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Toward Equitable Mental Health Education in Rural China Evidence from a Mixed-Methods Study in Guangxi Province

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Abstract

The mental health of school-aged children has become an urgent concern in rural China, where psychological services and educational resources remain underdeveloped. This mixed-methods study examines the current status, challenges, and strategies of mental health education management in rural schools in Guangxi Province. A 32-item questionnaire was administered to 320 primary and secondary teachers across six counties, assessing organizational management, implementation, support conditions, and outcomes. The instrument showed strong reliability (Cronbach's $\alpha = 0.893$) and validity (KMO = 0.902). Quantitative results revealed significant urban–rural disparities, with county town schools outperforming remote areas across all dimensions ($p < .001$). Support conditions emerged as the strongest predictor of outcomes ($r = .682$). Qualitative interviews identified barriers including a shortage of trained counsellors, weak parental engagement, and low mental health literacy. The study highlights gaps between policy intentions and implementation, recommending targeted funding, stronger organizational capacity, expanded teacher training, enhanced school–family–community collaboration, and continuous monitoring. These strategies provide actionable insights for policymakers and administrators to promote equitable and effective mental health education in rural China.

Keywords: Mental Health Education, Rural China, Guangxi Province, Educational Disparities, Mixed-Methods

Introduction

The mental health of children and adolescents has become an urgent global concern, with an estimated 10–20% of youth experiencing mental disorders worldwide (Ruan et al., 2024). In China, this issue has gained prominence within the education sector in recent years (Cui et al., 2021; Yuan et al., 2025). Epidemiological studies suggest that roughly 18% of Chinese school-aged children suffer from common mental health disorders such as anxiety or depression (Li et al., 2022), and the prevalence may have risen further in the wake of the COVID-19 pandemic (Fu et al., 2025). Alarmingly, the burden appears heavier in rural areas. Large-scale surveys indicate that rural students, especially those from underdeveloped regions, exhibit

higher rates of psychological problems compared to their urban counterparts (Jiang et al., 2022; She et al., 2022; Wang et al., 2021). For instance, a recent national report found that 21.5% of rural students have mild depressive symptoms and 8.1% have high-risk levels of depression – proportions above the national adolescent averages (Yuan, 2025). Rural children left behind by migrant parents are particularly vulnerable: approximately 70 million of these "left-behind" children (nearly 38% of China's rural child population) experience significantly elevated rates of depression and anxiety relative to non-left-behind peers (Ruan et al., 2024; Zhihan, 2025). Such disparities underscore the pressing need to address mental health in rural schools as a matter of educational equity and social justice.

Recognizing this challenge, the Chinese government has increasingly prioritized mental health education in schools through policy reforms. Top-level frameworks like the Healthy China 2030 blueprint (Central Committee of the CPC & State Council) explicitly call for strengthening mental health services and literacy across the population (Tao, 2023). In the education sector, the Mental Health Action Plan for Children and Adolescents (2019–2022) emphasized preventive school-based interventions and mandated that schools provide mental health services at all grade levels, with teachers playing a key role in psychological support (Qu et al., 2024). This was followed by the "Double Reduction" policy of 2021, aimed at easing academic pressure by reducing excessive homework and private tutoring to promote students' overall well-being (D. Wang et al., 2022). Most recently, authorities launched the Special Action Plan for Student Mental Health (2023–2025) along with a new national mental health work plan (2030), which together reinforce the integration of mental wellness into the education system (Guo, 2023; Huang, 2024). These policy initiatives advocate a proactive, systematic, and equity-driven approach, striving to embed mental health education into the routine fabric of schooling. The policy momentum thus provides a supportive context and a moral imperative for improving mental health education, particularly in underserved rural communities.

Despite such efforts, rural schools continue to face systemic barriers in implementing effective mental health education. Urban areas have generally progressed faster, benefitting from stronger infrastructure, better-trained staff, and greater policy support, whereas many rural regions remain under-resourced. In rural China, it is common for schools to lack full-time mental health professionals; only about 40% of primary and secondary schools nationwide have at least one full-time mental health teacher, and these are concentrated mainly in cities (Zhihan, 2025). The vast majority of rural schools rely on teachers who juggle multiple duties and often have minimal training in counseling or psychology (X. Wang et al., 2022). This staffing gap means that comprehensive mental health curricula or services are seldom in place – interventions, if any, are limited to occasional lectures or ad-hoc activities rather than integrated, ongoing support. Moreover, rural schools typically lack dedicated facilities (e.g. counseling rooms) and collaborative support networks, making it difficult to systematically address students' psychological needs (Song, 2023). Community and family support systems in rural areas are also weak; caregivers such as grandparents often have low mental health literacy and communities have scarce professional services (Qiu et al., 2022). In sum, the environments that rural children inhabit, including home, community, and school, are often ill-equipped to provide the mental health education and care that children require, even as the need is growing.

Compounding these structural challenges is a gap in research and practical guidance focused on rural mental health education. To date, most Chinese studies on student mental health have concentrated on urban populations or university students, leaving the needs of rural primary and secondary school students relatively understudied. While a substantial body of literature documents mental health trends and risk factors (e.g. for left-behind children) in rural China, far fewer studies have examined how rural schools can organize and deliver mental health education in practice. The management and implementation mechanisms, such as how schools plan programs, train teachers, involve parents, and coordinate with health services, remain poorly understood in the rural context. Existing school-based mental health programs and research pilots have largely been implemented in well-resourced urban settings or as short-term projects, with limited insight into scaling such programs in resource-constrained county settings. This represents a critical research gap, given that rural youth arguably stand to benefit the most from school mental health supports yet face the greatest obstacles in access.

In response to these gaps and inequities, the present study investigates the current status, challenges, and strategies of mental health education management in rural Chinese schools. Focusing on Guangxi, a predominantly rural and less-developed province typifying many of the issues, we adopt a mixed-methods approach to explore how mental health education can be systematically advanced in county-level school systems with limited resources. By combining quantitative surveys and qualitative interviews, our analysis provides an up-to-date, ground-level view of organizational structures, implementation practices, support conditions, and outcomes related to mental health education in rural schools. The aim is to not only identify weaknesses and disparities, but also to distil actionable insights for policy and practice. Ultimately, this study offers both theoretical and practical value: it enriches the literature on educational equity and school health by focusing on an underrepresented context, and it generates evidence-based recommendations to inform the development of a more equitable, sustainable mental health education system in rural regions. This contribution is timely for guiding future regional interventions and policy decisions under China's ongoing mental health and education reform initiatives.

Literature Review

International Developments in School Mental Health Education

Internationally, school-based mental health programs have evolved over decades as a crucial strategy to support youth well-being (Carta et al., 2015; Cilar et al., 2020; Margaretha et al., 2023; Wei & Kutcher, 2012). In Western countries, efforts to integrate mental health into education began in the early 20th century and have expanded into comprehensive models. For example, the United States pioneered school mental health services by establishing psychological clinics in the 1890s and later developing a multitier system of support (universal prevention, targeted intervention, and intensive services) through mid-century reforms (Weist et al., 2017). By the 2000s, many countries, including the US, UK, Canada, and Australia had embedded mental health promotion into school curricula and policies, emphasizing early intervention and resilience-building (Fenwick-Smith et al., 2018). Recent global frameworks, such as the World Health Organization's School Mental Health Manual, provide guidelines for low- and middle-income countries to implement school mental health services (Fu et al., 2025). These frameworks stress whole-school approaches and multi-sector collaboration as best practices. Empirical evidence supports the efficacy of school-based social-emotional

learning (SEL) programs in improving students' psychological outcomes across diverse settings (Cipriano et al., 2023; Durlak et al., 2022). However, researchers have noted that translating these models into under-resourced contexts comes with significant challenges. In many developing regions and rural areas, initiatives encounter barriers such as insufficient teacher training, scarce funding, and fragmented service infrastructure. For instance, studies in South Asia and Africa have found that without proper capacity building and community buy-in, even well-designed school mental health interventions struggle to sustain impact (Hamdani et al., 2021; Imran et al., 2018). These findings echo a broader lesson from global health: simply importing programs from high-resource environments is inadequate. Strategies must be tailored to local contexts and constraints. One promising adaptation is "task-shifting," wherein responsibilities for basic mental health support are moved to lay providers (e.g. teachers) when professionals are lacking (Cruz et al., 2021). This approach has been recommended by global mental health experts as a pragmatic way to bridge service gaps in low-resource settings (Galagali & Brooks, 2020). Recent trials, including in Pakistan and Uganda, show that training school teachers in fundamental counseling and mental health literacy can modestly improve student well-being (Imran et al., 2022; Siraj et al.). Nonetheless, task-shifting requires sustained support: teachers need ongoing training, curricular materials, and administrative backing to effectively take on quasi-counselor roles. In summary, the international literature highlights a duality: schools are a pivotal platform for mental health promotion worldwide, but realizing their potential, especially in rural or low-income areas, demands overcoming systemic implementation barriers. These insights set the stage for examining how China's rural schools compare and what unique challenges they face.

Mental Health Education in Rural China: Progress and Challenges

China's approach to school mental health has been shaped by rapid social changes and policy reforms over the past few decades. The rise of mental health education is often traced to the broader shift toward quality-oriented education (suzhi jiaoyu) in the 1980s, which encouraged attention to students' holistic development beyond academics (Li, 2025). Key milestones include the Ministry of Education's Guidelines for Mental Health Education in Primary and Secondary Schools (issued in 2002 and revised in 2012), which for the first time made psychological education an explicit component of the school mandate (Zhihan, 2025). These guidelines and subsequent circulars institutionalized mental health as a responsibility of schools, recommending that schools offer counseling services, mental health classes or activities, and crisis interventions as needed. In recent years, national initiatives like the Children and Adolescent Mental Health Action Plan (2019–2022) have further reinforced that mental health education should be integrated into school structures and daily routines (NHC, 2019) . Together, these policies advocate for routine psychological education as part of a well-rounded education, aiming to cultivate students' resilience and emotional well-being from early ages.

Despite these policy advances, a substantial urban–rural divide persists in the implementation of school mental health programs. Research within China consistently shows that rural schools lag behind their urban counterparts on multiple fronts. For example, Liu et al. (2025) and Hong (2023) note that while model urban schools have established counseling offices and hire mental health staff, many rural schools still lack even basic provisions like trained counselors or regular mental health classes. System-level analyses have pointed to shortfalls in teacher capacity, funding, and infrastructure as key constraints in rural areas (Chen, 2024;

Yu et al., 2019). Indeed, rural educators often have limited awareness or formal training in mental health and may not recognize psychological distress in students or know how to respond. Healthy China 2030 monitoring reports suggest that mental health education in rural schools is frequently perfunctory or "symbolic" in nature. Sun et al. (2022) found that many rural schools do not incorporate mental health topics into the classroom in any systematic way, lacking a structured curriculum or dedicated class time for psychological well-being. Wang (2022) further observed that the common practice in some rural counties is to hold one-off lectures or assemblies on mental health (often delivered by external experts during an annual session), with little follow-up in terms of counseling or interactive activities for students. Such approaches tend to be top-down and lecture-oriented, which may raise awareness but do not provide the sustained support or skills training that students need. Additionally, there is an overreliance on academic teachers to double as counselors in rural schools (Liu et al., 2022). Without specialized staff, homeroom teachers or school administrators, who are already overburdened, are expected to monitor student mental health, but they often feel ill-prepared and time-strapped to take on this role. The lack of a clear implementation framework means policies are not fully translating into practice on the ground. For example, although the national guideline recommends at least one counselor per school, many village schools share a single counselor across multiple campuses or have none at all (Liu et al., 2025). Furthermore, coordination with health services is weak: rural schools seldom have partnerships with psychologists or hospitals, and referral pathways for serious cases are underdeveloped (Hong et al., 2025). Cultural factors also play a role, and in tight-knit rural communities stigma around mental illness can be strong, causing families and even school staff to downplay mental health issues (Chen et al., 2025). All these factors contribute to a scenario where rural students remain underserved in terms of mental health support, even as they face distinctive stressors like parental out-migration, poverty, and academic pressure in under-resourced schools.

This gap in service provision is mirrored by a gap in the literature. Few studies have delved into how rural school systems can effectively implement mental health education under local constraints. Most Chinese research has either focused on measuring student psychological problems or evaluating specific intervention programs in small samples. There is a dearth of county-level, comprehensive studies examining the management side of mental health education, such as planning, inter-department collaboration, resource mobilization, and evaluation mechanisms, in rural school settings. As a result, school administrators and local policymakers have limited evidence-based guidance on building mental health initiatives that are sustainable in rural environments. To address this shortfall, scholars have called for more implementation-focused research and pilot projects in rural communities (Chen, 2024; Hong, 2023). There is also a recognized methodological gap: much of the existing research relies on quantitative surveys or isolated case studies, lacking the mixed-methods insights that capture contextual challenges and stakeholder perspectives (e.g., teachers' attitudes or local leadership support). Without understanding these on-the-ground factors, policies risk remaining aspirational. Therefore, advancing mental health education in rural China requires not only high-level policy commitment but also empirical studies that illuminate practical pathways and context-specific strategies.

In summary, the literature highlights both the necessity and difficulty of promoting mental health education in rural Chinese schools. International experiences underscore that schools

can be a cornerstone for youth mental health promotion, yet implementing such programs in low-resource settings is challenging without adaptations such as teacher capacity building and community engagement. Domestically, while policies have laid a strong foundation by legitimizing mental health education as part of schooling, rural areas continue to face entrenched barriers in execution, including manpower and material shortages, lack of training, and stigma. There is a critical need for research that bridges this "know–do" gap by examining how policy ideals can be realized in practice within rural school systems. The present study seeks to contribute to this need by providing empirical evidence from a rural province (Guangxi) and by focusing on the management mechanisms that underpin successful mental health education. By doing so, it will extend the current literature beyond problem description toward solution-oriented insights, offering guidance on how to build equitable mental health support systems for children in China's vast rural regions.

Methodology

Research Design

This study employed a quantitative survey-based research design, complemented by qualitative insights to provide triangulation and explanatory depth. The purpose of this design was to evaluate the current state of mental health education management in rural primary and secondary schools in Guangxi Province, China. The study examined four key dimensions derived from national policies and previous research: organizational management, implementation practices, support conditions, and educational outcomes. This descriptive and exploratory design was chosen to identify systemic gaps and propose practical, evidence-based strategies.

Research Method

The primary research instrument was a structured questionnaire designed using frameworks from national policy documents, validated educational management scales, and county-level mental health studies (Zhu, 2023). The questionnaire consisted of 32 items, divided into four dimensions:

1) Organizational Management (8 items): Focused on leadership teams, policy planning, institutional structures, and cross-departmental coordination.
2) Implementation Practices (10 items): Measured classroom-based mental health teaching, counseling services, extracurricular activities, and outreach efforts.
3) Support Conditions (7 items): Evaluated resource availability, financial investment, teacher training, and parental/community engagement.
4) Educational Outcomes (7 items): Assessed perceived program effectiveness, student involvement, and observable psychological improvements.

Responses were recorded on a five-point Likert scale (1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree), enabling quantification of subjective perceptions.

Population and Sample

A stratified random sampling approach was used to ensure balanced representation across regions with different economic and educational conditions. Participants included teachers who were directly or indirectly involved in mental health education initiatives in rural schools. Stratification was based on school location (county town, township, and remote village). A total of 350 questionnaires were distributed, with 320 valid responses returned, resulting in

an effective response rate of 91.4%. Demographic profile of the participants is presented in Table 3.1.

Table 3.1
Demographic Profile of the Participants

Demographic Variable	Percentage
Gender: Female	59.7%
Gender: Male	40.3%
School Type: Primary	71.8%
School Type: Secondary	28.2%
>5 years of experience	64.1%

Reliability and Validity

To ensure the robustness of the measurement tool, both reliability and validity analyses were conducted.

Content Validity: Five experts in educational psychology, rural education, and public health reviewed the questionnaire for relevance and clarity. Their feedback was incorporated into the final version. The Content Validity Index (CVI) of the instrument was 0.89, indicating high content relevance.

Construct Validity: Exploratory Factor Analysis (EFA) was performed using SPSS 27.0. The Kaiser-Meyer-Olkin (KMO) measure was 0.902, and Bartlett's Test of Sphericity was significant ($\chi^2 = 2643.82$, $df = 496$, $p < 0.001$). Four factors corresponding to the pre-defined dimensions were extracted, explaining 68.4% of the total variance.

Reliability: Internal consistency was evaluated using Cronbach's alpha coefficients (Table 3.2).

Table 3.2
Reliability Coefficients (Cronbach's Alpha) for Each Dimension and the Total Scale

Dimension	Cronbach's Alpha (α)
Organizational Management	0.87
Implementation Practices	0.88
Support Conditions	0.84
Educational Outcomes	0.86
Total Scale	0.893

Data Collection Procedure

Data collection was carried out over a four-week period in March 2025. School principals facilitated the distribution and collection of paper-based questionnaires. Participants were informed about the voluntary nature of the study and assured of confidentiality. All completed surveys were checked for completeness prior to data entry.

Data Analysis Techniques

Quantitative data were analyzed using IBM SPSS Statistics 27.0. The analysis framework included:

1) Descriptive Statistics: Means, standard deviations, and frequency distributions.
2) Inferential Statistics: Independent samples t-tests to compare school types, one-way ANOVA and LSD post hoc tests to examine differences by geographic location.

3) Correlation Analysis: Pearson correlation coefficients to assess relationships between support conditions and educational outcomes.
4) Additionally, qualitative data from six participants' open-ended responses and informal interviews were thematically analyzed.

Table 3.3 summarizes the statistical procedures employed in the analysis.

Table3.3
Overview of Data Analysis Procedures and Statistical Methods

Analysis Type	Description
Reliability Analysis	Cronbach's Alpha for internal consistency
Content Validity Review	Expert CVI assessment
Construct Validity	EFA with KMO and Bartlett's Test
Descriptive Statistics	Mean, SD, Frequency
Group Comparison	t-tests, ANOVA, LSD
Correlation Analysis	Pearson correlation between key variables

Findings

This section presents the key findings from the survey on mental health education management in rural schools across Guangxi Province. It includes descriptive and inferential statistical analyses based on SPSS outputs, focusing on four primary dimensions: organizational management, implementation of psychological education, support conditions, and perceived educational outcomes.

Descriptive Analysis

Table 4.1 displays the means and standard deviations of the four assessed dimensions, categorized by school location (county towns, townships, and remote villages). As the results show, county town schools scored the highest across all dimensions. In contrast, remote village schools had the lowest average ratings, particularly in support conditions and educational outcomes.

Table 4.1
Regional Comparison of Mean Scores on Mental Health Education Dimensions

Dimension	County Town (M)	County Town (SD)	Township (M)	Township (SD)	Remote Village (M)	Remote Village (SD)
Organizational Management	4.21	0.52	3.85	0.66	3.42	0.81
Implementation of Mental Health Education	4.1	0.6	3.71	0.7	3.38	0.76
Support Conditions	3.89	0.71	3.43	0.75	2.91	0.84
Educational Outcomes	4.0	0.68	3.56	0.74	3.02	0.78

Inferential Statistics: ANOVA Results

A one-way ANOVA was conducted to assess whether significant differences existed among the three school locations (county towns, township schools, and remote village schools)

across the four dimensions of mental health education management. The results indicated statistically significant differences in all four areas, as shown in Table 4.2.

Table 4.2
One-Way ANOVA Results for Differences Across Regions in Each Dimension of Mental Health Education

Dimension	F-value	df	p-value
Organizational Management	21.84	2, 317	< .001
Implementation of Mental Health Education	17.29	2, 317	< .001
Support Conditions	38.72	2, 317	< .001
Educational Outcomes	25.67	2, 317	< .001

Post hoc LSD tests revealed that schools located in county towns scored significantly higher than those in township and remote village areas across all four dimensions ($p < .01$). Moreover, statistically significant differences were also observed between township and village schools, particularly in support conditions and educational outcomes.

Independent Samples t-test: School Type Differences

An independent samples t-test was conducted to examine potential differences between primary and secondary school teachers' responses across the four dimensions. The analysis revealed no statistically significant differences ($p > .05$), indicating that school type had a limited impact on perceived mental health education management quality compared to geographic location.

Correlation Analysis

Pearson correlation analysis was performed to explore relationships between the dimensions. The analysis found a strong positive correlation between support conditions and educational outcomes ($r = .682$, $p < .001$), suggesting that better resources and infrastructure are linked to more effective mental health programs. Additionally, a significant positive correlation was observed between organizational management and implementation quality ($r = .608$, $p < .001$), highlighting the influence of institutional structure on program execution.

Supplementary Qualitative Insights

Qualitative data gathered from open-ended questionnaire responses and brief interviews with six teachers shed light on recurring challenges. Several illustrative quotes include:
"There's still no full-time counselor in our school. Psychological education is mostly left to homeroom teachers."
"Mental health lessons are scheduled but rarely delivered due to exam preparation."
"Parents in remote areas don't understand the value of counseling; they prefer discipline over dialogue."

These narratives provide context to the quantitative disparities, reflecting deeper structural constraints, cultural misunderstandings, and a general shortage of trained psychological professionals in rural schools.

Discussion

This section critically interprets the major findings presented in Chapter 4 through the lens of relevant literature and theoretical perspectives. The discussion focuses on four key themes:

(1) urban–rural disparities in mental health education management; (2) the significance of organizational and infrastructural support; (3) implications for school-based and systems-level management; and (4) teacher capacity and professional development.

Urban–Rural Disparities in Mental Health Education Management

The results demonstrated significant geographical disparities in mental health education management across the sampled schools. Schools in county towns consistently outperformed those in townships and remote villages across all four dimensions: organizational management, implementation, support conditions, and educational outcomes. This pattern is consistent with prior studies (Huang, 2024; Yang, 2024), which have indicated that urban schools benefit from stronger administrative leadership, more financial resources, and greater access to trained personnel.

From a systemic perspective, these disparities suggest that vertical policy implementation remains insufficient in rural contexts. Although national policy frameworks such as the "Special Action Plan for Student Mental Health (2023–2025)" advocate for equal development, practical implementation still favors urban centers. Structural constraints in remote areas—such as the lack of mental health personnel, facilities, and teacher training—continue to hinder program effectiveness.

Organizational and Infrastructural Support as Determinants of Effectiveness

Among the four dimensions, support conditions were found to be the most influential predictor of educational outcomes, as demonstrated by the strong positive correlation ($r = .682$, $p < .001$). The ANOVA and LSD post hoc results further confirmed that remote village schools consistently scored lowest in support conditions and outcomes. These findings reinforce the notion that infrastructural investments—such as counseling rooms, training opportunities, and mental health materials—are critical to program success (Siceloff et al., 2017).

The study also revealed deficiencies in the functional capacity of organizational units. Although most schools reported the existence of mental health committees or designated teams, qualitative insights suggested that these units are often nominal. Previous research similarly identified such units as "symbolic" or "hollow", lacking actual authority, staffing, or accountability mechanisms (Sun et al., 2022; Wang, 2022).

Implications for School-Based and Systems-Level Management

The results underscore a key limitation of decentralization in the school-based management (SBM) model: local autonomy does not guarantee effective implementation unless institutional readiness and capacity are simultaneously developed. Many rural schools lack the administrative structure, professional expertise, and community support required to sustain mental health programs (Perkins et al., 2021).

From a systems management perspective, the findings suggest the necessity of inter-sectoral collaboration. Effective mental health education cannot be achieved in isolation from local healthcare systems, family services, and civil society organizations (Organization, 2022). Coordination between educational and public health sectors is essential, especially in underserved rural regions.

Teacher Capacity and Professional Development

The shortage of professionally trained mental health educators remains a significant barrier. The study found no significant differences between primary and secondary school teachers in terms of reported practices, yet interviews revealed important qualitative distinctions. Secondary school teachers often prioritize academic content due to examination pressures, while primary school teachers tend to lack foundational knowledge in psychology and counseling (Ghaleb, 2024).

These findings point to the urgent need for professional development programs tailored to rural contexts. Incorporating mental health education into teacher certification and in-service training can enhance both awareness and instructional capacity. Moreover, incentivized participation in such programs may mitigate current deficiencies.

Contextualizing with National and International Policy

The findings are largely aligned with the goals of China's national education reform, which emphasizes equitable, prevention-oriented mental health services. However, a significant policy–practice gap persists. In contrast, international practices from countries such as Australia and the United States illustrate the benefits of integrated school-wide mental health systems that combine universal prevention, early detection, and targeted interventions (Baffsky et al., 2023; Fenwick-Smith et al., 2018).

Although direct adoption of foreign models is not feasible, these systems provide valuable insights into best practices, particularly regarding resource allocation, personnel training, and family–school collaboration. Bridging the policy–practice divide in China will require context-specific adaptations that recognize the unique challenges of rural education systems.

In sum, the discussion reinforces the argument that improving rural mental health education management in China requires a multi-faceted approach: one that addresses not only policy directives but also institutional capacity, professional training, and systemic collaboration.

Conclusion

This study offers a comprehensive evaluation of the management of mental health education in rural primary and secondary schools across Guangxi Province, China. Drawing upon a multidimensional framework encompassing organizational management, implementation practices, support conditions, and perceived educational outcomes, the research revealed systemic challenges and significant geographical disparities. Schools located in county towns consistently demonstrated stronger performance across all dimensions compared to township and remote village schools. Among the four dimensions, support conditions, which include funding, facilities, and professional staffing, proved to be the most critical determinant of effective mental health education.

Although most schools formally established organizational structures for psychological education, many lacked the institutional capacity to ensure effective implementation. The absence of significant differences between primary and secondary schools further emphasized that location and infrastructure, rather than school level, are the dominant factors influencing program quality. Strong correlations between organizational management and implementation, and between support conditions and outcomes, underscore the

systemic interdependence of these variables. However, the findings also exposed a persistent disconnect between national mental health education policies and actual practices in rural areas. Despite the intentions outlined in documents such as the "Special Action Plan for Student Mental Health (2023–2025)," the implementation of these initiatives in underdeveloped regions remains inconsistent, fragmented, and under-resourced.

To improve the effectiveness and equity of rural school-based mental health education, several practical measures are necessary. First, increased and targeted funding should be allocated for psychological service rooms, teaching materials, and trained personnel, particularly in remote areas. Tailored policy mechanisms must be introduced to address the distinct needs of economically disadvantaged schools. Second, schools need to develop functional organizational frameworks with clearly defined responsibilities and standard operating procedures to embed psychological services into day-to-day administration. Third, teacher capacity must be strengthened through pre-service training and in-service programs that focus on practical counseling skills, classroom interventions, and emotional literacy. Incentive mechanisms could be introduced to encourage participation in such training. Fourth, efforts should be made to build strong collaborations between families, schools, and local communities. Initiatives such as parental education campaigns and partnerships with local health agencies and NGOs can enhance awareness, reduce stigma, and establish referral networks. Lastly, robust systems for monitoring and feedback should be established at the township or county level, supported by student-centered tools such as psychological climate surveys and anonymous feedback channels to guide school-level decision-making.

While the study provides timely insights into a critical aspect of rural education, it is not without limitations. The findings are based solely on data from Guangxi Province and may not fully reflect the conditions of other rural regions in China. The reliance on teacher self-reports also introduces the possibility of reporting bias, and the scope of qualitative data was limited. Future research should expand the geographical scope to include broader provincial comparisons, incorporate student and parent perspectives for a more comprehensive understanding, and conduct longitudinal studies to assess the long-term impact of institutional reforms and training interventions. Additionally, the integration of digital and AI-based solutions in school-based psychological services warrants further exploration, especially in areas with limited human resources.

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