School Mental Health: Perceptions and Practice of School Psychologists

Dissertation

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By

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Abstract

Research indicates that the needs and numbers of students requiring mental health services exceed what is currently being offered and the consequences to children's health and development are dire (Farmer, Burns, Phillip, Angold, & Costello, 2003; Kataoka, Zang, & Wells, 2002). School psychologists are charged with significant responsibilities regarding the provision of mental health services to students and yet there are challenges that exist within schools related to role demands, ethical responsibilities, and needs of the students. There is a critical need to examine how school psychologists are adjusting their role to meet this need and the types of services they provide. This study was designed to explore (1) the types of mental health services school psychologists provide (2) the amount of time school psychologist devote to the provision of mental health services, (3) role perceptions and the extent to which school psychologists perceive they are meeting students' mental health needs, (4) barriers and facilitators to mental health service provision. Practicing school psychologists in the state of Ohio (N = 122) completed an online survey regarding perceptions and practices of mental health service provision within the schools. The results of the study found that a little more than half of school psychologists are providing mental health services, yet most agreed that it was in their role to provide such services. Of all the mental health services, participants reported that

assessment of social/emotional/behavior and formal consultation comprised most of their time related to mental health service provision. Most participants agreed that students were in need of mental health services further acknowledging that the services they currently provide are not meeting the needs of students. High caseloads and time and integration on site emerged as the most impactful barriers to mental health service provision. Implications of these findings are discussed.

Dedication

I dedicate this to Jeremy, Kevin, and Jack. Without your love, support, and patience this would not have been possible.

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Chapter 1: Introduction

Statement of the Problem

The U.S. Surgeon General defined mental health as "the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity" (U.S. Department of Health and Human Services, 2001, p.4). Undoubtedly, mental health is a critical component influencing children's learning and overall general health (Suldo, Friedrich, & Michalowski, 2010). There is resounding agreement within the literature that when children's mental health needs are not tended to properly their development and overall well-being can be negatively affected (Swerdlik & Meyers, 2003). The quality of children's mental health can be influenced by a variety of external factors placing them at a higher risk for problems (Adelman & Taylor, 2006). Everyday struggles at home, school, in their communities, and within their relationships with others can pose harm if children are ill equipped to manage them effectively. These challenges compounded by neglected mental health needs can result in a dangerous combination that may threaten healthy development. These challenges exist to varying degrees in every child's life, and while schools are unable to ameliorate all sources of negativity, the nation's stakeholders in children's mental health acknowledge the importance of helping children to manage the negative impacts that these influences may have throughout the course of their lives (Adelman & Taylor, 2006; U.S. DHHS, 1999).

Unfortunately, the mental health needs of school age children have grown exponentially over the years. One in every four to five youth in the U.S. meets criteria for a mental disorder with severe impairment across their lifetime (Merikangas et. al, 2010). Other studies have found mental disorder prevalence rates between 17% -21%, with some approximations reaching 38% (Committee on School Health, 2004; Goodman et al., 1997; Marsh, 2004). These prevalence numbers do not include *many* youth who are "at risk" and could benefit from help (Brown, Riley, & Wissow, 2007; Roberts, Roberts, & Xing, 2007). The most prevalent disorders among children between the ages of thirteen and eighteen include anxiety disorders (38%), behavior disorders (19.1%), mood disorders (14.3%), and substance abuse (11.4%), with 40% of those with one class of disorder also meeting criteria for another class of lifetime disorder. To compound matters, nearly half of all school age children in large urban communities' experience significant problems associated with learning, behavior, and emotional regulation. Many of these students experience these tribulations as a result of environmental factors rather than internal pathology. External risk factors include neighborhood, family, school, peer influence/interactions, economic deprivation, community disorganization, violence, drugs, poor quality caretaking and/or abuse (Adelman & Taylor, 2006).

While mental health disorders may not affect all students, most children experience some problems that may interfere with their learning (NASP, 2006). Children who struggle socially or emotionally are less likely to benefit from academic instruction (Gable & Van Acker, 2000; McClelland, Morrison & Holmes, 2000). Moreover, there exists a significant amount of literature that addresses the damaging effects that mental

health problems can have on children's overall developmental and well-being such as school failure, poor social skills, adjustment difficulties, substance abuse, communication problems, suicide, and a wide range of social, emotional and behavioral problems (Brener, Wiest, Adelman, Taylor, & Smiley, 2007; Meyers & Swerdlik, 2003).

Despite the growing problem, schools and communities are not meeting the need of mental health services that students require. It is estimated that an astounding two-thirds of all young people with mental health problems are not getting the help they should (Farmer et al., 2003; Kataoka, Zang, & Wells, 2002). One study found that 76.1% of Caucasian children, 76.5% of African American children, and 88.4% of Hispanic children have unmet mental health needs (Kataoka et al., 2002). This is especially true for impoverished children from racial and ethnic minority groups, as they are particularly susceptible to mental health difficulties and unfortunately have the greatest challenges accessing appropriate care (U.S. DHHS, 2001).

In determining how to address these issues, accessibility to services is a fundamental consideration, especially when considering the gap between the need for services and those that receive treatment (Farmer et al., 2003; Kataoka et al., 2002). Of those that do receive treatment, 70-80% receives services from within the schools (Foster et al., 2005). One study found that 11%–12% of youth in any given year accessed the education sector for mental health services. In contrast, only 7% and 4% of youth reported use of the inpatient and outpatient mental health clinics and general medical sector, respectively, for psychological care (Farmer et al., 2003).

Schools provide excellent settings for targeting children's mental health, their academic performance, and the important connection between them (Greenwood, Kratochwill, & Clements, 2008). Schools are logical environments to provide such services as children spend a majority of their day there (Brener et al., 2007); and they employ trained school based personnel qualified to provide mental health services such as school psychologists, counselors, nurses, and social workers. Furthermore, many school districts offer a range of programs and services oriented to student needs and problems. Some of these services are provided within the school district while others are carried out at or linked to specific schools within the district. Some are owned and operated by schools and implemented by school counselors, psychologists, social workers, and other student support staff, with additional support provided by community agencies (Brener et al., 2007). However, the literature continues to yield information supporting the disparity of services available and accessible by those in need.

While there is significant evidence referencing the need for mental health services in schools, many challenges exist. There are several barriers that impact the implementation and function of these services in schools (Powers, 2003). Results of a study conducted by Foster et al. (2005) found that schools identified several barriers to the provision of mental health services including lack of funding for mental health services; limited availability of services and providers on site or in the community; significantly increasing mental health needs; and families struggling with multiple issues such as unemployment, lack of insurance and linguistic barriers. Adelman and Taylor (1998) highlighted how the school culture, with its focus on instruction and academic

achievement, might not be structured to support a comprehensive approach to mental health service provision. Furthermore, lack of administrative and teacher support may function as a hindrance to the effective implementation and sustainability of programs within schools (Brown & Bolen, 2008). The reality of issues related to funding, staffing, training, role strain, parent factors, and high numbers of student needs compounded by the work load of school staff are significant factors when examining the provision of mental health services in schools. Despite the immense need, it may be difficult for mental health services to find adequate support for implementation and sustainability, especially working in inner city schools with a high prevalence of problems.

The alarming rate of mental health problems in children is not simply a problem that exists without support; but, rather it is an issue that has been attracting significant attention on local, state and national levels for decades. Public health officials, politicians, physicians, mental health professionals, and school professionals are just some of the major stakeholders involved in responding to the crisis that exists within our schools and among America's youth. School policy makers have a lengthy history of trying to assist schools in dealing with factors that interfere with learning. In addition, many government driven initiatives and a variety of mental and public health agendas have emerged to address the growing problems in our schools (Adelman & Taylor, 2006). These attempts are evidenced through the range of health, social service, counseling, and psychological programs schools have provided from the end of the 19th century through today. Despite these efforts, there exists significant problems meeting the

needs of students and with collaboration and coordination of school and community based services (Suldo et al., 2010).

In 1995, the Health Resources and Services Administration: Maternal and Child Health Bureau lead a federal initiative to support mental health schools. In 2000, they were joined by the Substance Abuse and Mental Health Administrative (SAMHSA) and the initiative was renewed which resulted in the funding of two national training and assistance centers for mental health in schools. Located at the University of California at Los Angeles and the University Of Maryland School of Medicine, these centers provide resources for school based mental health professionals and work to strengthen policies and programs in school mental health.

In September of 2000, the Surgeon General's Conference on Children's Mental Health was held to address the mental health issues prevalent in our schools and among our youth. Following that conference, on January 3, 2001, David Satcher, M.D., Ph.D., Assistant Secretary for Health and Surgeon General, released a *National Action Agenda for Children's Mental Health*, which outlined goals and strategies to improve the services for children and adolescents with mental health problems and their families. The report called to the forefront the crisis in mental health for children and adolescents and addressed several areas where improvement and attention is paramount in addressing this crisis before the nation. The goals included: creating awareness of mental health problems and reducing stigma, creating and implementing evidenced-based treatment interventions, improving the identification and assessment of mental health problems, eliminating racial and socioeconomic disparities, improving the accessibility of

treatment, improving the infrastructure of mental health service coordination, increasing access and provision of quality services, training frontline providers to identify and manage mental health issues and educate them about evidence based interventions, and monitoring access and provision of services to ensure coordination and quality. This agenda had implications for all those involved in the provision of mental health services for children and beyond; enveloping those that have significant interaction with children, particularity individuals working within the school environment (U.S. DHHS, 2001).

In 2002, during the George W. Bush administration, the *President's New Freedom Commission on Mental Health* was created to study the mental health service delivery system and make recommendations that would enable both children and adults with mental health problems to live, work, learn, and participate fully in their communities. The poor coordination of services among the systems that existed within the community and school arena was identified as an area in need of significant improvement. In their final report, the Commission recognized the important role that schools can play in meeting the mental health needs of children and adolescents. The implications from this report highlight the importance for school and community providers to work in tandem to help bridge the gap in need and service provision and accessibility was imperative (President's New Freedom Commission on Mental Health, 2003).

Furthermore, the *Individuals with Disabilities Education Improvement Act of 2004*, specifically addresses children with mental health problems. Children with emotional disturbance may be eligible for special education and related services under IDEA. This law requires schools to screen, assess, and plan treatments for students with

emotional and behavioral disorders. It further emphasizes special education and related services be designed to meet their unique needs and prepare them for employment and independent living (IDEA, 2004).

In 2005, the Substance Abuse and Mental Health Services Administration (SAMHSA) issued the *Federal Mental Health Action Agenda,* which outline the need to promote and provide early intervention services for at-risk children and identify ways in which these services could be efficiently and effectively delivered. A subsequent report was generated based on a survey of school mental health services conducted in 2002-2003. While the report was intended for policy makers at state and local levels, the information gathered offers a snapshot of what mental health services look like in the schools. It further serves to inform school professionals of student needs, services, coordination efforts, barriers, etc. (Foster et al., 2005).

These government initiatives have had a direct effect on the training and practice of school psychology. In 1997, the National Association for School Psychologists put out a document entitled *School Psychology: A Blueprint for Training and Practice II*. This document acknowledged the thrust for school psychologists to expand their role to meet the ever changing needs of the students. The document explicitly indicated the need for school psychologists to attend to school and students' needs as they relate to development and mental health, with special emphasis on prevention, wellness promotion, and crisis intervention. As a result they needed to be prepared with the knowledge and skills to identify and intervene with regards to developmental issues and psychopathology (Ysseldyke, et al., 1997).The blueprint not only had implications for practice, but for

training programs as well. Future practitioners needed to become better equipped to manage the problems related to mental health.

The 2002 Conference on the Future of School Psychology also addressed the changes in the role of school psychologists with significant emphasis on the paramount function of the school psychologist and their role in attending to students' mental health needs. The goals and principles that emerged from that conference identified the shift in focus toward improving academic competence, social and emotional functioning, family-school partnerships, classroom instruction, and school-based child and family health and mental health services for all learners (Ysseldyke et al., 2006).

In 2006, NASP came out with *Blueprint III: Model for School Psychology Training and Practice* which further reinforced and clarified the role of school psychologists, clearly highlighting the important role school psychologists must play in Enhancing the Development of Wellness, Social Skills, Mental Health, and Life Competencies. This document acknowledged that schools were increasingly becoming the main access point for mental health services and further emphasized the role of school psychologists as practitioners who can guide parents and teachers in learning how to create and sustain environments where students can feel protected; cared for; and experience the self-confidence to take risks as they grow and develop into healthy, well-functioning individuals. The document indicated that school psychologists should have specialized training in providing mental health services and should be used to provide those services both directly and indirectly. The document also recognizes that while school psychologists cannot be all things in the way of mental health they are equipped to

take leadership in this area armed with the knowledge to access resources and seek out assistance in areas of need (Ysseldyke et al., 2006).

As a result of these legislative and professional activities, school psychologists have come under increasing pressure to expand their role. Both legal and ethical standards highlight their responsibility in caring for the mental health needs of children (NASP, 2010). The logic that school psychologists fit uniquely into this role is supported by their training in both learning and mental health (Rappaport, Osher, Garrison, Anderson-Ketchmark, & Dwyer, 2003). School psychologists are trained to manage issues related to learning, mental health, socialization, emotions, and behaviors, and therefore possess the skills and knowledge to address these problems as they arise in schools (Rappaport et al, 2003). Furthermore, regarding the provision of these services, school psychologists are an ideal fit to deal with issues related to mental health (National Association of School Psychologists [NASP], 2006).

Despite their preparedness, school psychologists are often inundated by their obligations to special education (Massey et al., 2005). Most school psychologists report spending less than 25% of their time involved in direct services (Bramlett, Murphy, Johnson, Wallingsford & Hall, 2002; Hosp & Reschly, 2002). School psychologists report the most common mental health services provided include group counseling, individual counseling, and crisis intervention (Brener et al., 2001; Suldo et al., 2010; Brener et al., 2001). However, the number of students served by psychologists exceeds the NASP recommended ratio of one psychologist per 1000 students by two to three times (NASP, 2000, p.54). One study found that school psychologists serve an average of

9.9 students through individual counseling and 8.8 students through group counseling per school year (Curtis et al., 2008). These studies highlight the disparity between problem rates and service provision. These obstacles coupled with the immense mental health needs of students pose a significant challenge to schools psychologists as they attempt to negotiate their legal and ethical responsibilities related to address mental health needs in the children they serve.

Fortunately, school psychologists' professional roles have become more comprehensive since the profession's humble beginnings in the late 1800's. While the role still remains primarily focused toward assessment, with an average of 46%–55% of their time spent conducting psycho educational assessment; the role has begun to shift to include other practices; with 19%–26% of school psychologist time focused on direct interventions (e.g., counseling), 16%–22% in consultation, and 1%–2% in research (Hosp & Reschly, 2002). School psychologists may involve themselves in several activities that reflect their role as a mental health professional in the school including, but not limited to: development, support or facilitation of prevention and intervention programs, group and /or individual counseling, crisis intervention, behavioral interventions, case management, social-emotional behavior assessment, in service trainings, parent support groups, provide leadership regarding positive behavior supports, and ensuring that instructional and mental health supports are complimentary (Canter, 2006; Sudlo et al., 2010). It must be further stated that the level of involvement and the variety of activities related to the provision of mental health services varies significantly among the profession. While some school psychologists find themselves willing and able to support

a variety mental health services in schools, research indicates that others are limited by barriers that include role strain, lack of administrative support, few resources, resistant personnel, and insufficient training (Sudlo et al., 2010).

Rationale for the Current Study

The need for schools to respond to the growing mental health problems in children is immense. Research indicates that the needs and numbers of students requiring mental health services exceed what is currently being offered and the consequences to children's health and development are dire (Farmer et al., 2003; Kataoka, Zang, & Wells, 2002).

School psychologists are charged with significant responsibilities regarding the provision of mental health services and the schools. While their role is vital to providing these services, there are challenges that exist within schools related to role demands, ethical responsibilities, and needs of the students. Research has shown that school psychologists report wanting to increase their involvement in mental health service provision with the schools (Agresta, 2004; Hosp & Reschly, 2002); however, their role is limited due to their obligations to special education (Meyers & Swerdlik, 2003). It remains a challenging and often daunting task for professionals to negotiate the parameters of their position with the needs and demands of the position.

The legislative actions and initiatives that have emerged over the past 15 years to address mental health needs in children and adolescents have had a direct impact on the field of school psychology. This is further supported and evidenced in the practice and ethical standards of the field of school psychology. The fulfillment of these initiatives is

an ongoing effort with outcomes that have yet to be fully realized. While there are some positive changes within schools, there appears to be a gap between research and practice (Atkins, 2003).

There is a critical need to examine how school psychologists are adjusting to their changing role in the provision of mental health services and the mental health needs of the students they serve. While government initiatives and training and practice guidelines assert the vital role school psychologists play in the provision of mental health services, research has yet to explore school psychologists' perceptions regarding their role and the provision of mental health services. Furthermore, it is important to examine whether role perception is in alignment with the mental health activities of school psychologists. The results of the current study will provide nuanced information regarding the types of services provided and the average amount of time school psychologists spend delivering such services. In addition, it is important to determine what factors are impacting the provision of mental health services by school psychologists.

In acknowledgement of the unique differences between national regions and states, this study is designed to explore the mental health perceptions and practices of school psychologists in the state of Ohio. This is a fundamental first step in approaching this problem on state and local levels. Specifically, results from this study will provide a foundation for future research and may be used to inform education/training programs and professional development activities.

The results will also yield information on the factors that serve to promote or inhibit the provision of these services. Acknowledgement of these factors can inform

school psychologists as they negotiate their role to better serve the mental health needs of students. The foundation of this study can they lay the framework to build on how we improve, maintain or expand these activities to meet the growing needs of our students.

Research Questions

This study is designed to explore (1) the types of mental health services school psychologists provide, (2) the amount of time school psychologist devote to the provision of mental health services, (3) role perceptions and the extent to which school psychologists perceive they are meeting students' mental health needs, and (4) barriers and facilitators to mental health service provision.

The specific research questions for this study are:

(1) What types of mental health services do school psychologists provide?

(2) How much time do school psychologists spend providing mental health services?

(3) Do school psychologists perceive it as within their role to provide mental health services and do they believe they are meeting the mental health needs of their students?

(4) What barriers prevent the provision of services and what promoters facilitate the provision of mental health services?

Chapter 2: Literature Review

In order to truly address the problem of mental health in children and adolescents, it is important to understand the scope and magnitude of these issues. Unfortunately, the reality is that children and adolescents in the United States are dealing with mental health issues at staggering rates (Brown et al., 2007; U.S. DHHS, 1999). One in every four to five youth in the U.S. meets criteria for a mental disorder with severe impairment across their lifetime (Merikangas et. al, 2010). Other studies have found mental disorder prevalence rates between 17% -21%, with some approximations reaching 38% (Committee on School Health, 2004; Goodman et al., 1997; Marsh, 2004). These prevalence numbers do not include many youth who are "at risk" and could benefit from help (Brown, Riley, & Wissow, 2007; Roberts, Roberts, & Xing, 2007). In addition, these statistics may provide an underestimate of the problem as not all individuals seek treatment for mental health issues.

Common Mental Health Conditions in Children and Adolescents

The National Institute of Mental Health (NIMH) has identified several disorders that commonly affect school age children. Attention Deficit Hyperactivity Disorder (ADHD) is one of the most common conditions seen in the schools. Students with ADHD find it extremely challenging to control their impulses and/or pay attention, which in turn poses a significant challenge to learning. It is estimated that between three and five percent of children have ADHD, however, it is estimated that up to one half of all

children with ADHD are never diagnosed and therefore, many subsequently go untreated (NIMH, 2011). More recent studies show an increasing trend with 9% of children between the ages of 13 and 18 suffer with ADHD (Merikangas et al., 2010).

Both, Oppositional Defiant Disorder (ODD) and Conduct Disorder are characterized by persistent patterns of disobedient, hostile, and defiant behavior towards authority figures and rule-based systems. It is estimated that one to six percent of the school-age population is affected by ODD, with one to four percent of nine to seventeen-year-olds displaying behaviors consistent with Conduct Disorder (U.S. DHHS, 1999). Problems related to defiance and disobedience cause considerable problems for teachers and school administrators and greatly interfere with a student's ability to function effectively within their schools and communities.

Anxiety disorders are also quite prevalent within the school age population. Anxiety is generally characterized by excessive worry or fear and can interfere with healthy functioning and academic performance. Research found that 13% of students between the ages of nine and seventeen had been diagnosed with some form of anxiety disorder (U.S. DHHS, 1999). The National Institute of Mental Health found a lifetime prevalence rate of 25.1% for anxiety in children between the ages of 13 and 18 (Merikangas et. al, 2010).

Major depression is a condition characterized by sadness, low mood, irritability, lack of volition, etc. that may affect a young person's ability to think, feel, and behave in a typical manner. Depression can lead to a variety of problems including, but not limited to school failure, poor familial and social relationships, alcohol and drug use, and even

suicide. Studies have shown that, at any given time, as many as one in every 33 children may be suffering with clinical depression and the rate of depression among adolescents may be as high as one in eight (U.S. DHHS, 1999). The most recent statistics indicate that 11.2% of children and adolescents between the ages of 13 and 18 suffer with Major Depressive Disorder (Merikangas et. al, 2010).

Suicide is the third leading cause of death for 15 to 24-year-olds, and accounts for 12.3% of all deaths in that age group. In addition, 90% of children who commit suicide have a mental health disorder (U.S. DHHS, 1999). In 2009, the Center for Disease Control and Prevention conducted a study of United States High School students using the Youth Risk Behavior Survey. They found that females were more likely to report having considered, planned, and attempted suicide compared to males, with 17.4% of females considered suicide versus 10.5% of males; planned suicide: 13.2% (females) versus 8.6% (males) and attempted suicide: 8.1% (females) versus 4.6% (males) (CDC, 2009).

There are also several identified the risk factors associated with suicide including: family history of suicide, family history of child maltreatment, previous suicide attempt(s), history of mental disorders (particularly clinical depression), history of alcohol and substance abuse, feelings of hopelessness, impulsive or aggressive tendencies, cultural and religious beliefs (e.g., belief that suicide is noble resolution of a personal dilemma), local epidemics of suicide, feelings of isolation, barriers to accessing mental health treatment, loss (relational, social, work, or financial), physical illness, access to lethal methods, and unwillingness to seek help because of the stigma attached to

mental health, substance abuse disorders, or suicidal ideation (McLean, Maxwell, Platt, Harris, & Jepson, 2008).

In contrast, protective factors can provide some safeguards to individuals from experiencing suicidal thoughts and behavior. While protective factors have not been studied as extensively as risk factors; it is important to understand how protective factors can help inform how we respond to the mental health needs of children. The following have been identified as protective factors: effective clinical care for mental, physical, and substance abuse disorders, easy access to a variety of clinical interventions and support for help seeking, family and community support, support from ongoing medical and mental health care relationships, skills in problem solving, conflict resolution, and nonviolent ways of handling disputes, and cultural and religious beliefs that discourage suicide and support instincts for self-preservation (U.S. Public Health Service 1999). Suicide risk and protective factors are important considerations for school professional as we respond to the mental health needs of our students.

Suicide and Mental Illness

In 2001, Sanchez and Le sought to determine the association between suicide and mood disorders. They completed a review of the literature consisting of 15 studies published from 1978 to 2001. Their review included five studies investigating psychiatric diagnoses from psychological autopsies with children and adolescents, four studies investigating the prevalence of depression and suicide attempts, and six follow-up studies of depressed children and adolescents and suicide occurrences. Of the children who had attempted or completed suicide, mood disorders were the most common

diagnosis. Children and adolescents who experienced depression and another mental health disorder (externalizing disorders or substance use disorders) were at higher risk for suicide completion. However, researchers discovered that early identification and treatment of mood disorders decreased the probability of suicide completion. It is unclear how studies were selected for inclusion in the study. However, the review provided evidence of a link between mood disorders and suicide attempts and completion. Furthermore, the study identified the increased risk of suicide in children and adolescents with co-morbid mental disorders.

Another study conducted in 2004 by Kelly, Cornelius, and Clark examined the effects of psychiatric disorders on attempted suicide among adolescents with substance use disorders (SUD). The participants consisted of a sample of 503 adolescents, 315 (62.6%) males and 188 (37.4%) females diagnosed with substance use disorders. Participants were selected from a group of adolescents who had participated in research studies at the Pittsburgh Adolescent Alcohol Research Center between 1991-2000. The diagnosis of substance use disorders was determined using the expanded Structured Clinical Interview for DSM-III-R disorders with modifications including additional items from DSM-IV (1994) defined substance use disorders. Psychiatric disorders were assessed using the Kiddie-Schedule for Affective Disorders and Schizophrenia (K-SADS). Diagnoses were made in clinical consensus conferences that included the assessor, the assessment coordinator, and a clinically experienced faculty psychiatrist using the best estimate method. Information about suicide attempts were gathered through participant and parent report (Kelly et al., 2004).

The results found that 17% of the participants had attempted suicide during their lifetime. Of those 17%, 29.8% of females and 9.5% of males made one or more lifetime suicide attempts. Approximately 97% of males and 91% of females who attempted suicide met the diagnostic criteria for major depression as compared to 32.9% and 54.5% of non-attempters, respectively. Further analysis found that 13.8% of males and 14% of females who attempted suicide met diagnostic criteria for Bipolar disorder. Almost 70% of those who had attempted suicide (versus 49.2% non-attempters) met criteria for conduct disorder. Both males and females who attempted suicide reported using substances at an earlier age than those who did not make an attempt. Approximately 55% of those who attempted suicide in comparison to 30.1% of non-attempters met diagnostic criteria for ADHD (Kelly et al., 2004).

The results of the study support associations between mental illness and suicide attempts among adolescents with substance use disorders. These associations should both alert and inform schools, policy makers, and practitioners to the importance of intervening on behalf of the mental health of the children and adolescents.

In 2007, Klomek and colleagues sought to explore the association between bullying behavior and depression, suicidal ideation, and suicide attempts among adolescents. A self-report survey was completed by 9th through 12th grade students (n = 2,342) in six New York State high schools between the years of 2002 and 2004. Measures included a demographic questionnaire, the Beck Depression Inventory (BDI), the Suicide Ideation Questionnaire, the Diagnostic Review Schedule for Children, and a bullying questionnaire based on the World Health Organization study. Using regression

analysis, the results showed that approximately 9% of the sample reported being victimized frequently and 13% reported bullying others frequently. Both perpetrators and victims of frequent bullying were associated with higher risks of depression, suicidal ideation, and suicide attempts compared to those not involved in bullying behavior. Children who were frequently bullied in school had higher rates of depression (29.5%) than students who were not bullied (7.3%). In addition, participants who were only infrequently involved in bullying behavior (perpetrator or victim) had an increased likelihood of depression, suicidal ideation, and suicide attempts. Participants who reported being bullied frequently (11.5%) and less than weekly (7%) reported serious suicidal ideation (7%) and suicide attempt (10.8%). Participants who bullied others had elevated rates of depression (11%-18%), suicidal ideation (6%-7%) and suicide attempts (6%-8%) (Klomek, Marrocco, Kleinman, Schonfeld & Gould, 2007).

Psychopathology and School Related Outcomes

Researchers have found significant links between antisocial behavior and mental illness. Studies of incarcerated and adjudicated delinquents have confirmed the high prevalence of externalizing and internalizing psychopathology in this group (Haapasalo & Hamalainen, 1996; Pliszka, Sherman, Barrow & Irick 2000). Similarly, epidemiological studies have found that conduct disorder (CD) carries significant comorbidity with a number of psychiatric disorders such as Attention Deficit Hyperactivity Disorder (ADHD), major depression, and anxiety disorder. Students exhibiting these characteristics are at high risk for poor outcomes (Angold, Costello, & Erkanli, 1999).

French and Conrad (2001) conducted a longitudinal study examining the relationship between school dropout, peer rejection and antisocial behavior. Over a two-year period, 516 eighth-grade students in a suburban school district in the Pacific Northwestern United States participated in the study. Youth were assessed using peer ratings of antisocial behavior and social preference. Data was gathered in group assessment sessions. Ratings of anti-social behavior were obtained using a 10-item measure (4-point scale) that focused on characteristics of antisocial behavior. Ratings of social preference were obtained using a 9-item scale (4-point scale). Graduation rates and achievement scores were obtained from school records. The researchers found that antisocial behavior was strongly correlated with school dropout. Adolescents who demonstrated antisocial behavior as well as peer rejection had an increased rate of school dropout. Antisocial behavior was also related to poor academic performance.

In 2002, researchers Glied and Pine conducted a study to examine the correlates and consequences of high levels of depression in adolescents. The Commonwealth Fund Survey of the Health of Adolescent Girl (CFSAG) was a self administered survey that was provided to males and females between the ages of 10-18 (n = 4,648). The survey included questions on participants' health status, risk behaviors, and school performance. The Children's Depression Inventory was used to assess depressive symptoms of adolescents. Results showed that depression was present in 5% of males and 9% of females, with depression peaking at the age of 14 years for females. Depression was correlated with a history of physical or sexual abuse, violence in the home, and severe life stressors. Adolescents with depression also missed more days of school (p<.05) than

non-depressed adolescents and were two times as likely to have been retained a grade. Adolescents with depression reported higher rates of smoking ($p<.001$), alcohol and drug use ($p<.05$), and binge drinking. Suicidal thoughts were significantly more prevalent in adolescents with depression ($p<.001$) than those who were not experiencing depression. This study yielded important findings regarding academic and social outcomes of adolescents with depression.

Egger, Costello, and Angold (2003) examined the relationship between school refusal and child and adolescent psychopathology. Data was collected from the Great Smokey Mountains Study which included 4,500 children ages nine, 11, and 13 years who were recruited from the Student Information Management System of public schools in North Carolina. Participants' behaviors were screened using the Child and Adolescent Psychiatric Assessment (CAPA) and individuals interviews were also conducted. Except for ADHD, all diagnoses were based on parent and child report obtained through structured psychiatric interviews conducted with participants and their parents. The diagnosis of ADHD was based on structured psychiatric interviews conducted with participants' parents. School refusal was broken down into three subtypes including anxious school refusals (i.e., children who did not attend or left school due to intense anxiety), pure truancy (i.e., children who did not attend school or left school without permission or an excuse for reasons not associated with anxiety), and mixed school refusals (i.e., children with both anxious and truant refusals). Egger and colleagues additionally examined school resistance and nonattendance. Results indicated that solely anxious school refusals were associated with depression and separation anxiety; pure

truancy was associated with oppositional defiant disorder, conduct disorder and depression. Eighty-eight percent of children with mixed school refusals had a psychiatric disorder. Participants with both school refusals and poor attendance demonstrated increased rates of emotional and behavioral disorders. Participants in the anxious school refusals group and truancy group were significantly associated with child and adolescent psychopathology (Egger, Costello, & Angold, 2003).

Shahar and colleagues (2006) conducted a longitudinal study examining the relationship between adolescent self-criticism and depressive symptoms and grade point average (GPA) in sixth and seventh grade students (n = 466) in upstate New York. Measures for this study were the Depressive Experiences Questionnaire for Adolescents (self-criticism) and the Beck Depression Inventory (BDI) (depressive symptoms). Student GPAs were collected from the participants' report cards for the 1993-1994 and 1995-1996 school years. No gender differences in depressive symptoms were found. In general, males had lower GPAs and were more self-critical than females at initial and final evaluations. Depressive symptomatology was positively correlated with self-criticism (r = .33, p<.01). The higher the number of depressive symptoms the lower the participants GPA (r = -.37, p<.01). Similarly self-criticism was negatively correlated with GPA (r = -.30, p<.01). High levels of self-criticism and depressive symptoms had a negative effect on GPA ($ß$ = -.19, p<.01). Symptoms of depression had a negative effect on GPA ($ß$= -.23, p=.03) in females with low levels of self-criticism however, there was no effect for high levels of self-criticism. This study showed a moderate association

between depressive symptoms, self-criticism, and academic achievement among middle school students (Shahar et al., 2006).

Grover, Ginsburg, and Ialongo (2007) examined concurrent and long-term outcomes for children with symptoms of anxiety disorders. A community sample of 149 first grade children (ages five through eight) referred by their teachers from Baltimore public schools participated in this study. The majority (87.9%) of the participants were African American. Participants were assessed in the first grade and again in the eighth grade. To measure anxiety symptoms, researchers used the Baltimore How I Feel-Young Child Version, Child Report and Parent report. Teacher reports were gathered using the Shy Behavior subscale of the Teacher Observation of Classroom Adaptation-Revised in addition to structured interviews to assess children's performance on accepting authority, social participation, and self-regulation. Academic functioning was measured in first grade with the Comprehensive Test of Basic Skills. Eighth grade assessment of academic achievement was measured using the Kaufman Test of Educational Achievement (KTEA). Children experiencing symptoms of anxiety in first grade were three times more likely to score in the bottom 33% on tests of reading and mathematics than non-anxious children. This finding was consistent for reading achievement at the follow-up assessments conducted in the eighth grade. Children with symptoms of anxiety in the eighth grade were more than two times more likely to be in the lower 33% in mathematics achievement than children without significant anxiety. Children and adolescents with symptoms of anxiety were 12 times more likely than non-anxious children to be identified as low in social acceptance in the first grade, and three time

more likely to be rated low in social acceptance in the eighth grade. Children with symptoms of anxiety were three times more depressed and five times more aggressive than non-anxious children in the first grade. In the eighth grade, children with anxiety were rated as being six times more anxious than children in the non-anxiety group. Patterns of aggression were not significantly different in the eighth grade assessments (Grover, Ginsburg, & Ialongo, 2007).

Hughs, Lourea-Waddell, and Kendall (2008) conducted a study examining somatic complaints of children with anxiety disorders and non-anxious children to determine if somatic complaints were a predictor of poorer academic performance. Researchers used a structured diagnostic interview to assess children between the ages of 8-14 years (N = 108). Children were then divided into two groups: (1) children with anxiety disorders (n= 69) and (2) non-anxious children (n = 39). Parents completed the Child Behavior Checklist (CBCL), and Teachers completed the Teacher Report Form, measuring academic and adaptive functioning. Results indicated that frequent somatic complaints were associated with poor academic performance, suggesting that somatic complaints may play a role in the connection between anxiety disorders and poor academic functioning. Additionally, Hughs and colleagues stated that early identification and treatment of somatic complaints may result in increased academic achievement for children and adolescents. Despite these findings, there were some limitations. First, the researchers did not assess children in the control group to determine if they had other disorders. Future research may find it helpful to examine children co-morbid disorders

which may have contributed to poor achievement (Hughs, Lourea-Waddell, &Kendall 2008).

A 2008 study conducted by Davis, Ollendick, and Nebell-Schwalm looked at cognitive ability, achievement, and anxiety disorders in 161 children (mean age 10.56 years). Measurements included the Wechsler Intelligence Scale for Children -Third Edition, the Wechsler Individual Achievement Test- First Edition, the Anxiety Disorders Interview Schedule for DSM-IV: Child and Parent Versions, and the Continuous Performance Task. Assessments were conducted by doctoral students in clinical psychology program at a university-affiliated outpatient assessment and treatment clinic. Following the assessments, participants were then divided into two groups: (1) children with a diagnosis of anxiety disorders, and (2) the comparison group (children diagnosed with disorders other than anxiety). Analysis revealed that children diagnosed with anxiety scored significantly lower on all achievement subtests. Furthermore, anxiety disorders were negatively related to IQ scores in children with co-morbid disorders (Davis, Ollendick, & Nebell-Schwalm, 2008).

These studies provide a snapshot into how mental health problems can negatively impact children's ability to effectively function within and as they move through the education system. These problems may have a profound effect on their futures. Schools have the unique ability to intervene and promote optimal mental health. In doing so, the problems that have been shown to influence children can perhaps be prevented or minimized.

Unmet Mental Health Needs

Research is clearly offering evidence that children and adolescents are not receiving the mental health care they require. In 2002, Kataoka and colleges conducted a secondary data analysis of three nationally representative household surveys that were conducted between the years of 1996-1998. The surveys included in the analysis were the National Health Interview Survey (*n* = 11,017), the National Survey of American Families (*n* = 28,867), and the Community Tracking Survey (*n* = 8,852). The purpose of the study was to determine the rates which children (ages 3-17) used mental health services and how many mental health needs went unmet. Children were identified as having an unmet need if they exceeded a cutoff score on a mental health screening and did not receive any mental health services in the subsequent 12 months. The results found a prevalence of mental health disorders ranging from 6% - 7.5%, with lower rates (2% - 3%) for children ages three to five. Children with public insurance accessed services (9-13%) more than children who did not have insurance (4% - 5%) or children with private insurance (5% -7%). Across all surveys, male children used services more than female children. Seventy-nine percent of children who received cutoff scores indicating a need for mental health evaluation did not receive one, with Latinos and children without insurance showing the largest discrepancy. While this study did not specifically define what qualified as mental health services, how children were referred for services, or who was providing services and in what settings, it yielded vital data on the use of mental health services by children and adolescents in relation to the need for services (Kataoka, Zhang & Wells, 2002).

In 2003, Farmer and colleagues studied the points of entry for children and adolescents accessing mental health services and how they moved through five specific sectors including: general medicine, specialty mental health services, education, juvenile justice, and child welfare. The data were from the Great Smoky Mountains Study, a longitudinal epidemiologic study of mental health problems and service use among youths. The sample consisted of 1,420 youths who were nine, 11, or 13 years old at study entry. Each youth and a parent were interviewed at baseline and every year thereafter about the use of services for mental health problems over the three-year study period. A screening questionnaire based on externalizing items from the Child Behavior Checklist (CBCL) was used to oversample youths with behavioral problems. All youths with scores above a predetermined cutoff point, as well as a 10% sample of youths with lower scores, were recruited into the study. This process resulted in a sample of 1,346 youths, 1,073 (80%) of whom participated in the study. The results found population estimates for three years indicated that 33.6% received services for emotional, behavioral, or substance use problems from one or more of the five service sectors. Services were provided most often by the education sector (24.1%). Specialty mental health services were used by 14.2% of the population. Approximately 11% of youths used education services, 7% used specialty mental health services, 4% used general medical services, and 1%- 2% used child welfare or juvenile justice services. Services from the education sector were most common (42%), followed by specialty mental health services (24%), general medicine services (15%), and child welfare or juvenile justice services (4%-7%). Across all age groups, the education sector was the most common point of entry. For youths who entered services

before the age of five years, 44% entered through this sector; for those who entered services between the ages of five and eight, 48%; for youths who entered between the ages of nine and 13 years, 62%; and for youths who did not enter services until after the age of 13 years, 52% (Farmer et al., 2003).

Burns and colleagues (2004) conducted a study examining the use of mental health services among children in child welfare who had histories of maltreatment. This study included 3,803 children and adolescents between the ages of two and fourteen who were selected from the National Survey of Adolescent Well Being. This survey provided a nationally representative sample of children and adolescents who were investigated by child welfare due to allegations of maltreatment. The need for mental health services was determined by the documentation of a mental health disorder by a mental health professional. For children who did not have a diagnosis, need was determined by using the Child Behavior Checklist (CBCL), which was completed by the foster parent. Mental health service use was measured with the Child and Adolescent Assessment to determine what types of services were used in the year preceding the study. The results showed that 47.9% of the children scored in the clinical range on the CBCL and subsequently identified as in need of mental health services. Of these children only 11.7% received services. Further analysis revealed that only 6.6% of children between the ages of two and five years, 15.5% of children age's six to ten, and 25.9% of children between 11-14-years-old received the services they needed. Eighty-four percent of the overall sample did not receive necessary mental health services. Of the children who did receive services, 23.6% received them from inpatient or outpatient facilities, 22.4% from outpatient only,

19.5% in a clinic or private practice, 7.7% received in home counseling, 5.1% in psychiatric facilities', and 1.4% in day treatment centers. The authors note that all of the children in the study were in foster care placements during the duration of the study, but the length of time in care was not taken into account when evaluating the validity of the foster parents' reports (Burns et al., 2004).

Anderson and Gittler (2005) investigated the extent of unmet mental health needs in children and adolescents with mental health (MH) and/or substance abuse (SU) issues. This study took a retrospective look at the adolescents between the ages of 12 and 18 (*n*=188) who had been discharged from outpatient mental health or substance abuse centers. The results indicated that 36% of adolescents who needed treatment for both mental health and substance abuse disorders received that care. However, 64% of adolescents with co-occurring disorders did not receive treatment consistent with widely supported guidelines recommending that individuals with co-occurring disorders receive treatment for both their MH and SU problems. Those who received mental health services demonstrated improvement in mental health, but not in their substance abuse problems. In addition, those that received only substance abuse services demonstrated an improvement in their substance abuse issues but showed no improvement in their mental health issues. Furthermore, the authors note that research suggests that individuals with physical and sexual abuse histories have higher likelihoods for substance abuse and behavioral and emotional problems; however, this study found that adolescents with sexual abuse histories were more likely to receive mental health services alone. The

results of this study yielded information on the unmet mental health and substance abuse problems in adolescents. (Anderson & Gittler, 2005).

Current Mental Health Services in Schools

Mental health services in schools can vary significantly from state to state, district to district, and school to school. While there are a host of services that could be provided to students, the reality is that the needs and numbers of students exceed what schools can reasonably offer.

During 2002-2003 school year, Foster, Rollefson, Doksum, Noonan, Robinson, and Teich (2005) conducted a national survey on behalf of the Substance Abuse and Mental Health Services Administration (SAMHA) to examine school based mental health services. The survey was disseminated to a nationally representative random sample which included 21,125 (K-12) public schools and 1,595 of their associated districts. They achieved a response rate of 60.5% for schools and 59.85% for school districts, noting that large urban schools were the least likely to respond; which is highly relevant to the topic as there may be a significant degree of underreporting. As previously discussed, many children and adolescents in urban areas are at greater risk for problems and therefore gathering data from those areas is vital to understanding the problem (Adelman & Taylor, 2006). The results indicated that during the school year, 20% of students received mental health services, with 87% of the schools reporting that all students were eligible to receive services while 10% of schools reported an Individualized Education Plan (IEP) was required for a student to receive mental health services. It was further found that 83% of schools with high minority enrollments were less likely to offer services to all children

in comparison to 91% of schools with low minority enrollments (Foster et al., 2005). This finding is consistent with previous findings that those in minority groups (while at greater risk for problems) are less likely to receive services they need (U.S. Department of Health and Human Services, 2001).

Schools reported several types of mental health problems existing within their systems. Problems reported with the greatest frequency included social and familial problems, with females reporting more internal problems, such as anxiety and adjustment issues, and males more behaviorally related problems such as disruptive behavior and aggression. The problems reported also took on a developmental shift with behavior related problems more prevalent in the primary grades. While those behavioral problems remained at the middle school level, an emergence of social and interpersonal problems not reported in the primary grades were indicated. Behavioral problems seemed to fade at the high school level; however, were replaced by problems related to depression and substance abuse (Foster et al., 2005).

Several types of mental health services were identified as being provided within the school including: assessment, behavior management, consultation, case management, referrals, crisis intervention, individual counseling, group counseling, substance abuse counseling, medication for emotional or behavioral problems, referral for medication management, prevention and pre-referral interventions, and family support services. However, there was variability among the schools with regards to what types of services were provided and with what frequency. The most common types of services provided were short term services. Approximately 80% of schools surveyed reported providing

assessment, behavior management consultation, crisis intervention, and referrals. In addition, seventy-six schools reported providing individual counseling with seventy-one percent providing case management and sixty-eight percent providing group counseling. Sixty-three percent of schools indicated providing prevention programs with the most prevalent being programs such as substance abuse prevention. Only 59% of schools reported using curriculum based programs to enhance social and emotional functioning. School-wide screenings for behavioral and mental health problems and parent outreach programs were the least common strategies used. Services identified as the most challenging to provide were family support services, medication and medication management, substance abuse counseling, and referral to specialized programs. Thirty-two percent of districts reported that they used only school or district employees to provide mental health services, whereas 28% of districts reported that they contracted only with outside providers for mental health services. Furthermore, 49% of districts used some contracts or other formal agreements with community-based organizations and/or individuals to provide mental health services to their students. Service coordination and referrals were most frequently made with county mental health agencies (29%), community health centers (19%), individual providers (18%), and juvenile justice systems (17%) (Foster et al., 2005).

Seventeen percent of schools reported having an arrangement with a 'school-based health center' operated by a community based organization to provide mental health services to their students. One-third of schools reported that they 'rarely or never' held interdisciplinary meetings among mental health staff or shared mental health

resources and conducted joint planning sessions between mental health and other staff. However, 40% of schools did report holding such meetings, and one-third of those schools held weekly or monthly joint planning sessions between mental health and other school staff, as well as weekly informal communication. Sixty-nine percent of districts reported an increased need for mental health services since the previous year. Despite this, only 21% of districts reported that the number of mental health staff had increased since the previous school year, and 33% of districts reported that their funding for mental health services had decreased from the previous year (Foster et al., 2005).

This study's findings confirm that mental health services currently play a vital role in the school setting. The findings also support the notion that students' needs for mental health services are increasing, and that adequate funding and availability of community resources are paramount if schools are to meet the challenge of addressing these needs. Future research may want to expand the research to explore school-wide or classroom wide prevention efforts, how well services are meeting student needs, and the quality, adequacy, or appropriateness of services provided.

In 2004, the Annenberg Public Policy Center (APPC), as part of the Annenberg Foundation Trust at Sunnylands' Initiative on Adolescent Mental Health, surveyed over 1400 public school professionals to examine perceptions of mental health and how schools provide treatment and counseling for students in need of such services. Telephone interviews were conducted with 725 high-school and 515 middle-school professionals knowledgeable about the mental health services in their schools. Similar to the findings in the Foster et al, (2005) study, mental health problems appeared to have a

development component. Middle school professionals were more concerned about interpersonal conflict. In addition, many middle school professionals identify depression (57%) and use of alcohol (28%) and illegal drugs (37%) as at least moderate problems. Bullying was seen as a problem by 82% of professionals and fighting by 57% of professionals in middle schools (APPC, 2004).

Consistent with the Foster and colleagues (2005) findings, results indicated that the respondents viewed high school student depression and use of alcohol and illegal drugs as more serious problems than various forms of violence, including bullying, fighting and use of weapons. Sixty eight percent of the high school professionals surveyed identified depression as a great or moderate problem in their schools. In addition, there was an overall concern regarding the use of alcohol (71%) and illegal drugs (72%). More than half of high school professionals identified bullying as a great or moderate problem, with lower levels of concern expressed about fighting between students (37%) and weapon carrying (6%) at the high school level. Other concerns cited were anxiety disorders (42%), eating disorders (22%), and various forms of self harm such as cutting (26%). Mental health problems appeared to have a development component with middle school professionals reported more concerns about interpersonal conflict. In addition, many middle school professionals identify depression (57%) and use of alcohol (28%) and illegal drugs (37%) as at least moderate problems. Bullying was seen as a problem by 82% of professionals and fighting by 57% of professionals in middle schools. Although 66% of the high schools indicated having a process for referring students with mental health problems to services, only 34% of those reported

having a clear and coordinated process for identifying such students. Forty-two percent of middle school professionals reported having a clearly defined process for identifying students with mental conditions. Only 7% of high school professionals said that all students who might need counseling or treatment actually receive such services and only 31% said that most do. Consistent with the literature, the majority indicated that only half or fewer received the services they need, again highlighting the overall disparity of services in schools (APPC, 2004).

The Center for Disease Control conducted a study in 2006 designed to assess mental health and social services at state, district, and school levels. State level data were collected from education agencies in all 50 states and the District of Columbia among a nationally representative sample of school districts (n = 445) via computer-assisted telephone interviews or self-administered mail questionnaires. In addition, computer-assisted personal interviews were conducted with personnel in a nationally representative sample of elementary, middle, and high schools (n = 873). The questionnaires were designed to assess the requirements for provision of services; collaboration between school mental health and social services staff and other agency and organization staff; evaluation of school mental health and social services; required staffing; credentials required for school counselors, psychologists, and social workers; School-Based Health Center services (SBHCs); services not provided on school property; and the educational background and credentials of the person who oversees or coordinates school mental health and social services for the state or district. For the purpose of the study, standard mental health and social services were identified as counseling, psychological services,

crisis intervention, alcohol or other drug use treatment, or identification of emotional disorders. These were defined as services offered at school to all students and usually provided by a school counselor, psychologist, or social worker or by staff from a contracted community agency (Brener et al., 2007).

The results showed that 76.8% of schools had a person who oversees or coordinates standard mental health and social services at the school. Slightly more than 50% of all schools had a full-time counselor, 8.3% of all schools had a full-time psychologist, and 14.3% of all schools had a full-time social worker. When expanding the frame to include part-time personnel, 77.9% of schools had at least part-time or full-time counselor who provided mental health or social services to students at the school , but only 61.4% of the schools had at least one part-time or full-time, on site, school psychologist who provided services to students. Less than half (41.7%) of schools had a part-time or full-time school social worker who provided services to students (Brener et al., 2007). Based on these findings it is clear that although schools may have personnel that can provide services, the limited number of those employed by schools and/or limitations of their availability at a given school may leave districts struggling to meet the overwhelming need and numbers of students requiring services.

To further highlight the disparity of mental health personnel and subsequent services, The National Association of School Psychologists, the American School Counselor Association, and the School Social Work Association of America all have recommended ratios for the maximum number of students to each professional; which are 250 students per counselor, 400 per social worker, and 1,000 per school psychologist.

The average ratio in the United States is currently 2–3 times greater than the maximum levels recommended by each of these groups (American Counseling Association et al., 2006). These poor staffing ratios compromise the ability of professionals to sufficiently address the mental health needs of students.

Student assistance programs (SAPs) provide services designed to assist students experiencing personal or social problems that can impact school performance, physical health, or overall well-being. More than half (55.6%) of states and 73% of districts had adopted a policy stating that SAPs will be offered to all students. Similarly, 58.3% of states and 73.6% of districts had adopted a policy stating that schools will create and maintain student support teams, which was defined as teams of school staff who work together to provide assistance to students with disabilities or those who are experiencing academic difficulties or behavioral problems (Brener et al., 2007).

Overall, 29.9% of districts had at least one School Based Health Center (SBHC); which this study defined as a health center on school property where students could receive mental health and social services. District data indicated that referral of services to local mental health or social service agencies were for the provision of services for emotional or behavior disorders including identification and intervention, crisis intervention for personal problems, identification of referral for physical, sexual, or emotional abuse, familial problems, case management, and individual counseling. Sixty-two percent of districts, but only 35% of states have arrangements with community health centers to provide these types of services, whereas 71.9% of districts had either a SBHC or contracts with community services to provide services (Brener et al., 2007).

The provision of mental health services and the quality of those services can depend greatly on the education and training of the staff employed by the schools. Many, but not all, new hires were required to be licensed by the state in order to provide mental health services, however, the training requirements varied. For example, 71% of districts required that new counselors have a master's degree in counseling, while more than 15% only required an undergraduate degree in counseling; 81.7% of districts required state licensure or certification. Only 62% of districts required school psychologists have a master's in psychology, with 19% requiring other master's or undergraduate degrees. Despite this, most states (95.9%) and 73.4% of districts required state licensure or certification. Only 60% of states and 37.7% of districts required master's degrees to work as a school social worker. Twenty-two percent and 24% of states and districts respectively required undergraduate degrees only, but 95% (state) and 56.3% (district) required licensure or certification (Brener et al., 2007).

In terms of collaboration among professionals, 94.0% of states and 59.9% of districts, mental health or social services staff worked with health *education* staff, and in 85.4% of states and 58.9% of districts, they worked with health *services* staff. (Health education staff referred to staff that provided health education to students, whereas health services staff were medical professionals who provided medical services to students). District mental health or social services staff worked with a local mental health or social services agency in 76.1% of districts, with a local child welfare agency in 71.8%, and with a local health department in 59.8% of districts surveyed. In comparison to the data gathered in 2000, these collaborative efforts have increased (Brener et al., 2007).This

information is relevant particularity as we look at the coordination efforts among schools and communities. It is clear from these studies that while there are attempts to provide mental health services in schools, they vary widely and are overall insufficient in meeting student needs.

The Practice of School Psychologists

The roles and functions of school psychology practitioners were studied by Bramlett, Murphy, Johnson, and Wallingsford (2002) through a national survey of National Association of School Psychologist members (n=370). This study examined demographic information, professional activities, types of referrals, and crisis intervention activities of practicing school psychologists. The majority (63%) of respondents was female, 40% held Master's degrees, 36% held Specialist degrees, and 24% held Doctoral degrees. The average length of professional experience was 18 years with 10% reported being in the field less than ten years, 43% reported practicing between 11-20 years, and 46% reported practicing as a school psychologist for over 20 years. Participants reported the amount of time they engaged in assessment, consultation, interventions, counseling, conferencing (e.g., meetings with teachers and parents), supervision, in-service, research, parent training, and other activities. Not surprisingly, the results indicated that professional duties were primarily spent on assessment activities (46%). Involvements in other professional duties were as follows: consultation (16%), interventions (13%), counseling (8%), conferencing (7%), supervision (3%), in-service (2%), research (1%), and parent training (1%). Results revealed that 49% of school psychologists reported providing behavioral consultation, 6% provided mental health

consultation and 45% indicated that they utilized 'other' forms of consultation. Referrals included: reading problems (57%), written expression (43%), task completion (39%), mathematics (27%), conduct (26%), motivation (24%), defiance (17%), peer relationships (16%), listening comprehension (14%), oral expression (11%), cognitive disability (formerly mental retardation; 10%), truancy (8%), and violence (6%). Internalizing mental health problems such as depression, anxiety, social withdrawal and suicidal ideation were the least common referrals cited (Bramlett et al., 2002).

Regional Differences

In 2002, Hosp and Reschly administered a survey tool to school psychologists (n = 1,056) in an effort to examine the regional differences in the practice of school psychology. They also attempted to examine the regional effects of legislation on the roles and functions of school psychologists. The researcher examined the differences in assessment practices, job satisfaction, beliefs about reform that prevent or enable certain roles and caseloads. The participants were divided by the U.S. census regions. The average age was 47.2 years, the majority (66%) was female, 33%-50% of school psychologists had been in the field for over 15 years, and 28% held doctoral degrees. The author's noted a significant change in the demographics of school psychologists. In 1984, Smith found the average age for practicing school psychologists to be 38.1 years whereas in 1995, Reschley and Wilson found an average age of 41.4. Clearly, this shift will have an impact on the practice of school psychology. The results showed that school psychologists reported spending 46%–55% of their time conducting psycho-educational assessment alone. School psychologists in the Northeast region of the country were more

focused on determining the underlying reasoning for student difficulties and were more apt to use personality or projective assessments in their practice. Furthermore, they also spent more time providing direct interventions as opposed to assessments in comparison to school psychologists in the other regions of the United States. In the Southeast Region, practice was more focused on intelligence and achievement testing. Practitioners in the Atlantic, Pacific, and Gulf Coasts used both projective and visual-motor assessments more often than those in the Plains, Midwest, and Mountain regions. Furthermore, a majority of school psychologists expressed a desire to reduce their time devoted to assessment activities and increase their involvement in intervention, consultation, and research in an effort to establish more of a balance among these activities. Results indicated that roles have expanded to include other activities with 19%–26% of school psychologists reporting time spent on direct interventions (e.g., counseling), 16%–22% in consultation, and 1%–2% in research. Overall, school psychologists acknowledged the need to assist general education teachers with intervention strategies prior to determining special education eligibility. Furthermore, professionals concurred that consideration of a child's response to interventions as well as using curriculum based measures to assess students was necessary to respond to the unique needs of children with suspected disabilities (Hosp & Reschly, 2002).

Barriers and Facilitators to Service Provision

A study conducted by Massey, Armstrong, Boroughs, Henson and McCash (2005) was conducted to capture the experiences of school mental health services providers (internal and external) and identify supports and challenges with implementing

and sustaining mental health services in schools. Participants were mental health providers of school aged children working within the school or community. Participants included program supervisors, mental health professionals, social workers, school counselors, and school psychologists. Twenty-two participants were assigned to a focus group based on the federally funded grant program they worked in: School System Prevention Programs, School System Intervention Programs, Community Based Prevention Programs, and Community Based Intervention Programs. Focus groups were conducted over a six-week period during the final year of the grants with each group last approximately 90 minutes. Focus groups' audio tapes were transcribed and analyzed using an informal long table approach. Six team members condensed the data to relevant issues based on frequency and the specificity of the direct quotations. The results showed that challenges included difficulty getting resources, gaining visibility for programming, identifying staff contacts, forging relationships with school staff (community providers), obtaining status and legitimacy for programs, a lack of administrative support, and poor communication with coworkers. Internal providers reported greater success and voiced less problems understanding the school organization and gaining teacher and administrative support than did external providers. Both external and internal providers highlighted the importance of administrative and school support for the successful integration of mental health services in schools (Massey et al., 2005).

Suldo, Friedrich, and Michalowski (2010) conducted a study designed to explore why school psychologists were not providing the level of mental health services that

children need. They examined the factors that promote and limit the provision of mental health services by school psychologists. Participants included school psychologists (n = 39) from two distinctly different school districts; (A) an urban, ethnically diverse district, serving 200, 000 students and (B) a suburban district serving 65,000 students. Eleven focus groups were held (seven in district A and four in district B) during the 2006-2007 school year. Participants were groups based on years of experience; one to five years; six to 16 years; and 17 or more years of professional experience. One researcher served as the moderator for all the focus groups. Transcripts of sessions were analyzed by the research team by coding themes and subthemes. The results yielded several themes that were identified as barriers to the provision of mental health services by school psychologists and included: problems with the physical school environment for delivering services, insufficient support from the department and district administration, problems with school personnel, insufficient training, insufficient time and integration into the school site, personal characteristics, large caseloads, challenging student factors, and role strain.

Not surprisingly, most of the factors that serve as barriers to the provision of mental health services also functioned as supports to school psychologists' provision of mental health services. Enablers to the provision of mental health services included departmental and administrative support, personal characteristics, time and visibility at the school site, facilitative relationships with school staff, sufficient mental health training, school environments conducive to providing services, lower caseloads, and

community support. No comparisons were made between the two different schools (Suldo et. al, 2010).

The literature highlights the devastation poor mental health and illness can have on students' development and the issue is further compounded by scope of the problem. Furthermore, the literature reflects an extraordinary disparity of services provided to those in need. The role of schools, and particularly school psychologists, to lead the charge in responding to this epidemic is reflected in government initiatives as well as professional guidelines and standards. While it is clear that the both the need and expectation for school psychologists to move beyond their traditional roles in an effort to better respond to the growing mental health needs of America's students; it is unclear whether school psychologists are changing their practice as a result. Due to the changing shift in students' mental needs throughout the decades, over time training programs and professional practice standards have had to account for this change. The question then remains whether these standards, initiatives, and guidelines are being reflected in how school psychologists practice.

Chapter 3: Methods

This study is designed to explore (1) the types of mental health services provided by school psychologists, (2) the time school psychologists engage in the provision of mental health services, (3) role perceptions and the extent to which school psychologists perceive they are meeting students' mental health needs, and (4) barriers and facilitators to mental health service provision.

Research Design

This was an exploratory study examining the perceptions and mental health practices of school psychologists. This was a cross sectional survey; sampling information from participants at one point in time. This was a non-experimental design; and therefore there was no attempt at the manipulation of variables. Rather, this design was a form of descriptive research with the aim of describing the perceptions and practices of school psychologists in the state of Ohio.

Participants

The participants (N = 122) in this study were school psychologists who were members of the Ohio School Psychologists' Association (OSPA) currently working in school settings. Approximately 500 participants were recruited by email through the OSPA listserv. Of the participants, 144 participants that responded to the survey, 12 (8%) did not currently practice in the schools and 11 provided consent, but did not complete the survey resulting in a return rate of approximately 25%. In adherence with the rights of

the research participants and the Office of Responsible Research Practices, participants were permitted to skip questions they did not want to answer resulting in a different *n* for some questions. Characteristics of the participants were expected to be consistent with the demographics described in recent studies of school psychologists.

Demographics

Demographic information obtained was similar to a study conducted by Curtis et al. (2008) evaluating demographic information of NASP members. In the current study, the age range of the participants was between 25 and 68 (M = 39.95, SD = 12.17). The participants were 82.8% female and 17.2% male. They identified as 92.6% White, 2.5% African American, 1.6% Multiracial, 1.6% Other, 0.8% Asian American, and 0.8% Hispanic/Latino. Relative to highest degree obtained, the majority of participants held an Educational Specialist degree (54.9%), followed by Master's (34.4%), Doctorate (7.4%), and other (3.3%). The gender, age range, ethnicity, degree, credentials, professional affiliations, and practice settings are presented in Table 1. Similar to the current study, Curtis and colleagues found that 74% of school psychologists were female with an average age of 46. In addition, 92.6% of all respondents identified themselves as Caucasian with the remaining professionals identifying themselves as the following: African-American, 1.9%; Asian/Pacific Islanders, 0.9%; Hispanic, 3.0%; Native American/Alaskan Native, 0.8%; and Other, 0.8% (Curtis et al., 2008).

Table 1. Demographic Characteristics of Participants

		(n)	*Percent*
Gender			
	Female	101	82.8
	Male	21	17.2
Ethnicity			
	White	113	92.6
	Black or African American	3	2.5
	Multiracial	2	1.6
	Other	2	1.6
	Asian American	1	0.8
	Hispanic/Latino	1	0.8
Degree Earned			
	Specialist	67	54.9
	Master's	42	34.4
	Doctorate	9	7.4
	Other	4	3.3
Credentials	(may be licensed in more than one category)		
	ODE	117	95.9
	NASP	54	43.3
	Board of Psychology-School Psychology	19	15.6
	Board of Psychology-General Psychology	0	0
Professional Affiliations (may have membership in more than one organization)			
	OSPA	112	91.8
	NASP	82	67.2
	APA	40	32.8
	APA-16	7	5.7
	OPA	3	2.5
Number of Schools Served			
	1-2	59	48.3
	3-4	34	27.9
	5 or >	23	18.9
Setting			
	Urban	39	32
	Suburban	45	36.9
	Rural	36	29.5
Grade	(may work with more than one grade)		
	Preschool	34	27.9
	Elementary	93	76.2
	Middle	74	60.7
	High	80	65.6

Graduate Training/Continuing Education or Professional Development

Participants were also asked to indicate the level of emphasis of their Graduate Training and Continuing Education/Professional Development activities using the following Likert scale: none, minimal, some, a lot, and extensive. Participants were asked to estimate the extent of their training and education in the following areas: diagnosis/identification of mental health disorders, treatment of mental health disorders, designing and implementing evidence-based interventions for students with mental health problems, and school-wide intervention/prevention programming. Results are summarized in Table 2.

Table 2. Emphasis of Mental Health Training and Education

	(n)	*Mean*	*SD*
Graduate Training			
Diagnosis/Identification	119	3.03	0.92
Treatment	119	2.69	0.84
Evidence-Based Intervention	119	2.87	1.03
SW Intervention/Prevention	119	2.98	1.07
Continuing Education/Professional Development			
Diagnosis/Identification	118	2.94	0.90
Treatment	118	2.77	0.83
Evidence-Based Intervention	117	3.11	0.98
SW Intervention/Prevention	117	3.03	1.03

SW= school-wide

Recruitment

Participants were recruited through the Ohio School Psychologists' Association (OSPA) listserv using an e-mail (Appendix A). Permission for use of the listserv was requested and granted by the Kent State University's Division of Academic Computing and Technology list serv moderators. OSPA members received a recruitment email presenting them with the description, intended use of the survey, identification and access to the researcher, and the question of consent to participate. Participants then received a link to the survey via e-mail and were instructed to click on the link to access the survey. After clicking the link to indicate consent, participants were presented with the survey. Following the initial invitation to participate, participants were sent three follow-up reminders (two per week including the initial invitation). The reminder emails were sent to participants in order to increase the rate of participation (See Appendix B).

Instrument

The survey tool used in this study was developed based on a review of other surveys investigating the practices of school psychologists (Yates, 2003; Prout, Alexander, Fletcher, Memis, & Miller., 1993) and feedback from one pilot study.

A pilot study was conducted with twelve school psychology practicum students at the Ohio State University in order to address clarity of the survey questions, the time spent to complete the survey, and overall quality of the survey. Based on this information revisions were made and the revised survey was completed and reviewed by four practicing school psychologists. This information was used to construct the final version of the survey (see Appendix C).

The first section of the survey was made up of thirteen questions addressing demographic information (i.e., age, sex, ethnicity, degree earned, year of graduation, licensure and professional affiliations, work location, number of buildings, and population served). Questions regarding age, year of graduation, and number of schools served were open ended questions requiring that participants provide a numerical value in a text box. Questions asking participants to indicate their gender, ethnicity, highest degree, and primary employment location presented a list of options from which participants could select. Questions regarding ethnicity, highest degree, and primary employment location also offered an 'other' option which participants could endorse and type in a response that was not provided in the choices presented. The specific questions were as follows:

1. Are you currently practicing as a school psychologist? Yes No

2. Gender: Male/Female

3. Age: _____

4. Ethnicity:
Black or African American
Asian American
White
Hispanic/Latino
Native American
Native Hawaiian or other Pacific Islander
Multi racial
Other_____

5. What is your highest degree obtained?
Master's Specialist Doctorate Other_____

6. What year did you receive your graduate degree? _____

7. What credentials do you currently hold? (Check all that apply).
Licensure (or certification) as a School Psychologist from the Ohio Department of Education
Licensure as a School Psychologist from the State Board of Psychology
Licensure as a Psychologist from the State Board of Psychology
Nationally Certified School Psychologist from National Association of School Psychologists (NASP)

8. Please indicate your membership in any current professional associations (check all that apply):

National Association of School Psychologists (NASP)

American Psychological Association (APA)

APA Division 16 - School Psychology

Ohio School Psychologists Association (OSPA)

Ohio Psychological Association (OPA)

9. How many schools do you currently serve? _____

10. How would you best classify your primary employment location?

Urban

Suburban

Rural

*11. What population do you serve? (Select according to your **primary** employment location).*

Preschool

Elementary

Middle School

High School

*12. Where is your **primary** employment located? (Check one).*

Public School

Charter/Community School

County Agency (e.g., ESC)

State Support Team or Ohio Department of Education

Other Contract Services Agency (e.g., PSI, TES, Next Step)

Alternative School/Day Treatment/Residential Setting (e.g., PEP, Education Alternatives)
Private School
Other

13. What percentage of your student population receives free or reduced lunch at you primary school? _____

The second section of the survey contained eight items asking participants to indicate the emphasis of their graduate training (four items) and continuing education/professional development activities (four items) as it related to specific areas of mental health (diagnosis/identification, treatment, designing and implementing evidenced based interventions, and school-wide prevention/intervention programming). Participants were asked to endorse the emphasis of their graduate training using a five-point Likert scale (none, minimal, some, a lot, extensive). An identical item type was used to have participants endorse the emphasis of their continuing education/professional development in those specific areas. The items are as follows:

14. Please estimate the emphasis of your graduate training in the following areas: (None, Minimal, Some, A lot, Extensive)

a. Identification or diagnosis of mental health disorders
b. Designing and implementing evidence-based interventions for students with mental health problems
c. Individual Counseling
d. Group Counseling
e. School-wide intervention or prevention programming

15. Please estimate the Continuing Education or Professional Development completed in the following areas:

(None, Minimal, Some, A lot, Extensive)

a. Identification or diagnosis of mental health disorders

b. Designing and implementing evidence-based interventions for students with mental health problems

c. Individual Counseling

d. Group Counseling

e. School-wide intervention or prevention programming

The third section of the survey included two items asking participants about the professionals who provide mental health services within their schools. A close-ended, yes/no question was presented to participants asking if they provide mental health services in schools. Next, participants were asked to rank order the professionals that provide mental health services with the most frequency within the context of their primary work location. Participants were provided with a list of mental health professional titles as well as an 'other' option wherein they could type a text response if the list provided did not include a needed response. The items are as follows:

16. Identify the professionals in your school(s) who provide mental health services to students and rank order them according to who provides these services with the most frequency. (Rank only professionals that work in your ***primary*** *work location).*

School Psychologist

School Social Worker

School Mental Health Specialist

Behavior Specialist

School Counselor

Other_____

17. Do you currently provide mental health services to students? Yes or No

The fourth section of the survey included two items asking about school psychologists' role perceptions and students' mental health needs. The first item asked participants to indicate their level of agreement based on six statements regarding the perception of their role in relation to mental health services provision. Participants were required to endorse their level of agreement using a four-point Likert scale (strongly agree, agree, disagree, or strongly disagree). Five of the statements asked participants about their perception of their role and one statement asked participants to indicate agreement based on their perception of how others viewed their role in relation to mental health service provision. The items are presented below.

18. Please indicate the extent to which you agree with the following statements: Strongly Agree, Agree, Disagree, Strongly Disagree

a. I believe I am competent to provide mental health services to children and adolescents.

b. Most other professionals in my school view it as part of my role to provide mental health services to students.

c. I believe it is my role as a school psychologist to provide mental health services to students.

d. I believe it is my role as a school psychologist to provide individual counseling to students with mental health problems or illness.

e. I believe it is my role as a school psychologist to provide group counseling to students with mental health problems or illness.

f. I believe it is my role as a school psychologist to provide and/or support school wide prevention and intervention programming.

The next item included three statements regarding perceptions of students' mental health needs and the extent to which services provided by school psychologist and others are meeting those needs. Again, participants were required to endorse their level of agreement using a four-point Likert scale (strongly agree, agree, disagree, or strongly disagree). The item is specified below.

*19. Please indicate the extent to which you agree with the following statements (Base your answer on your **primary** work location):*
Strongly Agree, Agree, Disagree, Strongly Disagree

a. The students I serve are in need of mental health services.

b. The time I spend providing mental health services adequately meets needs of the students.

c. The time other school based personnel spend providing mental health services adequately meets the needs of the students.

The fifth section addressed the types of mental health services provided by school psychologists. Participants were presented with nine mental health service items and two 'other' text box options and asked to indicate the percentage of time in an average year they spend engaging in the following mental health related services. The mental health services listed were taken from the research regarding the types of services school psychologist report to provide (Canter, 2006; Suldo et al., 2010). The 'other' options were provided so that participants could indicate an activity that may not have been

included in the response items. Percentages values were summed to yield a total annual percentage of time spent provided mental health services.

20. Indicate the percentage of time in a typical school year you spend engaging in the following mental health related services (Does not need to total 100%):

a. Individual counseling (working one-on-one with a student over time to address a particular topic, skill, or issue)

b. Group counseling (working with three or more students over time to address a particular topic, skill, or issue)

c. Formal consultation related to mental health issues (formal meetings with an educational professional to address a particular topic, skill, or issue)

d. Social Emotional/ Behavior Assessment (any process aimed at the assessment of students' social/emotional status and/or behavior)

e. School-wide prevention/intervention (involvement in developing and/or implementing school-wide prevention or intervention supports)

f. Crisis Intervention (providing immediate and short term assistance to a student or family experiencing emotional, mental, physical or behavioral distress)

g. In-service training (providing formal training to employees within your employment setting(s))

h. Parent support groups (developing and conducting formal meetings with students' parents for the purpose of providing information and/or addressing a particular topic, skill or issue)

i. Case Management (coordination or referral of services on behalf of a student or family)

j. Other_____

k. Other_____

If participants recorded any number in the services of individual counseling they were presented with a question asking them to rank in order the referral concerns presented with 1=most prevalent, 2= second most prevalent, and so on. Participants were presented with ten individual counseling topics with two 'other' text boxes to type in a response not presented. Participants could rank as few or as many topics as they so chose. The item is presented below.

> *21. You indicated that you spend time conducting individual counseling during a typical school year. Rank the following concerns from most to least prevalent (1=most prevalent, 2=second most prevalent, and so on). Leave blank items that do not apply.*
>
> *Academic problems*
> *Behavioral problems*
> *Relational issues*
> *Bullying*
> *Depression*
> *Anxiety*
> *Suicidal Ideation*
> *Lesbian, Gay, Bisexual & Transgender (LGBT) issues*
> *Violence*
> *Family issues*
> *Other_____*
> *Other_____*

If participants reported spending any time on group counseling, they were asked to endorse all of the topics they deal with in group counseling. Participants were presented with the same ten group counseling topics as presented in individual counseling

with two ‘other’ text boxes to type in a response not presented. The item is presented below.

22. You indicated that you spend time conducting group counseling. What types of issues do you address? (Check all that apply).

Academic problems
Behavioral problems
Relational issues
Bullying
Depression
Anxiety
Suicidal Ideation
Lesbian, Gay, Bisexual & Transgender (LGBT) issues
Violence
Family issues
Other_____
Other_____

Similarly, if participants indicated spending any time on school-wide prevention/intervention programming, they were presented with a list of seven topics most commonly addressed through this service. They were also provided with an ‘other’ text box option to type and rank a response not included in the items presented. The item is as follows:

23. You indicated that you spend time participating in school-wide intervention/prevention activities. What types of issues do you address? (Check all that apply).

Positive Behavior Supports (PBIS)
Bullying

Substance use prevention
Pregnancy
Anger Management/ self-control
Stress Management
Lesbian, Gay, Bisexual & Transgender (LGBT) issues
Other _____

The next section of the survey consisted of two items addressing the perceptions of school psychologists regarding the barriers and facilitators to the provision of mental health services. First, participants were presented with eight barriers to the provision of mental health services and asked to rank the top three barriers as it relates to their experience by inserting a 1, 2, or 3 next to the appropriate item. Similarly, participants were presented with eight facilitators to the provision of mental health services and asked to rank the top three facilitators to the provision of mental health services as it relates to their experience. An 'other' text box was provided for participants to indicate a barrier and facilitator that may not have been presented in the response selection.

Lastly, participants were presented with an option ended item asking them to provide any additional information they may feel important to add regarding the topic of school mental health and school psychologists. Participants could type their response in the text box provided. The items are presented below.

24. The following factors have been identified as barriers to the provision of mental health services in schools. Rank the top 3 barriers to providing mental health services as it applies to your experience.

Problems with the physical school environment for delivering services
Insufficient support from the department and district administration

Problems with cooperation from school personnel

Insufficient training

Insufficient time and integration into the school site

Large caseload

Challenging student factors

It is not my role to provide mental health services to students.

Other_____

25. The following factors have been identified as facilitators to the provision of mental health services in school. Rank the top 3 facilitators to providing mental health services as it applies to your experience.

Departmental and administrative support

Facilitative relationships with school staff

Sufficient mental health training

School environments conducive to providing services

Manageable caseload

Students are amenable to service provision

It is my role to provide mental health services to students.

Other_____

26. Please use this space to provide any additional information you feel may be important to add regarding school psychologists and the provision of mental health services in schools.

Procedures

Approval for this study was obtained from the Institutional Review Board prior to the distribution of emails inviting participants to complete the survey. Participants were recruited through the Ohio School Psychologist's Association (OSPA) listserv using an e-mail. Permission for use of the listserv was requested and granted by the Kent State University's Division of Academic Computing and Technology listserv moderators.

OSPA members received a recruitment email presenting them with the description, intended use of the survey, identification and access to the researcher, and the question of consent to participate. Participants received a link to the survey in the initial and subsequent reminder e-mails and were able to click on the link to access the survey. After clicking the link to indicate consent, participants were then presented with the survey. Following the initial invitation to participate, participants were sent three follow-up reminders across a 14 day period (two follow up emails per week including the original invitation). The reminder emails were sent to participants in order to increase the rate of participation (See Appendix B).

Data Collection

After obtaining permission from the Kent State University's Division of Academic Computing and Technology to recruit participants through the OSPA listerv and receiving IRB approval, data was sought using the listserv and presented through online survey software called *Qualtrics*. Participants were presented with the recruitment email indicating the description of the study, intended use of the survey, names and contact information of the researchers, and consent to participate (Appendix A). After providing consent for participation, participants were provided with a link to the survey via e-mail and able to access the survey through a link that was provided in the email. After clicking the link to indicate consent, participants were then presented with the survey.

Research Questions and Data Analysis

Research Question # 1 – MENTAL HEALTH SERVICES

What types of mental health services do school psychologists provide? (Measured by questions 20-23).

Analysis: The analyses used were descriptive statistics to provide frequencies and percentages of various responses of all participants.

Research Question # 2 – MENTAL HEALTH SERVICE PROVISION

How much time do school psychologists devote to the provision of mental health services? (Measured by question 20).

Analysis: The analyses used were descriptive statistics to provide frequencies and percentages of various responses of all participants. Means and standard deviations were used to analyze the time spent providing specific mental health services. Total percentage of annual time spent providing mental health services was calculated for each participant by summing the percentage indicated by participants in all service areas.

Research Question #3 –PERCEPTIONS & MENTAL HEALTH NEEDS

Do school psychologists believe it is their role to provide mental health services and is their services provision meeting the mental health needs of children and adolescents? (Measured by questions 17 -19).

Analysis: The analyses used were descriptive statistics to provide frequencies and percentages of various responses of all participants. In addition, cross tabs statistics (Kendall's tau b) was used to learn if there was a relationship between perceptions of student mental health needs and the perception that those services meet the need.

Research Question # 4- BARRIERS AND FACILITATORS

What barriers and promoters contribute to the provision of services? (Measured by questions 24-26).

Analysis: The analyses used were descriptive statistics to provide frequencies and percentages of responses of all participants. In addition, opened ended comments were organized accordingly to themes. Almost all of the comments were related to barriers to mental health service provision by school psychologists and are organized according to the theme they represent (Appendix D).

Chapter 4: Results

The results of this study will be presented in the order of the research questions. This was an exploratory study designed to provide descriptive information regarding the perceptions and mental health practices of school psychologists in school settings.

Analysis of Research Question #1

The first research question was: (1) What types of mental health services do school psychologists provide?

The analyses used were descriptive statistics to provide frequencies and percentages of various responses of all participants. Of the participants who responded to these questions, 53.8 % (n = 64) indicated proving mental health services to students whereas 46.2 % (n = 55) indicated they did not provide such services. More specifically, participants indicated providing several different types of mental health services to students. Almost all the participants (91.7%) reported conducting social/emotional/behavior assessment in their practice as a school psychologist. Engaging in formal consultation with other educational professionals was endorsed by a majority with 77.4% of participants indicating involvement. Crisis intervention, individual counseling, school-wide intervention/prevention, case management, and in-service trainings followed formal consultation in that order. Group counseling and parent groups were endorsed by the fewest participants at 25.8% and 14%, respectively. The results are summarized in Table 3.

Table 3. Participants Indicating Provision of Specific Mental Health Services

Service	*(n)*	*Percent*
Social Emotional Assessment (*N* =112)	102	91.7
Consultation (*N* = 111)	86	77.4
Crisis (*N* = 112)	72	64
Individual (*N* = 112)	64	57
School-wide Intervention Prevention (*N* = 111)	58	52
Case Management (*N* = 111)	55	49.5
In-service training (*N* = 112)	47	42
Group Counseling (*N* = 112)	29	29.5
Parent Groups (*N* = 112)	16	14

More specifically, participants who indicated providing individual counseling (57%) were asked rank order topics in terms of prevalence of the presenting issues that they address within that service. Of the participants that indicated they provided individual counseling, almost all ranked behavioral issues as one of the top three referral concerns. In addition, a majority of those participants ranked academic issues as one of their top three referral topics. Issues of depression, family, relationships, anxiety, and bullying followed. Least prevalent were topics related to bullying, violence and LGBT. The results are summarized in Table 4.

Table 4. Frequencies and Percents for Top 3 Individual Counseling Topics

Topic	*(n)*	*Percent*
Behavior	59	84.7
Academics	50	66
Depression	36	52.8
Family	40	52.5
Relationships	29	51.7
Anxiety	42	42.9
Suicide	29	24.1
Bullying	32	15.6
Violence	19	15.8
LGBT	0	0

Of the participants that reported they spent time providing group counseling (25.8%, $n = 29$), the results indicated that similar to individual counseling, behavioral and academic issues were most frequently endorsed as issues in group counseling, whereas issues of violence, suicide, and Lesbian, Gay, Bisexual and Transgender (LGBT) were endorsed by the fewest number of participants. Bullying, relationships, anxiety, family issues and depression were endorsed as issues in group counseling in that order following academic issues. The results are summarized in Table 5.

Table 5. Frequencies and Percents for Group Counseling Topics

Topic	(*n* = 29)	*Percent*
Behavior	22	75.8
Academics	12	41.3
Bullying	12	41.3
Relationships	11	38
Anxiety	10	34.4
Family	9	31
Depression	6	20.6
Violence	5	17.2
Suicide	3	10.3
LGBT	1	3

If participants endorsed involvement with school-wide prevention and/or intervention activities (52%) they were asked to indicate the type of topics addressed through these activities. Involvement in Positive Behavioral Intervention and Support (PBIS) programming was the most frequently endorsed. The issue of bullying was the second most prevalent topic endorsed by those indicating involvement in these activities. Following the topic of bullying, anger management, stress management and substance use comprised the middle portion in that order. No participants indicated the issues of Pregnancy or LGBT as topics addressed through school-wide prevention and/ or intervention. The results are summarized in Table 6.

Table 6. School-wide Intervention/Prevention Topics

Topic	(*n= 58*)	*Percent*
PBIS	45	77
Bullying	34	58.6
Anger Management	16	27.5
Stress Management	13	22.4
Substance Use	6	10.3
Pregnancy	0	0
LGBT	0	0

Analysis of Research Question #2

The second question was: (2) How much time do school psychologists spend providing mental health services?

Descriptive statistics were used to examine the data. Specifically, means and standard deviations were calculated to determine the amount of time school psychologists reported spending on each of the activities in a typical year. Regarding the types of services provided, participants were asked to estimate the overall percentage of time spent providing various mental health services across an average school year. The results indicate that social/emotional/behavioral assessment was the most prevalent mental health service provided. Engaging in formal consultation activities came in second. Case management, school-wide prevention and/or intervention, individual counseling, and in-service training appeared to be moderately provided when looking at the participants as a whole; however, the large standard deviations suggest great variability in the time that school psychologist report providing such services. Crisis intervention, group counseling,

and parent support groups accounted for the least amount of time annually. The results are summarized in Table 7.

Table 7. Percentages of Annual Time on Mental Health Service Provision

Service	*Mean*	*SD*
Social/Emotional/Behavior Assessment	15.1	13.4
Formal Consultation	11.6	12.7
Case Management	4.4	8.2
School-wide prevention/intervention	4.1	6.3
Individual Counseling	3.6	5.2
In-Service Training	3.4	4.2
Crisis Intervention	2.3	3.9
Group Counseling	1.5	3.4
Parent Support Groups	0.8	2.9

Analysis of Research Question #3

The third research question analyzed was: (a) Do school psychologists believe it is their role to provide mental health services and (b) is their services provision meeting the mental health needs of children and adolescents?

The analyses used included descriptive statistics to provide frequencies, percentages, and cross tabs of responses across all participants.

For the first part of this question, participants were asked to rate their level of agreement to several statements regarding role perceptions as it applies to the provision mental health services in schools. A four point Likert scale was used (strongly agree, agree, disagree, and strongly disagree).

Role Perceptions

Nearly eighty percent of participants agreed that they were competent to provide mental health services to children and adolescents. In contrast to those who indicated that they provided mental health services (53.8%), an overwhelming majority of school

psychologists either strongly agreed or agreed that it was part of their role to provide mental health services to students (90.3%). Far fewer participants indicated that *other* school professionals viewed the provision of mental health services to students as a part of the school psychologist's role.

To gain a more thorough understanding of the types of mental health services school psychologists perceived as falling within their role, participants were asked to indicate their level of agreement regarding their role in the provision of individual and group counseling as well as school-wide intervention/prevention.

More than sixty-seven percent endorsed agreement that is within their role to provide individual counseling to students with mental health problems or illness. Even more participants agreed that it is their role to provide group counseling. The most robust agreement was revealed regarding school wide intervention/prevention service with almost all of the participants indicating that it was their role to provide or support school-wide intervention and/or prevention services to students. The results are summarized in Table 8.

Table 8. Role Perceptions

	(*n*)	*Percent*
Competency (*N* = 114)		
Strongly Agree	21	18.4
Agree	70	61.4
Disagree	21	18.4
Strongly Disagree	2	1.8
School Psychologist's Role-self (*N* = 113)		
Strongly Agree	29	25.7
Agree	73	64.6
Disagree	9	8
Strongly Disagree	2	1.8
School Psychologist's Role-others (*N* = 113)		
Strongly Agree	13	11.5
Agree	50	44.2
Disagree	40	35.4
Strongly Disagree	10	8.8
Individual Counseling (*N* = 113)		
Strongly Agree	11	9.7
Agree	65	57.5
Disagree	34	30.1
Strongly Disagree	3	2.7
Group Counseling (*N* = 113)		
Strongly Agree	7	6.2
Agree	79	69.9
Disagree	25	22.1
Strongly Disagree	2	1.8
School-wide Intervention/Prevention (*N* = 114)		
Strongly Agree	51	44.7
Agree	60	52.6
Disagree	2	1.8
Strongly Disagree	1	0.9

Student Needs & Service Provision

Participants were asked to indicate the extent to which they agree with the following statements: (1) *The students I serve are in need of mental health services. (2) The time I spend providing mental health services adequately meets the needs of the students.* Level of agreement was based on a four point Likert scale (strongly agree, agree, disagree, and strongly disagree). Overall, 99.1% (*n* = 114) of participants reported that they strongly agreed (51.7%, *n* = 59) or agreed (47.3%, *n*=54) that students were in need of mental health services. Furthermore, 89.4% (*n* = 101) of participants either disagreed (48.7%, *n* = 55) or strongly disagreed (40.7%, *n* = 46) that the mental health services they provided adequately met the students' needs.

Kendall's *tau b* coefficient was performed to examine the relationship between school psychologists' perceptions of the mental health needs of students and their perceptions of whether the services they provide meet that need. For participants in this study, there was a significant negative relationship ($\tau\beta$ = *-.28, n = 113, p =< .001)* between perceptions of students' needs and services they provided meeting that need at the *.05* level of significance. Specifically, most participants who strongly agreed or agreed that students were in need of mental health services also strongly disagreed or disagreed that the services they provided were adequately meeting the needs of students. The results are detailed in Table 9.

Table 9. Mental Health Service Provision and Student Need

			SERVICE PROVISION			
			Strongly Agree	Agree	Disagree	Strongly Disagree
NEED	Strongly Agree	Count	0 (0)	4 (6.8%)	23 (39%)	32 (54.2%)
		ADR	-1	-1.1	-2.2	3.1
	Agree	Count	1 (1.9%)	7 (13.2%)	31 (58.5%)	14 (26.4%)
		ADR	1.1	1.2	2	-2.9
	Disagree	Count	0 (0)	0 (0)	1 (100)	0 (0)
		ADR	-0.1	-0.3	1	-0.8

ADR= Adjusted Residual

To further understand the provision of mental health services within schools, participants were asked to indicate their level of agreement regarding their perceptions of whether *other* school personnel were meeting the mental health needs of students. Consistent with perceptions of their own services addressing student needs, 81.2% (*n* = 91) of participants either disagreed (*n* = 66, 58.9 %) or strongly disagreed (*n* = 25, 22.3%) that the services other school personnel provided adequately met the mental health needs of students, whereas 17.9% (*n* = 21) either agreed (16.4%, *n* = 20) or strongly agreed (0.8%, *n*=1).

Analysis for Question #4

(4) What barriers prevent the provision of services and what promoters facilitate the provision of mental health services?

The analyses used were descriptive statistics to provide frequencies and percentages of various responses of all participants. Participants were asked to rank the top three barriers and facilitators to mental health service provision as it applies to their experience. Participants were presented with a list of barriers and facilitators to the

provision of mental health services in schools that were identified in previous research. They could also type in their own response if the list was not comprehensive to their experience.

Barriers

Large caseload was endorsed as the most impactful barrier to the provision of mental health services with 38.5% of participants endorsing it as the largest barrier and 27% ranking it as the second largest barrier. Overall, 73% of participants ranked it as a top three barrier. Inadequate time and integration into the school site emerged as the second most impactful. Lack of administrative support also emerged as a significant barrier with a total of 36.9% of participants' overall endorsements. The least overall impactful barriers to mental health service provision were perceptions regarding providing mental health services as not falling into their role as school psychologists and problems with the school environment which interfered with service delivery. Results are summarized in Table 10.

The final question of the survey asked participants to provide any additional information they felt may be important to add regarding school psychologists and the provision of mental health services in schools. Most of the comments lent additional support to the impact of the barriers the participants were asked to rank. Comments were grouped according to the qualitative barrier label as indicated in the survey. Consistent with the results of the survey, a majority of the comments acknowledged large caseloads as a significant barrier to their provision of mental health services. Many comments also focused on lack of administrative support or narrow role perceptions of districts and

administrators, impeding the provision of mental health services. Several comments also addressed limited training and lack of opportunity to practice direct mental health services. The ‘other’ category held several comments regarding time constraints suggesting that the primary functions of their role limit their availability to provide mental health services (See Appendix D).

Facilitators

Consistent with barriers, manageable caseload was endorsed as the most impactful facilitator to the provision of mental health services. Overall, 45.9% of participants ranked it as a top three facilitator. Administrative support for the provision of mental health services was also a significant facilitator and ranked by 40.2% of participants. Sufficient training also yielded an overall facilitator endorsement by 40.2% of the participants; however, it is consider third in order of impactful facilitators as more individuals endorsed Administrative Support as their number one facilitator. Similar with the results of barriers to mental health service provision, the least overall impactful facilitators to mental health service provision were perceptions regarding providing mental health services as being within the role of the school psychologist and school environments conducive to mental health service delivery. The results are summarized in Table 10.

Table 10. Barriers and Facilitators to Mental Health Service Provision

	(n) Percent		*(n)/ Percent*
Barrier		Facilitator	
Caseload (1)		Caseload (1)	
1	47 (38.5)	1	19 (15.6%)
2	33 (27%)	2	25 (20.5%)
3	9 (7.4%)	3	12 (9.8%)
Total	89 (73%)	Total	56 (45.9%)
Time on Site (2)		Time on Site (5)	
1	32 (26.2%)	1	15 (12.3%)
2	27 (22.1%)	2	12 (9.8%)
3	15 (12.3%)	3	7 (5.7%)
Total	74 (60.7%)	Total	34 (27.9%)
Admin Support (3)		Admin Support (2)	
1	9 (7.4%)	1	18 (14.8%)
2	13 (10.7%)	2	15 (12.3%)
3	23 (18.9%)	3	16 (13.1%)
Total	45 (36.9%)	Total	49 (40.2%)
Training (4)		Training (3)	
1	6 (4.9%)	1	14 (11.5%)
2	9 (7.4%)	2	15 (12.3%)
3	21(17.2%)	3	20 (16.4%)
Total	36 (29.5%)	Total	49 (40.2%)
Student Factors (5)		Student Factors (6)	
1	3 (2.5%)	1	4 (3.3%)
2	10 (8.2%)	2	8 (6.6%)
3	6 (4.9%)	3	17 (13.9%)
Total	19 (15.6%)	Total	29 (23.8%)
Cooperation from Personnel (6)		Cooperation from personnel (4)	
1	3 (2.5%)	1	13 (10.7%)
2	4 (3.3%)	2	14 (11.5%)
3	8 (6.6%)	3	9 (7.4%)
Total	15 (12.4 %)	Total	36 (29.5%)
Job responsibility (7)		Job responsibility (7)	
1	7 (5.7%)	1	9 (7.4%)
2	4 (3.3%)	2	8 (6.6%)
3	4 (3.3%)	3	8 (6.6%)
Total	15 (12.3%)	Total	25 (20.5%)

Table 10. Continued

Table 10. Continued

Environment (8)		Environment (8)	
1	0 (0.0%)	1	11 (9%)
2	3 (2.5%)	2	5 (4.1%)
3	8 (6.6%)	3	8 (6.6%)
Total	11 (9.0%)	Total	24(19.7%)

Rankings indicated in () for Barriers and Facilitators

Chapter 5: Discussion

The purpose of this study was to examine the mental health perceptions and practices of school psychologists in the state of Ohio. In this chapter, the results of the study will be summarized and discussed in the context of other relevant studies. First, the findings regarding overall demographic information of school psychologists will be presented. Second, the school psychologists' role perceptions and students' needs will be discussed within the context of the types and amount of time spent providing various mental health services. Next, barriers and facilitators in relation to the provision of mental health services will be explored. Lastly, the limitations of the study will be reviewed. The chapter will conclude with a summary, a discussion of future directions for research suggested by the results of this study, and implications for training and current practice.

Demographic Information

Demographic information obtained in the current study is similar to a study conducted by Curtis et al. (2008) evaluating demographic information of NASP members. Their results showed that 74% of school psychologists were female with an average age of 46. In addition, 92.6% of all respondents identified themselves as Caucasian with the remaining professionals identifying themselves as ethnically diverse. Overall, Curtis and colleagues (2008) found that there were more school psychologist who held a Specialist degree (39.9%) than a Master's (35.7%) or a Doctorate (24.4%).

Moreover, of the NASP members surveyed 93.8% held certification and 30.6% were licensed findings (Curtis et al., 2008).

The present study found the age range of the participants was between 25 and 68 (*M*= 39.95, *SD*= 12.17); which reflects a shift compared to a previous survey of school psychologists that found data relating to age increasing with the mean age of 46 years (Curtis et al., 2008). Some possible reasons for the noticeable change in the current study may reflect shift in age due to retirement of the baby boom population and the high demand of school psychologists. Consistent with previous research, the participants were 82.8% female and 17.2% male (Curtis et al., 2008). They identified as 92.6% White, 2.5% African American, 1.6% Multiracial, 1.6% Other, 0.8% Asian American, and 0.8% Hispanic/Latino. Relative to highest degree obtained, the majority of participants held a Specialist degree (54.9%), followed by Master's (34.4%), Doctorate (7.4%), and other (3.3%). Ninety-six percent of participants are certified or licensed through the Ohio Department of Education, 43.3 % are certified through the NASP, and 15.3% are licensed as school psychologists through the State Board of Psychology. In terms of the number of schools served, 48.3% reported serving between one and two schools, 27.9% served three to four, and 18.9% served five or more schools.

Needs, Role Perception and Service Provision

Several studies have found that school psychologists provide at least some mental health services (Bramlett et al.; 2002; Curtis et al., 1999; Curtis et al., 2008; Villarin, 2005;Yates, 2003); however, the amount of time school psychologists spend providing mental health services has varied across studies. In general, research findings indicate

that 18%- 28.6% of school psychologists do not provide any type of counseling to students (Curtis et al., 1999 & Curtis et al., 2008), 34%-72% provide individual counseling (Curtis et al., 1999; Curtis et al., 2008; Yates, 2003) and 31.5%- 53.5% provide some form of group counseling (Curtis et al., 1999; Curtis et al., 2008). Previous studies indicated that the percentage of time school psychologist engaged in counseling in an average school year ranged from 8%-17.5% (Bramlett et al., 2002; Yates, 2003).

The results of the current study offer more nuanced information regarding the types of services provided and the average amount of time school psychologists in the state of Ohio spend delivering such services in a typical school year. The results of this study suggest that school psychologists acknowledge the alarming disparity between the mental health needs of students and the services provided by both themselves and other school professionals. Nearly all of participants (99.1%) agreed that students were in need of mental health services, whereas 89.4% report that their services are not meeting the need. So while the school psychologists in this study recognize the significant mental health needs among their students, many of them report that the services they provide are not able to meet the needs of students. Furthermore, 81.2% of participants acknowledged that *other* school personnel are falling short of meeting students' needs as well. This may suggest that perhaps even if students are receiving services from other school mental health professionals, they may not be receiving the quality, frequency, or duration of services necessary to improve functioning or remediate problems (Farmer et al., 2003; Kataoka, Zang, & Wells, 2002).

A majority of the participants (79.8%) agreed that they were competent to provide mental health services to children and adolescents. This is consistent with literature suggesting that school psychologists are trained to manage issues related to mental health (Rappaport, 2003) and is further supported by the results of this study regarding education and training in various areas of mental health. Despite feeling competent in the provision of mental health services, only 53.8% of participants indicated they spend a portion of their time providing mental health services. The fact that 90.3% of the school psychologists agreed that it was part of their role to provide mental health services to students makes this result all the more surprising. One explanation for this disparity most likely relates to the barriers to services provision which will be discussed later in this chapter.

With regards to individual counseling, 67.3% of participants believe it is their role to provide individual counseling to students with mental health problems or illness. Despite a majority viewing it as part of their role, only 57% of participants indicated that they provide individual counseling. Furthermore, mental health services comprised an average of only 3.6% of annual time for school psychologists in this study. This is consistent with previous research reporting that school psychologists serve 9.9 students through individual counseling per year (Curtis et al., 2008); however, it is unclear as to the frequency or duration of individual sessions. Of the of participants who indicated providing individual counseling, the most common referral concerns for individual counseling were behavioral issues (84.7%) and academics (66%). Not surprisingly, these may be the most common presenting concerns and most easily identifiable issues for

teachers, whereas the other issues may require training or additional assessment to be able to discern. Still prevalent, but less common concerns included depression (52.8%), family issues (52.2%), relationships (51.7%), anxiety (42.9%), suicide (24.1%), violence (15.8%), and bullying (15.6%). It should be noted that these issues might arise as secondary concerns related to the academic and behavioral issues.

As for group counseling, 76.1% agreed that it was their role to provide group counseling to students with mental health problems or illness. Surprisingly, the results revealed that only slightly more than one quarter of the participants indicated providing group counseling. In addition, on average, group counseling accounts for an extremely small percentage of school psychologists' time (1.5% of total time annually). This is supported by previous research indicating that school psychologists serve an average of 8.8 students per year through group counseling (Curtis et al., 2008); however, as with their reports of individual counseling, the results did not indicated the number or duration of sessions.

Issues addressed within the context of group counseling took on a similar pattern in terms of prevalence as individual counseling, but the numbers of participants reporting on these issues was far less which is consistent with the small percentage of time participants reported engaging in group counseling. Of the 25.8% of participants who indicated providing group counseling, the most common referral concerns for individual counseling were behavioral issues (75.8%), academics (41.3 %) and bullying (41.3%). This was not surprising because, again, those issues are most likely easily identified by teachers. Still prevalent, but less common concerns included relationships (38%), anxiety

(34.4%), family (31%), depression (20.6 %), violence (17.2%) suicide (10.3%), and LGBT issues (3%).

The most robust agreement was revealed regarding school-wide intervention/prevention services. More than ninety-seven percent agreed that it was their role to provide and/or support school wide intervention/prevention programming, yet only 52% of participants indicated involvement. It is possible that barriers associated with mental health service provision such as large caseload and limited time at one school building could explain this disparity. Furthermore, school-wide intervention/prevention only comprised an annual average of 4.1% of total time annually. Of those that indicated involvement, PBIS programming (77%) and bullying (58.6%) were the most frequently reported topics addressed with anger management (27.5%) and stress management (22.4%) garnering some responses. Substance use (10.3%) was endorsed by an extremely limited number of participants. This finding was surprising given that the use of alcohol and illegal drugs was identified in a national study as a significant concern by 71% and 72% high school professionals, respectively (Foster et al., 2005). Surprisingly, pregnancy and LGBT issues yielded no endorsements.

The results indicated that social/emotional/behavioral assessment was the most prevalent service, with almost all participants (91.8%) indicating providing such service. Furthermore, social/emotional/behavioral assessment received the most time with an average of 15.1% of school psychologists' time annually. This is not surprising given the expectations of the reauthorization of IDEA (2004) which requires that schools screen, assess and plan treatments for children with mental health problems (IDEA, 2004). It

bears noting that while assessment of social/emotional/behavior is often done within the context of evaluations for special education, it does not necessarily capture the number of students that may require identification and intervention for mental health problems, but do not rise to the level of requiring specialized instruction. Therefore, while reports of assessment activities may encompass a portion of the students in need it is likely an underestimation of what is necessary to identify and intervene with students in need of mental health services.

Following assessment, formal consultation activities came in second with more than 77% of participants reporting an average of 11.6% of annual time spent regarding issues of student mental health. This is consistent with results from a previous study indicating that school psychologist spend 16% of time in consultation; however, it must be noted that the researchers did not distinguish between formal or information consultation nor whether consultation was related to mental health issues or academic concerns (Bramlett et al., 2002).

Barriers and Facilitators

Several barriers to the provision of mental health services by school psychologists have been identified and include: problems with the physical school environment for delivering services, insufficient support from the department and district administration, problems with school personnel, insufficient training, insufficient time and integration into the school site, personal characteristics, large caseloads, challenging student factors, and role strain (Curtis et al, 1999; Suldo et al., 2010; Villarin, 2005; Yates, 2003).

In an effort to make sense of the disparity between role perception, need, and actual mental health service provision, the study sought to explore the factors that impede school psychologists from providing such services. Participants ranked the top three barriers to mental health service provision as it applied to their experience.

Overwhelmingly, the impact of large caseloads was identified by 73% of participants as the most profound barrier. This finding is consistent with previous research indicating the number of students served by psychologists exceeds the NASP recommended ratio of one psychologist per 1000 students by two to three times (NASP, 2000, p. 54). Limited time and integration on school site was identified by 60.7% of the participants came in second as the most impactful barrier. This is consistent with participants' reports of the number of schools they serve with 47% indicating serving three or more schools. Lack of administrative support fell in third with 36.9% of participants ranking it as one of their top three barriers. Perceptions of mental health service provision falling within their role and problems with school environments were rated by the fewest participants at 12.3% and 9%, respectfully. The top three barriers suggest an area that should be addressed through districts and/or legislation to help school psychologists' remediate some of the factors that interfere with their provision of mental health services. While other factors were not as impactful across the participants, they are still worthy of consideration as we look for solutions to mental health service provision.

Participants were invited to share any information they deemed relevant to school psychologists and the provision of mental health services. A vast majority of the

participants chose to comment on the barriers that significantly impact mental health service provision with high caseloads and limited administrative support emerging most frequently in their comments. For example, one participant wrote, "I would like to provide more time for mental health. My caseload is way too large to address mental health problems." Another commented, "As for the past 20 years, I have been specifically instructed not to do this [provide mental health services] unless extreme circumstances [warrant it]."

Another reason that many school psychologists might not provide health services could relate to others perception of the role of the school psychologist. Only slightly more than half of the participants reported that they believed that others view mental health services as part of the school psychologists' role. Again, the comments provided by the participants lent further support to this with many participants indicating the perception of their role as being extremely narrow, with primary emphasis on evaluation and activities related to special education. One participant commented, "In our district, school psychologists are not looked to as mental health experts. We are treated as psychometricans. They do not value our training or expertise." This commentary is not surprising given that school psychologists have historically been seen as the gatekeepers of special education and are still often viewed that way (Massey et al., 2005).

Perceptions about what factors facilitate mental health service provision were more evenly distributed across the categories. Not surprisingly, however, manageable caseloads emerged as the most impactful factor with nearly 46% of participants ranking it as one of their top three facilitators. Administrative support and sufficient training

emerged as second and third most impact yielding 40.2% of participants ranking it as their top three facilitators. Perceptions of mental health service provision falling within their role and school environments were the least impactful facilitators at 20.5% and 19.7%, respectfully.

Limitations

There are limitations to this study that might reduce the reliability and generalizability of the findings. The most significant limitation is the low response rate (25%). This limitation suggests that the sample might not be representative of all school psychologists in the state of Ohio. Second, because the sample was limited to school psychologists practicing in the state of Ohio; regional differences may exist that cannot be generalized to school psychologists across the country. Despite this, demographics of the sample were consistent with those found in the Curtis et al. (2008) study that surveyed NASP members.

The next limitation relates to methodology. No survey existed to target the specific research questions in this study and therefore it was developed specifically for this study. This may affect the reliability of the measurement itself and the subsequent results. For example, some participants indicated spending 100% or more of their total time on mental health service provision. This seems unlikely based on what is known about the role of the school psychologist and therefore the question may have been stated incorrectly or misinterpreted resulting in biased results.

Given that the intent of the study was exploratory, the statistics used can only describe the perceptions and practices of school psychologist regarding mental health

service provision. The study was intended to serve as a foundation for future research to build upon.

Implications and Directions for Future Research

Despite the limitations mentioned above, there are still implications that can be extrapolated for school psychologists. Perhaps given the limitations on time and narrow focus of the role, school psychologists need to become better equipped to participate in activities designed to target a larger population of students in need of mental health services (i.e., school-wide prevention and intervention services). While direct services such as individual counseling may be a needed service, it might not be the best use of school psychologists' time given the obligations towards special education activities. However, school psychologists may be able to prepare and educate teachers and other school personnel through school-wide trainings to identify and refer students who display indicators of mental health problems. Based on the results of this study, providing in-service trainings may be an underutilized role for the school psychologist that may be able to yield considerable benefits as school psychologists work toward closing the gap between mental health needs and services provided.

Furthermore, participants in this study acknowledged that group counseling and school-wide intervention and/or prevention fell firmly within their role, yet the number of school psychologists reporting involvement and the time spent on these services was far less than one might expect. Perhaps training programs and both state and national school psychology organizations should increase their emphasis on preparing school psychologists to design and implement mental health programming that can be sustained

and supported by educational professionals under their leadership. In doing so, school psychologists would be able to share the responsibility and also target a greater number of students in need. While this might require the utilization of more administrative skills for planning, the crux of the intervention and or prevention programming would suit school psychologists' knowledge and skills quite nicely.

In an effort to meet the immense need for mental health services, school psychologists may also want to consider creating school mental health action committee(s). Ideally, these committees would include all of the mental health professionals within that particular school. These committees could help coordinate and sustain mental health service provision by organizing and planning for both in school and community based services. Evaluating what services are able to be provided within the school, by whom, and for what types of referral concerns would help to begin meeting the greater need. Furthermore, in acknowledgement of the limitations on service provision within the school, identifying community resources and efficient referral systems for students and parents would be paramount. Lastly, the work involved in implementing and sustaining school-wide intervention and prevention activities would be a shared committee effort, allowing the school psychologists and other professional attend to the other functions of their positions.

Understanding how to screen for mental health problems is another consideration for the provision of mental health services. School psychologists would be paramount in assisting administrators and staff in screening for problems. School psychologists are extremely skilled in the area of assessment and report writing, spending the most time in

this area relative to mental health service provision; yet assessment is often limited to those at the Tier III level. While there is evidence support the prevalence of certain mental health problems in children and adolescents at particular developmental levels (Brener et al., 2007; Foster et al., 2005), assessment tools commonly used within the field are not necessarily conducive to screening large numbers of students. This could be an area of research and development that would benefit schools and students. Screening for mental health problems could also help inform state and local governments of student needs and subsequent service demand.

Future researchers may also want to gather more qualitative information by gathering data using focus groups. While many of the major referring concerns were quite general (i.e., behavior and academic) it might be helpful to gather more information regarding the specifics of these particular concerns (i.e., inattention, impulsivity, work refusal, etc.). In addition, given that school psychologists function rather independently within schools and therefore are responsible for how they conduct their practice, future researchers should look to practitioners to generate possible solutions to the barriers associated with mental health service provision.

The problem of the discrepancy between significant mental health needs of students and a lack of mental health service provision is clear. The comments from the participants in this study evidence the frustration school psychologists may experience regarding their challenges in meeting students' needs. Knowing that school psychologists' obligations to special education are firmly grounded, it would be useful for school psychologists to begin generating solutions to negotiate their role in a way that

allows them to begin closing the gap mental health needs and mental health service delivery.

Glossary of Terms

Mental health problems: A child or adolescent displaying the signs or symptoms of a mental illness or disorder. These symptoms do not meet the intensity or duration necessary in the diagnosis of a mental health disorder. However, signs and symptoms may warrant interventions regarding health promotions, prevention and treatment (U.S. DHHS, 1999).

Mental illness: A DSM-IV diagnosable mental disorder, which is noted by changes in thinking, mood, or behavior that causes distress and/ or impaired functioning.

Mental health services: Designing and implementing interventions for children and adolescents to assist them in overcoming mental health problems and increase success within school, home and the community.

Evidence-based practices: Interventions or treatments based on the integration of the best available research with clinical expertise in the context of student characteristics, culture, and preferences (APA Task Forces, 2006).

Consultation: Working cooperatively with school staff to address the mental health and educational needs of students.

Case management: Refers to the coordination of services on behalf of an individual

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APPENDIX A: Recruitment email

Dear School Psychologist,

My name is Renee A. Lake and I am a graduate student in the School Psychology program at the Ohio State University.

I invite you to participate in a research study I am conducting as part of my graduate studies. The purpose of the research study is to develop an understanding of the mental health perceptions and practices of school psychologists.

If you agree to participate, I would like you to complete an on-line survey. The survey asks for your gender, age, ethnicity, highest educational degree, and your practice setting. If you practice in a school setting you will also be asked about your training and education, practice as a school psychologist, and perceptions about your role. The survey will take 5-10 minutes to complete.
Participation is voluntary and you may withdraw at any time without penalty. You do not need to answer any questions you do not wish to answer.

You will be asked to provide information over the Internet. In an effort to protect your privacy, I will use a secure web site to collect the study information and password protected computers to store the study information. I will not collect your name or any identifying information about you in the survey.

I hope you will agree to complete the survey, which can be accessed by clicking on the link embedded on this page. By clicking on the link, you are giving informed consent for participation in the research study. Identifiable information will not be linked to completed surveys (i.e., your responses will not be linked to your identity). If you do not wish to participate in this study, do not click on the link provided.

Dr. Kisha Radliff is the primary contact person for this study; please contact her if you have any questions about the survey by phone at the Ohio State University (614-292-6485) or by email at radliff.2@osu.edu.

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact Ms. Sandra Meadows in the Office of Responsible Research Practices at 1-800-678-6251.

Thank you very much for your consideration of this research study. If you agree to participate in this study, please click on the link below or place the web address in your Internet browser: https://qtrial.qualtrics.com/SE/?SID=SV_bjh7SymnivJVMcR

Respectfully,

Kisha Radliff, Ph.D.
Assistant Professor
School Psychology
The Ohio State University

Renee A. Lake, M.S.Ed., M.A.
Doctoral Candidate/Graduate Researcher
School Psychology
The Ohio State University

APPENDIX B: Follow up email

Dear School Psychologist,

Recently you received an email inviting you to participate in an on line survey examining the perceptions and practices of school psychologists regarding the provision of mental health services in schools. We thank those who have already participated in the survey and encourage those who have not yet had the chance to participate to do so.

If you agree to participate, I would like you to complete an on-line survey. The survey asks for your gender, age, ethnicity, highest educational degree, and your practice setting. If you practice in a school setting you will also be asked about your training and education, practice as a school psychologist, and perceptions about your role. The survey will take 5-10 minutes to complete.

Participation is voluntary and you may withdraw at any time without penalty. You do not need to answer any questions you do not wish to answer.

You will be asked to provide information over the Internet. In an effort to protect your privacy, I will use a secure web site to collect the study information and password protected computers to store the study information. I will not collect your name or any identifying information about you in the survey.

I hope you will agree to complete the survey, which can be accessed by clicking on the link embedded on this page. By clicking on the link, you are giving informed consent for participation in the research study. Identifiable information will not be linked to completed surveys (i.e., your responses will not be linked to your identity). If you do not wish to participate in this study, do not click on the link provided.

Dr. Kisha Radliff is the primary contact person for this study; please contact her if you have any questions about the survey by phone at the Ohio State University (614-292-6485) or by email at radliff.2@osu.edu.

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact Ms. Sandra Meadows in the Office of Responsible Research Practices at 1-800-678-6251.

Thank you very much for your consideration of this research study. If you agree to participate in this study, please click on the link below or place the web address in your Internet browser: https://qtrial.qualtrics.com/SE/?SID=SV_bjh7SymnivJVMcR

Respectfully,

Kisha Radliff, Ph.D.
Assistant Professor
School Psychology
The Ohio State University

Renee A. Lake, M.S.Ed., M.A.
Doctoral Candidate/Graduate Researcher
School Psychology
The Ohio State University

APPENDIX C: Survey

1. Are you currently practicing as a school psychologist? Yes No

2. Gender: Male/Female

3. Age: _____

4. Ethnicity: Black or African American
Asian American
White
Hispanic/Latino
Native American
Native Hawaiian or other Pacific Islander
Multi racial
Other_____

5. What is your highest degree obtained?
Master‘s Specialist Doctorate
Other_____

6. What year did you receive your graduate degree? _____

7. What credentials do you currently hold? (Check all that apply).
Licensure (or certification) as a School Psychologist from the Ohio Department of Education
Licensure as a School Psychologist from the State Board of Psychology
Licensure as a Psychologist from the State Board of Psychology
Nationally Certified School Psychologist from National Association of School Psychologists (NASP)

8. Please indicate your membership in any current professional associations (check all that apply):
National Association of School Psychologists (NASP)
American Psychological Association (APA)
APA Division 16 - School Psychology
Ohio School Psychologists Association (OSPA)
Ohio Psychological Association (OPA)

9. How many schools do you currently serve? _____

10. How would you best classify your primary employment location?

Urban
Suburban
Rural

11. What population do you serve? (Select according to your **primary** employment location).

Preschool
Elementary
Middle School
High School

12. Where is your **primary** employment located? (Check one).

Public School
Charter/Community School
County Agency (e.g., ESC)
State Support Team or Ohio Department of Education
Other Contract Services Agency (e.g., PSI, TES, Next Step)
Alternative School/Day Treatment/Residential Setting (e.g., PEP, Education Alternatives)
Private School
Other

13. What percentage of your student population receives free or reduced lunch at you **primary** school?

14. Please estimate the emphasis of your graduate training in the following areas:
None, Minimal, Some, A lot, Extensive

a. Identification or diagnosis of mental health disorders
b. Designing and implementing evidence-based interventions for students with mental health problems
c. Individual Counseling
d. Group Counseling
e. School-wide intervention or prevention programming

15. Please estimate the Continuing Education or Professional Development completed in the following areas:
None, Minimal, Some, A lot, Extensive

a. Identification or diagnosis of mental health disorders

b. Designing and implementing evidence-based interventions for students with mental health problems

c. Individual Counseling

d. Group Counseling

e. School-wide intervention or prevention programming

16. Identify the professionals in your school(s) who provide mental health services to students and rank order them according to who provides these services with the most frequency. (Rank only professionals that work in your **primary** work location).

School Psychologist
School Social Worker
School Mental Health Specialist
Behavior Specialist
School Counselor
Other_____

17. Do you currently provide mental health services to students? Yes or No

18. Please indicate the extent to which you agree with the following statements:
Strongly Agree, Agree, Disagree, Strongly Disagree

a. I believe I am competent to provide mental health services to children and adolescents.

b. Most other professionals in my school view it as part of my role to provide mental health services to students.

c. I believe it is my role as a school psychologist to provide mental health services to students.

d. I believe it is my role as a school psychologist to provide individual counseling to students with mental health problems or illness.

e. I believe it is my role as a school psychologist to provide group counseling to students with mental health problems or illness.

f. I believe it is my role as a school psychologist to provide and/or support school wide prevention and intervention programming.

19. Please indicate the extent to which you agree with the following statements (Base your answer on your **primary** work location):
Strongly Agree, Agree, Disagree, Strongly Disagree

a. The students I serve are in need of mental health services.

b. The time I spend providing mental health services adequately meets needs of the students.

c. The time other school based personnel spend providing mental health services adequately meets the needs of the students.

20. Indicate the percentage of time in a typical school year you spend engaging in the following mental health related services (Does not need to total 100%):

Individual ounseling (working one-on-one with a student over time to address a particular topic, skill, or issue)
Group counseling (working with three or more students over time to address a particular topic, skill, or issue)
Formal consultation related to mental health issues (formal meetings with an educational professional to address a particular topic, skill, or issue)
Social Emotional/ Behavior Assessment (any process aimed at the assessment of students' social/emotional status and/or behavior)
School-wide prevention/intervention (involvement in developing and/or implementing school-wide prevention or intervention supports)
Crisis Intervention (providing immediate and short term assistance to a student or family experiencing emotional, mental, physical or behavioral distress)
In-service training (providing formal training to employees within your employment setting(s))
Parent support groups (developing and conducting formal meetings with students' parents for the purpose of providing information and/or addressing a particular topic, skill or issue)
Case Management (coordination or referral of services on behalf of a student or family)
Other_____
Other_____

21. You indicated that you spend time conducting individual counseling during a typical school year. Rank the following concerns from most to least prevalent (1=most prevalent, 2=second most prevalent, and so on). Leave blank items that do not apply.

Academic problems
Behavioral problems
Relational issues
Bullying
Depression
Anxiety
Suicidal Ideation
Lesbian, Gay, Bisexual & Transgender (LGBT) issues
Violence
Family issues
Other_____
Other_____

22. You indicated that you spend time conducting group counseling. What types of issues do you address? (Check all that apply).

Academic problems
Behavioral problems
Relational issues
Bullying

Depression
Anxiety
Suicidal Ideation
Lesbian, Gay, Bisexual & Transgender (LGBT) issues
Violence
Family issues
Other_____
Other_____

23. You indicated that you spend time participating in school-wide intervention/prevention activities. What types of issues do you address? (Check all that apply).

Positive Behavior Supports (PBIS)
Bullying
Substance use prevention
Pregnancy
Anger Management/ self-control
Stress Management
Lesbian, Gay, Bisexual & Transgender (LGBT) issues
Other _____

24. The following factors have been identified as barriers to the provision of mental health services in schools. Rank the top 3 barriers to providing mental health services as it applies to your experience.

Problems with the physical school environment for delivering services
Insufficient support from the department and district administration
Problems with cooperation from school personnel
Insufficient training
Insufficient time and integration into the school site
Large caseload
Challenging student factors
It is not my role to provide mental health services to students.
Other_____

25. The following factors have been identified as facilitators to the provision of mental health services in school. Rank the top 3 facilitators to providing mental health services as it applies to your experience.

Departmental and administrative support
Facilitative relationships with school staff
Sufficient mental health training
School environments conducive to providing services
Manageable caseload
Students are amenable to service provision
It is my role to provide mental health services to students.

Other_____

26. Please use this space to provide any additional information you feel may be important to add regarding school psychologists and the provision of mental health services in schools.

APPENDIX D: Comments

Large Caseload

1. In my setting, my test/place role is singular; the district has an extremely high caseload expectation.

2. I serve 8 schools-lone school psychologists in county school system serving ages 3-22. I barely have time to perform my primary duty (i.e. MFE's)

3. Many students would benefit from mental health, social/emotional support; however, ETRs/IEPs and compliance issues take the majority of my time.

4. Large case loads continue to keep jobs focused on legal rather than need of students.

5. Caseloads tend to be very large because there is considerable over-identification of students.

6. I do nothing but test, and it feels as though I am flipping hamburgers at McDonald's. I feel that our role needs to be better defined and we need to have lower caseloads in order to find the time to provide mental health support adequately.

7. Being a crucial team member for the special education process takes up 99% of my time with 4 buildings.

8. I would like to provide more time for mental health. My caseload is way too large to address mental health problems. Additionally, the schools do not want us pulling children from class more than necessary due to high stakes testing.

9. With special education compliance demands and high evaluation caseloads, I think school psychologists are seeing their roles restricted to duties related to compliance. Administration does not view mental health as a school psychologist's role, and I have attempted to carve out a niche in that area due to lack of time and inadequate training. I'm not sure more training would make a difference on that front, however, because other professionals fill that role, while my role is related to special education. My primary experience with mental health issues is through serving on my schools' intervention assistance teams.

10. I would love to have a day in my schedule reserved for mental health services. Right now, it's all about evaluations and handling crises.

11. My current position does not allow for the provision of mental health services (except in one extreme case) due to other responsibilities.

12. Budget short-falls and increasing caseloads render the provision of mental health services highly difficult.

13. Great topic. As a school psychologist, I feel we are a key mental health professional in the school; however, we are often limited to which skills and training we are allowed to use do to large caseloads and other assignments. I personally would welcome the opportunity to do more direct mental health support for our students.

14. The major factor in providing services in my district is time. I am the only school psych to service a district of 2,000 plus students with a 15% sped [special education] population.

15. In my district, it is generally not the role of the school psychologist to provide mental health services, although at times it is necessary. Other professionals in the school generally take that role. I feel that even though we attempt to address it, there are so many students and so few professionals that we are not meeting everyone's mental health needs. Furthermore, I feel that the training is lacking and that we are expected to primarily conduct evaluations to determine if a student qualifies for special education services. From what I have observed, I see most psychologists in a district like mine testing, writing, and attending ETR meetings.

Insufficient support from the department and district administration

1. As for the past 20 years, I have been specifically instructed not to do this unless extreme circumstances.

2. In our district, school psychologists are not looked to as mental health experts. We are treated as psychometricans. They do not value or training or expertise.
When I finished graduate school, I felt well trained. But now, 11 years later, I've lost my confidence to do much besides test. When you are the only psychologist in a district, and the administration is stretched really thin, it is difficult to be here. The administration is not really informed of what services a psychologist can provide besides testing, and frankly I'm not so sure of my skills anymore either. While I know my graduate training was thorough and is still relevant, I feel rusty.

3. Working out of an ESC in 2 different districts, neither administration really view my role as mental health provider. Unfortunately they see me more of a test-place role.

I would like to provide more time for mental health. My caseload is way too large to address mental health problems. Additionally, the schools do not want us pulling children from class more than necessary due to high stakes testing

4. With special education compliance demands and high evaluation caseloads, I think school psychologists are seeing their roles restricted to duties related to compliance. Administration does not view mental health as a school psychologists role, and I have to attempted to carve out a niche in that area due to lack of time and inadequate training. I'm not sure more training would make a difference on that front, however, because other professionals fill that role, while my role is related to special education. My primary experience with mental health issues is through serving on my schools' intervention assistance teams.

5. While I believe it is part of the role of a school psychologist to provide mental health services in schools, it seems it is often overlooked.

6. Many departments and school continue to view psychologist in a test and place framework. Budget short-falls and increasing caseloads render the provision of mental health services highly difficult.

Insufficient training

1. However, my MA was in special ed. (ED and SLD) and I went back to school in 1992 to get a school psych. certificate. I did have a bit more course work in 1992 in some of these areas that relate to mental health, though not much.

2. I see the students coming out of school psych. in the past few years with very limited knowledge of mental health issues including basic items such as how to make a diagnosis.

3. When I finished graduate school, I felt well trained. But now, 11 years later, I've lost my confidence to do much besides test. When you are the only psychologist in a district, and the administration is stretched really thin, it is difficult to be here. The administration is not really informed of what services a psychologist can provide besides testing, and frankly I'm not so sure of my skills anymore either. While I know my graduate training was thorough and is still relevant, I feel rusty.

4. I function as a band-aid; most students I see need more than I can give them due to time constraints and lack of specialized training in a number of disorders. I sometimes bring comfort only and refer out.

5. With special education compliance demands and high evaluation caseloads, I think school psychologists are seeing their roles restricted to duties related to compliance. Administration does not view mental health as a school psychologists role, and I have to

attempted to carve out a niche in that area due to lack of time and inadequate training. I'm not sure more training would make a difference on that front, however, because other professionals fill that role, while my role is related to special education. My primary experience with mental health issues is through serving on my schools' intervention assistance teams.

6. More mental health training/individual counseling skills should be provided in the school psychology graduate program.

7. In my district, it is generally not the role of the school psychologist to provide mental health services, although at times it is necessary. Other professionals in the school generally take that role. I feel that even though we attempt to address it, there are so many students and so few professionals that we are not meeting everyone's mental health needs. Furthermore, I feel that the training is lacking and that we are expected to primarily conduct evaluations to determine if a student qualifies for special education services. From what I have observed, I see most psychologists in a district like mine testing, writing, and attending ETR meetings.

8. Mental health issues/needs are prevalent every day. Very, very important topic. There are some unclear lines about confidentiality that I have found we were not trained in nor can any psychological organization provide insight to help answer my questions. I usually have to defer to the school lawyers and that makes me feel as though am uneducated in the job.

<u>It is not my role to provide mental health services to students.</u>

1. Also, I am not really sure if it is my role as school psychology. to provide mental health services as for the past 20 years, I have been specifically instructed not to do this unless extreme circumstances.

2. Our district employs licensed social workers to coordinate services with outside agencies, provide in-service presentations, and work with school staff to develop behavior plans. Our district also employs behavior analysts for severe behavior cases.

3. I do feel that provision of mental health service is within the role of school psych, however, in my experience, I have had extremely limited opportunity to provide such service.

4. I believe that school psychologists' role is to support the student's functioning at school. For extensive therapy, the student needs outside services.

5. Given our large caseloads I feel it is very difficult to provide mental health services to students in my buildings. I also feel, as a profession, we have gotten away from that role. The school counselor is looked at as the person to provide mental health services. The

school psychologist is looked at as the person to conduct evaluations for special education.

6. In my district, it is generally not the role of the school psychologist to provide mental health services, although at times it is necessary. Other professionals in the school generally take that role. I feel that even though we attempt to address it, there are so many students and so few professionals that we are not meeting everyone's mental health needs. Furthermore, I feel that the training is lacking and that we are expected to primarily conduct evaluations to determine if a student qualifies for special education services. From what I have observed, I see most psychologists in a district like mine testing, writing, and attending ETR meetings.

Problems with cooperation from school personnel

1. Coordination between the school and mental health providers is crucial but not always implemented the way it should be.

2. School personnel in this part of the state believe that the only thing school psychologists can do is test for special education placement.

3. It has been my experience that it is very difficult to educate school personnel regarding the other roles that school psychologists can take on.

4. Many departments and school continue to view psychologist in a test and place framework. Budget short-falls and increasing caseloads render the provision of mental health services highly difficult.

Other

1. Special education evaluations and other services with compliance timelines very often take priority over mental health services that have no such timelines.

2. Due to cuts in funding, limited personnel and time are major factors.

3. Although I see an immense need for wrap around services for students with disabilities, there is insufficient time and resources for them.

4. There is a great need for mental health services. More than can be addressed by one professional assigned to one building full-time.

5. Mental health issues/needs are prevalent every day. Very very important topic. There are some unclear lines about confidentiality that I have found we were not trained in nor can any psychological organization provide insight to help answer my questions. I usually have to defer to the school lawyers and that makes me feel as though am uneducated in the job.

6. There is a perception that I am not to be utilized for counseling only testing and assessment for special education eligibility in addition to OAA/gifted testing with the loss of elementary guidance counselors.

7. School resources are often the only readily available resources for many families. However, the mental health needs of students are frequently more severe and complex than school staffs have the time, training, competency, and role to address. My training s that in cases of significant mental health issues, a school psychologist should coordinate with and augment services by clinically-trained providers. Most students with significant needs are not getting consistent treatment with a clinical provider. This leaves me and other school staff in the position of being somewhat ineffective and stretching the bounds of competency. And leaves students and families in the position of receiving piecemeal supports focused on school, but not underlying mental health issues.