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# Impacts of Self-Efficacy on School Psychologists' Provisions of Mental Health Services

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IMPACTS OF SELF-EFFICACY ON SCHOOL PSYCHOLOGISTS'

PROVISIONS OF MENTAL HEALTH SERVICES

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A Thesis

Presented to

The Graduate Faculty

Central Washington University

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In Partial Fulfillment

of the Requirements for the Degree

Education Specialist

School Psychology

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by

Ashley Anne Jantzer

May 2019

CENTRAL WASHINGTON UNIVERSITY

Graduate Studies

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ABSTRACT

IMPACTS OF SELF-EFFICACY ON SCHOOL PSYCHOLOGISTS'

PROVISIONS OF MENTAL HEALTH SERVICES

by

Ashley Anne Jantzer

May 2019

The purpose of this thesis was to identify variables that predict a school

psychologist's self-efficacy in counseling abilities, as well as identify variables that

predict perceived barriers to implementing mental health services to students in a school

setting.  Participants were 84 school psychologists working in the state of Washington.

Participants were asked to complete a survey that included (a) demographic questions, (b)

a questionnaire about perceived self-efficacy in counseling abilities, and (c) a

questionnaire about perceived barriers to providing mental health services.  The results of

two multiple linear regression equations suggest that in this study, certain variables

predicted both self-efficacy and barriers.  The most noted variable in both equations was

the amount of coursework completed in graduate training related to counseling and

mental health services.

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TABLE OF CONTENTS

TABLE OF CONTENTS (CONTINUED)

Chapter                                                                                                        Page

LIST OF TABLES

CHAPTER I

INTRODUCTION

Self-efficacy is a concept that describes how an individual perceives their ability to complete a goal or engage in a task (Bandura & Locke, 2003). Often self-efficacy is confused with self-esteem, though self-efficacy relates to what an individual believes their capabilities are, and self-esteem is a reflection of an individual's perception of their self-worth (Bandura, 1997). Bandura's (1997) definition of self-efficacy is "beliefs in one's capabilities to organize and execute the courses of action required to produce given attainments" (p. 3). In other words, people will exert effort to complete a task based on whether or not they believe they can accomplish the task, even in the face of adversity.

Bandura (1997) suggests that self-efficacy can influence a range of outcomes, including an individual's exerted effort on a task, perseverance in the face of adversity, and the extent to which an individual endures despite barriers and setbacks. Self-efficacy can have a positive or negative impact on motivation and performance for a range of skills and behaviors; from academic outcomes to job performance (e.g., Alessandri, Borgogni, Schaufeli, Caprara, & Consiglio, 2015; Multon, Brown, & Lent, 1991). Perhaps most relevant to this study, Bandura (1997) implies that the strength of perceived self-efficacy directly impacts how much an individual perseveres when faced with obstacles. This study will ask two questions in relation to self-efficacy. First, are school psychologists with higher self-efficacy more likely to provide mental health services than school psychologists with lower self-efficacy? Second, how do self-efficacy and barriers interact in relation to providing mental health services?

CHAPTER II

LITERATURE REVIEW

**Role of School Psychologists**

Historically, school psychologists have placed an emphasis on testing and

eligibility determination for students who are referred for special education services

(Cummings et al., 2004). In order to understand the future of school psychology, Hyman

and Kaplinski (1994) surveyed practicing school psychologists to obtain feedback about

the then current state of the field. The authors asked questions that related to assessment,

consultation, psychotherapy, and pay scales. At the time of this study, 74% of

respondents felt that roles related to assessment were a necessary component of school

psychology practice. However, 78% of respondents also felt that the National

Association of School Psychologists (NASP) should strengthen graduate programs by

encouraging graduates to be trained in psychotherapy. In fact, 74% of responders agreed

that school psychologists should provide psychotherapy to students. The results of this

study demonstrate that the mental health needs of students have been an ongoing concern

in the field, particularly as it relates to who will provide mental health services (MHS) to

students.

NASP (2015) advocates for a comprehensive service delivery model that meets

the diverse needs of students, including mental health needs. However, there is still a gap

between the children with the most severe needs and their ability to receive adequate

support in the school setting (Farmer et al., 2003). Because NASP (2015) contends that

school psychologists are some of the best prepared mental health providers in schools, it

is important to understand the positive effects that school psychologists can have on the

mental health needs of their students.  However, diminishing numbers of professionals in the field, and an increasing number of students in the public-school system are causes of concern for practicing school psychologists and their already ambiguous role (Cummings et al., 2004).

NASP (2015) and Cummings et al. (2004) encouraged school psychologists to expand their services to include a multitude of dimensions, with a focus on social-emotional functioning, which requires the availability of mental health supports, training and resources.  However, graduate training programs can vary within and between states, with job requirements following a similar pattern depending on the district (Goforth, Yosai, Brown, & Shindorf, 2017; Hosp & Reschly, 2002).  In addition, several studies suggest that school psychologists are expected to engage in other substantive activities that compete for their already limited time, such as assessment and consultation (Atkinson, Squires, Bragg, Muscutt, & Wasilewski, 2014; Hanchon & Fernald, 2013; Suldo, Friedrich, & Michalowski, 2010).  Even still, research has shown that school psychologists are capable of affecting mental health and school-related outcomes for students when they provide MHS as part of their service delivery (Froiland, 2011; Lambros et al., 2016).

Froiland (2011), for example, demonstrated the positive effects of MHS provided by school psychologists on a student suffering from depression, anxiety, diminishing grades, and chronic absenteeism.  Utilizing single case design methodology, the author evaluated the use of a cognitive-behavioral counseling approach (i.e., a form of school-based MHS) with this student to determine if the treatment had an effect on the student.  After the mental health treatment was delivered for eight weeks, the author

demonstrated that the student's attendance increased, and the student's grades increased (i.e., grades improved overall from C's to A's). The student's own self-report indicated that she experienced lesser feelings of anxiety than before treatment and that her overall symptoms of depression decreased. The previously mentioned literature testifies to the need for more comprehensive MHS in schools, and the positive impact that appropriately delivered MHS can have on students.

Similar results have been obtained for larger samples. For example, Lambros et al. (2016) implemented a form of a comprehensive school-based mental health treatment for students with dual diagnosis. Participants were students who suffered from both intellectual disabilities and a mental health-related illness (i.e., anxiety). The authors found that after providing participants with school-based therapy, school absences and suspensions decreased significantly. In addition, the authors noted that parents self-reported an overall increase in their children's level of healthy functioning, including the area of social and adaptive skills, and a decrease in self-injurious behaviors and hyperactivity. Lastly, the authors found that both parents and therapists were satisfied with treatment outcomes, with therapists noting that the majority of students made progress towards predetermined goals.

There has been a recent legislative push for school psychologists to be providers of school-based mental health services (MHS), something that NASP has been advocating for some time (NASP, 2015). The Every Student Succeeds Act (ESSA) (2015), which is a reauthorization of the Elementary and Secondary Education Act of 1965 (2016), explicitly calls upon school psychologists to provide MHS within their schools. The ESSA includes school psychologists as service providers in response to

increasing support for students, which serves to enrich their academic performance.  With

a growing number of children and adolescents who need more comprehensive services

(Farmer, Burns, Phillips, Angold, & Costello, 2003), NASP (2015) recommends that

school psychologists expand their traditional roles to include MHS.

In the 2002 conference on the future of school psychology, professionals in the

field gathered in person and remotely to engage in discussions about the future of the

field of school psychology (Cummings et al., 2004).  In a review of the conference,

Cummings et al. (2004) outlined the major themes and critical outcomes from these

discussions.  In addition to addressing the current state of school psychology and what

future directions the profession should head, conference participants also determined

barriers and facilitators to the overall provision of psychological services.  Discussing

these factors allowed for a consensus on issues that might need to be addressed before

being able to expand the role of school psychologists.

**Mental Health Services**

Mental health, in general, is gaining necessary attention as educators are focusing

on children from a more holistic lens.  NASP (2015) recognizes the impact that poor

mental health can have on students, including pronounced negative effects on a child's

performance in school, ability to cope effectively, and engagement in positive behaviors.

These impacts on children have encouraged organizations such as NASP (2015) to

promote comprehensive supports that focus on the whole-child, rather than supports

isolated to academic needs.

Mental illness affects children and adolescents in staggering numbers; for

example, the Substance Abuse and Mental Health Services Administration (SAMHSA)

(2015) reports that in 2014, 11.4% of adolescents reported having at least one major depressive episode over the previous year. These trends are on the rise for both males and females. Several biologic and environmental factors can affect the presence and onset of clinical psychiatric disorders among children and adolescents (Costello, Copeland, & Angold, 2016). While it is necessary to acknowledge and identify risk factors in relation to childhood mental illness, therapeutic services are also a vital piece in helping children cope with and overcome such disorders. Many school psychologists agree that increasing public awareness of the mental health needs of students should be a top priority, and in fact, many school psychologists believe that the public needs to acknowledge the need for increased MHS in schools before they can begin to provide these services to their students (Cummings et al., 2004).

It is argued that schools are already in a prime position to offer MHS to children (Eklund, Meyer, Way, & McLean, 2017; Nastasi, Varjas, Bernstein, & Pluymert, 1998), and that children who may not otherwise have access to services do have access to MHS provided in school (Armbruster, Gerstein, & Fallon, 1997). For example, Farmer et al. (2003) estimated that 33.6 percent of adolescents receive some form of MHS, and of those, 60.1 percent receive MHS in school. Mental illness can affect a students' ability to perform well and function in school, making the need for adequate MHS a necessity (Perfect & Morris, 2011); however, decreases in funding of mental health programs have exacerbated an already apparent gap between those who need treatment and those who receive treatment (Cummings, Wen, & Druss, 2013).

Mental illness can have short and/or long-term effects on children. Porche, Costello, and Rosen-Reynoso (2016) observed mediating effects of adverse childhood

experiences on mental health and various academic outcomes. These researchers found that the number of adverse experiences increased the likelihood that a child would suffer from mental illness. Furthermore, the authors concluded that the prevalence of mental illness increased a child's chances of performing poorly in academics, being held back a grade, and having an individualized education plan.

The Great Smoky Mountains Study was a longitudinal study that examined mental health service use and needs among children and adolescents. The study was originally published by Costello et al. (1996). In a recent study, Costello et al. (2016) reviewed data from the Great Smoky Mountains Study to identify long-term outcomes resulting from the presence of mental illness in childhood. Upon reanalyzing the data, Costello et al. (2016) found that the presence of mental illness in childhood led to a variety of negative outcomes in adult life, such as physical and mental illness, legal problems including incarceration, poor job performance and difficulty keeping a job, and social problems including teen pregnancy and diminished social support. These negative adult outcomes were shown to be predicted by childhood mental illness even after childhood traumatic experiences (e.g., neglect) were accounted for (Costello et al., 2016).

Furthermore, Costello et al. (2016) sought to identify risk factors that contribute to the onset of various psychiatric disorders during the adolescent years. The authors found that puberty can be a factor in the development of certain disorders, with onset rates of depression increasing among adolescent females during pubescent years. In addition, the authors found that poverty is correlated with mental illness in adolescents. Specifically, they found that in families who were able to get out poverty, adolescents showed a decrease in the number of disorder-related symptoms than when they were in

poverty.  These results support the importance of identifying risk factors associated with mental illness in order to focus on prevention of long-term mental illness and negative long-term outcomes of childhood mental illness, especially for school psychologists working with adolescents in low socioeconomic areas.

Utilizing data from the 1996 Costello et al. study, Farmer et al. (2003) focused on the most common avenues that adolescents use to seek treatment.  The authors analyzed the epidemiological data and interviewed parents and their children and determined that a majority of youth who qualified for a psychiatric disorder received MHS within the school setting.  The authors also found that adolescents receiving services in school were less likely than those receiving treatment outside of school, to be referred to other community-based agencies for treatment.  The results of this study suggest that children who receive mental health services in the school setting may not receive collaborative services, such as being referred to a community-based mental health specialist.

Burns et al. (1995) also reviewed data from the Great Smoky Mountains Study of Youth to determine how severe the gap was between students who needed MHS and those who received them.  The authors found, similar to Farmer et al. (2003), that the school setting was the most common avenue for receiving treatment for symptoms of a psychiatric disorder.  However, even with approximately 80% of children receiving treatment in the school setting, only approximately 40% of children with a clinical psychiatric diagnosis received treatment in any setting, school or otherwise.  Based on the results, the authors concluded that the majority of children who need treatment for a psychiatric disorder and/or impairment were not receiving any form of treatment.  In addition, the authors suggested that future policies look at strengthening MHS and

competencies of mental health professionals in the school setting because that is where most children receive treatment.

The findings from Farmer et al. (2003) and Burns et al. (1995) show that students could benefit from further collaboration between school staff and outside agencies to provide treatment, in part because of the shortage of qualified school-employed personnel to be mental health providers. Collaboration is already a recommended component of school psychology practice according to NASP (2015), and school psychologists are trained to aid in supporting the mental health needs of students in this comprehensive manner (Meyers & Swerdlik, 2003).

**Variables Affecting School-Based Provision of MHS**

Previous literature has sought to understand what outside influences act as variables that affect the provision of MHS by school psychologists in order to advocate for expanding the roles of school psychologists to more readily incorporate MHS (Atkinson et al., 2014; Hanchon & Fernald, 2013; Suldo et al., 2010). Some researchers have noted that the gap between the need for MHS and those who actually provide those services may be impacted by more than barriers that school psychologists face in the field (Kaniuka, 2009). Kaniuka (2009) questions whether there is a "training-to-practice gap" in preparing school psychologists to competently provide MHS (p. 224). This implies that training programs may be underpreparing school psychologists to perform the mental health duties expected of them in the field. To address the mental health needs of children and adolescents, several studies have sought to determine if school psychologists are contributing to the school's provision of treatment services for mental illness', and if not, what is preventing them from doing so (Atkinson et al., 2014; Eklund et al., 2017;

Hanchon & Fernald, 2013; Meyers & Swerdlik, 2003; Suldo et al., 2010). To help address the need for MHS, school psychologists agree that school staff and the public at-large need to view them as qualified professionals competent to offer school-based MHS before they themselves can advocate for expanding their traditional role (Cummings et al., 2004).

Suldo et al. (2010) found that some school psychologists already provide MHS, with the most common services provided being: (a) group counseling, (b) individual counseling, and (c) crisis intervention. Ninety-one percent of respondents to this survey engaged in leading group counseling sessions, while 100% of 39 respondents led individual sessions and/or engaged in crisis intervention. However, the authors did not state how much time school psychologists were actually spending engaging in these activities. Similarly, Eklund et al. (2017) found that the three most common mental health services provided by respondents of their survey were: (a) crisis intervention, (b) individual counseling, and (c) group counseling. A limitation to these studies is that results were listed categorically, and no statistical analysis was done to determine if certain factors had an effect on the provision of MHS, or, how much time was dedicated to the provision of MHS. However, of importance is the identification that facilitators can aid in the provision of MHS by school psychologists.

In their 2010 study, Suldo et al. asked respondents about what factors enable them to provide MHS to their students. The authors found that participants mentioned several facilitating factors, including: department and administrative support, personal factors (e.g., wanting to provide counseling services), visibility within their school(s), strong working relationships with school staff, appropriate training and competence,

adequate space to provide MHS, manageable caseload, and lastly, community recognition and support.  Atkinson et al. (2014) also asked respondents about factors that enable them to provide MHS.  These authors found that the most common enabling factors among their participants were: quality and continuing training, autonomy, administrative support, personal factors (e.g., desire to provide MHS), legislation encouraging an expanded role, school personnel valuing the school psychologist as able to provide MHS, flexibility, and access to adequate supervision.  Squires and Dunsmuir (2011) also noted from their focus groups that strong supervision was one of the most influential facilitators to the provision of Cognitive Behavioral Therapy (CBT) in their study.

**Barriers.**  A review of the literature on the current state of school-based mental health services has identified the prevalence of children identified as being diagnosed with a mental disorder (e.g., depression and anxiety) and the inherent gap between those who need MHS and those who are able to receive them.  When looking at depression alone, 58.8% of adolescents who have experienced a major depressive do not receive any form of treatment (SAMHSA, 2015).  Cummings et al. (2013) recognize that strict federal and state budget cuts have affected mental health services across all modalities in recent years, and furthermore, these authors emphasize that cuts have also impacted schools' abilities to provide MHS to students in need.  The New Freedom Commission on Mental Health (2003) inspired focus on prevention and recovery instead of symptom management.  Specifically, it was recommended by the commission that schools serve the mental health needs of their students by promoting early detection of emotional and behavior disorders.

11

Recognizing the shortage of school psychologists and the inherent gap between students who need MHS and those who are able to receive them, Suldo et al. (2010) aimed to identify factors that influence whether or not school psychologists incorporate MHS into their practice. The authors surveyed 39 practicing school psychologists from both suburban and urban school districts by utilizing focus groups. The authors coded the focus group sessions to find themes between participants' responses. The findings suggest that some school psychologists do incorporate mental health services into their practice, but there are several common factors that influence service delivery and how much time they are able to dedicate to supporting the mental health needs of students.

Suldo et al. (2010) identified several common barriers mentioned by participants that prohibit the provision of adequate MHS. Barriers with the most mentions throughout all focus groups included problems with the school site, such as not enough space, role confusion among practitioners, and too much focus on academics. Lack of support from administration received the second most mentions (e.g., administration views school psychologist duties as those that pertain to evaluations only). The third most common barrier was conflicting views of other staff members, such as teachers not being receptive to school psychologists' abilities to provide MHS or lack of understanding of the importance of MHS. Insufficient training received the fourth most mentions, which included lacking knowledge of MHS, not enough opportunities to practice providing MHS in graduate training, as well as a general lack of confidence in providing MHS.

Meyers and Swerdlik (2003) reviewed previous literature that identified factors that influence the provision of MHS and listed similar common barriers as in the Suldo et al. (2010) study, including the importance of other job duties and limited time and

12

resources to reach the growing number of students who need additional supports.  The

authors listed the most common barriers to the provision of MHS by school psychologists

as: Lack of physical space for school-based clinics, not enough emphasis on preventative

service delivery models, stigma surrounding mental illness, lack of resources, not enough

integration between existing school programs, focus on physical health needs rather than

mental health needs, role ambiguity among school psychologists, and school

psychologists being pulled in too many directions.  The authors noted that of school

psychologists who do provide direct MHS to their students, most received more training

related to MHS than their colleagues who did not provide MHS.

  Squires and Dunsmuir (2011) ran focus groups to examine facilitators and barriers

that influenced educational psychologists' ability to provide a specific MHS, cognitive

behavioral therapy (CBT).  After coding the focus group sessions, the authors found that

barriers to the provision of CBT included lack of space in the school, issues pertaining to

confidentiality, student factors (e.g., attendance), and adequate training to provide CBT.

Specifically, as it relates to training, some participants believed they did not have enough

skill or competence to be able to provide CBT to students.

  These barriers are not unique to school psychologists in the United States; similar

studies have been carried out in other parts of the world.  For example, in a more in-depth

statistical analysis, Atkinson et al. (2014) used factor analysis to determine how different

facilitators and barriers described factors that influence aspects of school psychology in

the United Kingdom (UK).  Participants were asked to fill out either an online or paper-

and-pencil questionnaire relating to factors that influenced their provision of MHS.  The

authors found that identified barriers, such as limited amounts of training and not enough

practice, were statistically significant in describing how school psychologists' training influences their provision of MHS. Other barriers as indicated by participants included inadequate supervision, limitations with the traditional role expectations of school psychologists, limited time, and lack of stakeholder support (including not being viewed as competent to provide MHS).

In another study, Atkinson, Corban, and Templeton (2011) investigated what factors influence the delivery of MHS by educational psychologists in the UK by hosting focus groups and interviews. The authors found that educational psychologist participants listed several barriers to their provision of MHS. These barriers revolved around lack of time for service delivery and lack of perceived preparation to deliver MHS by school personnel. Participants also mentioned that because school staff often view them in a more traditional role (e.g., providing assessments), educational psychologists are not always viewed as competent to provide MHS. Because of the need for MHS, the authors suggested that these findings be used to support an increased role by educational psychologists in providing MHS.

While previous literature exists that examines the external barriers and facilitators to school psychologists' provision of MHS, there is much less research explicitly analyzing the internal characteristics and perceptions of practitioners. Specifically, researchers have not incorporated an analysis of practitioner self-efficacy and its role in the provision of MHS by school psychologists, which could be an important piece in evaluating training programs and service delivery. In spite of this, facilitators to the provision of MHS suggest that training and supervision are key components that

encourage school psychologists to expand their roles to cover MHS (Atkinson et al., 2014; Suldo et al., 2010; Squires & Dunsmuir, 2011).

Several barriers found in the literature point to components of self-efficacy as a contributing factor to the provision of MHS. For example, Suldo et al. (2010) did find that some school psychologists believe that not enough training (including a lack of confidence) inhibits them from providing MHS; however, these constructs were not explicitly explored in relation to providing MHS. School psychologists who receive training in MHS may be more likely to provide these services than those who do not receive such training (Meyers & Swerdlik, 2003; Squires & Dunsmuir, 2011). Similarly, some school psychologists indicate that they lack confidence in their skill set to deliver specific MHS (Squires & Dunsmuir, 2011) and that key stakeholders and the public may not have confidence in a school psychologist's ability to provide MHS (Atkinson et al., 2011).

**Self-Efficacy.** High-quality training programs are essential for developing a foundation of knowledge for school psychologists. NASP (2017) has outlined extensive criteria that graduate training programs must meet in order to be considered a NASP approved program. However, even when quality training is provided, school psychologists must believe that they are competent and able to provide MHS; this is where self-efficacy may impact MHS (Perfect & Morris, 2011). Research has found that some school psychologists do not believe they leave graduate school prepared to address the mental health needs of students (Hass & Domzalski, 2012), and this gives rise to the perceived ethical issues of school psychologists providing MHS. Perfect and Morris

15

(2011) advocate that school psychologists must believe they are competent before they can ethically provide such services.

The literature surrounding self-efficacy and school psychologists' provision of MHS is sparse; however, the literature does demonstrate how self-efficacy impacts other professional areas in the field of psychology.  For example, there is some literature surrounding self-efficacy and school counseling practice.  To help shed light on the need for more research in this area, Bodenhorn and Skaggs (2005) created the School Counselor Self-Efficacy Scale to promote future research on understanding the impacts of self-efficacy on school counseling practice.  The authors specifically designed the scale to aid in understanding of how well counseling programs prepare school counselors for the ever-changing demands of the field.  Similar to school psychologists, Bodenhorn and Skaggs noted the wide variety of responsibilities that are expected of school counselors.  This scale was intended to shed light on critical areas of professional development and graduate training so that training programs can increase self-efficacy in school counselors, thus increasing job performance.

Bodenhorn, Wolfe, and Airen (2010) used the School Counselor Self-Efficacy Scale (Bodenhorn & Skaggs, 2005) to determine if self-efficacy was a variable in increasing positive student outcomes, such as closing the achievement gap.  The authors found that participants who had higher self-efficacy responded to survey questions in a way that indicated they felt as though they influenced closing the achievement gap in their schools.  Results from this study further supported the idea that counselors with greater self-efficacy were able to make different impacts on their students than counselors with lower self-efficacy.  Also utilizing the School Counselor Self-Efficacy Scale

(Bodenhorn & Skaggs, 2005), Mullen and Lambie (2016) sought to identify if school counselors with higher self-efficacy provided a higher frequency of counseling interventions.  After reviewing responses from 693 participants, the authors found that counselors with high self-efficacy did, in fact, provide more counseling interventions to their students.

In a doctoral dissertation, Huber (2006) created the Huber Inventory of Self-Efficacy for School Psychologists – Research Version (HIS-SP-RV) in an effort to design a measure that could evaluate self-efficacy among school psychologists, as measures for similar fields such as counseling, have already been created.  The author contended that it may be beneficial to measure self-efficacy as it relates to school psychologists in the areas of research, professional and interpersonal skills, counseling abilities, assessment skills, and intervention and consultation skills.  This study was aimed at identifying a valid and statistically reliable scale to measure self-efficacy, and whether or not self-efficacy scores differed among professionals and students in different stages of their careers.  As previously mentioned, Huber found that graduate students and working professionals differed in self-efficacy scores, with graduate students reporting lower scores in the areas of assessment skills, counseling skills, and interpersonal skills.  The author demonstrated that self-efficacy among students and professionals in various roles can differ.

Sabourin (2015) as part of a doctoral dissertation, sought to identify how involved school psychologists are with Response to Intervention (RtI) implementation, and what their perceived self-efficacy was.  The author found that school psychologists had higher self-efficacy in areas of assessment, and lower self-efficacy in relation to RtI.  It was

further noted that because the role of school psychologists is changing from traditional assessment methods to an RtI framework, graduate programs should begin to increase efficacy in RtI.

In a pilot study, Runyon et al. (2017) measured self-efficacy among school psychologists to determine if self-efficacy had an impact on the use of Applied Behavior Analysis (ABA) techniques. Participants answered survey questions related to self-efficacy and training in ABA, as well as responding to a scenario where they were asked to rate three approaches to ABA. The authors found that school psychologists with higher self-efficacy were more likely to use ABA techniques and offer ABA services.

Self-efficacy has also been shown to be higher among school psychologists who have had the opportunity to practice consultation methods longer, suggesting that the amount of time spent on consultation during graduate training may have an effect on perceived self-efficacy once in the field (Guiney, Harris, Zusho, & Cancelli, 2014). One can ponder if these findings would remain true when assessing school psychologists' self-efficacy and their provision of MHS, as many graduate training programs have provided explicit training in MHS during more recent years with the call for school psychologists to provide more comprehensive services.

**Current Study**

Identifying which barriers already exist highlights the need for understanding how school psychologists can begin to work towards change in spite of these obstacles. Much of the previous literature utilizes descriptive statistics to identify the average numbers of respondents who answer questions in a similar manner (e.g., number of respondents who experience administrative push-back as a barrier to providing services) related to

variables that affect the provision of MHS (Eklund et al., 2017; Hanchon & Fernald, 2013; Suldo et al., 2010). In addition, previous research has indicated possible external barriers to school psychologists providing MHS (e.g., Atkinson et al., 2014; Meyers & Swerdlik, 2003; Suldo et al., 2010). Understanding which barriers already exist increases the need for understanding how school psychologists can begin to work towards change in spite of these obstacles. If self-efficacy plays a role in whether school psychologists provide MHS, then it may be necessary for graduate programs to increase trainees' competence in the area of mental health to support growth in self-efficacy. This study will expand upon previous literature by investigating whether there is a significant difference between school psychologists with high self-efficacy and their provision of MHS when compared to school psychologists with low self-efficacy.

To dive deeper into understanding if certain personal factors have an effect on school psychologists' providing MHS, this study will focus on the impact that self-efficacy may have on whether school psychologists personally advocate for themselves to provide MHS to their students. The purpose of this study is to determine whether school psychologists are providing MHS, and if their self-efficacy and/or barriers they experience affect whether they provide MHS to the students they serve. The current study is designed to build upon previous literature by examining the relationship of self-efficacy to the provision of school-based MHS by school psychologists. It is hypothesized that school psychologists with high self-efficacy beliefs will be more likely to provide MHS than school psychologists with lower self-efficacy, and that school psychologists with high-self efficacy will be more likely than school psychologists with low self-efficacy to provide MHS when barriers are high.

CHAPTER III

METHODS

**Participants**

The participants in this study were practicing school psychologists licensed in the state of Washington. A total of 88 school psychologists practicing in the state of Washington participated in this study. Four outliers were removed from the data set, which resulted in analyzing responses from a total of 84 participants. All participants were at least 18 years of age at the time they filled out the survey. Demographic information was collected to determine how representative the sample is in terms of gender, ethnicity, years worked, type of district (i.e., rural, suburban or urban), and student demographics. The sample of school psychologists who participated in this survey were predominantly Caucasian ($n = 75$) and identified as female ($n = 72$). Other ethnicities represented in this sample were: Hispanic ($n = 2$), Asian ($n = 2$), Latino ($n = 1$), Anglo ($n = 1$), African American ($n = 1$), and mixed ethnicity ($n = 1$). One participant did not identify their ethnicity. Years working as a school psychologist ranged from 1 year to 37 years. The sample represented school psychologists working in rural districts ($n = 21$), suburban districts ($n = 47$), and urban districts ($n = 16$). The sample was also represented by school psychologists working with different age groups, such as those working in elementary settings ($n = 41$), middle school settings ($n = 20$), and high school settings ($n = 23$).

Participants were recruited via a survey link posted on the Washington State Association of School Psychologists (WSASP) webpage. Participants were also recruited through direct emails sent to school psychologists in the state of Washington. The

principal investigator in this study sent a research outline to NASP to request recruiting a national sample of school psychologists; however, the research request to recruit through NASP was denied.

To include participants from WSASP, an email attachment was sent to the WSASP office manager outlining the purpose of the study. The attachment included the principal researcher's name, contact information, and the survey. The editor posted the study, including the principal researcher's name, contact information, and a link to the survey on the WSASP website under the page titled "Research Opportunities." In addition, a link to the survey was included in the electronic newsletter titled *Prior Written Notice*. A recruitment email was also sent directly to 683 practicing school psychologists in the state of Washington (see Appendix A). Results of an a priori power analysis suggested that 35 participants were needed to obtain significant results with an effect size of 0.50 and a power of 0.80 at a significance level of 0.05.

**Measures**

This study asked participants to fill out a survey using the Qualtrics online survey program. The first part of the survey was a 7-item questionnaire derived from the Huber Inventory of Self-Efficacy for School Psychologists – Research Version (HIS-SP-RV), developed by Huber (2006). To help facilitate published research in the area of self-efficacy among school psychologists, Lockwood et al. (2017) collected data on the psychometric properties of the HIS-SP-RV. The authors collected data from the HIS-SP-RV from 520 school psychology graduate students. The purpose of their study was to identify if the items in the HIS-SP-RV had good model fit. The authors found that several items did not have good model fit. This allowed the authors to create a short-

form version of the scale by only retaining the items that did have good model fit. This resulted in pairing down the original 74-item scale to a 35-item scale. The authors argued that the shorter version would be a more appropriate length for use in published literature. The resulting short-form reduced the *Counseling Skills* subscale from 10 items to 7 items.

The 7-item short-form *Counseling Skills* subscale derived from the original HIS-SP-RV was used in this study. Lockwood et al. (2017) determined that individual subscales can be useful in determining self-efficacy in specific areas, making it appropriate to utilize only the *Counseling Skills* subscale in this study. Cronbach's alpha was used to calculate internal consistency reliability among the scales. The authors found that the coefficient alpha for the *Counseling Skills* subscale was .92. The 7-items from the HIS-SP-RV *Counseling Skills* subscale measured the participant's perceived self-efficacy as it relates to counseling skills.

The second part of the survey included questions authored by the principal researcher in this study. These questions used Likert style responding to determine if and how much school psychologists are impacted by previously identified barriers in relation to proving MHS in the school setting. There are no psychometrics available for this scale because it was created solely for the purpose of this study.

**Procedure**

A link to the survey was posted on the WSASP website under the page titled "Research Opportunities." In addition, a link to the survey was included in the WSASP electronic newsletter titled *Prior Written Notice*. A recruitment email was also sent directly to 683 school psychologists working in public schools in the state of Washington.

Upon opening the survey from either the link provided by WSASP or the direct email, by typing the link address into their internet search bar, or taking a picture of the QR-Code provided in the direct email, participants were shown a screen that identified the (a) purpose of the study, (b) a statement that their participation is voluntary, (c) potential risks from participating in the study, and (d) assurance that they could exit out of the survey at any time and if so, their data would not be used (see Appendix B).  Because this survey was completed online, participants were not asked to sign a consent form; this allowed their identity to remain anonymous as the consent form would be the only document that would connect their identity to the survey questions; however, participants were asked to give assent before participating in the survey.  At the bottom of the page appeared two choices, *agree* and *disagree*.  If the participant selected *disagree*, the survey ended.  If the participant selected *agree*, a new page opened in which the survey began.  The first questions in the survey were demographic questions that are used contextualize the data.  Please see Appendix C for the demographic questionnaire.

The next question that participants were to answer as outlined in the introduction of this study was an initial question about if they provide mental health services in their practice (i.e., Do you provide mental health services in your primary school?).  An oversight in the creation of the survey resulted in this question not being included in the final survey.  Therefore, after participants answered the demographic questionnaire, the HIS-SP-RV short-form *Counseling Skills* subscale began (see Appendix D).  This is a 7-item scale that uses Likert-style responding.  This survey measured the respondents' self-efficacy in the area of counseling skills.

After the 7-item HIS-SP-RV short-form *Counseling Skills* subscale was
completed, participants were prompted to complete the next set of survey items (see
Appendix E). These items were questions related to school-level barriers that have been
previously identified as impacting the provision of MHS. These questions were
answered using Likert-responding. For example, questions included items relating to
physical space in the school, administration support, role ambiguity, stakeholder views on
the importance of MHS, time constraints, and resource constraints.

**Data Analysis**

Data was analyzed using the Statistical Package for Social Sciences (SPSS). Data
was analyzed using two multiple linear regressions, one for each dependent variable. The
dependent variables in this study are self-efficacy and barriers. Each multiple linear
regression included four independent variables, which are: Receiving training in mental
health in graduate school, degree type (i.e., Masters, Specialist, or Doctorate), number of
mental health/counseling related courses in graduate school, and post-graduate training in
MHS. Each independent variable was zero-coded in order for a multiple linear regression
analysis to be utilized. The resulting labels for each independent variable after being
zero-coded are as follows: Masters, specialist, doctorate, onetwo (1-2 courses), threefive
(3-5 courses), sixeight (6-8 courses), eightplus (more than 8 courses), no mental health
training, yes mental health training, no additional training, and yes additional training.

CHAPTER IV

RESULTS

The purpose of this study was to examine the relationship between self-efficacy in counseling abilities to the provision of school-based MHS, and to look further into the relationship between self-efficacy, provision of MHS, and the amount of perceived barriers a school psychologist faces. The adjusted research questions were, (a) what factors predict self-efficacy in counseling abilities, and (2) what factors predict perceived barriers to providing MHS. The principal investigator ran two multiple linear regressions in order to predict perceived barriers to providing MHS, and self-efficacy in counseling abilities based on degree level, mental health training in graduate school, number of courses taken related to MHS in graduate school, and training in MHS outside of graduate school.

The data were checked for the assumptions of a multiple regression. The assumptions of a linear relationship, normality, multicollinearity, auto-correlation, and homoscedasticity were met. Descriptive statistics, including mean and standard deviation for each independent variable in the barriers and self-efficacy model are outlined in Table 1. Table 1 shows 35.71% of the sample held a masters degree, 51.19% held a specialist degree, and 13.1% held a doctorate level degree. The results demonstrate that in regard to the number of MHS courses taken, 20.24% of participants took one to two courses, 54.76% took three to five courses, 9.52% took six to eight courses, and 10.71% took eight or more courses. In terms of mental health training in graduate school, 4.76% of participants did not receive any training, while 95.24% of participants did receive training. In terms of additional training outside of graduate school, 44.05% of

25

participants did not receive additional training, while 55.95% of participants did receive

additional training outside of their school psychology graduate program.

Table 1

*Descriptive Statistics*

| Variable | Mean |
|---|---|
| Masters | 35.71 |
| Specialist | 51.19 |
| Doctorate | 13.10 |
| OneTwo | 20.24 |
| ThreeFive | 54.76 |
| SixEight | 9.52 |
| EightPlus | 10.71 |
| NoMentalHealthTraining | 04.76 |
| YesMentalHealthTraining | 95.24 |
| NoAdditionalTraining | 44.05 |
| YesAdditionalTraining | 55.95 |
| Totals (*n* = 84) | |

**Barriers**

A multiple linear regression model was used to predict perceived barriers to

providing MHS based on the following predictor variables: Degree level, mental health

training in graduate school, number of courses taken related to MHS in graduate school,

and training in MHS outside of graduate school.  Results demonstrate that 17.9% of the

variance in perceived barriers can be explained by the independent (predictor) variables,

with an adjusted $R^2$ value of .179. Table 2 depicts the model summary.

26

Table 2

*Barriers Model Summary*

|  | R Square | Standard Error of Estimate |
|---|---|---|
| Barriers Model | .179 | 9.43577 |

The regression equation was significant, $F(7, 83) = 2.369$, $p = .030$; Table 3 depicts the ANOVA for the regression equation. The multiple linear regression equation was used to determine if degree level, mental health training in graduate school, number of courses taken related to MHS in graduate school, and post graduate training in MHS significantly predicted perceived barriers to providing MHS. The multiple regression analysis demonstrated that one predictor variable (taking six to eight courses in mental health) significantly predicted perceived barriers ($\beta = .266$, $p < .05$). Table 4 depicts the regression equation for each independent variable.

Table 3

*Barriers Model ANOVA*

|  | df | F | Sig. |
|---|---|---|---|
| Regression | 7 | 2.369 | .030 |
| Residual | 76 |  |  |
| Total | 83 |  |  |

*Note.* df = degrees of freedom. Sig. = significance. $p < .05$.

Table 4

*Coefficients*

| | Standardized Coefficients Beta | t | Sig. |
|---|---|---|---|
| (Constant) | | 8.232 | .000 |
| Specialist | .099 | .818 | .416 |
| Doctorate | .156 | 1.345 | .182 |
| Threefive | .207 | 1.496 | .139 |
| Sixeight | .266 | 2.043 | .045* |
| Eightplus | .243 | 1.849 | .068 |
| YesMentalHealthTraining | .021 | .183 | .856 |
| NoAdditionalTraining | -.217 | -1.931 | .057 |

Note. Barriers is the dependent variable. Sig. = significance. *$p < .05$.

**Self-Efficacy**

A multiple linear regression model was also used to predict perceived self-efficacy in counseling skills based on the following predictor variables that were also used in the barriers model: (a) degree level, (b) mental health training in graduate school, (c) number of courses taken related to MHS in graduate school, and (d) post graduate training in MHS. Results demonstrate that 45.7% of the variance in perceived self-efficacy can be explained by the independent (predictor) variables, with an adjusted $R^2$ value of .457. Table 5 depicts the model summary.

Table 5

*Self-Efficacy Model Summary*

| | R Square | Standard Error of Estimate |
|---|---|---|
| Self-Efficacy Model | .457 | 5.99573 |

The regression equation was significant, $F(7, 83) = 9.142$, $p = .000$; Table 6 depicts the ANOVA for the regression equation. The multiple linear regression equation was used to determine if degree level, mental health training in graduate school, number of courses taken related to MHS in graduate school, and post graduate training in MHS significantly predicted self-efficacy to providing MHS. The multiple regression analysis demonstrated that six predictor variables account for the variance in self-efficacy. Having a doctorate level degree ($\beta = .248$, $p < .05$), taking three to five courses ($\beta = .444$, $p < .05$), taking six to eight courses ($\beta = .357$, $p < .05$), taking more than eight courses ($\beta = .550$, $p < .05$), and having no additional training ($\beta = -.253$, $p < .05$) significantly predicted perceived self-efficacy. Table 7 depicts the regression equation for each independent variable.

Table 6

*Self-Efficacy Model ANOVA*

|  | df | F | Sig. |
| --- | --- | --- | --- |
| Regression | 7 | 9.142 | .000 |
| Residual | 76 |  |  |
| Total | 83 |  |  |

*Note.* df = degrees of freedom. Sig. = significance. $p < .05$.

Table 7

*Coefficients*

| Variables | Standardized Coefficients Beta | t | Sig. |
|---|---|---|---|
| (Constant) | | 8.937 | .000 |
| Specialist | 0.34 | .346 | .730 |
| Doctorate | .248 | 2.629 | .010* |
| Threefive | .444 | 3.946 | .000* |
| Sixeight | .357 | 3.374 | .001* |
| Eightplus | .550 | 5.149 | .000* |
| YesMentalHealthTraining | -.084 | -.907 | .367 |
| NoAdditionalTraining | -.253 | -2.767 | .007* |

*Note*. Self-efficacy is the dependent variable.  Sig. = significance. *$p$ < .05.

CHAPTER V

DISCUSSION

This study sought to answer two questions. First, what factors predict self-efficacy in counseling abilities, and second, what factors predict perceived barriers to providing MHS. Overall, Table 7 depicts the results of the multiple linear regression regarding perceived self-efficacy. The results suggest that having a doctorate level degree, taking three to five, six to eight, or more than eight mental health related courses in graduate school, and/or having no additional mental health training outside of participants' graduate training in school psychology predict perceived self-efficacy in counseling abilities. With regard to perceived barriers, Table 4 depicts that taking six to eight courses related to mental health/counseling predicted higher perceived barriers to the provision of MHS. That is, participants who took six to eight courses in graduate school were more likely to perceive experiencing more barriers to providing MHS.

**Self-Efficacy Model**

Results of this study demonstrated that the more courses taken related to MHS and having a doctorate level degree were the factors most likely to predict higher levels of self-efficacy. The negative coefficients beta depicted in Table 7 with regard to no additional training beyond graduate school was more likely to predict lower self-efficacy scores. These results do not suggest that taking more courses related to MHS in graduate school, having a doctorate level degree, or not receiving training outside of graduate school cause high/low self-efficacy. Rather, these results suggest that among participants surveyed, those who took three or more courses related to MHS and/or held a doctorate level degree were more likely to have higher self-efficacy scores. Participants who did

31

not have additional training outside of graduate school were more likely to have lower self-efficacy scores.

One possibility for these results could be that school psychologists who already had an interest in meeting the mental health needs of their students sought additional training. For example, in programs where graduate students are able to select the courses they take, those with an interest in MHS may have been more likely to take such courses. In addition, individuals with greater interest in directly serving the mental health needs of students may be more likely to obtain a doctorate level degree, which would afford them more training and practicum opportunities.

Variables that were not significantly predictive of self-efficacy scores were holding a specialist level degree or having mental health service training in graduate school. Previous research has suggested that graduate training may influence self-efficacy, with more training increasing one's self-efficacy in various areas (e.g., Guiney et al., 2014; Hass & Domzalski, 2012). The original doctoral dissertation authored by Huber (2006) demonstrated that graduate students and working professionals differed in their self-efficacy scores as measured by the HIS-SP-RV. In general, the author found that graduate students reported lower self-efficacy in the area of counseling than working school psychologists reported.

Results of the current study may support Huber's (2006) findings, suggesting that one possibility of higher self-efficacy is the number of graduate courses taken that relate to MHS. Another possibility is that not having MHS delivery training outside of graduate training predicts lower self-efficacy. For example, graduate students in Huber's (2006) study may not have completed all courses related to MHS, and participants may

32

not have had the opportunity for training outside of their graduate program. Research in other areas of school psychology services have indicated that more opportunities to practice services can increase self-efficacy (Guiney et al., 2014).

**Barriers Model**

Overall, results from the barriers regression model identified fewer predictive variables than the self-efficacy model identified. Only one predictive variable shown in Table 4 demonstrated significant variance in the regression equation. Taking six to eight courses related to MHS predicted higher perceived barriers. Several previous studies have identified that lack of training is in itself a barrier to the provision of MHS (e.g., Suldo et al., 2010). Meyers and Swerdlik (2003) found that school psychologists identified several barriers to being able to provide MHS. An important finding in their study indicated that of the school psychologists who were more likely to provide MHS, more training in MHS was a factor that played an important role. Therefore, it is possible that school psychologists who take six to eight courses are more likely to want to provide MHS services, and they may take more notice of barriers that affect their ability to do so. On the other hand, if this was the case for the current study, one could expect to see higher perceived barriers in participants who responded to having a doctorate degree, taking more than eight courses in MHS, and having (or not having) additional training. It is also possible that participants who hold doctorate degree or have additional training are more likely to face less barriers.

**Limitations**

Results of this study need to be interpreted with caution. First, these results only suggest that certain variables are predictive of perceived barriers and self-efficacy. This

study was not conducted using an experimental design, and therefore assumptions such as cause-and-effect cannot be made. Results of this study should only suggest that among participants who took this survey, self-efficacy and barriers were predicted by certain variables. While these results are consistent with previous research, it is important to caution that not all studies utilized the same measures of self-efficacy (Bodenhorn et al., 2005; Mullen & Lambie, 2016; Runyon et al., 2017). It is also important to note that because research in this area is limited, several studies address self-efficacy as it relates to school psychological services beyond MHS (e.g., Guiney et al., 2014; Runyon et al., 2017; Sabourin, 2015).

The sample used in this survey was one of convenience and does not represent a true random sample of school psychologists. School psychologists who have a greater interest in mental health may have been motivated to take this survey. Furthermore, school psychologists who already have high self-efficacy beliefs in the area of MHS may also have been more motivated to complete this survey. Because the participants represent a convenience sample, it is important to note that results may be skewed. Participants in this study represent school psychologists practicing in Washington state. If results were to generalize to school psychologists at a national level, then the sample would need to represent school psychologists from other states. In addition, this was not a robust sample, and the relatively small number of participants may have skewed the results.

The demographic questionnaire asked participants to respond to questions based on the primary school in which they work. Some school psychologists may split time between several buildings, making it difficult for these questions to be truly

representative of where they work.  It may have been more beneficial to ask participants to indicate where they spend most of their time.  Lastly, the demographic questionnaire did not specify if mental health and/or counseling related courses were taken during a school psychology graduate program.  Therefore, participants could have responded to taking mental health related courses in programs other than school psychology (e.g., mental health counseling or social work masters programs).

**Directions for Future Research**

General results of this study demonstrate that the number of mental health related courses taken during graduate school predicted higher levels of self-efficacy among participants.  Future research could build on these findings by analyzing the types of courses provided in mental health counseling.  For example, some graduate programs may offer more practicum type courses than others.  In addition, the number of mental health courses taken could be analyzed from a demographic perspective.   That is, are certain types of universities, or certain geographic areas, more likely to provide graduate students with more mental health courses?  Lastly, as it relates to coursework, future research could better determine if graduate students have freedom in selecting their coursework.  This would be important to address whether school psychologists with higher self-efficacy in MHS are more likely to choose how many courses related to MHS they take.

Identifying ways to increase self-efficacy is not unique to school psychologists. Bodenhorn and Skaggs (2005) developed a self-efficacy scale intended for school counselors.  The authors suggest that school counselor roles are becoming increasingly complex.  Therefore, their scale was designed to identify areas within a school

counselor's scope of competence that can increase a practitioner's self-efficacy. School psychologists face similar complexity of their role when working in the schools (NASP, 2015). Bodenhorn et al. (2010) and Mullen and Lambie (2016) surveyed school counselors using the scale developed by Bodenhorn and Skaggs (2005). Results demonstrated that school counselors with higher self-efficacy were more likely to perceive making positive changes in their schools, and they were more likely to provide direct services to students.

Future research could build off of Bodenhorn et al. (2010) and Mullen and Lambie (2016) by extending research to school psychologists to determine whether school psychologists with higher self-efficacy in MHS are more likely to provide direct MHS to students. The current study was limited in this capacity. It would be beneficial to identify if self-efficacy impacts the likelihood of providing MHS. Another way to build upon this would be to identify if school psychologists who have high self-efficacy are more likely to provide MHS even when faced with a high number of perceived barriers. In other words, are school psychologists with higher self-efficacy more likely to overcome a high number of barriers to provide direct services to students?

School psychologist roles are expanding (NASP, 2015), and graduate training programs are challenged to increase the capacity of their graduate students to provide a multitude of services. School psychologists cannot always change the barriers they face, such as lack of space, large caseloads, or lack of support. Students are in need of MHS, and those who need it most may be at a disadvantage to receive these supports (Farmer et al., 2003). Understanding the need for MHS, and barriers that prohibit school psychologists from providing them should increase the need for identifying variables that

can promote the provision of MHS among school psychologists.  Looking deeper into how self-efficacy can contribute to school psychologist's role may increase the capacity for graduate programs to intentionally support growth in self-efficacy as it relates to providing MHS.

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APPENDIXES

APPENDIX A

NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS RECRUITMENT
LETTER

Dear School Psychologist,

My name is Ashley Jantzer and I am a graduate student in the School Psychology Ed.S.
program at Central Washington University in Ellensburg, Washington.  I am contacting
you to ask for your help in completing a survey for my master's thesis.  I am researching
school psychologists' self-efficacy beliefs in counseling abilities, and how this relates to
providing mental health services in the schools.  You do not have to provide mental
health services in order to participate in this study.

My hope is to expand research in the area of self-efficacy and school psychologists;
specifically, how self-efficacy and barriers interact when a school psychologist does or
does not provide mental health services.  The purpose of this study is to examine whether
school psychologists are incorporating mental health services into their practice and if
their general self-efficacy and/or barriers they experience affect whether they provide
mental health services to the students they serve.

Your participation in this study is voluntary.  If you are interested in participating, please
type the link to the web-based survey provided below into your web browser.  Or, simply
take a picture of the QR-Code provided below and the survey will open on your
smartphone.  If you wish to participate in the survey, you will be asked to read an
informed consent document and give assent before participating.

If you have questions regarding this research, please contact the principal investigator,
Ashley Jantzer at Ashley.Jones@cwu.edu, or the faculty sponsor, Dr. Richard Marsicano,
NCSP, at Richard.Marsicano@cwu.edu.


Thank you for your consideration.

INFORMATION PAGE

**Study Title: Impacts of Self-Efficacy on School Psychologists Provisions of Mental Health Services**
**Principal Investigator:** Ashley Jantzer, Graduate Student, School Psychology Program, Department of Psychology, Central Washington University (Ashley.Jones@cwu.edu).
**Faculty Sponsor:** Richard Marsicano, Ph.D., NCSP, Assistant Professor, School Psychology Program, Department of Psychology, Central Washington University (Richard.Marsicano@cwu.edu).

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1. **What you should know about this study:**
   - You are being asked to join a research study.
   - This information page explains the research study and your part in the study.
   - Please read it carefully and take as much time as you need.
   - Ask questions about anything you do not understand now, or when you think of them later.
   - You are a volunteer. If you do join the study and change your mind later, you may quit at any time without fear of penalty. If you do choose to exit the study for any reason, your data will not be used.

2. **Why is this research being done?**
The purpose of this study is to examine whether school psychologists are incorporating mental health services into their practice. In addition, if their general self-efficacy and/or barriers affect whether they provide mental health services.

3. **Who can take part in this study?**
To participate, you must be 18 years of age or older. You must currently be a practicing school psychologist in any K-12 school setting within the United States.

4. **What will happen if you join this study?**
If you agree to participate, you will be asked to complete one computer-based survey. This includes answering demographic questions, a 7-item questionnaire related to self-efficacy, and a 10-item questionnaire related to barriers to the provision of mental health services. This survey will take approximately 20 minutes to complete.

5. **What are the risks or discomforts of the study?**
There are no anticipated risks associated with participating in this study.

6. **Are there benefits to being in the study?**
An individual may not directly benefit from participating. This study may benefit the field of school psychology by offering an understanding of factors that may enable school psychologists to provide mental health services.

7. **What are your options if you do not want to be in the study?**
You do not have to join this study.

8. **Will you be paid if you join this study?**

You will not be paid for joining this study.

**9.  Can you leave the study early?**
Your participation is completely voluntary.  You may exit the survey at any time without penalty.  If you choose to exit out of the survey once you have begun, your data will not be used.

**10.  What information about you will be kept private and what information may be given out?**
Your participation in this study is anonymous.  You will be asked to answer some demographic questions (example: gender, ethnicity, degree level, and previous training in mental health services).  You will not be asked to provide your name or any other identifying information that could connect you to this survey.  Due to the nature of web-based surveys, you cannot be guaranteed confidentiality.  In order to protect your responses in this survey, please close out of the browser after you have completed the survey.

**11.  What other things should you know about this research study?**
  **a.  What is the Human Subjects Review Council (HSRC) and how does it protect you?**
  This study has been reviewed and approved by the CWU Human Subjects Review Council. HSRC is made up of faculty from many different departments, ethicists, nurses, scientists, non-scientists and people from the local community. The HSRC's purpose is to review human research studies and to protect the rights and welfare of the people taking part in those studies.  You may contact the HSRC if you have questions about your rights as a participant or if you think you have not been treated fairly.  The HSRC office number is (509) 963-3115.
  **b.  What should you do if you have questions about the study?**
  Email the principal investigator, Ashley Jantzer, at Ashley.Jones@cwu.edu.

**12.  What does giving your assent mean?**
By selecting "agree" below, you are giving assent to participate in this study.  Your assent means that you understand the study plan and its purpose, have been able to ask questions about the information given to you in this form, and you agree to join the study.

APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE

Q3 How many years have you been working as a school psychologist?

_____

Q4 What gender do you identify with most?

_____

Q5 What is your ethnicity or race?

_____

Q6 What is your degree level?

○ Masters  (1)

○ Specialist  (2)

○ Doctorate  (3)

Q7 What is your primary school's geographic location?

○ Rural  (1)

○ Urban  (2)

○ Suburban  (3)

Q6 Did you receive counseling training or mental health delivery training in your graduate program?

○ Yes  (1)

○ No  (2)

Q7 If yes, how many courses did you take that had a focus on counseling or mental health delivery training?

○ 1-2  (1)

○ 3-5  (2)

○ 6-8  (3)

○ More than 8  (4)

Q8 Have you received additional mental health and/or counseling training outside of your program?

○ Yes  (1)

○ No  (2)

Q9 What age students do you primarily work with?

○ Elementary  (1)

○ Middle School  (2)

○ High School  (3)

Q10
Has your primary school gone through a crisis in the last two years?
Example, death of a teacher, death of a student, suicide, school shooting

○ Yes  (1)

○ No  (2)

Q11 If yes, please explain

_____

Q12 Where is your primary office located?

○ In school building  (1)

○ Offsite  (2)

HUBER INVENTORY OF SELF-EFFICACY FOR SCHOOL PSYCHOLOGISTS—
RESEARCH VERSION

COUNSELING SKILLS SUBSCALE

Q13 Please read the following questions and mark the answer that best describes your attitude to each question as indicated by the scale.

| | 1. Not well at all (1) | 2. (2) | 3. Not too well (3) | 4. (4) | 5. Pretty well (5) | 6. (6) | 7. Very well (7) |
|---|---|---|---|---|---|---|---|
| How well can you conduct crisis counseling? (1) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| How well can you apply leadership skills for crisis prevention and management? (2) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| How well can you assess appropriateness of referral for counseling? (3) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| How well can you use group counseling skills? (4) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| How well can you counsel children from different racial/ethnic groups? (5) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| How well can you counsel individual children? (6) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

| How well can you use effective counseling skills? (7) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| --- | --- | --- | --- | --- | --- | --- | --- |

BARRIERS

Q14 Please read the following questions and choose the answer for each question that best represents the school that you spend the most of your time in.

| | 1. Unlikely (1) | 2. (2) | 3. Somewhat unlikely (3) | 4. (4) | 5. Somewhat likely (5) | 6. (6) | 7. Extremely likely (7) |
|---|---|---|---|---|---|---|---|
| How likely is it that you have adequate space to provide counseling services? (1) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| How likely is it that you have enough time to provide counseling services? (2) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| How likely are school administrators to feel that addressing mental health is important to student success? (3) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| How likely are teachers to support addressing the mental health needs of students? (4) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| How likely is your building principal to feel that addressing mental health is important to student success? (5) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| How likely is it that school administrators view you as competent to provide mental health services to students? (6) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| How likely is it that teachers view you as competent to provide mental health services to students? (7) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| How likely is it that your building principal views you as competent to provide mental health services to students? (8) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| How likely are you to view that providing mental health services is part of your role? (9) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

| How likely is it that you received adequate training in graduate school to be able to provide mental health services to students? (10) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
|---|---|---|---|---|---|---|---|

APPENDIX F

DEBRIEFING SCRIPT

Potential Barriers Affecting the Provision of Mental Health Services
Thank you for participating in this study.  Your responses are anonymous.  No
identifying information was collected.  Your responses are valuable for identifying
potential variables that help school psychologists provide mental health services.  If you
have questions, please contact the principal investigator, Ashley Jantzer
(Ashley.Jones@cwu.edu), or the faculty sponsor, Richard Marsicano, Ph.D., NCSP
(Richard.Marsicano@cwu.edu).

**PLEASE CLOSE YOUR WEB BROWSER TO PROTECT YOUR PRIVACY**