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School Mental Health in Charters: A Glimpse of Practitioners from a National Sample

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School Mental Health in Charters: A Glimpse of Practitioners from a National Sample

Abstract

Charter schools are part of a global push for alternative governance models in public education. Even though U.S. charter schools enroll nearly 3.2 million children, little is known about school mental health (SMH) practice in charter schools. The current study was the first step in a line of inquiry exploring SMH and school social work practice in charter schools. Using cross-sectional survey research methods, the authors conducted brief one-time phone surveys with charter school social workers and counselors identified using a stratified random sampling strategy with national charter school lists. The final sample for analysis was 473 schools. Of these, 44.4% ($n = 210$) had a school social worker or counselor present at least one day per week, of whom 67 (30.5%) were school social workers. The school social work sample reported a number of job titles, including "school social worker" (67%) and many (13.4%) that were a variation of counselor (e.g., "behavioral counselor," "social emotional counselor"). Half were employed by their school, five were employed by an outside organization contracted with the school and eight were employed by the school's chartering organization. More than three-quarters (83%) had a master's degree in social work as their highest degree. Our findings provide a snapshot of the SMH and school social work workforce within the emerging practice setting of charter schools. Findings suggest that the SMH workforce may be professionally similar to those in traditional public schools, but with more flexibility for interprofessional collaboration, professional advocacy, and role definition. Other implications for research are also discussed.

Keywords

school mental health, charters, school social work

School Mental Health in Charters: A Glimpse of Practitioners from a National Sample

In recent decades, multiple countries (including Qatar, New Zealand, England, Chile, Nigeria, Thailand, England, Indonesia, South Korea, Uganda, Trinidad and Tobago, and the Netherlands) have introduced schools that blend public funds with governance models that are not subject to conventional governmental oversight. These models include charter schools, schools run by non-governmental organizations, publicly funded independent schools, government-funded private schools, and grant-maintained schools. While not identical in approach, these “public-private partnership” (PPP) models have in common predominantly public funding, accessibility to any eligible students, access to nongovernmental funds, and an emphasis on autonomy from governmental regulation in exchange for accountability to student performance standards, all in the interest of improved educational outcomes for students (Brewer & Hentschke, 2009). This type of autonomy stands in contrast to state-regulated, bureaucratically overseen positions in government-sponsored schools, and is often promoted as an opportunity for schools to innovate, unencumbered, in response to specific student and community needs. Concerns have been raised about PPPs’ lack of democratic accountability to governmental and citizen oversight, screening out of lower-performing students, and poor working conditions for educators (Ball, 2012; Termes et al., 2015; Verger et al., 2016), yet PPPs continue to proliferate globally. Pertinent to the present study, PPPs have autonomy over personnel: what kinds of personnel to hire, with what qualifications, and what kind of work those personnel will do (Davies & Hentschke, 1994). Because of their increased autonomy and flexibility, PPP schools represent a potential space for new responses to longstanding student support service delivery needs.

The United States provides a useful space for inquiry about student support delivery within PPP schools. U.S cities and states have actively engaged with the development of public-private partnership schools—called charter schools in the United States—since 1991 (LaRocque, 2008). Charter schools enroll more than 3.1 million children, a large proportion of whom belong to racially minoritized groups and/or live with poverty (NCES, 2020a). U.S. charter schools have received criticism due to evidence that they contribute to urban school racial segregation, reject and push out special education students, have negative discipline and social climates for BIPOC students, and are often positioned by states and cities to compete against unionized schools and districts (Monarrez et al., 2019; Sondel et al., 2019; Waitoller et al., 2019; White, 2018). Still, charters continue to receive widespread governmental and philanthropic support and draw attention for their potential for innovation.

Charter school proponents have emphasized their potential for academic innovation, although we consider their potential for student support innovation. U.S. schools face acute problems providing adequate student wellness supports (ACLU, 2019), in spite of evidence that schools are often the only spaces where students can receive psychosocial support services (Arnold et al., 2020). To date,

however, there is precious little understanding of social work or counseling practice in charter schools. Accordingly, the present study explores the presence and nature of social work and counseling services in this organizational setting. To frame this study's relevance, we next describe the state of charter schools in the United States and the psychosocial support problems in P-12 schools that are present in U.S. schools. These bodies of knowledge lead us to the research questions: 1) To what extent are mental health professionals present in charter schools? and 2) What training do charter school-based mental health professionals possess?

A stratified random sample of charter schools across the United States informs our answer to these questions. As we detail below, our findings demonstrate a diverse array of mental health professionals in charter schools, including school social workers and counselors, that have varied and inconsistent professional and educational backgrounds. Our article concludes with discussion of our findings and implications for school social work practice in both charter schools and traditional schools.

Literature Review

Public-private partnership schools like charter schools bring with them the promises of autonomy and innovation, which is evocative for U.S. school mental health practitioners. Just as educators have been stymied by stubborn systemic limitations, school-based mental health practitioners have struggled with dilemmas in their efforts to address student mental health and wellness concerns. Below, we briefly introduce public-private partnership and charter schools, considering the promise presented about innovation and autonomous decision making about student, educator and community needs. We then consider obstacles to U.S. school-based mental health practice and how charter schools might address these.

Charter Schools' Potential for Innovative Mental Health Promotion

Public-private partnership (PPP) schools, including charter schools, emerged in the 1990s as an alternative to traditional government-funded schools, aspiring to improve upon conventional schooling practices, increase access to no-cost schooling and to improve school quality at a low cost to the public (Baum, 2018). While PPP schools date back as far as government-church partnership schools in 18th century Ireland (Milne, 1974), these schools gained momentum at the turn of the 21st century. The rationale often put forward, in addition to those described above, is the push for "more flexibility to make decisions about how they operate and use funding to deliver specific school level targets" (Courtney, 2017, p.49). Citing these same objectives, U.S. educators and policymakers turned to charter schools in the early 1990s (Fabricant & Fine, 2012). The term "charter" refers to the charter document that operators receive from states allowing schools to operate under public auspices without being part of a public school district. The number of charter schools in the United States has increased steadily, now exceeding 7,200, with schools operating in 44 states (NCES, 2020b). Charter

schools' proponents describe the "bargain" struck by charter school operators as one wherein charters receive autonomy and must deliver student performance in return (Brinson & Rosch, 2010). Under this agreement, charter school leaders and educators face fewer state- or school district- imposed bureaucratic challenges to the implementation of strategies intended to increase student achievement (Bulkley & Fisler, 2003; Toma & Zimmer, 2012). Charter school leaders typically make autonomous decisions about budgetary, hiring, curricular and instruction, and select resources and programs that will fit their student body's unique needs (Baker & Dickerson, 2006; Carrasco & Gunter, 2019; Oberfield, 2017).

While the degree of autonomy experienced by charter schools varies by state (Brinson & Rosch, 2010), this autonomy is presumed to create space for innovative educational practices. According to Lubienski (2003), the charter school logic model holds that structural reforms like deregulation and provider competition lead to increased opportunity for innovation in areas such as merit pay and the use of private capital and parental involvement contracts, thereby ostensibly promoting student achievement and parent satisfaction. Under the last two U.S. presidential administrations, charter operators have seen expanded access to federal funds specifically designated for charter schools, often in the name of supporting innovative responses to chronic student underachievement (Corbett, 2015). The federal 2015 Every Student Succeeds Act (ESSA), for example, includes dedicated funding to charter schools that supports the opening of new charter schools, the replication of successful schools, and facilities financing (OESE, 2020).

Empirical research is mixed on the extent to which innovation in charter schools has occurred, but the assumption persists that a unique opportunity for innovation exists in charters.

While evidence does not consistently point to charters' ability to *accomplish* innovation, it is certain that charters are home to mental health professionals serving in as-yet underexplored capacities. And though the number of mental health practitioners in charters is not well understood, emerging scholarship describes their work. (Reference suppressed) (2016), for example, examined differences between school social work practice tasks across several school types including charter schools, traditional public schools, and schools operated by the state after persistent low academic performance (called "takeover" schools in some states). The study demonstrated school social workers in takeover schools were more likely to engage in student and teacher sessions than those in traditional public schools. Takeover school social workers were also more likely to engage in classroom-based work. Charter school social workers engaged more in group and individual counseling than did traditional and takeover school social workers and were less likely to provide assessment or evaluation. While this study's sample is small, it provides some of the only insight into the potential uniqueness of student support work in charters as compared to traditional public schools.

School Mental Health Funding and Practice Problems in U.S. Schools

Further, potential exists within charter schools to address funding and practice dilemmas faced by school mental health providers in traditional public schools. At a basic level, many traditional public schools employ insufficient or no school-based mental health support personnel (American Civil Liberties Union, 2019). The fields of school counseling, school psychology and school social work all decry inadequate funding to meet school demands. Individual school counselors serve an average of 482 students, and school social workers serve an average of 880 students, rather than the 250:1 student-to-practitioner ratio recommended for both professions (Fuschillo, 2018; NASW, 2018; NCES, 2019). Students in schools that primarily serve students of color encounter even higher student-to-practitioner ratios (NCES, 2019). Amid the hotly contested Chicago Teachers Union strike in 2019, striking teachers demanded a social worker for every school, rather than the one social worker per 1,238 students employed at the time (Bouleanu, 2019).

Funding for school mental health positions typically comes from local school districts, which encounter multiple, competing demands for funding support. The American Counseling Association successfully lobbied for federal funds to support school counselor positions as part of the federal Every Student Succeeds Act (ESSA), which now provides grants under the Student Support and Academic Enrichment Program (ACA, n.d., OESE, 2019). School social workers generate funds to support their positions through grant-writing and Medicaid billing for certain services they provide (Wisconsin Department of Public Instruction, n.d.), but many of these funding sources are time-limited or restricted to specific activities. Similarly, some states mandate school social worker and school psychologist involvement in special education eligibility testing, which generates financial support for positions but can also dominate practitioners' roles and priorities (Kelly et al., 2015).

Practitioners also encounter restrictions upon their employability in many public school districts. In the decentralized U.S. public school system, state and local boards of education oversee public schools and determine the necessary qualifications and certifications for school-based mental health practitioners. As a result, professional clinical degrees (in fields such as school counseling, school social work and school psychology) are often insufficient to qualify a practitioner for employment in a public school, and state certifications are also required (American School Counselor Association, 2020; SocialWorkLicensure.org, 2020). Further, licensure and certification requirements vary across states. In light of these substantial limitations, charter schools' comparative deregulation and decision-making autonomy create space that could allow for alternative approaches to the employment of school-based mental health practitioners.

The present study examines staffing patterns in the charter school setting. As a preliminary inquiry into how charter schools engage school-based mental health professionals, we investigated the degree to which these professionals are present in a nationally representative sample of charter schools.

Methods

We used a cross-sectional survey to address the research questions: 1) To what extent are mental health professionals present in charter schools? and 2) What training do charter school-based mental health professionals possess?

Data Collection Procedures

One-time phone surveys were conducted with charter school social workers and counselors whom we identified using a stratified random sampling strategy of all registered charter schools in the United States in the 2013-2014 school year (NCES, 2015). U.S. states and the District of Columbia were placed within one of five strata based on the number of charter schools within the state at the time, ranging from 20 to 1,125 schools. We determined this strategy would prevent oversampling of states with the most and the fewest charter schools. For example, California had the most charter schools (1,125) but some states had as few as 20 charter schools at the time. States with fewer than 20 charter schools ($n = 6$) were eliminated completely to avoid oversampling as well. Ten states had no charter schools at the time. Table 1 describes the strata.

We randomly selected 300 schools (approximately 20%) from each stratum for feasibility. We then called each selected school and asked to speak with the school's counselor or school social worker. If we were connected, we proceeded with the phone survey. If we were told that the school employed neither a counselor nor a social worker, we recorded that information. We used replacement sampling until we reached a sample of near 20% for each stratum.

Measures

The survey interview consisted of six items that gathered basic descriptive information about the participant's job title, employer (e.g., school district, charter management organization), license obtainment, and highest degree earned. All interviewers used a detailed script to administer the survey verbally. Responses were recorded on an Excel spreadsheet and then compiled across interviewers to form the full database.

Sample

We determined some of the schools within our original sampling frame had closed, while others did not have working phone numbers or did not answer after three call attempts. Replacement sampling allowed us to replace some of these

schools, yet there were times when the same schools were selected for replacement. In the end, we spoke with individuals from 995 charter schools (a 66% response rate). We were unable to determine if 520 (52.5%) of the schools employed a school social worker or counselor. Common causes for a non-determination were that the respondent: did not know, declined to reveal that information, or indicated a “yes” but the school social worker or counselor did not respond to our outreach. We removed these schools from the analysis, leaving a final sample of 471 schools.

Data Analysis

Data were transferred from Excel to SPSS at the completion of data collection. We used descriptive statistics to address the research questions. Chi-square analyses examined if having a practitioner and practitioner licensure status differed across strata.

Results

Presence in Charter Schools

Results are presented in Table 2. Of the 471 schools in the sample, 44.2% ($n = 208$) had a school social worker or counselor present at least one day per week. The Chi-square analysis indicated that the presence of a practitioner at sampled schools differed significantly across strata ($\chi^2(4, 471) = 79.27, p = .00$). Strata 3 and 4 had the fewest practitioners present at least one day per week and included states with moderate numbers of charter schools, such as Michigan, Ohio, New York, and Louisiana. Of sample schools with a practitioner, 31% ($n = 65$) employed school social workers. Other practitioners identified as school counselors ($n = 54, 26\%$) or counselors ($n = 37, 18\%$), while 52 practitioners (25%) had other related titles, such as “family support specialist” or “student service coordinator,” even though their educational backgrounds were in social work or counseling (see section titled “Training” for more information). Among school social workers, job titles included “school social worker” (67%) and others (13.4%) that were a variation of counselor (e.g., “behavioral counselor,” “social emotional counselor”; not inclusive of “counselor” and “school counselor”). Other job titles included “life skills coach,” “outreach coordinator,” “mental health specialist” and “family advocate.” Half of the school social workers were employed by the school’s chartering organization and the remainder were employed by a contracting organization such as the school community’s local public school district, the county office of education, or local non-profit or for-profit mental health provider organizations. Among the counselor sub-sample ($n = 70$), 88.6% were employed by the school’s chartering organization.

Training

Nearly half of those we sampled (44.4%; $n = 89$) held a degree in counseling (e.g., school counseling, community counseling), 64 (32.3%) held degrees in social

work, 36 (17.3%) held an undergraduate or graduate degree in another field, and 10 (fewer than 5%) held degrees in education (nine participants did not provide educational information). Three participants did not report pre-professional training in social work, counseling or psychology. Instead, they respectively held bachelor's degrees in "sociology with a minor in psychology and an emphasis in criminal justice," communications, and sociology. In terms of graduate education, more than three-quarters (83%) of the social work sub-sample held a master's degree in social work as their highest degree. All of the counselors reported graduate degrees in counseling. Nearly three-quarters (72.6%; n = 151) of practitioners reported having a state-level license or certification for their current job. The number of licensed or certified practitioners was significantly greater for Stratum 1 (California) compared to all other strata ($\chi^2(4, 184) = 12.63, p = .01$). We could not examine differences in educational attainment across strata due to insufficient cell sizes.

Discussion

This study's results offer insights on state-, charter network, - and school-level factors that shape mental health practice in schools. They suggest there may be state-specific characteristics that guide the hiring of mental health professionals in schools. In this sample, states that had the fewest practitioners in schools were not states with the fewest number of charter schools, suggesting other factors may influence a school's hiring and use of a mental health practitioner. It is possible that those states with the most charter schools (i.e., California, Texas, and Florida) were particularly intentional in the inclusion of mental health practitioners. Our results also indicate there is a diverse array of professional backgrounds among mental health professionals in U.S. charter schools. From the variations in position titles that include school social worker, behavior counselor, and social emotional counselor to varied educational backgrounds, participating school-based mental health professionals in charter schools have significant heterogeneity. While the current sample in our study was limited, social workers were a prominent group. Additionally, the structure of participants' positions varied, with about half of the sample being employed directly by the charter school or operator, and the rest employed through a contract between the school and other organizations. The majority of the sample had advanced degrees, and many held licensure and certifications specific to their positions in schools. In fact, practitioners in California (stratum 1) were most likely to hold licensure in comparison to every other state in the sample.

Our results mirror ways in which traditional public schools utilize different structures of employing school-based mental health professionals (Kelly et al, 2016). Similarly, some work directly for school districts while others are employed by community based mental health agencies. However, in the present study's sample, charter operators not only hired social workers directly and through community based mental health providers, but also hired many different types of professionals to provide mental health services. Additionally, charter operators provided mental health professionals with a wide range of job titles as discussed

above. Among our sample, those providing mental health services in charters often included non-social workers with varied educational backgrounds. These variations in our sample shed light on potential nuances for personnel decision-making, interprofessional collaboration. Further, the slight variation across strata in sampled schools' presence of a mental health professional and those professionals' licensure status demonstrates there may be regional or other characteristics (e.g., statewide charter legislation) that influence the mental health workforce in charter schools.

Limitations

Along with its contributions to the literature, this study also had several limitations. First, the data were collected using traditional phone-based interviews, a method that involves the challenges of making contact with potentially non-working numbers or unattended voicemails. Given the difficulties of contacting participants, we also were unable to conduct more robust survey collection. Additionally, the nature of charters often includes frequent shifts in charter operations including staff changes, school closure, school name changes, and school consolidation. These factors complicated data collection and limited our sampling strategy over time. Second, the survey results were limited in scope by our instrument's deliberate brevity. The tradeoff for securing participation with a very short survey is that our results demonstrate charter school providers' presence, academic degree and title, but do not shed light on how the participants provide school based mental health services.

Third, the potential sensitivity of our survey may have skewed participation rates. There is sustained controversy around charter schools in the United States with many being maligned for lack of efficacy, equity, and rigor (e.g., Eastman et al, 2017). U.S. charter schools are steeped in the contentious politics of school choice. Proponents argue charter schools provide a superior education, while opponents argue education is a public good that must extend civil rights to all (Jason, 2017). Many charter practices have been questioned by school equity advocates (Pearson et al, 2015), and the desire to portray charter schools in a positive light may have been at the forefront of participants' minds. As such, we occasionally encountered suspicion among school personnel, which made it challenging to obtain full information during the data collection process. These limitations highlight the challenges of survey research on an often-controversial topic, but we feel they do not diminish the quality of the data that we ultimately did collect.

Implications for Research

Scope of practice. As the present study identifies varied staffing practices in charter schools, it also suggests areas for further inquiry. Future research could engage a larger, more diverse sample to understand the differences across states, regions, and professionals employed in charter schools. Additionally, this study could be bolstered by a second phase of research that seeks to gain a more in-depth

understanding of school-based mental health practice in charters. An exploration of the similarities and differences in charter school social work and traditional public school social work would build on work such as (Reference suppressed, 2016), which outlines practice differences between charters and traditional public schools in one state in the United States. Comparative studies of U.S. charter and international public-private partnership schools could shed light on employment patterns and practice decisions that are unique to this form of schooling, as well as variation across nations.

Professional development. Likewise, future research might explore the preparation and professional development needs of charter school mental health professionals to inform charter school-specific professional training and professional development. It remains unclear what professional preparation school-based mental health professionals in charter schools may need to address students' concerns, and whether findings in this area might suggest space for innovation in school-based mental health professional preparation more generally. Further, given the statistically significant differences in mental health practitioner presence and licensure in this study, it would be useful for future studies to explore state-specific requirements, guidance, and regulations. This may be especially relevant for states with both the most and fewest charter schools.

School leadership. Our findings also suggest further inquiry that involve school leaders. As key decision-makers in staffing and job responsibilities, particularly in charter schools that do not necessarily have the same bureaucratic structures for hiring and supervision as traditional public school districts, charter school leaders stand to substantially influence school-based mental health personnel hiring practices and subsequent employment. Research on mental health services in charter schools could include school leader perspectives on the need for, structure of, and benefits of these services. Limited research examines school principals' perspectives on school mental health and student support (e.g., Iachini et al., 2015) and even less so for charter schools. For example, (Suppressed reference et al) (2018) found the principal of a mid-size charter school hired a school social worker as the dean of students given her background in positive behavior supports and interventions and her prior influence on school climate. Principal involvement in mental health professional hiring is not well understood, however, and charter school may prove a pivotal location for such research given the potential for greater professional latitude.

Social work supervision. Staffing flexibility in charters means school based mental health professionals serve in various leadership and clinical roles, such as deans, special education directors, family liaisons and behavioral coaches. Additional research could illuminate ways in which school based mental health employment arrangements ultimately shape how and from whom school based mental health providers receive supervision (Suppressed reference et al.) (2017). Supervision assignments are known to influence practitioners' performance evaluations and access to professional development, with those serving under

principals often lacking access to useful mental health resources (Suppressed reference et al) (2017).

Implications for Practice

Innovation in hiring and role definition. Our study demonstrates how mental health professionals from multiple professional backgrounds serve charter schools, and thus how the autonomy that charter schools have may contribute to flexible and varied hiring practices and role definition. Less prohibitive regulatory standards may enhance charter schools' ability to meet students' mental health and support needs, by approaching job descriptions, hiring practices or role structures in a flexible manner, in turn allowing schools to provide and adjust services. Such an approach might also highlight ways to racially and linguistically diversify the school-based mental health practitioner workforce.

However, our findings do suggest the possibility of a loosening of professional standards that some charter school critics have anticipated. If charter schools use autonomy to hire less qualified practitioners, their ability to meet students' support needs may be compromised. Given the large number of minoritized students in charter schools and charter schools' mixed record with the enrollment of special education-eligible students (e.g., Barnard-Brak et al., 2018; Waitoller et al., 2017), unorthodox hiring practices may signal a problematic enactment of autonomy. While there is little cross-disciplinary research on the combined school mental health workforce, the school social work literature offers a clue about comparisons to public schools. Of the 3,700 school social workers sampled in the most recent national school social work survey (Kelly et al, 2015) only 57% reported a licensure or certification, with more than 40% without a license. Thus, the 25% non-licensed charter sample represents a smaller proportion of practitioners, comparable to school social workforce in traditional public schools.

Interprofessional collaboration. Additionally, because our participants reported multiple educational and practice backgrounds, perhaps the unique autonomy and flexibility in charter school staffing decisions could provide an opportunity for increased interprofessional collaboration between school social workers and other mental health and wellness professionals. Also, there may or may not be traditional issues of "turf" in interprofessional work within charters given the different parameters of practitioners' work there. Successful interprofessional collaboration requires clear communication by each profession represented to work on a goal to which each profession can contribute (McRae, 2012). A lack of synergy among providers of different professions can lead to practitioners feeling marginalized in decision making, leading to less robust outcomes for provider teams (Cleak & Williamson, 2007).

Professional advocacy. Professional advocacy is another pressing implication of our study. Our results indicate that both counselors and social

workers have varying professional titles within their charter schools, as well as other practitioners with similar titles. Professional clarity seems obscured, which suggests potential larger issues of professional turf as well as appropriate education and preparation for the multiple, potentially overlapping mental health roles and responsibilities in schools.

Networking and professional development. The results of this study also provide helpful guidance for professional development and networking among school-based mental health professionals. Variations within expertise and educational background in our sample suggest the helpfulness of targeted training for mental health practitioners in charter schools. These learning opportunities could be specifically tailored to charter school structures and operations so that school-based mental health professionals receive information that can be appropriately applied in this setting. To date, it is unclear whether mental health professionals in charter schools are more alike across professions due to their unique practice setting, or if there remain considerable professional differences. While research should continue to investigate this area, professional development must keep pace with the changing needs of charter school practitioners.

Conclusion

As students in charter schools, like those in other schools around the world, adjust to the pre- and post- COVID learning environment, charter school leaders must prioritize the delivery of school mental health to these students. As long-term mental health outcomes begin to manifest for students who have survived the global pandemic, charter leaders are presented an opportunity to examine their strategy for provision of mental health services and to maximize the usefulness of flexibility to meet student needs.

Few studies investigate mental health services in charter schools despite their increasing presence in both the United States and international educational landscape. This study was a first effort to identify and document school-based mental health professionals' presence in charter schools, along with these practitioners' professional profiles, including job titles, professional preparation, and licensure status. Our nationally representative sample offers a glimpse of mental health practice in charter schools, indicating that most practitioners have professional backgrounds in social work or counseling with graduate education and licensure. Nevertheless, the job titles of school-based mental health professionals in charter schools vary considerably and are not necessarily connected to a practitioners' training or professional identity. It also is clear the autonomy afforded to charter schools may enhance their ability to flexibly hire mental health professionals. Given schools' difficulties employing sufficient numbers of school-based mental health professionals to meet students' needs, these findings may signal an alternative path toward the goal of providing the support students deserve.

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Table 1. Number of schools and states in each stratum.

Stratum	Criteria for Number of Schools	Range of Number of Schools	States
1	20-1000	21-95	New Mexico, Utah, Georgia, New Jersey, Massachusetts, Indiana, Tennessee, Illinois, South Carolina, Missouri, Maryland, Arkansas, Idaho, Nevada, Hawaii, Alaska, Oklahoma, Rhode Island, New Hampshire, Delaware,
2	101-300	109-242	Wisconsin, New York, Colorado, Minnesota, Pennsylvania, North Carolina, Oregon, Louisiana, District of Columbia
3	301-600	370-600	Arizona, Ohio, Michigan
4	601-1000	600-658	Texas, Florida
5	1000+	1,125	California

Note. States with fewer than 20 charter schools were eliminated to avoid over- and under-sampling. States are listed in order from highest number of schools to lowest number of charter schools within the stratum.

Table 2. Results across Strata (N = 471 schools)

	Stratum					χ^2	df	p
	1	2	3	4	5			
Mental Health Professional								
No	58	24	34	110	37			
Yes	60	61	30	17	40			
Total	118	85	64	127	77	79.27	4, 471	.00
Highest Educational Attainment								
Bachelor of Social Work	1	2	1	1	1			
Undergraduate degree, other	1	5	1	2	0			
Master of Social Work	25	17	8	2	6			
Master's degree, Counseling	17	24	14	8	25			
Master's degree, Education	3	0	2	3	2			
Graduate degree, other	9	8	3	1	6			
Total	56	56	29	17	40			
Licensure Acquired								
No	6	16	3	5	3			
Yes	46	36	21	11	37			
Total	52	52	24	16	40	12.63	4, 184	.01

Note. A chi-square test was not conducted to examine differences in highest educational attainment due to insufficient cell sizes across stratum.

