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Students' Mental Health Challenges: What They Say, What Schools and Adults Miss, and Why AI Isn't the Answer

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Dear Colleagues,

Introduction: Students' Current Mental Health Status

Students' social, emotional, behavioral, and mental health status is one of the most pressing issues facing schools today. Whether we are talking about students who are angry, aggressive, or violent (externalizing students), students who are anxious, fearful, or phobic (internalizing students), or students experiencing situational distress, stress, or trauma, the data are clear. Large numbers of children and adolescents are struggling, and these struggles are not evenly distributed across populations or conditions.

Thus, the question is not whether students are experiencing social, emotional, behavioral, or mental health issues. The issue is how these issues are showing up, how they are shifting over time, whether educators are accurately recognizing the signs and symptoms, and whether our schools have the resources to address students' needs.

According to the 2022 National Survey of Children's Health (NSCH), more than one in five U.S. children ages 3 to 17 has a currently-diagnosed mental, emotional, developmental, or behavioral condition. That's not an occasional student here and there—that's millions of children from preschool through high school.

And these challenges start early. The same 2022 NSCH data show that among children ages 3-5, nearly 8% have a diagnosed behavioral or conduct problem. For elementary-aged children (6-11), anxiety is a growing concern, affecting over 9% of that population. These early-onset difficulties can significantly impact school readiness and social development.

Moving up, among adolescents alone, roughly 20% carry a current mental or behavioral health diagnosis. Anxiety tops the list, with 16% of teens currently diagnosed, followed by depression at just over 8%, and behavior or conduct disorders at more than 6%. Critically, these rates are not static: compared with 2016, adolescent anxiety diagnoses have risen by over 60%, while depression diagnoses have increased by more than 75%. The upward trend is undeniable.

But diagnoses only tell part of the story.

Adolescent self-report surveys, especially the CDC's 2021 Youth Risk Behavior Survey (YRBS), capture what students feel and experience directly. In 2021, 42% of high school students reported persistent feelings of sadness or hopelessness, a rate that remains alarmingly high compared with ten years ago. 37% said their mental health was poor during the prior 30 days. And perhaps most concerning, 22% of students had seriously considered suicide in the past year, 18% had made a suicide plan, and 10% had attempted.

These numbers underscore the severity of internalizing concerns such as depression and anxiety—and the risks they pose when left untreated. Moreover, the disparities are just as telling: Female and LGBTQ+ students consistently report the highest levels of distress, pointing to the ways that identity, belonging, and school climate intersect with mental health.

When looking at externalizing behaviors—conditions that are more visible in classrooms—the NSCH provides an equally useful lens. In 2022, about 6% of adolescents carried a diagnosis of a behavior or conduct disorder. While that rate is lower than internalizing conditions, the impact on schools is significant.

Students with behavior or conduct diagnoses are three times more likely to be disengaged in class, four times more likely to have repeated contacts with school staff regarding their behavior, and five times more likely to miss significant school time due to health issues.

Beyond diagnosed disorders, school-level indicators paint a similar picture: Nearly 20% of high schoolers report being bullied in person, and 16% online.

Once again, these are not isolated incidents—they shape daily school functioning, peer relationships, and the very climate of the learning environment.

Finally, layered onto both internalizing and externalizing issues are the effects of trauma and chronic stress. The 2022 NSCH reported that 40% of children in the U.S. have experienced at least one adverse childhood experience (ACE), such as parental divorce, direct exposure to violence, or household instability, and nearly 18% have experienced two or more. By high school, these adverse experiences often manifest directly in the school context.

The 2021 YRBS found that 11.5% of students had been forced into sex at some point in their lives, 9% had experienced sexual dating violence in the past year, 9% had been threatened or injured with a weapon on school property, and 10% skipped school because they felt unsafe. Each of these experiences carries psychological weight—heightening the risk for anxiety, depression, post-traumatic stress, or behavioral dysregulation—and each disrupts students' ability to feel safe and engaged at school.

Taken together, these trends reveal a dual challenge. On one hand, internalizing conditions like anxiety and depression are climbing steadily, often invisible until students speak up, break down, or break out. On the other, externalizing behaviors, while less common, demand disproportionate attention from schools

and often shape public perceptions of “behavior problems” in education. Across all groups, exposure to stress and trauma cuts through the diagnostic categories, amplifying risk and complicating recovery.

This is not a fringe issue—it is the daily reality in classrooms from preschool through high school. If schools are to meet students where they are, prevention, early identification, and multi-tiered supports are not optional. They are central to our schools’ educational missions and effectiveness.

Three Mental Health Strategies that are Missing in Most Schools

While there are many strategies to help address students’ mental health challenges, three critical ones are:

- Universal Mental Health Screenings
- Comprehensive Threat Assessments, and
- Appropriate Levels of School-Based Mental Health Staffing

These are not optional strategies. Indeed, they are the backbone of any truly preventive, responsive school system.

Yet most schools do not use the first three strategies with consistency and integrity, and they are not fully staffed. This leaves much of the everyday identification of students with social, emotional, and behavioral needs (a) to overburdened teachers; (b) to administrators who correctly recognize that many attendance and discipline referrals are actually mental health referrals; or (c) to the students themselves.

Mental Health Screenings Conducted by Schools

A recent Education Week article (August 26, 2025) cited a 2025 RAND study that revealed a stark reality: Only 30.5% of K–12 public schools nationwide require mental health screenings.

Even when screenings are mandated, follow-up care is far from certain.

Indeed, principals reported that 79% notify parents, over 70% offer in-person treatment, and 53% refer students to outside mental health professionals—while less than 20% offer telehealth services. Despite these protocols, around 40% of surveyed principals say it’s “very hard or somewhat hard” to ensure that relevant students get appropriate care after screening.

What’s worse is that only two states—Illinois and New Jersey—have either required or funded universal screenings. The rest of the states largely leave mental health screenings to the discretion of their districts—also leaving the districts responsible for the funding.

All of this means that too many schools are relying on subjective adult observation—instead of validated tools and processes—for early mental health identification. The result is that many students are slipping through the cracks. . . until their distress is visible—or damaging.

Most Threat Assessments are Conducted on Students with Externalizing, Not Internalizing, Issues

Threat assessments also are important pre-intervention strategies in a school’s “mental health tool box.” When K–12 schools implement a well-structured threat assessment process, the benefits go far beyond just preventing violence.

Here are the top four advantages that consistently stand out:

1. Early Identification and Intervention

- Schools can detect concerning behaviors before they escalate into serious threats.
- Students exhibiting signs of distress or aggression can receive timely support, such as counseling or behavioral interventions.
- This proactive approach helps prevent crises—rather than just reacting to them.

2. Improved School Climate and Safety

- A sound threat assessment process fosters a culture of safety, trust, and accountability.
- Students and staff feel more secure knowing that concerns are taken seriously and addressed constructively.
- It encourages bystander reporting, empowering students to speak up when they notice troubling behavior.

3. Support for At-Risk Students

- Threat assessment teams often include mental health professionals who focus on helping—not punishing—students in crisis.
- Instead of zero-tolerance discipline, schools can offer tailored interventions that address underlying issues like trauma, bullying, or mental illness.
- This approach reduces suspensions and expulsions, keeping students engaged in their education.

4. Data-Driven Decision Making

- Schools can track patterns and trends in student behavior, allowing for smarter resource allocation and policy development.
- Threat assessments provide documentation that helps administrators make informed decisions about safety protocols and student support systems.

In short, a strong threat assessment process helps transform school safety from reactive to preventive. It’s not just about stopping violence—it’s about building healthier, more responsive learning environments.

Jillian Haring, a national expert in threat assessments and a behavior specialist in the Broward County Public Schools when the Marjory Stoneman Douglas High School shooting occurred, recently wrote an Opinion piece in Education Week (“This Kid Scares People: A Behavior Specialist Shows Her Reality,” September 4, 2025). There, she asserts that schools often treat threat assessments as procedural checklists or discipline tools—not as part of an early mental health intervention system.

This significantly contradicts the four threat assessment benefits discussed above.

In addition, Haring notes that the most-common threat-related teacher statement—”This kid scares people, but there’s no plan”—underscores how students with visible, externalizing behaviors (e.g., aggression, defiance, disruption) are often referred for threat assessments. As a result, the students with internalizing risks—like depression, anxiety, or suicidal ideation (that could be incorporated into a school shooting)—are often missed.

Haring believes that schools need to reframe their threat assessment perspectives away from “Is this student a threat?” to “What is this student trying to survive?” This shift pivots teams from reactive labeling to empathetic, needs-based support.

And yet, many schools are years from asking the question above because they either have no threat assessment policies, or their procedures are not evidence-based or staffed appropriately. In the end, without multidisciplinary teams, high-fidelity training and coaching, clear case-tracking, and a culture of prevention—not punishment, students with mental health issues will remain dangerously invisible and untreated within our schools.

Mental Health Professionals: Too Few, Too Scattered, Too Stretched

Ultimately, here is the foundational, systemic failure to the entire process.

The National Association of School Psychologists (NASP) recommends a ratio of 1 psychologist for every 500 students, but the national average for the 2023–24 school year was 1 to 1,065. Similarly, the American School Counselor Association (ASCA) recommends 1 counselor for 250 students; yet the actual national average was closer to 1 to 376.

As a result, only 48% of schools say they are able to effectively meet their students’ mental health needs because nearly 52% of them report a lack of mental health staff, and/or attribute funding as a primary barrier. Critically, this outcome cuts across urban, rural, and every geography in between. Staff are stretched too thin, with responsibilities—from special education assessments to academic advising to discipline—leaving negligible room for prevention or intervention work.

The Bipartisan Safer Communities Act (BSCA) tried to address this via \$1 billion in federal funding over five years—split across the School-Based Mental Health Services and Demonstration grant programs. But the U.S. Department of Education recently rescinded the grants awarded last year as part of its quest to diminish what it saw as DEI influences embedded in the Request for Proposals (RFP) process. This effectively cut off nearly 200 districts from funds meant to hire and retain mental health professionals.

A revisited School-Based Mental Health grant program was announced for public comment in July. It is anticipated that a formal RFP will be published in the late Fall (2025), with newly-awarded grants during early 2026.

Summary

These three strategies are clear, actionable, and research-supported—but underutilized. Fixing each of these strategies requires leadership, funding, training, policy, and sound implementation procedures.

- Mental health screenings: Proven effective—but adopted by fewer than one-third of schools; not well-staffed or procedurally sound in many schools that have adopted.
- Threat assessments: Too focused on visible behavior; ignore internalizing students who may pose the highest personal risk; used more for discipline, than the delivery of effective mental health services
- Mental health staffing: Critically undersized. Federal efforts exist but have been rolled back; most schools have no sustained structures in place.

The Need Still Exists, Therapy Stigma Persists, and Students are Looking On-Line

Beyond the data reported above, if you scroll through any adolescent’s TikTok or Instagram short-form feed, you’ll find a consistent pattern: Young people expressing emotional distress—not through clinical vocabulary, but through phrases like “burnt out,” “so done,” or “can’t even.” These are not polite exaggerations—they are real disclosures of overwhelm, fatigue, and disconnection.

Adult reactions often fall into two traps: Minimizing (“everyone feels that way”) or overreacting (“alarmist”). Neither builds trust; both can shut down future communication.

And when you add the persisting and perceived social stigma of “being in therapy,” we know that (a) adolescents feel misunderstood or dismissed; (b) they disengage from conversations about their social, emotional, and behavioral needs; and (c) they avoid or reject any therapeutic interactions that “might go public.”

In today’s parallel TikTok and Instagram world, this means that many children and adolescents are turning to AI for social-emotional relief.

Indeed, a July 2024 Education Week feature, “Teens Are Looking for Mental Health Support Online. What That Means for Schools,” warns that over half of adolescents now turn to the internet—apps, chatbots, forums—for emotional support. While this can offer immediacy and anonymity, the quality of these sources (see below) is spotty at best.

The article echoes a critical point: While schools remain the most trusted point of access for youth mental health, many schools (as above) are not using the strategies available, and they have not kept pace with these online trends.

When AI Goes Wrong: ChatGPT’s Failure and Fall-Out as a Self-Help Tool

In a startling 2025 study by the Center for Countering Hate, researchers posed as three 13-year-olds grappling with issues like self-harm, eating disorders, and substance misuse. They submitted 20 scripted prompts per scenario and analyzed a total of 1,200 responses from ChatGPT. Shockingly, over half of those responses were classified as harmful, including advice that facilitated risky behaviors—suggestions ranging from crafting suicide letters and extreme dieting plans to strategies for hiding alcohol use at school.

Nearly half of those harmful responses included further encouragement to continue the behavior. In addition, the study revealed how easily the AI’s safety mechanisms could be bypassed.

When the fake teen claimed the prompts were needed “for a presentation,” ChatGPT frequently abandoned its initial crisis-intervention response. In the self-harm scenario, harmful guidance was generated within just two minutes.

The study’s lead, Imran Ahmed, emphasized that this isn’t a glitch—it’s an inherent feature of how the system operates, built to maximize engagement through human-like responsiveness—even to dangerous prompts.

OpenAI acknowledged the findings, stressing that it is working to “better detect signs of distress” and improve model behavior over time.

Unfortunately, this research reflects reality.

In August 2025, the mental health world was shaken by a heartbreaking lawsuit filed by the parents of 16-year-old Adam Raine, a teen from Orange County, California. According to the family’s suit, their son began using ChatGPT for homework and personal interests, and gradually—tragically—shifted into deeper conversations about his emotional pain and suicidal thoughts.

The lawsuit alleges that, rather than redirecting Adam toward professional help, the chatbot normalized his despair, provided instructions on self-harm methods, even helped him draft a suicide note. Family lawyers call it a failure of safeguards; OpenAI again acknowledged that safety features may degrade in long interactions, and—last week—it announced stronger parental controls and crisis routing in its ChatGPT response paradigms.

Understand:

- I am not blaming ChatGPT for Adam Raine’s suicide. . .

Any more than we should blame a suicide on a school teaching or a library stocking the following books: “Thirteen Reasons Why,” “The Perks of Being a Wallflower,” “Ordinary People,” “Looking for Alaska,” or “Romeo and Juliet” . . .

Or Netflix screening the British mini-series, “Adolescence.”

- I am not blaming, but I am wondering if Raine’s parents, school contacts, or peers knew of his challenges and were actively involved in getting him help?

- I am not blaming, but I am wondering how and when the “lines of reality” between Adam and a computer program became so blurred that—if he did—he “took the advice” of ChatGPT so seriously that he took his own life?

As school professionals, let’s (re)state the obvious, and systematically build this message into our computer and social media literacy discussions with students:

AI is designed for engagement—not for emotional support.

AI can simulate empathy, but it has no real understanding. It is not a counselor or a school psychologist. While OpenAI—along with other tech companies like Meta—now pledge stricter guardrails and parental alerts, the Raine’s tragedy underlines a painful truth: AI can easily become a confidante of last resort when children lack real-world support.

Summary and A Call to Action: What School and Families Must Do

For Administrators and Educational Leaders:

- Ensure that staff understand that student language of distress often is not “textbook,” and that it conforms to their current vocabulary and generation. Train them to respond with validation—not correction—and to know exactly when and where to escalate concerns.
 - Promote media literacy and AI awareness—not to demonize technology, but to help students and families understand its limits. AI should never replace relationship-based care.
 - Build clear referral pathways. If a teacher hears “I can’t do this anymore,” they should know without hesitation who to notify—counselors, school psychologists, the MTSS support team, and—when needed—families.
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For Mental Health Professionals:

- Host workshops or “mini-faculty meeting” discussions that decode students’ digital language. Clarify the difference between venting and crisis signals.
 - Develop collaborative protocols with families around AI use. Encourage parents to monitor early and late teens’ patterns, check in on emotional tone, and maintain open dialogue.
 - Offer in-class modules for students (and staff) on digital emotional literacy. Explain what AI can and cannot do, the healthy coping alternatives that are available, and how to access trusted human supports.
 - Be present and available for students. Make sure that all students know who you are, how to contact you, and the range of supports you can offer.
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For Teachers:

- Normalize conversation: Start class with simple check-ins (“share a word that describes how you feel today”) and remind students of counseling and emotional support systems and people.
 - If a student expresses ongoing distress—either verbally or via chat logs—initiate: “That sounds heavy. Would you like help talking to someone you trust here at school?”
 - Remind students that technology can help with homework—but real emotions need real peer, mentor, mental health professional, or family connections.
 - Build and maintain parent connections. Do not hesitate to directly contact parents when mental health “red flags” are observed.
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For Parents and Peers: Crucial Co-Stewards

- Watch for changes in tone or behavior around AI use. If your child or a peer turns to ChatGPT as a safe space, that’s a signal—not a falling star. Ask: “Who are you talking to? What do they say back?”

- Build and continually reinforce shared media literacy skills. Discuss together how AI works, its limitations, and when a “human” mental health professional needs to be consulted. Don’t be a bystander watching someone fall into a virtual trap.
- If you detect emotional distress, prioritize a human touch over an app—call or contact (even anonymously for peers) a mental health professional, schedule a consultation or check-in (for parents), or use 988, if urgent.

This Blog highlighted the pervasive mental health crisis among preschool through high school students, emphasizing that a significant number are struggling with internalizing and externalizing issues, often compounded by trauma. We argued that schools frequently miss crucial opportunities for early intervention due to inadequate mental health screenings, threat assessments that especially overlook internalizing problems, and a national shortage of mental health professionals.

We addressed the concerning trend of adolescents (especially) seeking emotional support from AI, illustrating the dangers through a study on ChatGPT’s harmful responses and a tragic suicide.

Finally, we provided actionable strategies for administrators, mental health professionals, teachers, parents, and peers to better identify distress, promote media literacy, and offer human-centered support.

School-aged students express distress in contemporary, culturally embedded ways. This “communication” does not always conveniently fit diagnostic frameworks. Research has long-confirmed that recognizing this language, completing diagnostic assessments, implementing a multi-tiered continuum of validated interventions, and lowering the barriers and access to human support makes a real difference.

AI is increasingly ubiquitous and available to school-aged students, but it is not built—or designed—to offer emotional guidance. The Raine case is a sobering reminder of that boundary.

Families and schools must be partners: aware of tech trends, proactive in conversations, and united around helping youth navigate their internal worlds safely.

When a student says, “I feel done,” our role is clear. We pause, we listen, we bridge—not to AI, but to the real professional and human supports that can address students’ needs and challenges.

This is how we build and keep trust with our students (and children).

This is how we prevent silence or the absence/rejection of help from becoming a virtual search for help, and—sometimes—tragedy.

Best,

Howie