and staff recognize mental health issues does your local educational agency (LEA) provide?
2. What partnerships does your LEA have to help meet students' mental health needs?
3. Does your LEA have a clear and consistent anti-bullying policy? What does district data (e.g., student climate surveys) indicate about the effectiveness of our existing policies and practices?
4. What social-emotional learning programs does your LEA provide and at what grade levels?
5. What are your board's priorities for supporting students' mental health?

Endnotes

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Deborah Anderluh is the former communications director for the Steinberg Institute, a Sacramento-based nonprofit dedicated to advancing sound public policy on mental health issues. She is currently the West Coast Enterprise Editor for Kaiser Health News.