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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.

Keywords

Schools; Mental Health; Demographic Factors

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 (World Health Organization, 2014; National Association of School Psychologists, 2006). 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

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Disclaimer: The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention or the U.S. Public Health Service Commissioned Corps.

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

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 (Schwarz, 2009; Knopf, Park, & Mulye, 2008; Murphey, Barry, & Vaughn, 2013; Kessler et al., 2012; American Academy of Pediatrics [AAP], 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 (AAP, 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 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 (Brener, Everett Jones, Kann, & McManus, 2003; Balaji, Brener, & McManus, 2010). 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 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 and 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 and 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 hours/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.

2.6 School demographic measures

The MDR database collects school enrollment data. These data were used to categorize schools into small, medium, and large size. This was determined by calculating the tertiles by school level. For example, for elementary schools, the school enrollment values associated with the tertiles were calculated and then these values were used to categorize schools into the small, medium, and large groups. The same was done separately for middle and high schools. The MDR database categorizes schools into four different types:

public, state-administered, Catholic, and other private. For this analysis, public and state-administered schools were combined into one category and Catholic and other private schools were combined. The MDR database includes an affluence indicator that assesses school-level socioeconomic status based on a proprietary algorithm incorporating data points ranging from MDR-specific variables to Census data. The original variable categorized affluence into five levels: low, below average, average, above average, and high. For this analysis, we re-categorized this variable into three levels: low/below average, average, and above average/high.

2.7 Statistical analysis

This analysis includes reports of the prevalence or mean of specific school health practices related to mental health and differences in estimates by school demographics. All analyses were conducted using weighted data and with SUDAAN statistical software which accounts for the complex sampling design at the school level. Chi-square analysis was used to examine whether there was an association between these school-level practices and school-level demographic characteristics. When a significant Chi-square was found ($p < .05$) for variables with 3 or more categories, pairwise testing was performed to determine differences between individual categories.

3. Results

3.1 Overall school findings

Table 1 presents the percentage of schools with staffing characteristics, facilities and equipment, and specific services related to mental health and social services. Staffing and time spent providing services among mental health and social services staff was higher for school counselors than for school psychologists and social workers. More than 50% of schools provided the facilities and equipment included in this analysis; more than 90% of schools provided a private room for counseling students and locked storage. The provision of specific services varied widely, from approximately 40% to over 90%. Individual counseling was the most common service schools provided.

3.2 Differences by school type

Differences in the percentage of schools reporting specific practices related to mental health and social services by school type are presented in Table 2. Public and state-administered schools were more likely than Catholic or private schools to have a school counselor (83.6% vs. 62.2%, p=.005), school psychologist (67.7% vs. 20.6%, p<.001), and school social worker (53.3% vs. 17.5%, p<.001). However, only school counselor hours/week significantly differed by school type, with public and state-administered schools having a higher percentage than Catholic or private schools (80.0% vs. 58.1%, p=.04). Public and state-administered schools were more likely than Catholic or private schools to have a private room for counseling students (95.2% vs. 84.8%, p=.04), a dedicated phone line for standard mental health or social services staff (69.3% vs. 36.8%, p<.001), and an answering machine or voice mail reserved for standard mental health or social services (70.7% vs. 40.7%, p<.001). Public and state-administered schools were significantly more likely than

Catholic or private schools to provide all mental health and social services except family counseling.

3.3 Differences by school size

Differences in the percentage of schools reporting specific practices related to mental health and social services by school size are presented in Table 3. Differences in the availability of a school counselor and a school psychologist were observed by school size. Large schools were more likely to have school counselors (95.0%) than were both medium (75.0%) and small (66.0%) schools. Small schools were less likely to have school psychologists (42.4%) than were both medium (65.5%) and large (67.9%) schools. Significant differences in hours/week by school size were observed only for school counselors; small schools were less likely than both medium and large schools to provide at least 30 counselor hours/week (small: 42.0%, medium: 81.9%, large: 87.4%). Significant differences were observed by school size for all facilities and equipment variables examined except having a service room not within view of the main office. In all of these cases, small schools were less likely than both medium and large schools to provide these facilities and equipment. Significant differences were observed by school size for all specific mental health and social services except family counseling. For case management, small schools were less likely to provide this service (69.9%) than were both medium (88.3%) and large (86.9%) schools. For group and individual counseling and self-help or support groups, all school sizes differed from each other significantly. In these cases, the percentage of schools providing these services increased as school size increased. For comprehensive assessment or intake evaluation and peer counseling or mediation, small schools were less likely to provide these services than large schools (58.4% vs. 78.0% and 58.1% vs. 77.0%, respectively).

3.4 Differences by school level

Differences in the percentage of schools reporting specific practices related to mental health and social services by school level are presented in Table 4. Elementary schools were less likely than both middle and high schools to have a school counselor (72.6% elementary, 82.1% middle, 88.3% high). All staff hours/week differed significantly by school level. For school counselors, all school levels significantly differed from each other (elementary: 65.6%, middle: 77.8%, high: 94.6%). For school psychologists and school social workers, high schools were more likely than elementary and middle schools to have this staffing for at least 30 hours/week. High schools were significantly more likely to have a private room for counseling students as compared to middle and elementary schools (98.3% high, 89.4% middle, 92.3% elementary). These same differences were observed for the percentage of schools having an answering machine or voice mail reserved for standard mental health or social services (75.2% high, 61.1% middle, 60.5% elementary). No significant differences were identified in specific mental health and social services by school level.

3.5 Differences by affluence

Differences in the percentage of schools reporting specific practices related to mental health and social services by affluence level are presented in Table 5. Only two significant findings were observed. Schools of low/below average affluence were less likely than schools of average and above average/high affluence to provide at least 30 school psychologist

hours/week (low/below average: 11.9%, medium: 26.9%, large: 31.7%). Schools of average affluence were significantly more likely than schools of above average/high affluence to provide family counseling (50.5% vs. 34.0%).

4. Discussion

School mental health staff are specially trained in not only mental health, but in the functioning of school systems and learning (Cowan, Vaillancourt, Rossen & Pollitt, 2013; American Counseling Association, American School Counselor Association, National Association of School Psychologists, & School Social Work Association of America, 2006). These professionals are essential to providing high quality and effective services that are appropriate to the school context (Cowan et al., 2013). While most schools that provide mental health services have at least one professional who provides services to students (Foster et al., 2005), an interdisciplinary mental health staff is useful as different professionals provide individual skills that complement one another (Cowan et al., 2013). More than three fourths of schools in the current study had a school counselor on staff, but only approximately half had a school psychologist or school social worker. This may suggest that many schools do not have adequate, interdisciplinary staff available to provide mental health and social services to students. Adequate staffing allows for schools to conduct an assessment of needs and provide a range of services, and allows for adequate staff time for planning and problem solving (Cowan et al., 2013). Establishing policies can help support schools in their efforts to improve their unmet needs in staffing, and identifying disparities in school resources can help determine priorities.

Schools provide an ideal setting for these services as they eliminate many barriers to access to care (American Academy of Pediatrics & Council on School Health, 2004; Murphey et al., 2013; Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007). This study found that there was variation in the facilities and equipment that schools provide. The majority of schools, regardless of demographics, provide a locked storage space for files related to the standard mental health or social services provided to students. This is one critical aspect of maintaining student privacy and confidentiality (Taras et al., 2004). While the majority of schools, regardless of demographic characteristics, provide a private room for counseling students, in only approximately half of schools, the primary location where students go to obtain standard mental health or social services is not within view of the main office. Since seeking mental health services can be stigmatizing, it is important for schools to provide a private and comfortable physical space for these services (American Academy of Pediatrics & Council on School Health, 2004). Schools can further protect students' privacy by locating service areas not within view of the main office, a location where school administrators, other school staff, and students may gather.

The AAP Council on School Health recommends screening and early intervention of at-risk students and families (American Academy of Pediatrics & Council on School Health, 2004). The school sector is a leading provider of services for children with mental health needs (Green et al, 2013). Schools can provide a variety of services, such as group, individual, and family counseling, to best meet the needs of the students and their families (American Academy of Pediatrics & Council on School Health, 2004; Cowan et al., 2013; Kindall,

2009). At least three quarters of schools provided case management, individual counseling, and group counseling. Fewer schools provided other services. To better support students, schools can provide a wider complement of service options as the best service option may vary by student, situation, and particular mental health or social services issue. However, it is important to note that schools cannot address student mental health alone. School mental health professionals can link students and families with community services to provide a continuum of mental health care (National Association of School Psychologists, 2006).

In this study, at least one disparity in staffing was observed across all school demographics. However, the significant differences were not uniform across demographics. Differences in facilities and equipment were observed by all school demographics except affluence. While there were no differences in the provision of services by school level, all services other than family counseling differed by school type (public/State-administered schools > Catholic/private schools) and size (lowest percentages observed among small schools). In contrast, family counseling did differ by affluence level. Differences by school type may be influenced by differences in the funding models of public vs. Catholic schools (Frabutt, Clark, & Speech, 2011). In Catholic and other private schools, administrators and other stakeholders must turn to development, institutional advancement, fundraising, and benefaction to meet needed funding levels; student support and mental health services are considered non-essential add-ons (Frabutt et al., 2011). Differences by school size may also be related to funding levels, but also could be attributed to differences in service need and the variety of mental health and social services presented at school. The frequency of various mental health problems differs by school level (Foster et al., 2005). Further, literature suggests that behavioral problems may be more serious as school level increases (Weist et al., 2000). This may help explain differences in the mental health and social services available in schools by level. It is interesting that while several demographic differences were observed for school type, size, and level, only two significant differences were observed by affluence. Further, these differences were not in the same direction. This findings may contradict arguments that 1) more affluent schools have more of these practices in place because they can afford them and 2) less affluent schools have more of these practices in place because they need them since their students are at disproportionate risk.

Little research is available regarding how practices related to school mental health and social services differ by school demographics. Two studies using previous cycles of SHPPS data have examined differences in mental and social services practices by school demographics (Balaji et al., 2010; Brener et al., 2003). Though these studies examined different variables, both studies found that larger schools were more likely than smaller schools to have mental health and social services staff and found that public schools were more likely than either Catholic and other private schools to have such staff (Balaji et al., 2010; Brener et al., 2003). A study of U.S. elementary and secondary schools also indicated that public schools had better staffing for mental health staffing as compared to Catholic schools, but statistical comparison testing results were not provided (Frabutt et al., 2011). This is comparable with the findings for school type (section 3.2); for more than half of the staffing variables, public or State-administered schools were more likely to provide specific staffing as compared to Catholic or private schools. A report using data from a nationally representative sample of public elementary, middle, and high schools in the United States further indicated that

the type of staff in schools varied somewhat by school level, but also did not provide statistical comparison testing (Foster et al., 2005). This is in line with the findings for school level (section 3.4); for more than half of the staffing variables, significant differences were observed by school level. No previous studies were identified that compared facilities and equipment for mental health and social services. Two studies reported about demographic differences in the availability of mental health and social services. Frabutt et al (2011) found that public schools were more likely to provide all mental health services studied as compared to Catholic schools, but statistical comparison testing results were not provided. This is in line with the findings for school type (section 3.2); all services except family counseling differed by school type. Data from a 1994–1995 study of schools in the U.S. found that the availability of mental health counseling did not differ by school size (Slade, 2003). This differs from the findings for school size (section 3.3) as significant differences were observed by school size for all mental health and social services except family counseling.

4.1 Limitations

The results of this study should be evaluated in the context of its limitations. First, these data are based on self-report; therefore, the data rely on knowledge of the respondents and their interpretation of existing practices, and over- and under-reporting is possible. Second, this was the first SHPPS cycle in which there was no simultaneous data collection in states and school districts, which limits the types of analyses that could be performed. SHPPS is also limited in its ability to provide data on the quality of practices measured. Third, some of the school demographics were associated with each other, but this could not be controlled for in this analysis. Lastly, SHPPS 2014 is not designed to determine why demographic differences in school mental health and social services practices exist.

5. Conclusions

SHPPS 2014 results help describe the extent to which the nation’s schools are providing services that support students’ mental health. The data show that schools vary in their ability to provide mental health and social services to students and in the facilities and equipment available to them for the provision of these services. Individual schools can use these study results to assess how they compare to other schools with similar characteristics. This school-level data can help identify not only strengths but service gaps, which can guide efforts to better serve students and their families. The results can help schools determine what additional assistance may be needed to further develop their mental health and social services programs. Specifically, schools can worth with districts and states to help establish policies and seek resources for improving the availability of school-based mental health and social services. Further, they can work with families and others involved in supporting students to strengthen areas in need of improvement. At the national level, these results can be used to help target resources and technical assistance efforts.

School policies and community support for mental health and social services can help students receive appropriate, complete, and effective care. Future research that includes examinations of the intensity and quality of mental health services, unmet needs in schools,

and barriers to provision of services can determine the most effective ways for schools to address the mental health and social services needs of their students.

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Table 1

Weighted prevalence of mental health and social services staffing characteristics, facilities and equipment, and specific services—School Health Policies and Practices Study, 2014.

Policy/Requirement	% or mean
Staffing characteristics	
Part-time/full-time school counselor	78.5
Part-time/full-time school psychologist	56.2
Part-time/full-time school social worker	45.3
30+ school counselor hours/week	75.9
30+ school psychologist hours/week	24.9
30+ school social worker hours/week	35.5
School counselor hours/week (mean)	51.3
School counselor hours/week (mean)	19.2
School social worker hours/week (mean)	23.8
Facilities and equipment	
Private room	92.8
Dedicated phone line	61.7
Answering machine or voice mail	63.8
Locked storage	90.4
Service room not within view of main office	55.7
Specific services	
Case management	81.9
Family counseling	41.8
Group counseling	75.8
Individual counseling	91.4
Comprehensive assessment or intake evaluation	66.5
Peer counseling or mediation	69.6
Self-help or support groups	52.4

Table 2

Differences in school mental health and social services practices by school type —School Health Policies and Practices Study, 2014.

	Public/State	Catholic/Private	Chi-square (p-value)	P-value
Staffing characteristics				
Part-time/full-time school counselor	83.6	62.2	8.2	.005
Part-time/full-time school psychologist	67.7	20.6	25.8	<.001
Part-time/full-time school social worker	53.3	17.5	24.9	<.001
30+ school counselor hours/week	80.0	58.1	4.1	.04
30+ school psychologist hours/week	24.7	27.8	0.0	.84
30+ school social worker hours/week	35.4	35.7	0.0	.98
Facilities and equipment				
Private room	95.2	84.8	4.3	.04
Dedicated phone line	69.3	36.8	19.5	<.001
Answering machine or voice mail	70.7	40.7	13.5	<.001
Locked storage	92.6	83.0	3.1	.08
Service room not within view of main office	54.6	59.8	0.5	.47
Specific services				
Case management	88.8	58.9	15.0	<.001
Family counseling	44.7	32.4	3.2	.08
Group counseling	84.3	48.1	18.9	<.001
Individual counseling	96.7	73.8	10.9	.001
Comprehensive assessment or intake evaluation	74.2	41.0	18.1	<.001
Peer counseling or mediation	74.8	52.2	10.3	.002
Self-help or support groups	59.2	30.0	19.1	<.001

Table 3

Differences in school mental health and social services practices by school size —School Health Policies and Practices Study, 2014.

	Small	Medium	Large	Chi-square	P-value
Staffing characteristics					
Part-time/full-time school counselor[ab]	66.0	75.0	95.0	10.6	<.001
Part-time/full-time school psychologist[ac]	42.4	65.5	67.9	6.3	.002
Part-time/full-time school social worker	34.8	50.8	46.4	2.5	.08
30+ school counselor hours/week[ac]	42.0	81.9	87.4	11.7	<.001
30+ school psychologist hours/week	16.9	23.1	23.2	0.4	.66
30+ school social worker hours/week	31.3	32.6	27.3	0.1	.90
Facilities and equipment					
Private room[ac]	84.3	94.2	97.9	5.0	.008
Dedicated phone line[ac]	44.7	66.6	70.5	5.4	.005
Answering machine or voice mail[ac]	45.6	66.0	76.7	7.0	.001
Locked storage[ac]	79.3	94.8	97.1	6.8	.002
Service room not within view of main office	62.7	51.7	49.0	1.7	.18
Specific services					
Case management[ac]	69.9	88.3	86.9	4.7	.01
Family counseling	36.4	43.3	39.3	0.6	.54
Group counseling[abc]	62.6	81.7	90.9	7.8	.001
Individual counseling[abc]	81.5	94.0	99.2	7.6	.001
Comprehensive assessment or intake evaluation[a]	58.4	68.5	78.0	3.2	.04
Peer counseling or mediation[a]	58.1	70.6	77.0	3.3	.04
Self-help or support groups[abc]	34.3	54.6	76.7	11.9	<.001

[a]Significant difference between small and large sized schools.

[b]Significant difference between medium and large sized schools.

[c]Significant difference between small and medium sized schools.

Table 4

Differences in school mental health and social services practices by school level —School Health Policies and Practices Study, 2014.

	Elementary	Middle	High	Chi-square	P-value
Staffing characteristics					
Part-time/full-time school counselor[ab]	72.6	82.1	88.3	5.3	.006
Part-time/full-time school psychologist	58.1	56.9	50.6	1.0	.38
Part-time/full-time school social worker	45.9	42.0	48.1	0.7	.52
30+ school counselor hours/week[abc]	65.6	77.8	94.6	15.6	<.001
30+ school psychologist hours/week[bc]	20.8	22.5	40.0	3.9	.02
30+ school social worker hours/week[bc]	29.4	33.6	52.4	3.8	.03
Facilities and equipment					
Private room[bc]	92.3	89.4	98.3	5.7	.004
Dedicated phone line	59.4	59.7	70.3	2.3	.11
Answering machine or voice mail[bc]	60.5	61.1	75.2	4.4	.01
Locked storage	89.1	89.7	94.6	1.8	.17
Service room not within view of main office	59.1	47.0	58.5	2.7	.07
Specific services					
Case management	82.2	79.8	83.9	0.4	.67
Family counseling	38.2	43.7	48.5	1.5	.22
Group counseling	79.1	71.4	73.7	1.3	.27
Individual counseling	90.9	89.5	95.1	1.7	.18
Comprehensive assessment or intake evaluation	69.0	62.9	65.0	0.7	.49
Peer counseling or mediation	67.8	66.8	77.8	2.7	.07
Self-help or support groups	49.5	54.2	57.3	0.9	.41

[a]Significant difference between elementary and middle schools.

[b]Significant difference between elementary and high schools.

[c]Significant difference between middle and high schools.

Table 5

Differences in school mental health and social services practices by affluence —School Health Policies and Practices Study, 2014.

	Low/Below Average	Average	Above Average/High	Chi-square	P-value
Staffing characteristics					
Part-time/full-time school counselor	85.6	79.0	70.5	3.0	.05
Part-time/full-time school psychologist	55.2	61.7	55.5	0.4	.67
Part-time/full-time school social worker	47.3	39.0	47.5	0.7	.48
30+ school counselor hours/week	74.4	73.0	78.6	0.3	.72
30+ school psychologist hours/week[ab]	11.9	26.9	31.7	5.1	.007
30+ school social worker hours/week	31.2	44.0	34.9	0.6	.57
Facilities and equipment					
Private room	94.1	93.4	91.1	0.4	.70
Dedicated phone line	62.7	58.3	64.0	0.4	.70
Answering machine or voice mail	63.1	61.8	66.5	0.2	.79
Locked storage	90.2	92.7	89.3	0.4	.70
Service room not within view of main office	50.8	50.2	61.4	2.0	.14
Specific services					
Case management	81.7	88.2	79.5	1.5	.24
Family counseling[c]	43.6	50.5	34.0	3.1	.05
Group counseling	76.1	77.7	75.5	0.1	.95
Individual counseling	91.9	94.7	88.6	1.1	.33
Comprehensive assessment or intake evaluation	67.1	66.3	66.7	0.0	.99
Peer counseling or mediation	68.0	71.7	68.9	0.1	.87
Self-help or support groups	50.7	56.9	53.2	0.4	.67

[a]Significant difference between low/below average and average affluence schools.

[b]Significant difference between low/below average and above average/high affluence schools.

[c]Significant difference between average and above average/high affluence schools.