

School Mental Health Resources and Adolescent Mental Health Service Use

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Objective: Although schools are identified as critical for detecting youth mental disorders, little is known about whether the number of mental health providers and types of resources that they offer influence student mental health service use. Such information could inform the development and allocation of appropriate school-based resources to increase service use. This article examines associations of school resources with past-year mental health service use among students with 12-month *DSM-IV* mental disorders. **Method:** Data come from the U.S. National Comorbidity Survey Adolescent Supplement (NCS-A), a national survey of adolescent mental health that included 4,445 adolescent–parent pairs in 227 schools in which principals and mental health coordinators completed surveys about school resources and policies for addressing student emotional problems. Adolescents and parents completed the Composite International Diagnostic Interview and reported mental health service use across multiple sectors. Multilevel multivariate regression was used to examine associations of school mental health resources and individual-level service use. **Results:** Nearly half (45.3%) of adolescents with a 12-month *DSM-IV* disorder received past-year mental health services. Substantial variation existed in school resources. Increased school engagement in early identification was significantly associated with mental health service use for adolescents with mild/moderate mental and behavior disorders. The ratio of students to mental health providers was not associated with overall service use, but was associated with sector of service use. **Conclusions:** School mental health resources, particularly those related to early identification, may facilitate mental health service use and may influence sector of service use for youths with *DSM* disorders. *J. Am. Acad. Child Adolesc. Psychiatry*, 2013;52(5):501–510. **Key Words:** mental health, schools, services

Adolescents with psychiatric disorders are consistently underserved by the US child mental health services system.¹⁻³ Among those who do receive services, schools are the most frequent providers²⁻⁶ and are gateways to additional services, as students receiving school-based services are often subsequently seen in the specialty mental health sector.^{7,8} As such, the President's New Freedom Commission on Mental Health, the Department of Health and Human Services, and the Institute of Medicine have specifically called for schools to enhance their early identification methods,⁹⁻¹¹ recognizing that whether, and how quickly, youth with psychiatric disorders connect with services has

considerable implications for the trajectory of mental health care and subsequent psychiatric and educational outcomes.^{8,12,13}

A number of school-level factors may influence service provision for youth with psychiatric disorders. Most notably, the number of mental health service providers on-site has consistently been associated with increased mental health service contact.¹⁴⁻¹⁷ However, other school resources may be equally important as the sheer number of providers. In particular, prevention activities and school-based mental health screening may facilitate early identification and increase openness to mental health service receipt.^{18,19} Outreach to families may reduce barriers to service access.²⁰ Formal connections to community-based providers may facilitate more rapid or targeted referrals.²¹



This article is discussed in an editorial by Dr. Peter S. Jensen on page 458.

Existing studies have not examined the importance of these school-level factors in influencing receipt of mental health services and, in particular, the relative importance of number of providers as compared to the nature of the mental health resources that schools provide. The current report uses data from the National Comorbidity Survey Adolescent Supplement (NCS-A) to examine associations of school mental health resources with student use of mental health services in schools, as well as services in other sectors of the child mental health system.

METHOD

Study Sample

As described in more detail elsewhere,²²⁻²⁴ the NCS-A was carried out between 2001 and 2004 in a dual-frame (household and school) national sample of adolescents (13–17 years of age) and their parents. Only the school sample is included in the current report. School selection initially targeted 289 nationally representative schools serving middle and high school students; however, only 81 schools (28.0%) enrolled. The primary reason for refusal was a reluctance to release student information for research studies. For each school refusing to participate, replacement schools were selected that matched initial refusal schools in size, geographic area, and other demographic characteristics. Because of the low initial recruitment rate, multiple replacement schools were contacted whenever possible. The final sample included 320 schools, reflecting this expansion of recruitment. To identify whether school replacement introduced bias, NCS-A household sample respondents who were students in schools that refused to participate were compared with respondents in matched replacement schools. Analyses indicated no bias in estimates of either prevalence or treatment of disorders.²³ Because of methods used to match replacement schools, demographic characteristics were comparable to those of initially selected schools. The conditional (on school participation) adolescent response rate in the school sample was 82.6% (detailed in Kessler *et al.*²²).

One parent or surrogate (henceforth referred to as “parents”) was asked to complete a self-administered questionnaire about their adolescent’s developmental history and mental health. Parent response rate (conditional on adolescent participation) was 83.7% in the school sample. Recruitment consent procedures were approved by Human Subjects Committees of both Harvard Medical School and the University of Michigan. Cases were weighted for residual discrepancies between sample and population socio-demographic and geographic distributions. Weighted composite socio-demographic distributions closely approximated those of the US Census population (weighting procedures detailed elsewhere²²).

The principal and a mental health coordinator in each NCS-A participating school were asked to complete a survey about school resources and policies regarding student emotional problems. Mental health coordinators were selected by principals as a person most knowledgeable of school mental health policies and were typically guidance counselors (50.2%) or school administrators (20.2%). When self-report surveys could not be obtained, respondents were offered the opportunity to complete a telephone or in-person survey. Surveys were completed by both the principal and mental health coordinator in 227 schools (a response rate of 70.9%). A comparison of the 227 schools with complete survey data to the 93 schools without complete data found no significant differences in public versus private status, student-to-teacher ratio, or proportion of non-Latino white students in the school (based on data from the Quality Education Data database, <http://www.qeddata.com>). Based on NCS-A data, there were also no significant differences in the proportion of students with serious emotional disturbance or the proportion receiving either any mental health services or school-based mental health services. However, schools with complete principal and mental health coordinator data were significantly more likely to be located in rural than in major metropolitan or other urban areas.

Analyses in the current report were limited to 4,445 students with complete adolescent–parent data who attended these 227 schools. Schools were primarily public (79.0%) and were well distributed among major metropolitan (37.0%), other urban (38.0%), and rural (25.0%) areas. They had a median of 70.0% non-Hispanic white students, with an interquartile range (IQR; 25th–75th percentiles) of 9.0% to 94.0%. Median enrollment across these schools was 662.1 students (IQR = 335.5–1025.6) and median student/teacher ratio was 15.7 (IQR = 13.4–19.6).

School-Level Measures

Ratio of Students to Mental Health Providers. Principals indicated the number of Full-Time Equivalent staff (FTEs) allocated for mental health service provision, including both regular school staff and contracted providers, hired at full-time, part-time, and hourly rates. A ratio variable indicated the number of students per FTE mental health provider (student/provider ratio).

Type of School Mental Health Resources. We created six indicators of type and intensity of school mental health resources, based on principal and mental health coordinator reports. First, we coded whether each of 15 topics concerning mental health, violence, and substance use were part of the required curricula presented to students (Cronbach’s $\alpha = 0.92$). The second indicator represented the number of different prevention activities (e.g., violence prevention, substance use prevention, peer mediation) ($\alpha = 0.79$). The third represented the number of different early identification resources (e.g., identification or referral for abuse or emotional problems) ($\alpha =$

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