

 Research Article

Differences in Factors that Limit School Efforts to Provide Mental Health Services by School Level: A National Analysis

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Abstract

The degree to which factors limited the efforts of school leaders to provide mental health services to their students was addressed in this multiyear investigation. We analyzed national data from the National School Survey on Crime and Safety for the 2015-2016 and 2017-2018 school years. A causal-comparative research design was used because of the use of pre-existing data. In this survey, school principals and/or designees were asked about numerous school programs, student achievement, and student demographic characteristics. We analyzed only those survey questions directly related to providing mental health services. Inferential statistical procedures revealed the presence of statistically significant differences in a lack of access to mental health professionals and a lack of community support for both school years. Elementary schools had a higher percentage of effort limited in a major way by a lack of access to mental health professionals and community support than did middle or high schools. Additionally, elementary schools had the highest percentage limited in a major way for: lack of parental support, concerns about reactions from parents, reluctance to label students, and payment policies. Implications for policy and practice were discussed, as well as recommendations for further study.

Keywords: Elementary School, Mental Health Professionals, Mental Health Disorders, Middle School, School-Based Health Centers, School Survey on Crimes and Safety

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1. INTRODUCTION

According to Lai et al. (2016), “Schools are in a key position to identify mental health problems early and provide appropriate services or links to services” (p. 1). Additionally, school-based mental health centers assist in mitigating barriers that may interfere with accessing mental health services. Moreover, adolescence is an advantageous period of development to address mental disorder concerns, as most mental health conditions emerge prior to 20 years of age (Salerno, 2016). If not addressed, adolescents with mental illnesses grow up to be adults with mental illnesses who have difficulties finding and maintaining employment and being productive citizens. Consequently, if the needs of students who have mental health concerns continue to be unmet, society will aid in perpetuating a cycle of mental health neglect that can affect generations to come. Because children, youth, and adolescents spend the majority of their time in K-12 schools, educational leaders need to understand barriers that limit access to mental health services and to be able to seek out solutions that will encourage increased utilization.

Barriers and challenges regarding why students do not seek out mental health services teeters on a continuum of reasons. Some of these limitations include a lack of awareness on how to obtain assistance, a lack of transportation to mental health facilities, inadequate funding, inadequate access to mental health professionals, and stigmatization. To gain a better understanding into these challenges, Ijadi-Maghsoodi et al. (2018) conducted a study on the perspectives of low-income minority groups on assistance searching and challenges to receiving mental health services at school-based health center sites. The study took place

in a large urban community and included focus groups consisting of 76 middle and high school students at nine school-based health center sites. Participants reported that teachers were the primary source of support regarding mental health issues. Mental health counselors and peers were also mentioned as key supporters. Students identified relationships and trust as essential components in seeking out support for mental health concerns. Obstacles to accessing school-based health centers included: humiliation; apprehension of being judged; confidentiality concerns; a feeling of needing to hold information inside; and lack of awareness. In an effort to mitigate these barriers and enhance mental health involvement, students recommended making school-based health centers more relaxed, increasing understanding of mental health, and improving relationships with schools and school-based health center's staff.

In a similar study, Dunfee (2020) examined literature on the effects of school-based health centers from the viewpoint of various stakeholders. Dunfee (2020) began with a descriptive review regarding the origins of school-based health centers. Information was presented regarding the demographics of school-based health centers, percentages of centers present at each school level, and the benefits of having school-based health centers located within schools. Revealed in this article were multiple limitations in establishing school-based health centers. These limitations included cost, funding, and economic effects. "The initial cost to design, build, and stock a school-based health center, ranged from \$41,450 to \$378,704, and the annual cost to staff, restock, and operate a school-based health centers ranged from \$16,322 to \$659,684" (Dunfee, 2020, p. 1). It was noted that only 20% of funding came from the school system. Over 51% of funding support of school-based health centers derives from Federally Qualified Health Centers. Additionally, state and local government, insurance companies, private foundations, local businesses, and corporations assist in funding these centers. The cost of building school-based health centers remains an obstacle to their expansion, but inventive partnerships help districts address barriers to funding.

In a similar study, Larson et al. (2017) explored literature on childhood trauma and its effect on student success as it relates to mental illness. They also analyzed the literature to determine the influence school-based health centers that utilized mental health services had on adolescents. Results were: (a) school-based health centers are one possible intervention to support childhood trauma, behavioral health, and academic success; (b) school-based health centers improve accessibility and the use of mental health services; (c) the GPAs of students who utilized school-based health centers improved; and (d) the correlation between trauma and decreased academic success was mediated by mental health illnesses. "The mental health disorders that had the greatest impact on academic achievement were PTSD, depression, and anxiety" (Larson et al., 2017, pp. 681-682).

Bersamin et al. (2016) conducted an investigation of 948 schools in California to gain an in-depth understanding of the circumstances that necessitate school-based health centers and increase awareness of possible obstacles. Of the 948 schools included in the study, 88 had onsite school-based health centers. Findings from the study were that the majority of school-based health centers were located in cities (65.9%) and suburbs (23.9%). Rural areas and towns accounted for 6.8%. Additionally, schools with school-based health centers had a higher percentage of students of color who were economically disadvantaged, as characterized by the number of students who received free and reduced lunch services. Some of the services provided through these centers were mental health services, medical care, family planning clinics, and dental health. Resources, needs, and political philosophy are related to the existence of school-based health centers in California. For example, schools in the district with a higher percentage of registered Republicans were least likely to have a school-based health center. Consequently, it is crucial to consider how geographic contextual factors may influence the development of health services designed to facilitate positive health outcomes. Moreover, for school district leaders who would like to establish school-based health centers, building strong partnerships with local health providers can assist in addressing the unmet needs of students.

In an effort to determine the possible implications of stigmatization on K-12 students who participate in specific mental health services interventions, Gronholm et al. (2018) conducted a systematic literature review. By analyzing eight qualitative studies, the researchers established the presence of three mega themes that included negative labeling in which students were labeled as being different, strange, weird, crazy, or psycho. Confidentiality concerns were also noted as students felt that they could not trust their interventionist. A fear of others finding out about their mental health concerns caused hesitation when seeking out assistance. Similarly, another stigma-related obstacle was "restricted disclosure" (p. 22), where students believed that there would be adverse consequences if they opened up. To reduce the effects of

stigmatization, practitioners need to build relationships and trust. In this study, students reacted favorably when the key substance of interventions stressed connections and applicable strategies to manage the stressors that come with everyday life (Gronholm et al., 2018).

In another investigation, Bowers et al. (2013) surveyed 49 high school students with and without mental health concerns and interviewed 63 professionals who were associated with school-based mental health to gain insight into their perception regarding stigma. A larger number of adolescents considered stigma as one of the main barriers to accessing school mental health services. Participants with mental health concerns ranked not knowing where to go to get help as the second most common challenge. However, participants without any mental health-related issues recognized pressure from peers and a lack of knowing they have a mental health problem as the second most common factor toward accessing mental health services. Stigma as a barrier becomes detrimental when it inhibits people from pursuing the help they need. Unfortunately, suicide is a common result for those individuals who suffer from a mental illness and who do not seek assistance (Bower et al., 2013).

From 1999 to 2016, the suicide rate increased by 25.4% (America's Health Ranking, 2020) in the United States. Suicide is the second leading cause of death among youth and adolescents (Miller, 2019), and many of these individuals suffer from issues that are associated with mental illness or substance abuse. LeCloux et al. (2017) analyzed data from the National Longitudinal Study of Adolescent Health that included a sample of suicidal youth. Revealed in their investigation was that school-based mental health centers greatly increase the likelihood of adolescents who are susceptible to suicide access mental health services. Other barriers that hinder access to mental health services were an insufficient knowledge of available services, insurance issues, extended waiting lists, financial limitations, transportation concerns, not meeting eligibility criteria, and high levels of staff attrition in mental health agencies.

Additionally, Reinke et al. (2011) conducted a study in which 292 teachers reported reasons why students with mental health needs "fall through the cracks" (p. 8). Participants reported that children's mental health needs were not being met because of insufficient parental support, a lack of staff training/coaching, and a lack of prevention programs. In regard to barriers, the top three factors that limited supporting students with mental health concerns were: (a) an inadequate number of school mental health practitioners, (b) a lack of preparation and training to meet the mental health needs of children, and (c) insufficient funding for school-based mental health.

However, to bridge this gap, parental involvement is paramount. In an exploratory study conducted by Searcey Vulpen et al. (2018), 607 parents and guardians participated in a survey regarding the needs, inadequacies, and limitations of school-based mental health services. Descriptive information was gathered by allowing parents to choose from a list of behaviors that represented various mental health disorders. Additionally, parents were given an open-format question. Researchers collected data on the following: (a) The role of schools in addressing mental health needs, (b) Perceptions of gaps in services, and (c) Resources for information on mental health concerns and services. Searcey Vulpen et al. (2018) concluded that 63% of respondents indicated that their child experienced anxiety, and 59% suggested that their child was affected by other students who had experienced a personal behavioral health concern. Over 75% of respondents agreed that schools should be involved in addressing student mental health issues as well as taking an active role in connecting families and children to school-based and community-based service providers. In regard to accessing services, over 85% of parents stated that they would contact their child's school counselor, pediatrician, or a community mental health agency if they had concerns regarding their child's mental health.

1.1. Research Questions

The following overarching research questions were addressed in this investigation: During the 2015-2016 and 2017-2018 school years, what is the difference in the frequency of factors that limit mental health efforts by school level (i.e., elementary, middle, and high school)? regarding the following sub-questions were addressed: (a) What are the differences between efforts limited by inadequate/lack of access to licensed mental health professionals by school level?; (b) What are the differences in efforts limited by inadequate funds by school level?; (c) What are the differences between efforts limited by potential legal issues for school or district (e.g., malpractice, insufficient supervision, confidentiality?; (d) What are the differences between efforts limited by lack of parental support?; (e) What are the differences between efforts

limited by concerns about reactions from parents by school level?; (f) What are the differences between efforts limited by a lack of community support for providing mental health services to students in your school?; (g) What are the differences between efforts limited by a reluctance to label students with mental health disorders to avoid stigmatizing the child by school level?; and (h) What are the differences between efforts limited by written or unwritten policies regarding the school's requirement to pay for the diagnostic mental health assessment or treatment of students? Six of these eight research questions were answered separately for the elementary, middle, and high school levels and were analyzed for two school years (i.e., 2015-2016, and 2017-2018). Data for the research question "What are the differences between efforts limited by parental support by school level?" was only available for the 2015-2016 school year. Similar data were available for only the 2017-2018 school year for the research question, "What are the differences between efforts limited by concerns about reactions from parents by school level?"

2. METHOD

2.1. Research Design

In this multiyear analysis, a causal-comparative research design was present because of the use of pre-existing data. Already existing survey data for the 2015-2016 and 2017-2018 school years were obtained and analyzed to address the research questions previously delineated. In this type of study, the independent and dependent variables cannot be adjusted or controlled. Moreover, any extraneous variables that might be present are unknown. Accordingly, Johnson and Christensen (2017) cautioned against making cause-and-effect determinations from causal-comparative research investigations. In this investigation, the independent variable was school level: elementary schools, middle schools, and high schools. The dependent variables were responses of educational leaders to questions regarding the factors that limit school efforts to provide mental health services.

2.2. Participants and Instrumentation

Participants in this study were principals or a designee considered an expert on campus safety who participated in a safety survey that questioned schools in regard to school mental health services, along with other safety and security data from public schools. The School Survey on Crime and Safety gathers data from educational leaders from primary and secondary public schools as mandated by the federal government. The survey questions focused on various school-related safety and security issues that may aid school administrators in adopting effective safety measures, preventing or reducing safety concerns, and identifying gaps or areas of need that will ensure the safety and well-being of students and staff. Participants completed the survey by answering the questions with either: limits in a major way, limits in a minor way, or does not limit. In this investigation, the term school level refers to the conventional elementary, middle, and high school grades. The data analyzed herein were from the survey administrations in the 2015-2016 and 2017-2018 school years.

The School Survey on Crime and Safety was conducted seven times. The National Center for Education Statistics, however, only recently added a section on school mental health services in the following two school years: 2015-2016 and 2017-2018. Prior to these years, addressed in this survey were one of two or both of the following questions regarding mental health: (a) How many mental health agencies were involved in schools' efforts to promote safe, disciplined, and drug-free schools?; and (b) How many paid counselors or mental health professionals were employed at schools? Definitions pertaining to the survey's data on school mental health services were added to the School Survey on Crime and Safety by the National Center for Education Statistics in the 2015-2016 school year. For more information about the psychometric qualities of this survey, readers are directed to the website.

3. RESULTS

To determine the degree to which the differences were present in the frequency of factors that limited mental health efforts by school level (i.e., elementary, middle, and high school) for the 2015-2016 school year, Pearson chi-square procedures were conducted. The statistical procedure was viewed as the

optimal statistical procedure to use because frequency data were present for the school level and for the eight dependent variables. Because these variables were categorical in nature, chi-squares are the statistical procedure of choice (Slate & Rojas-LeBouef, 2011). Because the available sample size per cell was more than five, the underlying assumptions of the Pearson chi-square statistic were met.

3.1. Inadequate/Lack of Access to Mental Health Professionals

With respect to mental health efforts limited by inadequate/lack of access to mental health professionals for the 2015-2016 school year, a statistically significant difference was yielded, $\chi^2(4) = 18.31$, $p = .001$, a below small effect size, Cramer's V of .07 (Cohen, 1988). As revealed in Table 1, one-third of elementary schools' efforts to provide mental health services were limited by inadequate/lack of access to licensed mental health professionals in a major way in comparison to slightly over one-fourth of middle schools. Less than one-fourth of high schools were limited by inadequate access to licensed mental health professionals in a major way.

Table 1. Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by Inadequate/Lack of Access to Licensed Mental Health Professionals by School Level for the 2015-2016 School Year

School Level	Major	Minor	Did Not Limit
Elementary	($n = 171$) 33.1%	($n = 169$) 32.8%	($n = 176$) 34.1%
Middle	($n = 198$) 27.5%	($n = 244$) 33.9%	($n = 277$) 38.5%
High	($n = 175$) 22.6%	($n = 275$) 35.5%	($n = 324$) 41.9%

Note. The n represents the number of schools.

For the 2017-2018 school year, the result was statistically significant, $\chi^2(4) = 14.83$, $p = .005$, Cramer's V of .05, a below small effect size (Cohen, 1988). Delineated in Table 2 are the descriptive statistics for efforts limited by inadequate/lack of access to mental health professionals. Slightly over two-fifths of elementary schools' efforts were limited by inadequate or a lack of access to mental health professionals in a major way. In comparison, slightly over one-third of middle schools and one-third of high schools were limited in providing mental health services by inadequate access to mental health professionals in a major way.

Table 2. Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by Inadequate/Lack of Access to Licensed Mental Health Professionals by School Level for the 2017-2018 School Year

School Level	Major	Minor	Did Not Limit
Elementary	($n = 281$) 41.9%	($n = 194$) 28.9%	($n = 196$) 29.2%
Middle	($n = 369$) 37.8%	($n = 327$) 33.5%	($n = 279$) 28.6%
High	($n = 333$) 33.4%	($n = 335$) 33.6%	($n = 329$) 33.0%

Note. The n represents the number of schools

3.2. Inadequate Funding

Concerning mental health efforts limited by inadequate funding for the 2015-2016 school year, a statistically significant difference was not yielded, $\chi^2(4) = 6.50$, $p = .16$. Though not statistically significant, nearly half of elementary schools were limited to providing mental health services due to inadequate funding in a major way in comparison to slightly over-two fifths of middle and high schools. Table 3 contains the descriptive statistics for this analysis.

Table 3. Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by Inadequate Funding by School Level for the 2015-2016 Year

School Level	Major	Minor	Did Not Limit
Elementary	($n = 250$) 48.4%	($n = 139$) 26.9%	($n = 127$) 24.6%
Middle	($n = 313$) 43.5%	($n = 208$) 28.9%	($n = 198$) 27.5%
High	($n = 320$) 41.3%	($n = 233$) 30.1%	($n = 221$) 28.6%

Note. The n represents the number of schools

Regarding inadequate funding to provide mental health services to students for the 2017-2018 school year, a statistically significant difference was not yielded, $\chi^2(4) = 3.19$, $p = .53$. Similar percentages of

elementary, middle, and high schools, over 50%, were limited in providing mental health services to students by inadequate funding in a major way. Table 4 contains the descriptive statistics for this analysis.

Table 4. Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by Inadequate Funding by School Level for the 2017-2018 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 355) 52.9%	(<i>n</i> = 166) 24.7%	(<i>n</i> = 150) 22.4%
Middle	(<i>n</i> = 491) 50.4%	(<i>n</i> = 251) 25.7%	(<i>n</i> = 233) 23.9%
High	(<i>n</i> = 485) 48.6%	(<i>n</i> = 274) 27.5%	(<i>n</i> = 238) 23.9%

Note. The *n* represents the number of schools

3.3. Potential Legal Issues

For the third research question concerning potential legal issues as a factor in providing mental health services to students for the 2015-2016 school year, the result was not statistically significant, $\chi^2(4) = 5.45$, $p = .24$. Potential legal issues did not limit nearly three-fifths of elementary, middle, and high schools' effort to provide mental health services to students. Revealed in Table 5 are the descriptive statistics for this research question.

Table 5. Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by Potential Legal Issues by School Level for the 2015-2016 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 69) 13.4%	(<i>n</i> = 140) 27.1%	(<i>n</i> = 307) 59.5%
Middle	(<i>n</i> = 82) 11.4%	(<i>n</i> = 235) 32.7%	(<i>n</i> = 402) 55.9%
High	(<i>n</i> = 89) 11.5%	(<i>n</i> = 226) 29.2%	(<i>n</i> = 459) 59.3%

Note. The *n* represents the number of schools

Concerning potential legal issues as a factor in providing mental health services to students for the 2017-2018 school year, the result approached, but did not reach, the conventional level of statistical significance, $\chi^2(4) = 7.80$, $p = .10$. Potential legal issues did not limit over half of elementary, middle, and high schools. Delineated in Table 6 are the descriptive statistics for potential legal issues that limit schools' efforts to provide mental health services to students.

Table 6. Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by Potential Legal Issues by School Level for the 2017-2018 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 133) 19.8%	(<i>n</i> = 179) 26.7%	(<i>n</i> = 359) 53.5%
Middle	(<i>n</i> = 177) 18.2%	(<i>n</i> = 307) 31.5%	(<i>n</i> = 491) 50.4%
High	(<i>n</i> = 161) 16.1%	(<i>n</i> = 295) 29.6%	(<i>n</i> = 541) 54.3%

Note. The *n* represents the number of schools

Table 7. Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by Lack of Parental Support by School Level for the 2015-2016 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 145) 28.1%	(<i>n</i> = 226) 43.8%	(<i>n</i> = 145) 28.1%
Middle	(<i>n</i> = 151) 21.0%	(<i>n</i> = 356) 49.5%	(<i>n</i> = 212) 29.5%
High	(<i>n</i> = 133) 17.2%	(<i>n</i> = 389) 50.3%	(<i>n</i> = 252) 32.6%

Note. The *n* represents the number of schools

3.4. Lack of Parental Support

Regarding mental health efforts limited by lack of parental support for the 2015-2016 school year, the result was statistically significant, $\chi^2(4) = 22.62$, $p < .001$. The effect size for this finding, Cramer's *V* of .08, was a below small effect size (Cohen, 1988). Half of middle and high schools were limited in a minor way by lack of parental support, compared to slightly over two-fifths of elementary schools. Table 7 contains the descriptive statistics for this analysis.

3.5. Concerns About Reactions From Parents

With respect to efforts limited by concerns about reactions from parents for the 2017-2018 school year, the result was statistically significant, $\chi^2(4) = 17.81, p = .001$, Cramer's V of .058, a below small effect size (Cohen, 1988). Almost 30% of elementary schools and 30% of high schools were limited in a minor way by concerns about reactions from parents, compared to 35% of middle schools. Delineated in Table 8 are the descriptive statistics for this analysis.

Table 8. Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by Concerns about Reactions from Parents by School Level for the 2017-2018 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 77) 11.5%	(<i>n</i> = 195) 29.1%	(<i>n</i> = 399) 59.5%
Middle	(<i>n</i> = 73) 7.5%	(<i>n</i> = 345) 35.4%	(<i>n</i> = 557) 57.1%
High	(<i>n</i> = 75) 7.5%	(<i>n</i> = 301) 30.2%	(<i>n</i> = 621) 62.3%

Note. The *n* represents the number of schools

3.6. Lack of Community Support

Concerning efforts limited by a lack of community support for providing mental health services to students for the 2015-2016 school year, the result was statistically significant, $\chi^2(4) = 13.94, p = .007$, Cramer's V of .06, a below small effect size (Cohen, 1988). Elementary and middle schools had almost twice the percentage of high schools that were limited in a major way by a lack of community support. Table 9 contains the descriptive statistics for this analysis.

Table 9. Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by a Lack of Community Support by School Level for the 2015-2016 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 73) 14.1%	(<i>n</i> = 163) 31.6%	(<i>n</i> = 280) 54.3%
Middle	(<i>n</i> = 83) 11.5%	(<i>n</i> = 234) 32.5%	(<i>n</i> = 402) 55.9%
High	(<i>n</i> = 60) 7.8%	(<i>n</i> = 261) 33.7%	(<i>n</i> = 453) 58.5%

Note. The *n* represents the number of schools

Regarding efforts limited by a lack of community support for providing mental health services to students for the 2017-2018 school year, the result was statistically significant, $\chi^2(4) = 19.22, p = .001$, Cramer's V of .06, a below small effect size (Cohen, 1988). Elementary schools had a higher percentage of efforts limited in a major way by a lack of community support than did middle or high schools. Delineated in Table 10 are the descriptive statistics for this analysis.

Table 10. Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by a Lack of Community Support by School Level for the 2017-2018 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 88) 13.1%	(<i>n</i> = 179) 26.7%	(<i>n</i> = 404) 60.2%
Middle	(<i>n</i> = 88) 9.0%	(<i>n</i> = 288) 29.5%	(<i>n</i> = 599) 61.4%
High	(<i>n</i> = 87) 8.7%	(<i>n</i> = 238) 23.9%	(<i>n</i> = 672) 67.4%

Note. The *n* represents the number of schools

3.7. Reluctance to Label Students

With respect to efforts limited by a reluctance to label students with mental health disorders to avoid stigmatizing the child for the 2015-2016 school year, the result was statistically significant, $\chi^2(4) = 24.27, p < .001$, Cramer's V of .08, a below small effect size (Cohen, 1988). As revealed in Table 11, elementary schools had the highest percentage of efforts limited in a major way by a reluctance to label students with mental health disorders to avoid stigmatizing the child, compared to high schools. Middle schools had the second-highest percentage, followed by high schools.

Table 11. Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by a Reluctance to Label Students by School Level for the 2015-2016 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 61) 11.8%	(<i>n</i> = 185) 35.9%	(<i>n</i> = 270) 52.3%
Middle	(<i>n</i> = 70) 9.7%	(<i>n</i> = 227) 31.6%	(<i>n</i> = 422) 58.7%
High	(<i>n</i> = 40) 5.2%	(<i>n</i> = 258) 33.3%	(<i>n</i> = 476) 61.5%

Note. The *n* represents the number of schools

Concerning efforts limited by a reluctance to label students with mental health disorders to avoid stigmatizing the child for the 2017-2018 school year, the result approached, but did not reach, the conventional level of statistical significance, $\chi^2(4) = 7.95$, $p = .09$. Though not statistically significant, elementary schools and middle schools had similar percentages of effort limited in a major way by a reluctance to label students with mental health disorders to avoid stigmatizing children in comparison to high schools which had a lower percentage. Revealed in Table 12 are the descriptive statistics for this analysis.

Table 12. Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by a Reluctance to Label Students by School Level for the 2017-2018 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 71) 10.6%	(<i>n</i> = 202) 30.1%	(<i>n</i> = 398) 59.3%
Middle	(<i>n</i> = 101) 10.4%	(<i>n</i> = 281) 28.8%	(<i>n</i> = 593) 60.8%
High	(<i>n</i> = 80) 8.0%	(<i>n</i> = 268) 26.9%	(<i>n</i> = 649) 65.1%

Note. The *n* represents the number of schools

3.8. Payment Policies

Regarding mental health efforts limited by payment policies for the 2015-2016 school year, the result was not statistically significant, $\chi^2(4) = 7.38$, $p = .12$. Payment policies did not limit three-fifths of elementary and high schools from providing mental health services to students. Additionally, payment policies did not limit nearly three-fifths of middle schools' mental health efforts. Table 13 contains the descriptive statistics for this analysis.

Table 13. Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by Payment Policies by School Level for the 2015-2016 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 80) 15.5%	(<i>n</i> = 129) 25.0%	(<i>n</i> = 307) 59.5%
Middle	(<i>n</i> = 108) 15.0%	(<i>n</i> = 198) 27.5%	(<i>n</i> = 413) 57.4%
High	(<i>n</i> = 87) 11.2%	(<i>n</i> = 216) 27.9%	(<i>n</i> = 471) 60.9%

Note. The *n* represents the number of schools

With respect to mental health efforts limited by payment policies for the 2017-2018 school year, the result was statistically significant, $\chi^2(4) = 14.06$, $p = .007$, Cramer's *V* of .05, a below small effect size (Cohen, 1988). High schools had the highest percentage of efforts that did not limit mental health services to students compared to middle and elementary schools. Delineated in Table 14 are the descriptive statistics for this analysis.

Table 14. Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by Payment Policies by School Level for the 2017-2018 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 71) 10.6%	(<i>n</i> = 202) 30.1%	(<i>n</i> = 398) 59.3%
Middle	(<i>n</i> = 101) 10.4%	(<i>n</i> = 281) 28.8%	(<i>n</i> = 593) 60.8%
High	(<i>n</i> = 80) 8.0%	(<i>n</i> = 268) 26.9%	(<i>n</i> = 649) 65.1%

Note. The *n* represents the number of schools

4. DISCUSSION

Data regarding the frequency of mental health efforts limited by inadequate access to professionals by the school level were obtained and analyzed from the national School Survey on Crime and Safety for two years. These two surveys were completed by school principals and/or their designees, based upon their knowledge of school program offerings. Inferential statistical analyses revealed that efforts limited by inadequate access to professionals were statistically significantly different by school level. During the 2015-2016 school year, elementary schools had nearly the same percentage of efforts that were limited in a major and minor way by inadequate access to professionals. Additionally, nearly the same percentage of elementary schools were not limited at all. Furthermore, all school levels had higher percentages that were not limited by inadequate access to professionals. Contrasting results, however, were present in the 2017-2018 school year. High schools had the same percentage of efforts limited by inadequate access to professionals in all categories. Furthermore, all school levels had higher percentages limited in a major way by inadequate access to professionals.

Regarding efforts limited by inadequate funds, results were not statistically significant for the 2015-2016 school year. Almost 50% of elementary schools were limited by inadequate funding. Similar findings were present for this survey question in middle and high schools. Concerning efforts limited by inadequate funds for the 2017-2018 school year, results were not statistically significant. Again, similar findings were present for this survey question across all three school levels.

Concerning efforts limited by potential legal issues, results were not statistically significant for the 2015-2016 school year. More than half of all three school levels were not limited by potential legal issues. Similarly, for the 2017-2018 school year, statistically significant differences were not revealed. The percentages, however, slightly decreased across all school levels for efforts not limited by potential legal issues. In comparison to the previous year, a 5 to 6% increase was observed in percentages in efforts limited in a major way by potential legal issues.

Efforts limited by a lack of parent support were statistically significant for the 2015-2016 school year. Elementary schools had a higher percentage of efforts limited by a lack of parental support in a major way. Middle schools provided the second most efforts, limited by a lack of parental support in a major way, and high schools provided the least. During the 2017-2018 school year, efforts limited by concerns about reactions from parents were statistically significant. Although the percentages were low across all school levels, elementary schools had the highest percentage of efforts limited in a major way by concerns about reactions from parents. Middle and high schools had the same percentage of efforts limited in a major way.

With respect to the investigation about efforts limited by a lack of community support, results were statistically significant for the 2015-2016 and 2018-2018 school years. Over half of all three school levels were not limited by a lack of community support for both school years. High schools declined by 10% compared to elementary by 5% and middle school by 3%. A decline was also observed in efforts limited in a major way, with a change of 2-3% points across all levels.

Efforts limited by reluctance to label students to avoid stigmatization for the 2015-2016 school year were statistically significant by school level. However, statistically significant differences were not yielded for the 2017-2018 school year. From the 2015-2016 school year to the 2017-2018 school year, efforts limited in a minor way by a reluctance to label students declined across all three school levels. Additionally, efforts limited in a major way remained somewhat the same across the elementary and middle school level for both school years. Furthermore, from the 2015-2016 school year to the 2017-2018 school year, an increase was present in all school levels that were not limited by a reluctance to label students.

Statistically significant differences for efforts limited by payment policies were not present for the 2015-2016 school year. From the 2015-2016 school year to the 2017-2018 school year, a slight decline was observed in efforts limited in a major way for payment policies for all three school levels. For the 2017-2018 school year, findings were not statistically significantly different by school level.

In a previous investigation, Harper and Slate (2023) addressed the issue of schools providing assessments for mental health disorders. They analyzed two years of data from the same survey as this article. They documented the presence of differences by school level in mental health disorder assessment. In a more recent article, Peters-Corbett et al. (2024) addressed barriers to mental health program

implementations in school settings. Their findings were congruent with the results of our multiyear article. Of note were their practical recommendations for ways to improve implementation processes.

4.1. Implications for Policy and Practice

Several policy implications may be made based on the findings of this study. To begin, legislators should develop annual awareness campaigns to promote understanding of mental health, knowledge of available treatment, and how to seek assistance. Second, federal and state regulatory agencies should reexamine the licensing requirements of school counselors. All school counselors should be required to be licensed after a certain number of years in education. Finally, federally funded mental health care agencies/organizations should be required to develop partnerships and support local public school districts to meet the mental health needs of students who have been identified with mental health concerns.

Concerning implications for practice, school leaders should implement teacher initiatives at each school level, as teachers are a primary support for mental health issues. School districts should consider reimagining the role of the counselor on the secondary level. Districts could pay for counselors to be licensed and allow them to function in a dual capacity when needed, or eventually fade out the time-consuming responsibility of (scheduling) and reassign roles. Parent initiatives/classes should also be offered at the district and campus level to engage and educate parents in community mental health activities. Additionally, schools should take an active role in connecting families and children to school-based and community-based service providers. To address funding concerns, schools should build strong partnerships with local health providers. These partnerships may be able to assist in addressing funding issues and the unmet needs of students.

4.2. Recommendations for Future Research

Several recommendations for further inquiry may be made based on the findings of this nationwide investigation. Researchers are encouraged to consider conducting a mixed-method study or qualitative analysis regarding students' perceptions of mental health barriers and their impact on services received by the school level. Exploring students' perspectives on this issue may offer insights into how to overcome limitations associated with providing mental health services to students. In this investigation, potential legal issues were one of the factors that limited schools' mental health efforts in a major way; as such, a more in-depth investigation of legal concerns and mental health in K-12 schools will add to the existing body of literature. Additionally, a further investigation regarding the differences in a lack of parental support and concerns about reactions from parents is also recommended. Although parental support and concerns about reactions from parents were only analyzed for one school year, a study concerning these factors over multiple school years would contribute to the material already available.

4.3. Limitations

Readers should be cautious in the extent to which they make generalizations from this investigation. First, the survey data analyzed were from a national sample. As such, the degree to which our results would be transferable to schools in any particular state is not known. Second, the extent to which the perceptions of the educational leader who completed the survey matched the reality of mental health services that were present is also not known. Third, the two years of data collected by this national survey were prior to the COVID-19 pandemic. Given the severe effects of this pandemic, not only on student learning but also on student and family emotional health, our findings may accurately represent what is occurring years after the pandemic.

5. CONCLUSION

Through inferential statistical analyses of national survey data, statistically significant differences were present for the majority of the research questions with the exception of questions regarding mental health efforts limited by inadequate funding and potential legal issues for the 2015-2016 and 2017-2018

school years, and payment policies for the 2015-2016 school year. The following factors: (a) inadequate access to mental health professionals; (b) inadequate funding; and (c) potential legal issues, revealed an increase from the 2015-2016 school year to the 2017-2018 school year in the percentages of all school levels that were limited in a major way by mental health efforts. A decline occurred from the 2015-2016 school year to the 2017-2018 school year in percentages at all school levels that were not limited in any way by these same mental health efforts. As such, school leaders are encouraged to analyze the components of a school-based health center and consider how to employ some, if not all, of these components into an already established school system.

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