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Mental health and social services in schools: Variations by school characteristics—United States, 2014☆

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ABSTRACT

Schools serve as a mental health service provider for students with related disorders. This study reported on specific mental health and social services practices overall and by school demographics in U.S. schools using data from the 2014 School Health Policies and Practices Study, a cross-sectional study of a nationally representative sample of schools with any of grades kindergarten through twelve, and an extant source of school demographics. Differences in mental health and social services staffing, facilities/equipment, and services were observed across school demographics. These data will help identify service gaps, which can guide efforts to better serve students and families.

1. Introduction[1]

Mental health is an important component of overall health (World Health Organization, 2014). Good mental health helps youth succeed in school and in life (National Association of School Psychologists, 2006). When students receive socio-emotional and mental health support, they perform better academically, have improved learning, have better behavior, and feel more connected with others (National Association of School Psychologists, 2006). Poor mental health is associated with various forms of discrimination, social exclusion, unhealthy behaviors, violence, delinquency, school dropout, and physical illnesses (National Association of School Psychologists, 2006; World Health Organization, 2014). Though mental health disorders are influenced by multiple social, psychological, and biological factors, all segments of the population are affected (World Health Organization, 2014). Among youth under the age of 18, mental disorders is one the top-ranked medical conditions in terms of direct medical spending (Soni, 2014). Of the top five conditions, mental disorders had the highest average expense per child (Soni, 2014).

The prevalence of anxiety, mood, behavior, substance use, and eating disorders during the past twelve months among adolescents aged 13–17 years has been estimated to be 40.3% (Kessler et al., 2012), and approximately half of lifetime mental health conditions begin by adolescence (Kessler et al., 2007). Therefore, it is important for prevention and screening efforts related to mental health to take place before adulthood. Only 45.0% of adolescents with any psychiatric disorder during the past twelve months received services for emotional or behavioral problems during that period (Costello, He, Sampson, Kessler, & Merikangas, 2014). Unfortunately, many adolescents do not seek out or receive treatment for these issues due to multiple reasons, which may include lack of access, insurance coverage issues, lack of coordinated care, a shortage of specialized care providers, lack of stable living conditions, confidentiality issues, and fear of stigmatization (Kessler et al., 2012; Knopf, Park, & Mulye, 2008; Murphey, Barry, & Vaughn, 2013; Schwarz, 2009; Taras, 2004).

Schools are ideal settings for mental health services (National Association of School Psychologists, 2006) as the first signs of mental health issues often emerge at school (Richardson, Morrissette, & Zucker, 2012). In the United States, among adolescents aged 13–17 years with a DSM-IV disorder in the past twelve months who receive any mental health services, more than half obtain their services in schools (Green et al., 2013). The American Academy of Pediatrics recommends that schools have a multidisciplinary student support team to assist students identified with a mental health problem (Taras, 2004). School-based programs can identify students with or at-risk for mental health issues, refer them for appropriate assessments and interventions, and monitor and manage students' mental health needs (Taras et al., 2004). These programs have the benefits of reaching a

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[1] SHPPS: School Health Policies and Practices Study. MDR: Market Data Retrieval. AAP: American Academy of Pediatrics.

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large number of adolescents, since students spend a substantial proportion of their waking hours in school, and providing services to groups that may traditionally have problems with accessing care (Murphey et al., 2013).

Little is known about the extent to which practices related to school mental health and social services are in place in schools nationwide and how these practices vary by school characteristics. Data such as these can be helpful in determining which types of schools have gaps in regards to their mental health and social services for students and can assist with future planning of resource allocation. This can help ensure that all students have access to school programs that support their appropriate and effective mental health care. Previous studies utilizing data from the School Health Policies and Practices Study (SHPPS) have examined the association between school health policies and practices by school demographic characteristics (Balaji, Brener, & McManus, 2010; Brener, Everett Jones, Kann, & McManus, 2003). Brener et al. (2003) found that at least one of the mental health and social services variables included in their analysis differed by school type, school size, percentage of white students, and urbanicity. Balaji et al. (2010) found that at least one of the mental health and social services variables included in their study (differed by school type, school size, discretionary dollars per pupil, and percentage of students qualifying for free-lunch funds. These manuscripts reported on various components of school health and did not focus specifically on mental health and social services. A recent manuscript using SHPPS 2012 data reported district-level demographic differences in school mental health and social services policies and found several significant associations (Demissie & Brener, In press). That study examined 13 school mental health and social services policies and found many associations with region, metropolitan status, and district affluence, but few associations with percentage of students receiving free or reduced-priced lunch and majority minority status (based on percentage of non-Caucasian students). More recent mental health and social services data are available from SHPPS 2014, which report school-level practices rather than district-level policies (Centers for Disease Control & Prevention, 2015). This analysis expands upon these earlier SHPPS publications as it uses the latest school-level data and provides a detailed look at school mental and social services staffing characteristics, facilities and equipment, and specific services. It examines how these practices vary by school type, size, level, and affluence.

2. Materials and methods

2.1. Participants and procedures

SHPPS is a national survey periodically conducted since 1994 to assess school health policies and practices for ten components of school health. Data are collected from some combination of states, districts, schools, and classrooms depending on the administration year. During February–June 2014, SHPPS collected data on mental health and social services among a nationally representative sample of schools with any of grades kindergarten (first year of primary education) through twelve (final year of secondary education) using computer-assisted personal interviewing or paper questionnaires. The SHPPS 2014 questionnaires can be obtained at www.cdc.gov/shpps. After relevant permissions were obtained when necessary, schools were contacted and the principal or other school contact identified the most knowledgeable respondent for each questionnaire and module. Overall, of 828 eligible schools, 76% (n=631) completed at least one module across the questionnaires. This analysis examined data from the school-level Mental Health and Social Services questionnaire. For this questionnaire, of 807 eligible schools, 68% (n=545) completed this questionnaire. The SHPPS 2014 data were weighted to produce national estimates; base weights were determined by selection probability and then adjusted for nonresponse to produce final weights. A detailed description of the SHPPS 2014 methods has been published previously (Centers for Disease Control & Prevention, 2015). SHPPS data were linked with extant data on school characteristics from the Market Data Retrieval (MDR) database. Data included in the MDR database are collected annually; the database contains a range of information about individual U.S. schools (Market Data Retrieval, 2013).

2.2. Mental health and social services measures

This analysis examined data on 18 school mental health and social services practices related to staffing characteristics, facilities and equipment, and provision of mental health and social services. These practices are described below. The questionnaire used to assess these practices is available at http://www.cdc.gov/healthyyouth/data/shpps/questionnaires.htm.

2.3. Staffing characteristics

The SHPPS 2014 questionnaire asked respondents about standard mental health and social services, defined as services available to all students at school. Questions about staffing for standard mental health and social services at the school referred to both contracted providers and regular school staff. Respondents were asked if they had part-time or full-time school staff who provide standard mental health or social services to students at their school. Three types of staff were assessed: school counselor, school psychologist, and school social worker. Respondents were also asked how many of these staff provided standard mental health or social services to students at their school and how many hours per week, during the past 30 days, each staff person spent at their school on average. For each staff type, these two variables were combined to calculate individual staff hours/week (counselor, psychologist, and social worker). This variable was examined in two different ways: continuously and dichotomized at 30 h/week (representing full-time: six hours per day x five school days).

2.4. Facilities and equipment

Questions were also included about facilities and equipment that might be available for school mental health or social services staff to use at school. Respondents were asked if their school had: (1) a private room for counseling students, (2) a dedicated phone line for standard mental health or social services staff, (3) an answering machine or voice mail reserved for standard mental health or social services staff, and (4) locked storage space for files related to the standard mental health or social services provided to students. Response options for these questions were yes and no. In addition, respondents were asked "Where in relation to your school's main office is the primary location where students go to obtain standard mental health or social services?" Response options included within the same office suite as the main office, within view of the main office, or not within view of the main office. The response of interest was not within view of the main office.

2.5. Provision of mental health and social services

Respondents were asked to report activities of mental health or social services staff such as school counselors, psychologists, and social workers. They were instructed to not include activities by teachers in the classroom or activities by nurses or physicians. Seven services were assessed: (1) case management for students with emotional or behavioral problems, (2) family counseling, (3) group counseling, (4) individual counseling, (5) comprehensive assessment or intake evaluation, (6) peer counseling or mediation, and (7) self-help or support groups. The response options were yes and no.