



# Differences in School Efforts to Provide Assessments for Mental Health Disorders by School Level: A National Analysis

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<p><b>Abstract:</b> The degree to which diagnostic assessments were available to students under the official responsibilities of a licensed mental health professional by school level was addressed in this study using data from the National School Survey on Crime and Safety for the 2015-2016. For the 2017-2018 school year, the extent to which schools provided diagnostic mental health assessments to evaluate students for mental health disorders by school level was also examined. Nearly 75% of elementary schools did not provide diagnostic assessments at school by school-funded mental health professionals compared to 60% of elementary schools that did not provide diagnostic assessments outside of school by a school-funded mental health professional. Implications for policy and practice were discussed, as well as recommendations for further study.</p>	<p style="text-align: center;"><b>Research Paper</b></p>
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## INTRODUCTION

According to Mental Health America (2018), “63.1% of youth with major depression do not receive any mental health treatment” (p. 1). Mental illness has been related to numerous issues such as poor academic success, weakened relationships with peers, decreased level in attendance, and an increase in misbehavior (Swick & Powers, 2018; Von der Embse *et al.*, 2017). Unfortunately, adolescents with a mental illness (e.g., emotional disturbance) are often classified as being unruly or exhibiting behavioral difficulties rather than having mental health problems. This misappropriation of terminology prevents students from receiving the help they need. Unaddressed mental health is linked with health, educational, and developmental concerns for youth, including violence, suicidal ideation/suicide, substance abuse, and poor academic performance (Hodges *et al.*, 2021; McLeod *et al.*, 2016; Walker *et al.*, 2010).

Although the K-12 educational system is one of the primary access points for mental health services, school personnel are failing to identify, assess, and provide treatments and services to those adolescents who need it the most (Bains & Diallo, 2016; Von der Embse *et al.*, 2017). Instead of providing appropriate services and identification systems for students who need mental health services, schools most often refer to strategies and techniques that are reactive in nature. For example, according to the Children and Adults with Attention-Deficit/Hyperactivity Disorder manual (2017), students with mental illnesses are more likely to have a school history of suspension or expulsion. In the context of adolescent mental health and care, under-identification rates, inadequate care coverage, and a subpar standard of service are not unusual (Koning *et al.*, 2019). Educational leaders who are responsible for ensuring that the needs of students are met, should consider the interconnectedness of the Response to Intervention process and how this system may affect the identification of students with mental health needs. Incorporating a school based mental health care center is another method

in which schools across the United States have sought to bridge the mental health and academic gap. A more cost effective approach, however, may include school based programs.

To provide students who have mental health conditions with effective interventions, evidenced-based assessments or programs should be included among the resources used. The National Center for Education Statistics reported data from the 2016 and 2018 School Survey on Crime and Safety from approximately 4,800 public schools where principals documented an increase in the number of diagnostic mental health assessments provided (e.g., psychological/psychiatric diagnostics assessments) to evaluate students for mental health disorders at school from 35% in 2016 to 49% in 2018. In regard to providing treatment on campus for students with mental health disorders by a school-employed mental health professional, a paltry increase of only 2% was established from 2016 (35%) to 2018 (37%). Schools in the United States are still improving in the area of providing substantial treatment, diagnostics, and assessments for students with mental disorders on campus. However, it is clear that some schools are taking additional measures to ensure that students are assessed and treatment is provided.

To investigate which elements may be connected to the use of evidenced-based assessments, Connors *et al.*, (2015) conducted a study that included 144 school mental health professionals from various states. They determined that to increase assessment utilization, measures must be easy to use, provide immediate feedback, and be able to track students' progress and treatment over time. Challenges in administering assessments were attributed to (a) difficulty in contacting the parents, 67%, and (b) parents and students not understanding assessment questions, 70%. Additionally, 29% of clinicians agreed that other barriers to implementation included not having access to the assessments they were most comfortable with, not having access to the assessments they need, and not having enough time during the school day to assess. Additional findings were that 80% of clinicians used academic outcome indicators as the most frequently used assessment data. Insufficient access to treatment and intervention for individuals who have mental health disorders can adversely affect student educational outcomes. A solution that may assist in minimizing this concern is the commission of school based health centers.

School-based health centers have been established to meet the needs of individuals with mental health concerns. For example, Swick and Powers (2018) evaluated a school based support program in which its primary functions were to (a) broaden the capacity of elementary schools in meeting the needs of students who have mental health concerns that adversely affect their academic performance, and (b) strengthen the

educational and behavioral health of children with psychological concerns. They gathered data on 322 students, 80% of whom were Black and at risk of academic failure due to their mental health needs. From the six elementary schools that participated, substantial progress was noted in students' reading and mathematics performance.

In another investigation, Guzman (2011) analyzed whether mental health conditions present in a screening conducted in the first grade were linked to lower academic performance test scores in the fourth grade. Being identified as a student with mental health problems in the first grade was statistically significantly related to standardized achievement test performance three years later. Of note was that, mental health was the second most powerful predictor of academic outcome in the study. Students with overall, "mental health risk have lower levels of subsequent academic achievement as measured by standardized academic achievement tests when compared with students who are not at overall mental health risk" (Guzman, 2011, p. 409).

The approach used in this next investigation was similar to the one used by Guzman (2011). To investigate the assertion that mental health and academic performance are closely linked, Murphy (2015) conducted a longitudinal study to determine whether first grade mental well-being predicted future academic performance and whether remission of mental health conditions predicted better academic results. In this study, one of the world's biggest school-based mental health services, called *Habilidades de Vida* or Skills for Life was used. Data were taken from 37,397 Chilean students in first grade in 2009 and third grade in 2011. Academic success was statistically significantly predicted by first grade academic achievement but also by first grade mental health. Additionally established was that mental health assessed near the beginning of Grade 1 independently predicted the percent of school days children would attend in Grades 1 and 3. School mental health indicators could be one of the most crucial variables determining academic achievement in elementary school children, and they may be especially influential in identifying adolescents who may benefit from proactive approaches. School-based preventive programs may favorably influence students' academic and mental health outcomes (Murphy, 2015).

In a recent investigation in Colorado, Westbrook *et al.*, (2020) conducted a longitudinal study about the opening of school based mental health centers in high schools and their influence on graduation rates. They compared high schools without school-based health centers to high schools that opened school-based mental health centers between 2000 and 2018. Westbrook *et al.*, (2020) established that high schools that opened a school-based health center had statistically significant higher graduation rates than high schools that did not have a school-based health center.

In a systematic literature review, Larson *et al.*, (2017) determined that extended exposure to severe childhood trauma adversely influences academic performance when mediated by mental health conditions. In 8 out of 10 studies, a high risk of increasing mental health disorders with poor academic performance for adolescents who experienced severe childhood trauma was determined. Students of color who were in poverty and who were subjected to trauma were more likely to developmental health disorders (e.g., anxiety, depression, conduct disorder, post-traumatic stress disorder, suicidal ideation, attention deficit hyperactivity disorder) and have lower GPAs than their peers who had not experienced trauma or victimization (Larson, 2017, p. 677).

Similar to Larson *et al.*, (2017), Knopf *et al.*, (2016) conducted a systematic literature review of 46 studies. They focused on school-based health centers providing mental health care or a combination of psychiatric and other services. Results were that school-based health centers contributed to a plethora of improved wellness and educational outcomes. Effectiveness was correlated with extended hours and a continuum of services available. Educational gains related with school-based health centers include a decrease in suspension rates, drop-out rates, and grade retention. Moreover, increases in GPAs and grade promotion were noted.

### Statement of the Problem

Adolescents who experience a mental health crisis are more likely to have lower educational attainment than adolescents who do not experience a mental health crisis (Murphy, 2015). Researchers (Guzman *et al.*, 2011; Larson *et al.*, 2017; Merikangas *et al.*, 2010; Murphy *et al.*, 2015) have conducted studies to substantiate the claim of strong relationships between children and adolescents' mental health and academic success. Unmet or untreated mental health needs can lead to poor educational outcomes, such as poor grades, an increase in suspensions, a decline in attendance, grade retention, delays in reading, and an increase in school dropouts (Murphy, 2015). As such, educational leaders must investigate measures that will mitigate the mental health and achievement gap. By establishing a multi-tiered system of support, educational leaders, teachers, and staff may be able to meet the needs of students who are experiencing a mental health crisis. Moreover, as educational leaders make a concerted effort to understand the dynamics between educational outcomes and mental health, they will inherently contribute to an improved climate and culture where the needs of the whole child are being addressed.

### Purpose of the Study

The first purpose of this study was to determine the extent to which differences existed for diagnostic assessments services available to students at school by

school-funded mental health professional for the 2015-2016 school year. The second purpose of this study was to examine the degree to which differences were present in the frequency of schools to provide diagnostic mental health assessments to evaluate students for mental health disorders by school level (i.e., elementary, middle, and high school) for the 2017-2018 school year. The third purpose was to ascertain the degree to which differences were present in whether diagnostic assessments were available at school by school-employed mental health professionals for the 2015-2016 school year. The fourth purpose of the study was to determine the extent to which differences existed in diagnostic mental health assessment services provided to students at school by a school-employed or contracted mental health professional by school level for the 2017-2018 school year. The fifth purpose was to examine the degree to which difference were present in the frequency of schools to in providing students diagnostic assessments outside of school by school-funded mental health professionals for the 2015-2016 school year. The sixth purpose was to ascertain the degree to which differences were present in whether diagnostic mental health assessment services provided to students outside of school, by a school-employed or contracted mental health professional for the 2017-2018 school year.

### Significance of the Study

As reported by the National Alliance on Mental Illness (2021), 16.6% of adolescents will experience a mental health crisis. Accordingly, the state of an individual's mental health may alter at any point in time depending on environmental influences, biological factors, and other external/internal factors (National Alliance on Mental Illness, 2021). Educational leaders and educators need to be aware of students' mental status and to be on alert if they begin to observe a sudden drop in grades, attendance, or behavioral changes. According to Substance Abuse and Mental Health Services Administration (n.d.), mental health functions on a continuum. For example, just as physical health, can range from well to ill, so can mental health.

Educational leaders, teachers, and staff, as well as other school stakeholders, assume the responsibility of knowing and understanding the unique needs of their students. Moreover, data are used to gain a complete understanding of the students they serve. For example, educators look at demographics, socioeconomic status, ethnicity/race, at risk status, language, and other variables when determining how to meet the individualized needs of students. Unfortunately, the mental health status of students is rarely considered when making these decisions (Substance Abuse and Mental Health Services Administration, p. 1). One of the most effective measures in identifying students' areas of strengths and weaknesses is through a process referred to as Response to Intervention. Although predominantly used as an academic framework to assist students who are at risk and struggling with academic performance

(Franklin *et al.*, 2017) this tiered system of intervention has the potential to aid in the identification of students with mental health concerns.

The reauthorization of the Individuals with Disabilities Education Act instituted a new system for determining an impairment, termed Responsiveness to Intervention (United States Department of Education, n.d.). When deciding if a child has a particular learning disorder, a local educational agency can implement a process of review and monitoring to determine the child's response to evidence based intervention over time. By implementing a similar system for identifying children with mental health needs, educators will play a proactive role in closing the achievement and mental health divide. One of the main functions of educators is to ensure that students are learning at high levels. If student psychological needs are not fulfilled, academic performance may suffer. Academic success is a by-product of mental health (McGrath, 2010).

### Research Questions

In this study, the following research questions were addressed: (a) What is the difference in diagnostic assessments at school by school-funded mental health professionals for the 2015-2016 school year?; (b) What is the differences in diagnostic assessment for mental disorders for the 2017-2018 school year?; (c) What is the difference in diagnostic assessments at school by school-employed mental health professionals for the 2015-2016 school year?; (d)What is the differences in diagnostic assessments at school by school-employed or contracted mental health professionals for the 2017-2018 school year?; (e) What is the difference in diagnostic assessments outside of school by school-funded mental health professionals for the 2015-2016 school year?; (f) What is the difference in diagnostic assessments outside of school by school-employed or contracted mental health professionals for the 2017-2018 school year. These six research questions were analyzed separately. The 2015-2016 questions on the School Survey on Crime and Safety regarding diagnostic assessments and mental health were slightly altered during the 2017-2018 school year.

## METHOD

### Research Design

A non-experimental, causal comparative research design was present herein. Archival data from the 2015-2016 and 2017-2018 National School Safety Datasets were retrieved and examined in this section. Due to the pre-existing data, neither the independent variables of school level (i.e., elementary, middle, and high schools) nor the dependent variables of mental health could be manipulated or modified. Dependent variables were responses to six questions regarding (a) What is the difference in diagnostic assessments at school by school-funded mental health professionals for the 2015-2016 school year?; (b) What is the differences in diagnostic assessment for mental disorders for the

2017-2018 school year?; (c) What is the difference in diagnostic assessments at school by school-employed mental health professionals for the 2015-2016 school year?; (d)What is the differences in diagnostic assessments at school by school-employed or contracted mental health professionals for the 2017-2018 school year?; (e) What is the difference in diagnostic assessments outside of school by school-funded mental health professionals for the 2015-2016 school year?; (f) What is the difference in diagnostic assessments outside of school by school-employed or contracted mental health professionals for the 2017-2018 school year. These six research questions were analyzed separately.

### Participants and Instrumentation

Data analyzed in this article were obtained from the 2015-2016 and 2017-2018 School Survey on Crime and Safety (SSOCS), a nationally representative survey of K–12 public schools in the United States. This survey, managed by the National Center for Education Statistics, is the main source of statistics on crime and safety in schools located in the United States. Participants in this investigation were public school principals or person with the most expertise of school crime and safety. Respondents were asked to report on a range of safety and crime related questions including school mental health services, staff training and practices, parent and community involvement at school, disciplinary actions and other factors related to school crime and safety (Jackson *et al.*, 2018; Padgett *et al.*, 2020).

For the context of this research, the term school level refers to the traditional elementary, middle, and high school levels. The SSOCS was conducted seven times. However, the National Center for Education Statistics 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, this survey only addressed one of two or both of the following questions regarding mental health: (a) How many mental health agencies were involved in school's efforts to promote safe, disciplined, and drug-free schools?; and (b) How many paid counselors or mental health professional were employed at schools? (Chaney, 2015; Izrael, 2006; Ruddy, 2009, 2010; United States Department of Education, National Center for Education Statistics, 2003). Definitions pertaining to the survey's data on school mental health services were added to the SSOCS by The National Center for Education Statistics during the 2015-2016 school year.

In 2015-2016 the formal definitions for (a) diagnostic assessment, (b) mental health disorder, and (c) mental health professionals were added to the survey in accordance with the addition of a new section on school mental health services. However, in 2017-2018 the term "Diagnostic assessment" was changed to "Diagnostic mental health assessment," and its definition was modified to assist participants in differentiating diagnostic evaluations for mental health disorders from

assessments that may be used to indicate other health or academic concerns. The term mental health professional was also revised. A revision to the definition added clarification to emphasize that mental health providers must be licensed (Padgett *et al.*, 2020).

Diagnostic mental health assessment is defined as an evaluation conducted by a mental health professional that identifies whether an individual has one or more mental health diagnoses. This is in contrast to an educational assessment, which does not focus on clarifying a student's mental health diagnosis (Padgett *et al.*, 2020, p. A-3).

Archival data were collected from the 2015-2016 and 2017-2018 National School Safety Datasets and converted to Statistical Package for Social Sciences (SPSS) data. Survey questions were recoded using a codebook: (a) What is the differences in diagnostic assessments services available to students at school by school-funded mental health professional for the 2015-2016 school year, (b) What is the differences in the frequency of schools to provide diagnostic mental health assessments (e.g., psychological/psychiatric diagnostics assessments) to evaluate students for mental health disorders by school level (i.e., elementary, middle, and high school) for the 2017-2018 school year, (c) What is the differences in diagnostic assessments available at school by school-employed mental health professionals for the 2015-2016 school year, (d) What is the differences in diagnostic mental health assessment services provided to students at school by a school-employed or contracted mental health professional by school level for the 2017-2018 school year, (e) What is the differences in the availability of diagnostic assessments outside of school by school-funded mental health professionals for the 2015-2016 school year, and (f) What is the differences in diagnostic mental health assessment services provided to students outside of school, by a school-employed or contracted mental health professional for the 2017-2018 school year.

## RESULTS

To determine the degree to which the differences were present in the frequency of schools in

providing diagnostic mental health assessments to evaluate students for mental health disorders by school level 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 school level and for the six dependent variables: (a) diagnostic assessments services available to students at school by school-funded mental health professional for the 2015-2016 school year, (b) diagnostic mental health assessments to evaluate students for mental health disorders by school level (i.e., elementary, middle, and high school) for the 2017-2018 school year, (c) availability of diagnostic assessments at school by school-employed mental health professionals for the 2015-2016 school year, (d) diagnostic mental health assessment services provided to students at school by a school-employed or contracted mental health professional by school level for the 2017-2018 school year, (e) availability of diagnostic assessments outside of school by school-funded mental health professionals for the 2015-2016 school year, and (f) diagnostic mental health assessment services provided to students outside of school, by a school-employed or contracted mental health professional for the 2017-2018 school year. Because these variables were categorical, chi-squares are the statistical procedure of choice (Slate & Rojas-LeBouef, 2011). With the large sample size, the available sample size per cell was more than five. Therefore, the underlying assumptions of the Pearson chi-square statistic were met.

### At School by School-Funded Mental Health Professionals

Concerning the first research question for the 2015-2016 school year, the result was statistically significant,  $\chi^2(2) = 26.74 p < .001$ . The effect size for this finding was small, a Cramer's V of .12 (Cohen, 1988). As delineated in Table 1, nearly three-fourths of elementary schools did not provide diagnostic assessments at school by school-funded mental health professionals. In comparison, slightly over three-fifths of middle schools and high schools did not provide such services.

**Table 1: Descriptive Statistics for Frequencies and Percentages of Diagnostic Assessments at School by School-Funded Mental Health Professionals by School Level for the 2015-2016 School Year**

School Level	Yes	No
Elementary	(n = 132) 25.6%	(n = 384) 74.4%
Middle	(n = 265) 36.9%	(n = 454) 63.1%
High	(n = 302) 39.0%	(n = 472) 61.0%

**Note.** The *n* represents the number of schools.

### Diagnostic Mental Health Assessments for Mental Disorders

Regarding diagnostic mental health assessments for mental disorders for the 2017-2018

school year, a statistically significant difference was revealed,  $\chi^2(2) = 32.08, p < .001$ , small effect size, Cramer's V of .11 (Cohen, 1998). Half of elementary schools did not provide diagnostic mental health

assessments for mental disorders. In contrast, over two-fifths of middle schools and less than two-fifths of high

schools did not provide such services. Table 2 contains the descriptive statistics for these analyses.

**Table 2: Descriptive Statistics for Frequencies and Percentages of Diagnostic Mental Health Assessment for Mental Disorders by School Level for the 2017-2018 School Year**

School Level	Yes	No
Elementary	( <i>n</i> = 330) 49.2%	( <i>n</i> = 341) 50.8%
Middle	( <i>n</i> = 548) 56.2%	( <i>n</i> = 427) 43.8%
High	( <i>n</i> = 629) 63.1%	( <i>n</i> = 368) 36.9%

**Note.** The *n* represents the number of schools.

#### At School by School-Employed Mental Health Professionals

With respect to diagnostic assessment at school by school-employed mental health professionals for the 2015-2016 school year, a statistically significant difference was yielded,  $\chi^2(2) = 26.02$ ,  $p < .001$ , small effect size, Cramer's *V* of .11 (Cohen, 1988). As

revealed in Table 3, almost three-fifths of elementary schools did not provide diagnostic assessments at school by school-employed mental health professionals, compared to more than half of middle schools, and less than half of high schools that did not provide such assessments.

**Table 3: Descriptive Statistics for Frequencies and Percentages of Diagnostic Assessments at School by School-Employed Mental Health Professionals by School Level for the 2015-2016 School Year**

School Level	Yes	No
Elementary	( <i>n</i> = 216) 41.9%	( <i>n</i> = 300) 58.1%
Middle	( <i>n</i> = 335) 46.6%	( <i>n</i> = 384) 53.4%
High	( <i>n</i> = 431) 55.7%	( <i>n</i> = 343) 44.3%

**Note.** The *n* represents the number of schools.

#### At School by School-Employed or Contracted Mental Health Professionals

Concerning the 2017-2018 school year, a statistically significant difference was not present by school level,  $\chi^2(2) = 2.35$ ,  $p = .31$ . Elementary schools

provided the fewest diagnostic mental health assessment at school by school-employed or contracted mental health professional, followed by middle schools and then high schools. Table 4 contains the descriptive statistics for this school year.

**Table 4: Descriptive Statistics for Frequencies and Percentages of Diagnostic Assessments at School by School-Employed or Contracted Mental Health Professionals by School Level for the 2017-2018 School Year**

School Level	Yes	No
Elementary	( <i>n</i> = 282) 85.5%	( <i>n</i> = 48) 14.5%
Middle	( <i>n</i> = 481) 87.8%	( <i>n</i> = 67) 12.2%
High	( <i>n</i> = 559) 88.9%	( <i>n</i> = 70) 11.1%

#### Outside of School by School-Funded Mental Health Professionals

Regarding diagnostic assessment outside of school by school-funded mental health professionals for the 2015-2016 school year, a statistically significant difference was revealed,  $\chi^2(2) = 21.52$ ,  $p < .001$ , small

effect size, Cramer's *V* of .10 (Cohen, 1988). As revealed in Table 5, three-fifths of elementary schools did not provide diagnostic assessments outside of school by a school-funded mental health professional compared to a little over half of middle schools and less than half of high schools.

**Table 5: Descriptive Statistics for Frequencies and Percentages of Diagnostic Assessments Outside of School by School-Funded Mental Health Professionals by School Level for the 2015-2016 School Year**

School Level	Yes	No
Elementary	( <i>n</i> = 207) 40.1%	( <i>n</i> = 309) 59.9%
Middle	( <i>n</i> = 338) 47.0%	( <i>n</i> = 381) 53.0%
High	( <i>n</i> = 412) 53.2%	( <i>n</i> = 362) 42.8%

**Note.** The *n* represents the number of schools.

#### Outside of School by School-Employed or Contracted Mental Health Professionals

For the 2017-2018 school year, the result approached, but did not reach, the conventional level of

statistical significance,  $\chi^2(2) = 5.03$ ,  $p = .08$ . Although nearly one-third of all school levels did not provide mental health assessments outside of school by school-employed or contracted mental health personnel,

elementary schools were more likely not to provide these services followed by high schools and then middle

schools. Delineated in Table 6 are the descriptive statistics for this analysis.

**Table 6: Descriptive Statistics for Frequencies and Percentages of Diagnostic Mental Health Assessments Outside of School by School-Employed or Contracted Mental Health Professionals by School Level for the 2017-2018 School Year**

School Level	Yes	No
Elementary	( <i>n</i> = 204) 61.8%	( <i>n</i> = 126) 38.2%
Middle	( <i>n</i> = 378) 69.0%	( <i>n</i> = 170) 31.0%
High	( <i>n</i> = 425) 67.6%	( <i>n</i> = 204) 32.4%

**Note.** The *n* represents the number of schools.

## DISCUSSION

Data regarding the frequency of schools in providing diagnostic assessments at school by school-funded mental health professionals by school level were obtained and analyzed from the national SSOCS for the 2015-2016 school year. Inferential statistical analyses revealed that diagnostic assessments at school by school-funded mental health professionals were statistically significantly different by school. Elementary schools had the highest percentage that did not provide diagnostic assessments to students under the official responsibility of a licensed mental health professional. Nearly 10% fewer middle and high schools did not provide such services. This occurrence could be due to all school levels having school-employed educational assessment diagnosticians to perform these assessments.

During the 2017-2018 school year, providing diagnostic mental health assessments to evaluate students for mental health disorders was also statistically significant by school level. Nearly half of elementary schools provided diagnostic mental health assessments to evaluate mental health disorders. In contrast, more than half of middle and high schools provided such services.

Diagnostic assessments at school by school-employed mental health professionals were statistically significantly different by school level in the 2015-2016 school year. Almost three-fifths of elementary schools did not provide diagnostic assessments at school by school-employed mental health professionals, compared to more than half of middle schools and less than half of high schools that did not provide such assessments. Regarding diagnostic mental health assessment at school by school-employed or contracted mental health professionals, a statistically significant difference was not present for the 2017-2018 school year. Elementary schools provided the fewest diagnostic mental health assessments at school by school-employed or contracted mental health professional, followed by middle schools and then high schools.

Regarding diagnostic assessments outside of school by school-funded mental health professionals for the 2015-2016 school year, a statistically significant difference was revealed. Diagnostic assessments were

available to slightly over half of high school students outside of school by a mental health professional. Less than half of middle and elementary schools ensured that this mental health service was available to students. In the 2017-2018 school year, diagnostic mental health assessments outside of school by school-employed or contracted mental health professionals was not statistically significant by school level. Over two-thirds of elementary, middle, and high schools provided students diagnostic assessments outside of school by school-employed or contracted professionals.

### Implications for Policy and for Practice

Based on the results of this study, several implications can be made for policy. Policymakers should rethink the role of mental health experts at each school level and explore reforming how licensed professional counselors are employed on and off campuses. In this study, mental health professionals are professionals who are licensed (e.g., psychiatrists, psychologists, psychiatric/mental health nurse practitioners, psychiatric/mental health nurses, clinical social workers, and professional counselors). Currently on the elementary level, counselors, whether licensed or not, are used as guidance counselors. At the secondary level, a major responsibility includes creating and assisting students with scheduling and graduation. By restructuring how licensed counselors are used on campus, more students may have more access to diagnostic assessments. Second, schools and universities should include an introductory course identifying the interconnectedness between various mental health professions and the educational setting and how these professions can contribute to providing mental health services/diagnostic assessments in K-12 schools. Third, policymakers should implement awareness campaigns each school year regarding mental health awareness and assessments.

Implications for practice include awareness efforts provided at all school levels and implementation of the Response to Intervention framework for mental health. Similar to the Response to Intervention framework that is used for academics, Tier I would consist of prevention and awareness. Tier II would include a screening for students who display certain behaviors such as suicide, drug abuse, cutting, and depression or students who have been identified to be in

crisis. Lastly, Tier III would address the needs of students who need intensive support such as counseling, psychological evaluation, and other clinical care. School campus principals and/or administrators should gather input from teachers, counselors, and other mental health professionals regarding how this system could be implemented efficiently and effectively at each school level.

### Recommendations for Future Research

Based upon the results discussed in this article, additional recommendations for future research can be made. First, researchers are encouraged to replicate this study using more current data. Second, researchers should consider a study on contracted mental health professionals and how they support schools to bridge the mental health gap in the area of diagnostic assessments. Moreover, researchers should analyze the differences in factors that limit school efforts to provide mental health services by school level. A final recommendation for future researchers would be to analyze differences in staff training and practices by school level as this investigation could provide insight regarding mental health and training in the educational arena.

## CONCLUSION

Through inferential statistical analyses of national survey data, statistically significant differences were present for all research questions except for the two questions regarding diagnostic assessment at school and outside of school by school-employed or contracted mental health professionals. For the 2015-2016 school year, students at all school levels were less likely to receive diagnostic assessments at school by school-funded mental health professionals. During the 2017-2018 school year, students at all school levels were more likely to be provided diagnostic mental health assessments for mental disorders. Readers should note, however, that a substantial percentage of students was present who are not being provided this service. School leaders and administrators should strongly consider implementing the Response to Intervention framework for mental health. This system could aid in identifying students who are at risk for mental health disorders and provide next steps for teachers and parents.

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