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Counseling, Psychological, and Social Services Staffing: Policies in U.S. School Districts

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Abstract

Introduction: Schools are in a unique position to meet the mental and behavioral health needs of children and adolescents because approximately 95% of young people aged 7–17 years attend school. Little is known, however, about policies related to counseling, psychological, and social services staffing in school districts. This study analyzed the prevalence of such policies in public school districts in the U.S.

Methods: Data from four cycles (2000, 2006, 2012, and 2016) of the School Health Policies and Practices Study, a national survey periodically conducted to assess policies and practices for ten components of school health, were analyzed in 2017. The survey collected data related to counseling, psychological, and social services among nationally representative samples of school districts using online or mailed questionnaires. Sampled districts identified respondents responsible for or most knowledgeable about the content of each questionnaire.

Results: The percentage of districts with a district-level counseling, psychological, and social services coordinator increased significantly from 62.6% in 2000 to 79.5% in 2016. In 2016, 56.3% of districts required each school to have someone to coordinate counseling, psychological, and social services at the school. Fewer districts required schools at each level to have a specified ratio of counselors to students (16.2% for elementary schools, 16.8% for middle schools, and 19.8% for high schools), and the percentage of districts with these requirements has decreased significantly since 2012.

Conclusions: Increases in the prevalence of district-level staffing policies could help increase the quantity and quality of counseling, psychological, and social services staff in schools nationwide, which in turn could improve mental and behavioral health outcomes for students.

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INTRODUCTION

Among youth, mental disorders can lead to negative behavioral, educational, and health outcomes.^{1,2} A nationally representative study of adolescents aged 13–18 years showed that approximately 50% have experienced at least one DSM-IV mental disorder (including anxiety, mood, behavioral, substance use, and other disorders) during their lifetime and 22% of these adolescents had disorders with severe impairment or distress.³ Adolescence is a critical time for prevention, screening, and intervention of such disorders because approximately half of lifetime mental and behavioral health conditions begin by adolescence.⁴

Though there are effective preventive and treatment interventions for mental and behavioral disorders,^{5–7} few adolescents access them. Only 45% of adolescents with any mental, emotional, or behavioral disorder during the past 12 months received services for these problems during that period.⁸ Because approximately 95% of youth aged 7–17 years attend school,⁹ schools are in a unique position to meet the mental and behavioral health needs of children and adolescents. Among U.S. adolescents aged 13–17 years with a DSM-IV disorder in the past 12 months who receive mental health services, more than half obtain services at school.¹⁰ For many disorders, use of school mental and behavioral health services also is associated with increased use of community-based services (e.g., community mental health centers).¹¹ To ensure that students have access to school mental and behavioral health services, which might include counseling, psychological, and social services (CPSS), schools must be appropriately staffed to provide these services. One way to ensure this is to enact relevant policies at the district level. Little is known, however, about policies related to CPSS staffing in school districts. This study examines the prevalence of such policies in the U.S.

METHODS

Study Sample

Data were obtained from four cycles (2000, 2006, 2012, and 2016) of the School Health Policies and Practices Study (SHPPS), a national survey periodically conducted to assess policies and practices for ten components of school health. During each cycle, SHPPS collected data related to CPSS among a nationally representative sample of school districts using online or mailed questionnaires. Sampled districts identified respondents who were responsible for or most knowledgeable about the content of each questionnaire. Detailed information about SHPPS methods has been published previously.¹²

Measures

In 2016, questionnaire respondents were asked what entity employs CPSS staff. Questions related to school staffing policies and practices in multiple years are listed in Table 1. Sample sizes ranged from 445 to 684; response rates ranged from 63% to 70%. Results were

linked with the Market Data Retrieval education database (<http://schooldata.com/education-database/#k12>) to obtain data on district-level characteristics.

Statistical Analysis

All analyses were conducted in 2017 with data weighted to produce national estimates using SAS, version 9.3, and SUDAAN, version 11.0.1, software to account for the sampling design. Prevalence estimates and 95% CIs were computed for the variables measured only in 2016. Secular trend analyses took into account all years of available data and were performed using logistic regression analysis to determine whether changes over time were statistically significant. Analyses of the two variables with data for 2000–2016 controlled for district region, metropolitan status, percentage of white students, and affluence. Analyses of the three variables assessed only in 2012 and 2016 controlled for these same variables plus the percentage of students receiving free or reduced-price lunch (this variable was not available in 2000). Changes are reported if $p < 0.05$.

RESULTS

In 2016, school CPSS staff were employed by the school district in 89.4% (95% CI=86.3%, 91.8%) of districts; by schools in 25.3% (95% CI=21.6%, 29.4%); by local mental health and social services agencies in 19.9% (95% CI=16.5%, 23.8%); and by some other organization or agency in 20.9% (95% CI=17.4%, 24.8%). The prevalence of specific staffing policies and practices among districts between 2000 and 2016 is shown in Table 1, although not all questions were asked in all survey years. Controlling for district-level characteristics, the percentage of districts that had someone to oversee and coordinate CPSS in the district increased significantly between 2000 and 2016, from 62.6% to 79.5%. The percentage of districts requiring schools to have a CPSS coordinator also increased significantly during this same time period, from 40.8% to 56.3%, although the percentage of districts requiring school coordinators was lower in each survey year than the percentage with district-level coordinators.

In 2016, <20% of districts required schools at the elementary, middle, or high school level to have a specified ratio of counselors to students, and the percentage of districts that required a specific ratio for each school level decreased significantly between 2012 and 2016.

DISCUSSION

It is encouraging that the majority of districts have CPSS coordinators and require schools to have school-level coordinators, as coordination can have an impact on quality and delivery of mental and behavioral health services. CPSS coordinators can coordinate various providers within and outside of schools (such as other healthcare or social service agencies) to ensure that student needs are met.² Coordination of services can also result in a clear mission, goals, and objectives that promote the integration of procedures and programs.¹³ The finding that CPSS staff are usually employed by the district underscores the importance of district-level coordination. District-level coordinators can determine how best to assign CPSS staff to individual schools within their district. At the school level, integration of services within the larger school environment can help ensure resources, such as provision of

confidential space for providing services, and help minimize lost class time for students seeking services.² Coordination of mental health and educational professionals in schools is a method for enhancing the provision of services to address students' social, emotional, and behavioral health needs.¹⁴ School and district officials have indicated that coordination and close working relationships, support from mental health program advocates and school leadership, and resources are factors that can affect school mental and behavioral health services.¹⁴

A Framework for Safe and Successful Schools makes six policy recommendations for schools to support effective school safety, one of which is to "improve staffing ratios to allow for the delivery of a full range of services and effective school-community partnerships."¹⁵ Key personnel listed are school counselors, school psychologists, school social workers, and school nurses.¹⁵ School professional associations (e.g., American School Counselors Association, National Association of School Psychologists, and School Social Work Association of America) recommend specific staffing ratios in schools.^{16–18} SHPPS, however, only collects data on school counselor staffing ratios. The American School Counselors Association recommends a counselor-to-student ratio of 1:250.¹⁶ Although schools might have adequate counselor-to-student ratios without a district-level requirement, such requirements are one avenue to ensuring sufficient staffing in schools. Indeed, youth are more likely to receive counseling if their state directly subsidizes counselors or even simply recommends a minimum counselor-per-student ratio.¹⁹ Therefore, the low percentage of districts with ratio requirements (less than 20%) is of concern. When staffing in schools is not adequate, higher caseloads result, stretching school counselors thin and diverting attention away from mental health, considering the multiple responsibilities that school counselors have.²⁰ School and school district officials have also reported that staffing difficulties have affected the implementation of school mental and behavioral health services.¹⁴ Between 1995–1998 and 2007–2010, outpatient visits to physicians resulting in mental and behavioral disorder diagnoses per 100 population increased significantly for youths.²¹ This indicates an increasing demand for mental and behavioral health services. Consequently, ensuring proper staffing may become more important in the future, which makes the observed decrease in the percentage of districts requiring specified counselor-to-student ratios concerning.

In addition to documenting the prevalence of district policies related to staffing, it is important to understand how such policies are associated with district demographic characteristics. A previous study using SHPPS 2012 data examined the association between district-level policies related to staffing, staff qualifications, and provision of services and district geographic region, metropolitan status, affluence, percentage of students receiving free or reduced-price lunch, and percentage of nonwhite students. Policies varied by numerous characteristics, but region was the only variable to be associated with the majority of policies.²² For example, Southern districts had higher odds of requiring schools to have a specified counselor-to-student ratio as compared with Northeastern districts, whereas Northeastern districts had higher odds of requiring educational and credentialing requirements for school CPSS staff compared with other regions.²²

Limitations

This study has several limitations. First, district-level policies are not a direct measure of school-level practices. Second, these data do not measure the quality and enforcement of district-level policies, only whether such policies exist. Third, these data are self-reported; therefore, results rely on knowledge of the respondents and their interpretation of policies. Finally, although trend analyses controlled for available district-level characteristics, it is not known whether other variables might explain these trends.

CONCLUSIONS

The provision of school CPSS can improve early identification of students with issues and address some of the barriers that impede adolescents from receiving treatment for their mental and behavioral disorders.^{2,23} Increases in the prevalence of district-level staffing policies could help increase the quantity and quality of CPSS staff in schools nationwide, which in turn could improve mental and behavioral health outcomes for students.

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Brener and Demissie developed the study concept and design; acquisition, analysis, or interpretation of data; drafted the manuscript; and provided critical revision of the manuscript for important intellectual content. Brener provided administrative, technical, or material support, and study supervision.

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REFERENCES

1. American Academy of Child and Adolescent Psychiatry. Cost effectiveness of prevention and early intervention. www.aacap.org/App_Themes/AACAP/docs/Advocacy/policy_resources/Cost_Effectiveness_Fact_Sheet_2011.pdf. Published 2011. Accessed June 14, 2017.
2. AAP Committee on School Health. School-based mental health services. *Pediatrics*. 2004;113(6):1839–1845. 10.1542/peds.113.6.1839. [PubMed: 15173522]
3. Merikangas KR, He J, Burstein M. Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication-Adolescent Supplement (NCS-A). *J Am Acad Child Adolesc Psychiatry*. 2010;49(10):980–989. 10.1016/j.jaac.2010.05.017. [PubMed: 20855043]
4. Kessler RC, Amminger GP, Aguilar-Gaxiola S, Alonso J, Lee S, Ustun TB. Age of onset of mental disorders: a review of recent literature. *Curr Opin Psychiatry*. 2007;20(4):359–364. 10.1097/YCO.0b013e32816ebc8c. [PubMed: 17551351]
5. Hunsley J, Elliott K, Therrien Z. The efficacy and effectiveness of psychological treatments. Ottawa, Ontario: Canadian Psychological Association www.cpa.ca/docs/File/Practice/TheEfficacyAndEffectivenessOfPsychologicalTreatments_web.pdf. Published 2013. Accessed June 14, 2017.
6. National Research Council, Institute of Medicine. Preventing mental, emotional, and behavioral disorders among young people: progress and possibilities. Washington, DC: National Academies Press, 2009 10.17226/12480.

7. The Australian Psychological Society. Evidence-based psychological interventions in the treatment of mental disorders: a literature review. Third edition. www.psychology.org.au/Assets/Files/Evidence-Based-Psychological-Interventions.pdf. Published 2010. Accessed June 14, 2017.
8. Costello EJ, He J, Sampson NA, Kessler RC, Merikangas KR. Services for adolescent psychiatric disorders: 12-month data from the National Comorbidity Survey-Adolescent. *Psychiatr Serv*. 2014;65(3):359–366. 10.1176/appi.ps.201100518. [PubMed: 24233052]
9. Snyder TD, de Brey C, Dillow SA. Digest of Education Statistics 2015 (NCES 2016–014). Washington, DC: U.S. Department of Education, National Center for Education Statistics, Institute of Education Sciences <https://nces.ed.gov/pubs2016/2016014.pdf>. Published 2016. Accessed June 26, 2017.
10. Green JG, McLaughlin KA, Alegria M, et al. School mental health resources and adolescent mental health use. *J Am Acad Child Adolesc Psychiatry*. 2013;52(5):501–510. 10.1016/j.jaac.2013.03.002. [PubMed: 23622851]
11. Tegethoff M, Stalujanis E, Belardi A, Meinlschmidt G. School mental health services: signpost for out-of-school service utilization in adolescents with mental disorders? A nationally representative United States cohort. *PLoS One*. 2014;9(6):e99675 10.1371/journal.pone.0099675. [PubMed: 24911241]
12. Centers for Disease Control and Prevention (CDC). Results from the School Health Policies and Practices Study 2016. Atlanta, GA: CDC, 2017 https://www.cdc.gov/healthyyouth/data/shpps/pdf/shpps-results_2016.pdf.
13. Freeman EV. School mental health sustainability: Funding strategies to build sustainable school mental health programs. Washington, DC: Technical Assistance Partnership for Child and Family Mental Health www.air.org/sites/default/files/downloads/report/Challenges%20to%20Mental%20Health%20Agency%20Partnerships_2.pdf. Published 2011. Accessed June 26, 2017.
14. U.S. Government Accountability Office. School mental health: role of the Substance Abuse and Mental Health Services Administration and factors affecting service provision. GAO-08-19R. www.gao.gov/new.items/d0819r.pdf. Published 2007. Accessed June 14, 2017.
15. Cowan KC, Vaillancourt K, Rossen E, Pollitt K. A framework for safe and successful schools [Brief]. www.nasponline.org/Documents/Research%20and%20Policy/Advocacy%20Resources/Framework_for_Safe_and_Successful_School_Environments.pdf. Published 2013. Accessed June 14, 2017.
16. American School Counselor Association. The ASCA national model: a framework for school counseling programs. Executive summary. www.schoolcounselor.org/asca/media/asca/ASCA%20National%20Model%20Templates/ANMExecSumm.pdf. Accessed November 13, 2017.
17. National Association of School Psychologists. Model for comprehensive and integrated school psychological services. www.nasponline.org/standards-and-certification/nasp-practice-model. Published 2010. Accessed November 13, 2017.
18. School Social Work Association of America. National school social work practice model. www.sswaa.org/?page=459. Accessed November 13, 2017.
19. Reback R Schools' mental health services and young children's emotions, behavior, and learning. *J Policy Anal Manage*. 2010;29(4):698–725. 10.1002/pam.20528. [PubMed: 20964104]
20. Torres Z Student-to-counselor ratios bring challenges for mental health support. *The Denver Post*. www.denverpost.com/2014/02/01/student-to-counselor-ratios-bring-challenges-for-mental-health-support/. Published February 1, 2014. Accessed June 14, 2017.
21. Olfson M, Blanco C, Wang S, et al. National trends in the mental health care of children, adolescents, and adults by office-based physicians. *JAMA Psychiatry*. 2014;71(1):81–90. 10.1001/jamapsychiatry.2013.3074. [PubMed: 24285382]
22. Demissie Z, Brener N. Demographic differences in district-level policies related to school mental health and social services-United States, 2012. *J Sch Health*. 2017;87(4):227–235. 10.1111/josh.12489. [PubMed: 28260247]
23. Judge David L Bazelon Center for Mental Health Law. Effective mental health services integrated in schools: what works. www.bazelon.org/wp-content/uploads/2017/01/WayToGo3.pdf. Accessed June 15, 2017.

Trends Over Time^a in the Percentage of Districts With Specific CPSS Staffing Policies-SHPPS

Table 1.

Policy	Year				p-value
	2000, %	2006, %	2012, %	2016, %	
Has someone in the district who oversees or coordinates CPSS ^b	62.6	71.9	63.1	79.5	0.0018**
Requires each school to have someone to oversee or coordinate CPSS at the school ^b	40.8	49.9	43.6	56.3	0.0001**
Requires schools at each level to have a specified ratio of counselors to students ^c					
Elementary schools	NA	NA	26.4	16.2	0.0128*
Middle schools	NA	NA	26.4	16.8	0.0264*
High schools	NA	NA	32.0	19.8	0.0345*

Note: Boldface indicates statistical significance (* $p < 0.05$; ** $p < 0.01$).

^a Significant linear trends based on regression analyses with all years of available data. Models contained a linear time variable created by coding each year with orthogonal coefficients to account for unequal temporal spacing.

^b Model adjusted for district region, metropolitan status, percentage of white students, and affluence in 2006, 2012, and 2016.

^c Models adjusted for district region, metropolitan status, percentage of white students, affluence, and percentage of students receiving free or reduced-price lunch. CPSS, counseling, psychological, or social services; NA, not asked in this survey year; SHPPS, School Health Policies and Practices Study.