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Mental Health Services In Schools: School Psychologists' Current Practices And Perspectives

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MENTAL HEALTH SERVICES IN SCHOOLS: SCHOOL PSYCHOLOGISTS' CURRENT PRACTICES AND PERSPECTIVES

An Abstract of a Thesis

Submitted

in Partial Fulfillment

of the Requirements for the Degree

Specialist in Education: School Psychology

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ABSTRACT

It is estimated that approximately 7.5 to 9 million children and adolescents are in need of mental health services, but that only 20% of these youths actually receive the services they need (National Association of School Psychologists [NASP], 2002). Because of this, schools across the nation have begun to take preventative measures, specifically school-based mental health services. School psychologists are uniquely prepared to provide these services, but little attention has been paid to their needs and concerns regarding such services. Therefore, members of NASP were given a survey to assess current practices and perspectives regarding mental health services in schools. The effects of years of practice, degree status, and National Certified School Psychologist certification on availability and provision of services and ratings of training adequacy and comfort are explored, along with a number of other factors. Limitations of this study, ideas for future research, and implications of the results will also be discussed.

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CHAPTER 1

INTRODUCTION

Today's children face numerous stressors in life, including poverty, parental divorce, child abuse, developmental and educational transitions, and domestic, community, and school violence. Children who face one or more of these stressors have an increased risk for mental health problems (Buchko, 1999; Mash & Wolfe, 2002). For example, suicide is currently the third leading cause of death among teenagers (Columbia University TeenScreen Program, 2005), and it is highly correlated with a number of mental health problems including depression and anxiety (Buchko, 1999; Mash & Wolfe, 2002). It is estimated that approximately 7.5 to 9 million children and adolescents are in need of mental health services, but that only 20% of these youths actually receive the services they need (National Association of School Psychologists [NASP], 2002).

Children with mental health problems face a number of negative outcomes if they do not receive treatment. These negative outcomes, which include school failure, drop out, behavior problems, and school violence, greatly affect a child's academic performance and development of social skills (NASP, n.d.b.). Increasingly, schools have begun to provide mental health services to better serve their students and avoid the negative outcomes associated with mental illnesses. School psychologists receive training in many areas pertaining to mental health in schools, such as prevention, wellness promotion, and crisis intervention (Ysseldyke et al., 1997). Though school psychologists have the ability to be mental health service providers, little attention has been paid to their needs and concerns regarding mental health service programs in schools.

Definition of Mental Health Service Programs in Schools

Mental health service programs should be thought of as programs that provide a "continuum of services" (Nastasi, 2000), ranging from prevention and assessment to intervention and treatment. Mental health service programs promote the socio-emotional well being of students, and in turn can have a positive impact on students' educational outcomes (Nastasi, 2000). Promotion of students' well being can be accomplished by providing the following services: prevention (e.g., crisis prevention and mental illness prevention programs [i.e., social skills, friendship groups, or anti-bullying groups]), assessment (e.g., socio-emotional assessment, consultation regarding mental health and behavioral concerns, and mental health screening [e.g., identifying at-risk students in need of further assessment]), and intervention (e.g., individual or group counseling and crisis intervention). These services can be provided by outside agencies or by qualified school employees.

The School Psychologist's Role

School psychologists can, and do, play a large role in these mental health service programs. Services that school psychologists can provide include consultation, assessment, designing interventions or prevention programs, monitoring these interventions and preventions, and educating others in the schools about mental health issues. They can also help prevent mental illness in schools by addressing the psychosocial factors of mental health such as social skills and conflict resolution skills. School psychologists can serve as liaisons between the schools and outside agencies. Most often, however, school psychologists provide training, consultation, and

assessments for school-based mental health programs (Dwyer & Bernstein, 1998; Pfeiffer & Reddy, 1998).

Issues Pertaining to Mental Health Service Programs in Schools

There are a number of issues that pertain to the provision of mental health services in schools. One critical issue pertains to the funding and costs of mental health service programs (Hunter et al., 2005; Nealis, 2004b). School officials are concerned that mental health programs will put a large strain on their already limited funds. Funding for mental health programs through the government is available, but there are not any funding options specifically for mental health programs (Nealis, 2004b). Other funding options include grants or private foundations, but these options are often time-limited and cannot support a program in the long-term (Hunter et al., 2005).

Schools also do not have a complete understanding of the costs of mental health service programs. Because there is so much variation in the design of mental health programs, it is difficult to determine exactly how much these programs cost schools. Total average costs per student per year range from $90 to $225 (Chatterji, Caffray, Crowe, Freeman, & Jensen, 2004; Nabors, Leff, & Mettrick, 2001). Without an understanding of the costs involved, few schools are willing to implement mental health service programs.

School psychologists already have a full agenda, and there is a concern that they will not have enough time available to provide mental health services (Sheridan, Napolitano, & Swearer, 2002). There is also concern that school psychologists do not have enough training in mental health, especially in areas of direct intervention and

diagnosis, to provide services (Nastasi, 2000; Pfeiffer & Reddy, 1998). Other issues pertaining to mental health service programs in schools include the lack of conclusive research on the outcomes of these programs, the possible unnecessary medication and labeling of students, and a loss of parental rights with regards to consent (Nealis, 2004a).

There is little knowledge about school psychologists' views on these issues, despite their large role in mental health service programs. Only one study regarding school psychologists' perspectives of these programs could be located. Repie (2005) asked school psychologists their views pertaining to students' presenting problems, family-based barriers, community/clinic-based barriers, and receptiveness/support. Participants were not asked about their views on the issues relevant to mental health service programs in schools or their concerns about such programs. Because school psychologists often play a large role in these programs, it is important to know what their attitudes are toward school–based mental health programs and how prepared they feel to provide mental health services. Knowing school psychologists' perspectives could provide insights into areas that need future research and areas in which more training is needed.

Purpose

The purpose of this paper is to discuss the need for mental health service programs in schools in light of the prevalence rates and effects of mental health problems. The nature of and issues associated with mental health service programs in schools and school psychologists' roles in these programs are also discussed. In light of the need for further research on school psychologists' current practices and perspectives

regarding mental health services in schools, the purpose of this study will be to examine the practices and perspectives of members of the National Association of School Psychologists (NASP). Specifically, this research will answer the following questions: (1) What is current practice regarding mental health services in schools? (2) How prepared do school psychologists think they are to provide mental health services? (3) What are school psychologists' attitudes toward providing mental health services in schools?

Limitations

The participants of this study were chosen through a random sample of NASP's membership list. This method of sampling creates some limitations to this study. First, NASP's membership includes those who are not practicing school psychology. The aim of this study was to survey only practicing school psychologists. Thus, a few participants' surveys could not be used in data analysis. This reduced the already small sample size by 14 participants.

Because all participants are members of NASP, it may be that these school psychologists are more involved in mental health issues and are more familiar with the issues relevant to mental health service programs in schools. Also, NASP advocates for school psychologists as mental health service providers. Therefore, it is possible that school psychologists who are members of NASP are more likely to provide mental health services in schools and to feel positively about it. Nevertheless, a large number of school psychologists are members of NASP and therefore the sample has a high likelihood of representing the population of school psychologists in the United States.

Summary

This chapter highlights the need for assessing school psychologists' current practices and their perspectives regarding mental health service programs in schools. The chapter also presents the rationale for the proposed study. Chapter 2 will provide a review of the literature regarding the need for and issues pertaining to mental health service programs in schools, and school psychologists' roles as mental health service providers. Chapter 2 also examines the need for further research in these areas. Chapter 3 will describe the research methodology, including the procedure, materials, and data analyses to be used. Chapter 4 will discuss the results. Finally, Chapter 5 will include a discussion of the results, conclusions, implications, and limitations.

CHAPTER 2

LITERATURE REVIEW

Suicide is the third leading cause of death among 15- to 19-year-olds in America. Seventeen percent of adolescents (3.4 million) have thought seriously about suicide in the past year, and 9% (1.8 million) have attempted suicide (Columbia University TeenScreen Program, 2005). Because of the strong link between suicide and mental health problems (Hallfors et al., 2004; Mash & Wolfe, 2002; Whelley, Cash, & Bryson, 2002), schools across the nation have begun to take preventative measures, specifically school-based mental health service programs. School psychologists, with their training in prevention, wellness promotion, and crisis intervention, are well prepared to provide these services. In general, school psychologists tend to play large roles in school-based mental health service programs. However, little attention has been paid to their needs and concerns regarding such programs. This chapter discusses the role of school psychologists in mental health service programs, the need for such programs, and the concerns relevant to these programs. The limitations of current research, ideas for future research, and implications of such services will also be discussed in this chapter. The next chapters discuss the methods and results of a study that assesses the needs and concerns of school psychologists regarding mental health service programs in schools, along with the roles that school psychologists actually fulfill in these programs. The final chapter includes a summary of the results, conclusions, implications, and limitations.

Mental Health and Mental Illness

First, it is important to distinguish *mental health* from *mental illness*. The National Association of School Psychologists (NASP) defines mental health as "the achievement of expected developmental cognitive, social, and emotional milestones" (2003, ¶ 1). The United States Department of Health and Human Services – Substance Abuse and Mental Health Services Administration (SAMHSA, 1997) defines mental health as "how people think, feel, and act as they face life's situations." Mental health also includes psychosocial factors such as social skills, problem solving skills, conflict resolution skills, and self-control skills (Mash & Wolfe, 2002).

Signs of mental healthiness include the formation of secure attachments, ability to adapt to change, and use of effective coping skills (NASP, 2003; Whelley et al., 2002). Mental health affects a person's general physical health, ability to make decisions, and, in the case of students, success in the classroom (Department of Health and Human Services [DHHS], 2000; NASP, 2003; SAMHSA, 1997). Mental illness, or mental health problems, denotes all psychological and psychiatric disorders and their symptoms. Psychological and psychiatric disorders are characterized by significant changes in cognitions (thoughts), affect (feelings or mood), and/or behavior. To receive a diagnosis for a disorder, there must be significant impairment in a person's ability to function along with a significant amount of distress (Mash & Wolfe, 2002).

Prevalence Rates of Mental Illness

Approximately one-sixth of all children and adolescents are in need of mental health services, but only one in five of these children typically receive services (Buchko,

1999; NASP, 2002). Only 20% of these children and adolescents actually receive the services they need (NASP, 2002). Only 3% of children and adolescents receive services in the community, leaving schools to provide the necessary services (Buchko, 1999; NASP, 2003). Without school-based services, many students would never receive the help they need.

Left untreated, mental illnesses tend to persist into adulthood (Mash & Wolfe, 2002), however, with early interventions, mental illness can be adequately managed. The DHHS (2000) states that 74% of 21-year-olds with mental health illnesses have a history of mental illness. Also, most adult anxiety and depressive disorders are preceded by either anxiety or depressive disorders in adolescence (Pine, Cohen, Gurley, Brook, & Ma, 1998).

Risk Factors for Mental Illness

Children and adolescents increasingly face a number of familial and psychosocial stressors that put them at risk for mental health problems (Policy Leadership Cadre for Mental Health in Schools, 2001). Some common risk factors include living in poverty, parental divorce, child abuse, developmental and educational transitions, and domestic, community, and school violence. Along with reports of child neglect and abuse, rates of children living in poverty and in single parent homes have been increasing (Buchko, 1999). Several researchers have found that poverty and other risk factors have a cumulative effect on the development of children and their emotional resiliency (see Buchko, 1999; Davies, 2004).

When coupled with other risk factors, these stressors have even greater effects on a child's emotional and intellectual development. Other risk factors include biological factors (e.g., prematurity and physical health problems), family factors (e.g., resources and supports), and parenting issues (e.g., parenting style and parental mental health). These risk factors seldom occur in isolation, therefore putting children and adolescents at higher risks for other chronic mental health problems (Buchko, 1999).

Effects of Mental Illness

Mental illness disrupts a child's academic performance and development of social skills (NASP, 2002). It is linked to involvement in the juvenile system and future criminal activity (DHHS, 2000; NASP, 2003). Mental health problems have been correlated with a number of other negative outcomes such as special education referral, school failure, dropping out, behavior problems, family conflicts, school violence, substance abuse, self-injurious behavior, and physical health problems (National Advisory Mental Health Council's Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment [NAMHC], 2001; Pagano, Cassidy, Little, Murphy, & Jellinek, 2000; SAMHSA, 1997; Whelley et al., 2002). Untreated mental health problems can lead to more serious problems later in life, as the above-mentioned effects compound over time (Buchko, 1999).

Mental Health Services in Schools

As shown in the literature, untreated mental health problems have significant effects on a child's development. In fact, such effects are greater than the effects associated with all but the most severe medical illnesses (NAMHC, 2001; Pagano et al.,

2000; Saunders & Wojcik, 2004). Mental health problems can develop early on during a person's life, sometimes as early as infancy (Mash & Wolfe, 2002; Whelley et al., 2002). Most children with mental illnesses are not identified until the illness significantly affects their schoolwork or social interactions (DHHS, 2000). By this time the illness has already taken its toll on the child's development. However, if these problems were addressed early on, many of the negative outcomes discussed above could potentially be avoided or minimized (Buchko, 1999; Pagano et al., 2000). This is why mental health services in schools are needed.

Definition of Mental Health Service Programs in Schools

Mental health programs in schools provide a "continuum of services" (Nastasi, 2000; Nastasi, Pluymert, Varjas, & Bernstein Moore, 2002) that range from screening and prevention to diagnosis and treatment. These programs can be comprehensive and require professionals who receive training in clinical skills and in the psychosocial factors of mental health to provide services (Nastasi et al., 2002). Mental health services in schools promote the socio-emotional well being of students, and services should include more than just therapy or counseling. These programs could include the following to address mental illnesses and the accompanying psychosocial factors: socio-emotional assessment, individual or group counseling, consultation regarding mental health and behavioral concerns, crisis intervention and prevention, mental health screening (identifying at-risk students in need of further assessment), and mental illness prevention programs (i.e., social skills, friendship groups, or anti-bullying groups; Center for Mental

Health in Schools [CMHS], 2006; Hunter et al., 2005; Nastasi, 2000; NASP, 2001; NASP, n.d.c.; Pluymert, 2002; Whelley, Cash, & Bryson, 2004).

Mental health services are not new to schools, as evidenced by the disability category "emotionally and behaviorally disabled." Past mental health service programs have focused more on identifying students rather than on creating interventions for students with mental health problems (Hunter et al., 2005). As more and more stressors are placed on today's children and adolescents, schools have begun to take a more active role in maintaining students' mental health. However, increasing accountability pressures from NCLB have caused schools to focus mainly on raising achievement test scores (CMHS, 2005; CMHS & Center for School Mental Health Assistance [CSMHA], 2004). It is likely that mental health programs are not seen as a priority in schools since planning and implementing such programs would take up too much of their time and resources.

Several researchers have found mental health programs to be effective in alleviating some of the effects of mental health problems (see Nastasi, 2000). Schools with these programs tend to show an increase in academic functioning (Dryfoos, 1995; Haynes & Comer, 1996; Miller, Brehm, & Whitehouse, 1998) and a reduction in the number of students involved in risk-taking behaviors (Caplan et al., 1992; Miller et al., 1998). School-based services have been found to be more effective than other service sectors in some studies (Durlak & Wells, 1997) and just as effective as other service sectors in other studies (Armbruster & Lichtman, 1999; Harrington et al., 2000). Thus, these results are inconsistent and more research is needed.

Service Models

There are several models of mental health service programs that have been proposed. Mental health services can be provided through school-clinic collaboration, in-school clinics staffed by outside agencies, and in-school clinics staffed by school employees. For further description of service models see Adelman and Taylor (2000), Armbruster and Lichtman (1999), Buchko (1999), CMHS (2006), Chatterji et al. (2004), Foster et al. (2005), Hunter et al. (2005), Jepsen, Juszczak, and Fisher (1998), Pfeiffer and Reddy (1998), and Pluymert (2002). Services provided through school-clinic collaboration require a strong, communicative relationship between school employees and clinic employees. School employees refer students to the clinic where assessments and treatments are carried out. School employees are involved in consultation and collaboration with the clinic employees regarding treatment and outcomes. In-school clinics staffed by outside agencies also involve school-clinic collaboration. However, the in-school clinics provide services at the school rather than at the clinic. In-school clinics staffed by school employees also provide on-site services, but those providing the services are actual school employees. These service providers may be school psychologists, school counselors, school social workers, school nurses, psychiatrists, and/or clinical psychologists (Flaherty et al., 1998; Foster et al., 2005).

School Psychologists as Mental Health Care Providers

According to NASP, school psychologists are qualified to be mental health care providers. The implementation of mental health service programs can have significant effects on schools and school psychologists. School psychologists can be viewed as

partners and as facilitators of collaboration with teachers, administrators, and other mental health care providers (NASP, 2001). They can also: play a large role in the development and maintenance of mental health service programs in schools; provide services such as interventions, assessments, and consultation with service providers and school staff; be responsible for grant writing to get funding for such programs; help design programs such as lunch groups and group counseling sessions and choose assessment tools; administer and score tests; and evaluate programs and share the results with others involved in the program (Nastasi, 2000; Pfeiffer & Reddy, 1998; Sheridan et al., 2002).

Another important service school psychologists can provide is to assist schools in reducing the stigma associated with mental illness by conducting in-services and by educating the community in areas such as risk factors and warning signs of mental illnesses. This means that they need to stay abreast of the literature on mental health and any policies regarding mental health in schools. Not only do they need to educate others in mental health in general, but they also need to educate others in mental health service programs. School psychologists can train staff in how to administer screening tools and their purpose, along with training in how to spot the different symptoms of mental illness. Acting as liaisons between schools and community service providers, school psychologists can create and maintain the relationships that are necessary for schools to make appropriate referrals. In addition, school psychologists can create ties with universities so research on mental health service programs can be conducted. School psychologists could even conduct research themselves (Nastasi, 2000; NASP, n.d.c.).

Research has shown that school psychologists tend to spend most of their time conducting psychoeducational assessments (Curtis, Hunley, Walker, & Baker, 1999; Foster et al., 2005; Reschley, 2000; Reschley & Wilson, 1995). However, school psychologists still find some time to participate in mental health service programs. Most school psychologists serve as trainers, consulters, and/or assessors rather than as primary mental health treatment providers (Dwyer & Bernstein, 1998; Pfeiffer & Reddy, 1998). No studies could be located that describe school psychologists' roles in mental health service programs in schools.

School psychologists who are trained at NASP-accredited programs are equipped to provide the above services. Training domains are clearly laid out by NASP (Ysseldyke et al., 1997) and training programs must provide evidence that their students have met these requirements. Specifically related to the area of mental health is the Prevention, Wellness Promotion, and Crisis Intervention Domain. Under this domain, NASP states that "school psychologists must have knowledge of child development and psychopathology in order to develop and implement prevention and intervention programs for students with a wide range of needs and disorders" (Ysseldyke et al., 1997, p. 15).

As described, school psychologists can play a major role in school-based mental health programs. Little research, however, has been conducted to assess school psychologists' attitudes toward and perspectives regarding school-based mental health programs. In the only study available on this topic, Repie (2005) assessed special education teachers', school counselors', and school psychologists' views of students'

presenting problems, family-based barriers, community/clinic-based barriers, and receptiveness/support. This study did not assess the needs of school psychologists, such as their concerns regarding their position as mental health service providers, yet this information is needed to provide insight into school psychologists' needs and views as mental health care providers.

The Need for Mental Health Service Programs in Schools

School psychologists have the necessary tools to be mental health service providers and there is a strong need for mental health service programs in schools. Despite the frequency and developmental impact of mental illness, professionals and paraprofessionals often have difficulty recognizing the essential symptoms or negative impacts of these disorders. Indeed, most of the symptoms exhibited by adolescents with mental illnesses are internal, and therefore go unnoticed by many parents and teachers. Because of this, there are often low concordance rates between children's report of mental illnesses and parents' and teachers' reports of mental illness (Pagano et al., 2000; Reynolds, 2002).

Primary care physicians identified 19% of all children and adolescents they saw as having behavioral and or emotional problems. Out of those children and adolescents, parents identified only 7% of them as having problems (DHHS, 2000). Pagano et al. (2000) found that one out of eight children who reported symptoms associated with mental illnesses were not identified by their parents as having symptoms. As adolescents begin to assert their independence from home, less conversation occurs between the parents and the teen (Pagano et al., 2000). This makes it even more difficult for parents to

recognize symptoms of mental illnesses. Teachers also have difficultly recognizing symptoms reliably, especially high school teachers (Reynolds, 2002). These teachers often have a large number of students and limited time (often just 40 or 50 minutes) with them each day. In addition, children and adolescents have very low self-referral rates (Evans, 1999; Reynolds, 2002). Younger children may not be able to provide verbal descriptions of these symptoms (e.g., Sheeringa & Zeanah, 1995; Whelley et al., 2002). Unless the symptoms are asked about directly, most mental health problems in children and adolescents may go undetected (Pagano et al., 2000).

The Carnegie Council on Adolescent Development's Task Force on Education of Young Adolescents states that "school systems are not responsible for meeting every need of their students. But where the need directly affects learning, the school must meet the challenge" (1989, p. 61). Additional arguments for mental health service programs in schools will be discussed below, beginning with the effect of mental health problems on schools.

Mental Health Problems Effects on Schools

Mental health is essential for the development of thinking, learning, and communication skills (DHHS, 2000; Wrobel, 2001). Students with mental health problems have an increased number of absences and a decreased ability to concentrate in class (Association of State and Territorial Health Officials [ASTHO] & the Society of State Directors of Health, Physical Education and Recreation [SSDHPER], 2002). Adolescents who experience mental illnesses often tend to report problems related to academic tasks (DHHS, 2000; Dwyer, 2004; Mash & Wolfe, 2002; NASP, 2003). In fact,

one symptom of depression in adolescents is lowered school performance and engagement (Reynolds, 2002). For example, Bernstein, Borchardt, and Perwin (1996) found that children with elevated levels of anxiety were 7.7 times more likely to be in the lowest quartile of reading achievement and 2.4 times more likely to be in the lowest quartile of math achievement. Not only do mental health problems directly affect learning, but they are also correlated with other barriers to learning. Substance abuse, violence, family conflicts, behavioral problems, and physical health problems are all barriers to learning that are correlated with mental health problems (Foster et al., 2005).

The correlation between academic functioning and mental health indicates that there is a need to address mental health problems (Nastasi, 2000). When mental health problems are addressed there are fewer school absences, fewer discipline referrals, and increased school performance (Iglehart, 2004; Nastasi, 2000; NASP, 2005; NASP, n.d.b.; Pagano et al., 2000). It has also been found that increased mental health services can decrease referrals for special education services (Buchko, 1999; Knoff & Batsche, 1995) and may result in higher standardized test scores and better grades (Fleming et al., 2005). Decreases in disciplinary referrals, out-of-school suspensions, and student grade retention are also associated with mental health service programs in schools (Knoff & Batsche, 1995).

Federal Legislation Supporting Mental Health Services in Schools

On January 8, 2002, President Bush signed into Congress the No Child Left Behind Act (P.L. 107-110; Unites States 107th Congress). This act states that "the purpose...is to ensure that all children have a fair, equal, and significant opportunity to

obtain a high-quality education and reach, at a minimum, proficiency on challenging...academic achievement standards and state academic assessments" (p. 115 Stat. 1439). To meet the goals of the NCLB, schools must address all factors that affect academic performance including mental health problems (ASTHO & SSDHPER, 2002; CMHS, n.d.; Curran, 2003; Dwyer, 2004). Mental health services in schools can allow schools to prevent the development of mental illnesses in students, to identify students who may have mental illnesses, and to assist students in getting the help they need. By offering these services to all students, schools can ensure that no child will be left behind. Therefore, federal law supports the use of mental health services in schools.

Accessibility of Mental Health Services in Schools

Aside from family, schools have the most influence on the lives of children and adolescents (ASTHO & SSDHPER, 2002; Evans, 1999; Reynolds, 2002). Children are required to attend school; thus they spend the large portions of their waking hours at school. Having mental health services available in schools makes it easier for all students to have access to mental health care. School-based programs are often more affordable than other care sectors, and many of the issues regarding transportation are avoided (CMHS, n.d.; CMHS & CSMHA, 2004; Evans, 1999; NASP, 2003; Pagano et al., 2000). Also, school-based programs may make it possible for adolescents to have independent access to services (Gatlin, 2004).

Schools are also where students receive the most services. Researchers have consistently found that the field of education provides the majority of mental health services and that schools are often the most common entry point into the different mental

health service sectors. However, these services are not as intensive and persistent as the services provided through other mental health sectors. Children and adolescents who received services in schools tended to receive services less often than those youths receiving services in other sectors. These children and adolescents also had less contact with therapists during the time periods that they were receiving services than those youths receiving services in other sectors (Burns et al., 1995; Farmer, Burns, Phillips, Angold, & Costello, 2003; Farmer, Stangl, Burns, Costello, & Angold, 1999).

Addressing the Stigma of Mental Health

In America, there is a stigma surrounding mental illness. There is a general belief that mental illnesses can be controlled, and that a person with a mental illness is to blame for having the disorder (Corrigan, Watson, & Miller, 2006). According to SAMSHA (1996), families often do not seek help because they fear what others will think of them. Since virtually everyone in American society has involvement in the school system at some point in their lives, schools can have a significant impact on society's beliefs. Schools can become venues for the education of mental health and mental illness. School-based mental health services can also reduce the stigma of mental health simply by becoming an everyday presence in schools (Saunders & Wojcik, 2004). Through educating society and being an everyday presence in schools, school psychologists involved in school-based mental health services can minimize the stigma associated with mental health (CMHS & CSMHA, 2004; Foster et al., 2005; NASP, 2003).

Concerns About Mental Health Services in Schools

In their report, the President's New Freedom Commission on Mental Health recommended that "early mental health screening, assessment, and referral to services be common practice" (2003, Goal Four, p. 8). The DHHS argues "that the promotion of mental health in children and the treatment of mental disorders should be major public goals" (2000, Overarching Vision section, ¶ 1). Why, then, has very little changed with respect to the provision of mental health services?

Although many agree with the intent of school-based mental health services, there are a number of issues surrounding mental health services in schools. Participants at the *Approaches to School Mental Health Evidence-Based Partnerships: Key Obstacles and Strategic Opportunities Summit* in 2003 identified a number of obstacles to school mental health service programs. These included a lack of funding and resources, a mental health stigma and a lack of mental health awareness and education, insufficient training, and lack of evidence-based school mental health interventions (Hunter et al., 2005). The greatest of these issues pertained to funding. This issue is discussed below, along with cost concerns, outcomes concerns, training concerns, time concerns, attitude concerns, medication concerns, mental health stigma concerns, and parental consent concerns.

Funding Concerns

Opponents of mental health services in schools state that such services will create competition for the limited funds that are available to schools (CMHS, n.d.). Financial constraints are continually identified as one of the most common barriers to mental health service programs in schools (Foster et al., 2005; Hunter et al., 2005, Repie, 2005). There

are government funding options available for school-based services, but the funding that is available specifically for mental health services is relatively low (Nealis, 2004b). Title V of NCLB and State Grants for Innovative Education are some resources (Nealis, 2004b). A number of other NCLB Provisions also include options for funding mental health services (NASP, 2002). The Individuals with Disabilities Education Act (IDEA); the Safe Schools – Healthy Students Initiative; the Healthy Schools, Healthy Communities program; State special education funds; and local governmental funds can also provide the necessary monies for mental health service programs (Foster et al., 2005, Hunter et al., 2005). Medicaid is another avenue available for obtaining funds for those students that qualify (Buchko, 1999; DHHS, 2000; Pluymert, 2002; Wrobel, 2001).

Aside from government funding, other options are available. Funds can be obtained through grants or private foundations. It may also be beneficial to have schools work in conjunction with universities on research projects. Inviting graduate students into schools will also help fulfill the need for more research on mental health services. Though these alternative funding options are available, they are often short-lived funding options since they provide only short-term funds (Hunter et al., 2005).

Cost Concerns

Another concern related to funding is the lack of data detailing the costs of mental health programs in schools (Foster et al., 2005). There has been very little research on this topic, despite the fact that guidelines for analyzing the costs of mental health programs have been developed (Chatterji et al., 2004). Because of the variation in mental health programs (i.e., number of staff members, employers of staff members, and services

offered) it is difficult to determine exactly how much mental health programs cost schools. Total average costs per student have been found to range from $90 to $225 per year (Chatterji et al., 2004; Nabors et al., 2001). Without knowledge of the costs involved, few schools are willing to implement mental health programs (CMHS, 2001).

Outcomes Concerns

The provision of mental health services is often correlated with a number of positive outcomes, such as fewer school absences, fewer discipline referrals, and increased school performance (Iglehart, 2004; Nastasi, 2000; NASP, 2005; NASP, n.d.b.; Pagano et al., 2000). However, research has not consistently shown this. Some researchers have demonstrated that school-based services are more effective than other services (see Durlak & Wells, 1997), whereas other researchers have found school-based services to be just as effective as other services (Armbruster & Lichtman, 1999; Harrington et al., 2000).

Repie (2005) found that special education teachers, school counselors, and school psychologists have rated mental health services in schools as ineffective in general. However, the stakeholders in a mental health program assessed by Nabors, Reynolds, and Weist (2000) rated their program as effective. As mentioned earlier, it is difficult to evaluate mental health service programs because there is a wide array of different program options and a wide array of different evaluation techniques. Therefore, it will be challenging to reach a consensus about the outcomes of mental health programs.

Training Concerns

According to NASP, school psychologists are considered mental health care providers. In *School Psychology: A Blueprint for Training and Practice II* (Ysseldyke et al., 1997), NASP argues that school psychologists should be knowledgeable in prevention, wellness promotion, and crisis intervention, but they are not required to be experts in such areas. Most of the mental health services that schools can and do provide fall into these categories of prevention, wellness promotion, and crisis intervention. School psychologists should also be adept at conducting program evaluations, providing progress monitoring, and consulting.

However, comprehensive mental health programs need professionals who receive training in clinical psychology in order to provide diagnoses and treatment (Nastasi et al., 2002). School psychologists are not required to be experts in clinical psychology. Therefore, those who oppose mental health service programs in the schools fear that school psychologists do not have enough training in mental health to provide services (Nastasi, 2000; Pfeiffer & Reddy, 1998). However, among doctoral level training programs, school psychology and clinical psychology curricula tend to be more alike than different (Cobb et al., 2004). School psychology curricula in general tend to include fewer classes on counseling, psychotherapy, psychopharmacology, and neuropsychology, but more educational classes in comparison to clinical psychology curricula. Although school psychologists tend to receive less training in counseling or treatment, most school psychologists do receive training in the psychosocial factors of mental health and are

therefore able to provide services related to these factors. These services could include social skills training and preventative anger management training.

Among school psychology training programs, doctoral and nondoctoral school psychology curricula are often similar in course work (Brown & Minke, 1986; NASP, n.d.a.; Teglasi & Pumroy, 1982). However, Reschly and McMaster-Beyer (1991) point out that nondoctoral programs may have less depth or be less rigorous than doctoral programs. Also, doctoral program in general require more hours of internship than nondoctoral programs (Reschly & McMaster-Beyer, 1991). Finally, there is as much variation between doctoral and nondoctoral programs as there is within each individual program, with curricula and practica hours dependent on the institutions' orientation (Cobb et al., 2004; Reschly & McMaster-Beyer, 1991). Despite these differences and variations in training, school psychologists with doctoral degrees and school psychologists with nondoctoral degrees report similarities in involvement in different job activities such as assessment or intervention (Brown, Swigart, Bolen, Hall, & Webster, 1998).

As detailed above, school psychologists receive training on some issues regarding mental health. In addition, there is large variability in school psychologists' training experiences (Fagan & Sachs-Wise, 2000). Thus, it is not clear how well prepared school psychologists think they are to provide mental health services. Because of the potential variability in background, feelings of preparedness may also vary.

Time Concerns

As stated above, it is suggested that school psychologists are well suited to the role of providing mental health services in schools. School psychologists have a wide range of roles and responsibilities to fulfill. As a result, school psychologists receive training in many areas, including child development, instructional techniques, and mental health issues. Because school psychologists typically have heavy caseloads regarding special education referrals, they spend most of their time conducting assessments (Fagan & Sachs-Wise, 2000). The combination of heavy caseloads and time spent conducting assessments leaves very little time for school psychologists to provide mental health services (Sheridan et al., 2002). As noted above, the most recent assessments of school psychologists' roles show that school psychologists spend the majority of their time conducting psychoeducational assessments (Curtis et al., 1999; Reschly & Wilson, 1995). School psychologists, however, report that they would prefer to spend less time conducting assessments and more time providing direct interventions and consulting with others (Reschly, 2000; Reschly & Wilson, 1995).

Attitude Concerns

Attitude is a strong predictor of behavior (Albrecht & Carpenter, 1976; Bentler & Speckart, 1979; Bentler & Speckart, 1981; Manstead, Proffitt, & Smart, 1983; Zuckerman & Reis, 1978). Therefore, school psychologists' attitudes toward the provision of mental health services in schools affect whether or not school psychologists actually offer mental health services. If school psychologists have positive attitudes toward mental health services in schools, school psychologists will be more likely to

provide and advocate for the delivery of these services. It may be the case that school psychologists who have poor attitudes toward mental health services in the schools may not provide mental health services even if they have the training and opportunity to do so.

Medication Concerns

Opponents of school-based mental health services believe that some parents have felt forced to medicate their children as a result of seeking treatment in the schools. These opponents argue that pharmaceutical companies are supporting the President's New Freedom Commission on Mental Health, resulting in the forced drugging of children seeking services. Opponents fear that schools will require children to be medicated in order for them to attend school. However, schools are not allowed to provide medication without parental consent (Nealis, 2004a). Schools may recommend that children be medicated, and parents still have the right to choose whether or not their child is medicated.

Mental Health Stigma Concerns

Considering the stigma that surrounds mental illness, it is reasonable that many fear a label of "mentally ill." Labeling children is especially damaging because their labels will be with them for the rest of their lives (Nealis, 2004a). Opponents of school-based mental health services feel that mental health services will result in children receiving unnecessary stigmatizing labels.

Parental Consent Concerns

Another issue surrounding mental health services in schools is parental consent. Opponents of school-based programs argue that parents will lose their parental rights if

such programs are implemented (Nealis, 2004a). However, most schools that offer mental health services require parental consent. Concern arises when critics examine the kind of parental consent that is being obtained by program coordinators. There are two kinds of parental consent: active and passive. Active consent is when parents sign and return consent forms if they want their child to participate. Passive consent is when parents have to return forms only if they do not want their child to participate. Active consent is preferred over passive consent because it ensures that all parents will have seen the consent forms because all parents are required to turn in a form.

Conclusions

Mental health problems affect 12 to 15% of all American children and adolescents, but only 20% of those needing services actually receive the help they need. Untreated mental health problems have significant effects on the development and academic performance of children and adolescents. It is difficult for teachers and parents to identify most mental health problems in youths, and children and adolescents often have low self-referral rates.

Schools are the most convenient place for treatment services to be received after mental health problems have been reliably identified by a qualified professional. This is because children and adolescents are required to attend school, thereby making it possible to reach most children and adolescents. Schools are also ideal locations for the provision of preventative services focusing on the psychosocial factors related to mental illnesses. Federal legislation (NCLB) supports mental health services in schools, but there are a

number of concerns regarding such services within schools. These concerns need to be addressed before mental health service programs in schools can be effective.

There is some evidence that mental health service programs in schools are effective (see CMHS, 2005), but the results of such studies are mixed because of the concerns noted previously. Much more research needs to be done before schools will implement these programs. Areas for future research include the cost, effectiveness, and acceptability of mental health service programs in schools.

School psychologists can play an invaluable role in school-based mental health service programs. In fact, NASP states that school psychologists are mental health care providers. Given this, it is important to assess how school psychologists feel about their role as mental health care providers and their concerns and perspectives regarding this role. Because of the dearth of research on this topic, this research project focused on assessing the current practices and perspectives of school psychologists in regards to mental health services in schools.

CHAPTER 3

METHODS

This research examined the current practices and perspectives of school psychologists with respect to mental health service programs in schools. The research addressed the following questions: (1) What is current practice regarding mental health services in schools? (2) How prepared do school psychologists think they are to provide mental health services? (3) What are school psychologists' attitudes toward providing mental health services in schools?

Participants and Procedures

A random sample of 250 school psychologists who are members of NASP was obtained by contacting NASP for a random list of members. A 50% response rate was obtained, resulting in a sample of 125 participants. However, NASP's membership list includes members that are not practicing school psychologists. The focus of this study is on practicing school psychologists' roles and perspectives; thus, those participants who were not labeled as practicing school psychologists on the list provided by NASP were not included in the final sample. Fourteen participants were removed from the final sample, resulting in a sample of 111 practicing school psychologists.

The majority of the sample was female (77.5%) with an average age of 45 years (SD = 11.36 years). About 40% of the sample had been practicing for 1 to 10 years; about 26% for 11 to 20 years; and about 32% for 21 or more years. The majority of the sample had nondoctoral degrees (73.9%) rather than doctoral degrees (26.1%). Finally, a little

over half of the sample (56.8%) had their NCSP certification whereas 36% did not have their NCSP certification (the remaining 7.2% declined to provide this information).

Approval from the University of Northern Iowa's Institutional Review Board was obtained before the study was conducted. A cover letter explaining the study and consent (see Appendix A) and the survey (see Appendix B) were mailed to each participant in December 2006. A follow-up letter (see Appendix C) and survey were sent to those who did not respond to the initial mailing in January 2007. To allow the researcher to resend the survey to those who do not respond to the initial recruitment effort, surveys were coded and matched with a school psychologists' name and mailing address. After the second recruitment, the lists of codes and corresponding names and mailing addresses were destroyed.

Materials

A 10-question survey (see Appendix B) was developed using current literature on mental health services in schools reported in the literature review of this paper. This survey was developed to assess school psychologists' current practices and their perspectives regarding mental health service programs in schools. A definition of mental health services in schools was given at the beginning of the survey, followed by a number of questions regarding practices of and attitudes toward these services.

To assess current practice, school psychologists were asked about the availability of a variety of mental health services at their schools, along with whether or not they provide these services. Participants were also asked whether or not, to the best of their knowledge, federal monies were available to fund mental health programs in schools. To

assess level of preparedness, participants were asked how well trained and how comfortable they thought they were to provide a variety of mental health services on a 4-point Likert scale, with 4 being very well trained or very comfortable.

Finally, participants' attitudes toward mental health services were assessed by asking whether or not certain mental health services should be provided, how important a number of reasons are for providing mental health services (on a 4-point scale, with 4 being very important), how concerned they are in regards to the issues surrounding mental health services in schools (on a 4-point scale, with 4 being very concerned), and how interested they are in participating in mental health service programs in their schools (on a 4-point scale, with 4 being very interested).

As mentioned above, participants were asked how important a number of reasons are for providing mental health services. These reasons include: a high frequency of children and teens with mental illnesses, the persistence of mental health problems into adulthood if they are not treated, the effects of mental illnesses on students' ability to do well in school, the link between mental illnesses and a number of negative outcomes (i.e., drop out, behavior problems, and substance abuse), the difficulty in recognizing mental illnesses due to their internal nature, the low self-referral rates of children and adolescents, and the large number of stressors children and adolescents face.

Participants were also asked about a number of concerns. These concerns include: limited funding, limited knowledge of costs of providing mental health services, lack of time available for school psychologists to provide these services, lack of training for school psychologists to provide these services, lack of conclusive research on the

outcomes of providing these services, the possibility of students being unnecessarily medicated due to service provision, the possibility of students being labeled and stigmatized due to service provision, and the possibility of services being provided without parental consent.

Participants were asked about their interest in serving in a number of roles associated with mental health service programs. These roles include: developing a program, training school staff, writing grants, evaluating a program, providing mental health services, educating others on mental health and mental illnesses, and serving as liaisons between schools and mental health clinics.

Data Analyses

Data analyses were conducted using SPSS version 12.0 (SPSS Inc., 2004), ZumaStat version 4.0.1 (Jaccard, 2006), and G*Power 3 (Buchner, Edrfelder, & Faul, 1997). SPSS was used for the majority of analyses. ZumaStat was used to conduct the follow-up pairwise comparisons for Chi-square analyses. G*Power was used to conducted effect size and power analyses. A short description of the analyses and the results of these analyses are discussed in the next chapter.

When reporting effect sizes, the following conventions apply (Cohen, 1988). For *t*-tests, an effect size *d* ranging from .20 to .49 is considered small, from .50 to .79 is considered medium, and from .80 and above is considered large. For one-way analyses of variance (ANOVAs), an effect size *f* ranging from .10 to .24 is small, from .25 to .39 is medium, and from .40 and above is large. For one-way multivariate analyses of variance

(MANOVAs), an effect size f^2 ranging from .02 to .14 is small, from .15 to .34 is medium, and from .35 and above is large. For chi-square analyses, an effect size *w* ranging from .10 to .29 is small, from .30 to .49 is medium, and from .50 and above is large.

CHAPTER 4

RESULTS

Current Practice

Availability and Provision of Services

Percentages of those participants who said that mental health services are available in their schools and those participants who said that they provide these services are reported in Table 1. Overall, the majority of the participants stated that the services are available in their schools, ranging from 55% for mental health screening to 100% for consultation for behavioral concerns.

Table 1. *Current practice: Availability and provision of mental health services*

	Availability		Provision	
	N	%	*N*	%
Socio-emotional assessment	111	99.1	108	95.5
Individual counseling	110	95.5	105	70.3
Group counseling	111	89.2	107	51.4
Consultation for mental health concerns	111	98.2	107	92.8
Consultation for behavioral concerns	111	100.0	108	96.4
Crisis intervention	110	96.4	105	81.1
Crisis prevention	107	72.1	103	50.5
Mental health screening	109	55.0	107	39.6
Mental illness prevention	109	83.8	104	43.2

The majority (i.e., 80% or higher) of the sample stated that they provide socio-emotional assessment, consultation for mental health concerns, consultation for behavioral concerns, and crisis interventions. Less than half of the participants stated that they provide mental health screening and mental health prevention.

Chi-square analyses were conducted to examine the associations of group status (years of practice, degree status, or NCSP) with the availability or provision of each service. Follow-up pairwise comparisons were conducted to further examine the associations for each group. Three Chi-square analyses were statistically significant for years of practice: for the provision of crisis prevention ($\chi^2[N = 102, 2] = 6.34, p < .05$) and for the availability and provision of mental health screening ($\chi^2[N = 108, 2] = 12.01$, $p < .001$; $\chi^2[N = 106, 2] = 11.17, p < .01$, respectively). Given a medium effect size ($w = .30$) and the sample sizes reported above, power was estimated to be high or approaching high (ranging from .78 to .80). Therefore, these tests have enough power to detect any effects that years of practice may have on availability and provision of services.

For those participants who have been practicing for 1 to 10 years, follow-up pairwise comparisons showed that fewer participants said they provide crisis prevention than we predicted ($n = 41, z = 2.53, p < .05$). For those participants who have been practicing for 11 to 20 years, fewer said that screening is available at their schools than expected ($n = 29, z = 2.68, p < .01$) and fewer said they provide screening than expected ($n = 28, z = 2.08, p < .05$). Finally, for those who have been practicing for 21 years or more, a greater number said that screening is available than expected ($n = 35, z = 3.38, p$

$< .001$) and a greater number said they provide screening than expected ($n = 35$, $z = 3.33$, $p < .001$).

Knowledge of Funding

Only half of the participants (50.5%) knew that federal monies are available to fund mental health service programs in schools. Chi-square analyses were conducted to examine the associations of group status (years of practice, degree status, and being NCSP certified) with knowledge of federal funding. Follow-up pairwise comparisons were conducted to further examine the associations for each group.

The analysis for degree status was statistically significant, $\chi^2(N = 102, 1) = 7.76$, $p < .01$. Given a medium effect size ($w = .30$) and a sample size of 102, power was estimated to be high (.86). This test is strong enough to detect the effects that degree status has on knowledge of federal funding. Follow-up analysis showed that for those with nondoctoral degrees, fewer participants than expected said that they did not think federal funding is available ($n = 75$, $z = 3.00$, $p < .01$). On the contrary, more participants with doctoral degrees than expected said that they think federal funding is available ($n = 27$, $z = 3.00$, $p < .01$).

Preparedness

Adequacy of Training

Overall, participants felt that they were at least well trained (equivalent to a 3 on the scale). Means and standard deviations for the sample as a whole are reported in Table 2. A one-way multivariate analysis of variance (MANOVA) was conducted in order to

examine the effects of years of practice on feelings of adequacy of training. Follow-up independent sample *t*-tests were conducted to evaluate years of practice effects on feelings of training adequacy for the services.

Table 2. *Preparedness: Feelings of adequacy of training*

	N	*M*	*SD*
Socio-emotional assessment	111	3.62	.51
Individual counseling	111	3.21	.76
Group counseling	111	3.00	.79
Consultation for mental health concerns	111	3.45	.63
Consultation for behavioral concerns	111	3.64	.54
Crisis intervention	111	3.31	.71
Crisis prevention	111	2.96	.83
Mental health screening	110	2.98	.85
Mental illness prevention	110	3.08	.73

The overall MANOVA was statistically significant, $\lambda = .74$, $F(18, 196) = 1.78$, $p < .05$, $f^2 = .16$. Power was estimated to be high (.97), suggesting that this test is powerful enough to detect differences among the years of practice groups. The effect size (f^2) was estimated to be medium, suggesting a clinically useful result. Follow-up analyses involving screening showed that those who have practiced for 11 to 20 years felt significantly less well trained ($n = 29$, $M = 2.52$, $SD = .87$) than those who have practiced for 1 to 10 years ($n = 44$, $M = 3.05$, $SD = .78$, $t[71] = 2.71$, $p < .01$, $d = .65$) and those who have practiced for 21 years or more ($n = 36$, $M = 3.25$, $SD = .77$, $t[63] = 3.59$, $p <$

.001, $d = .90$). Effect sizes for these two comparisons were estimated to be medium and high (.65 and .90, respectively), meaning that these results are clinically useful.

Another one-way MANOVA was conducted to examine the effects of degree status on feelings of adequacy of training. Again, follow-up independent sample *t*-tests were conducted to evaluate degree status effects on feelings of training adequacy for the services.

The overall MANOVA was statistically significant, $\lambda = .83$, $F(9, 100) = 2.29$, $p < .05$, $f^2 = .20$. With this medium effect size, power was estimated to be high (.91), meaning that the MANOVA was strong enough to detect the effects of degree status on training and that these results are clinically useful. Follow-up analyses were statistically significant for each service. Results are reported in Table 3. Those participants with doctoral degrees felt significantly more well trained than those with nondoctoral degrees for all services. The effect sizes of these results are all medium or large, with the exception of the effect size for consulting for behavior problems ($d = .47$). These effect sizes indicate that the results are clinically useful and the differences should be examined further.

Finally, a one-way MANOVA was conducted to examine the effects of being NCSP certified on feelings of adequacy of training. This MANOVA was not statistically significant, $\lambda = .95$, $F(9, 92) = .58$, $p = .81$.

Table 3. *Preparedness: Feelings of adequacy of training by degree status*

	Nondoctoral (n=81)		Doctoral (n=29)				
	M	*SD*	*M*	*SD*	*t*	*p*	*d*
Assessment	3.56	.52	3.83	.38	2.56	.05	.55
Ind. counseling	3.10	.70	3.59	.82	3.09	.01	.67
Group counseling	2.84	.70	3.41	.87	3.52	.001	.76
Consult. – mh	3.35	.64	3.76	.51	3.11	.01	.67
Consult. – behavior	3.58	.57	3.83	.38	2.19	.05	.47
Crisis intervention	3.21	.72	3.59	.63	2.52	.05	.55
Crisis prevention	2.83	.82	3.34	.77	2.92	.01	.63
Screening	2.81	.79	3.45	.83	3.69	.001	.80
Illness prevention	2.98	.72	3.38	.68	2.60	.05	.56

Comfort Level

Overall, participants felt at least comfortable providing the services (equivalent to a 3 on the scale). Means and standard deviations for the sample as a whole are reported in Table 4. A one-way MANOVA was conducted in order to examine the effects of years of practice on comfort level. Follow-up independent sample *t*-tests were conducted to evaluate the effects of years of practice on comfort level for providing the services.

Table 4. *Preparedness: Comfort level*

	N	*M*	*SD*
Socio-emotional assessment	110	3.73	.47
Individual counseling	110	3.25	.82
Group counseling	111	2.96	.90
Consultation for mental health concerns	111	3.48	.62
Consultation for behavioral concerns	111	3.64	.52
Crisis intervention	111	3.21	.78
Crisis prevention	110	2.95	.90
Mental health screening	110	2.94	.85
Mental illness prevention	110	3.06	.84

The overall MANOVA was statistically significant, $\lambda = .73$, $F(18, 190) = 1.78$, $p < .05$, $f^2 = .17$. Given this medium effect size, power was estimated to be high (.97). Follow-up analyses showed that those who have been practicing for 21 years or more felt significantly more comfortable providing individual counseling ($n = 34$, $M = 3.62$, $SD = .60$) than those who have been practicing for 1 to 10 years ($n = 44$, $M = 3.09$, $SD = .86$,

$t[76] = 3.06, p < .01, d = .70$). Also, those who have been practicing for 21 or more years felt significantly more comfortable providing crisis prevention and screening ($n = 34$, $M = 3.29$, $SD = .80$; $n = 34$, $M = 3.21$, $SD = .84$, respectively) than those who have been practicing for 11 to 20 years ($n = 28$, $M = 2.75$, $SD = .1.04$, $t[60] = 2.31, p < .05, d = .59$; $n = 28$, $M = 2.64$, $SD = .87$, $t[60] = 2.62, p < .05, d = .67$, respectively). Effect sizes for these analyses were all estimated to be medium, meaning that these results are clinically useful.

A one-way MANOVA was conducted to examine the effects of degree status on comfort level. Again, follow-up independent sample *t*-tests were conducted to evaluate the effects of degree status on comfort level for providing the services. The overall MANOVA was statistically significant, $\lambda = .80$, $F(9, 96) = 2.74, p < .01, f^2 = .25$. Given the medium effect size, power was estimated to be high (.96). Follow-up analyses were statistically significant for all services but socio-emotional assessment and mental illness prevention. Results are reported in Table 5. Those participants with doctoral degrees felt significantly more comfortable providing the services than those with nondoctoral degrees. The effect sizes of these results are all medium or large, with the exception of the effect size for screening ($d = .45$). These effect sizes indicate that these differences are clinically meaningful.

Finally, a one-way MANOVA was conducted to examine the effects of being NCSP certified on comfort level. This MANOVA was not statistically significant, $\lambda = .98$, $F(9, 88) = .24, p = .99$.

Table 5. *Preparedness: Comfort level by degree status*

	Nondoctoral (n=81)		Doctoral (n=29)				
	M	*SD*	*M*	*SD*	*t*	*p*	*d*
Assessment	3.68	.50	3.86	.35	1.78	.08	-
Ind. counseling	3.14	.81	3.62	.73	2.79	.01	.61
Group counseling	2.81	.87	3.41	.87	3.11	.01	.68
Consult. – mh	3.33	.62	3.83	.47	4.01	.001	.87
Consult. – behavior	3.56	.55	3.86	.35	2.73	.01	.60
Crisis intervention	3.10	.77	3.62	.62	3.26	.01	.71
Crisis prevention	2.84	.89	3.34	.86	2.60	.05	.57
Screening	2.83	.83	3.21	.86	2.08	.05	.45
Illness prevention	3.00	.86	3.24	.79	1.31	.19	-

Relationship Between Adequacy of Training and Comfort Level

Pearson correlation coefficients were computed in order to explore the relationships between ratings of training adequacy and ratings of comfort for each service by group status. First correlations between the two ratings were computed for each service. This was followed by the independent correlational analysis for each group. Estimates that range from .00 to .39 are considered to be low or slight; those that range from .40 to .60 are considered to be moderate, and those that are greater than or equal to .61 are considered high.

Results of the correlations between the two ratings for each group are reported in Table 6. The correlations among the ratings ranged from .65 to .88 for those who have been practicing for 1 to 10 years, from .52 to .86 for those who have been practicing for 11 to 20 years, from .70 to .91 for those who have been practicing for 21 or more years, from .59 to .82 for those who have nondoctoral degrees, from .77 to .90 for those who have doctoral degrees, from .59 to .85 for those who are NCSP certified, and from .66 to .86 for those who are not NCSP certified. For each service and group, ratings of training adequacy and ratings of comfort were significantly correlated. Those who said they felt highly trained in the provision of a service also said they felt comfortable providing that service.

Independent correlation analyses were conducted to determine whether ratings of adequacy of training were correlated with ratings of comfort level as a function of group status (years of practice, degree status, and being NCSP certified). Examination of the *z*-

Table 6. *Correlations among ratings of training adequacy and ratings of comfort for each service by group*

	Years of Practice			Degree Status		NCSP Certification	
	1-10 ($n = 45$)	11-20 ($n = 29$)	21+ ($n = 36$)	Nondoc. ($n = 81$)	Doc. ($n = 29$)	Yes ($n = 63$)	No ($n = 40$)
Assessment	.65**	.52**	.75**	.59**	.88**	.59**	.66**
Ind. counseling	.78**	.71**	.70**	.68**	.86**	.68**	.81**
Group counseling	.81**	.79**	.81**	.74**	.86**	.75**	.84**
Consult. – mh	.76**	.82**	.74**	.73**	.87**	.78**	.81**
Consult. – behavior	.88**	.76**	.87**	.82**	.88**	.85**	.84**
Crisis intervention	.81**	.78**	.91**	.82**	.77**	.79**	.84**
Crisis prevention	.74**	.86**	.89**	.78**	.90**	.80**	.85**
Screening	.73**	.75**	.89**	.76**	.87**	.77**	.85**
Illness prevention	.86**	.77**	.77**	.79**	.83**	.73**	.86**

Note. ** Indicates significance at $p < .01$

test estimates showed that there were no significant differences in terms of how correlated ratings of training adequacy are with ratings of comfort for each group.

Effects of Provision and Group on Training and Comfort

One-way analyses of variance (ANOVAs) were conducted in order to examine the effects of whether or not a participant provides a service on ratings of training adequacy and comfort. Due to the large number of statistical tests performed, a Bonferroni correction was applied yielding an alpha level of .003 (.05/18) for each ANOVA. Statistically significant results are reported in Tables 7 and 8.

For ratings of training adequacy, whether or not a participant provides a service had significant effects for five of the nine services. For ratings of comfort, whether or not a participant provides a service had significant effects for six out of the nine services. In all cases, those who provide the service rated training adequacy and comfort higher than those who do not provide the service. Effect sizes were all medium to large (ranging from .30 to .48), meaning that these results are clinically meaningful. Finally, power for each analysis was estimated to be high (ranging from .85 to .99).

Attitudes Toward Providing Services

Overall Beliefs About Appropriateness

The majority of the participants (95.5%) agreed that school psychologists should provide mental health services in schools. Chi-square analyses were conducted to examine the associations of group status (i.e., years of practice, degree status, or NCSP)

Table 7. *Effects of provision on ratings of training adequacy*

	Provides			Does Not Provide							
	n	*M*	*SD*	*n*	*M*	*SD*	*F*	*df*	*p*	*f*	Power
Assessment	106	3.63	.50	2	3.50	.71	.13	1, 106	.72	-	-
Ind. counseling	78	3.36	.70	27	2.93	.83	6.94	1, 103	.01	-	-
Group counseling	57	3.30	.68	50	2.68	.77	19.50	1, 105	.001	.31	.89
Consult. – mh	103	3.51	.58	4	2.75	.50	6.86	1, 105	.01	-	-
Consult. - behavior	107	3.65	.52	1	3.00	-	1.59	1, 106	.21	-	-
Crisis intervention	90	3.46	.60	15	2.60	.83	23.12	1, 103	.001	.31	.86
Crisis prevention	56	3.34	.67	47	2.49	.80	34.33	1, 102	.001	.42	.99
Screening	44	3.52	.55	62	2.56	.80	47.06	1, 104	.001	.47	.99
Illness prevention	48	3.40	.57	55	2.80	.76	19.86	1, 101	.001	.30	.85

Table 8. *Effects of provision on ratings of comfort*

	Provides			Does Not Provide							
	n	*M*	*SD*	*n*	*M*	*SD*	*F*	*df*	*p*	*f*	Power
Assessment	103	3.75	.46	2	3.50	.71	.57	1, 103	.45	-	-
Ind. counseling	77	3.48	.66	27	2.74	.90	20.51	1, 102	.001	.32	.91
Group counseling	57	3.40	.68	50	2.50	.86	36.69	1, 105	.001	.45	.99
Consult. – mh	103	3.53	.59	4	2.75	.50	6.83	1, 105	.01	-	-
Consult. – behavior	107	3.64	.52	1	3.00	-	1.53	1, 106	.22	-	-
Crisis intervention	90	3.39	.67	15	2.40	.74	27.56	1, 103	.001	.35	.94
Crisis prevention	56	3.36	.70	46	2.46	.91	31.87	1, 100	.001	.45	.99
Screening	44	3.50	.55	62	2.53	.80	47.80	1, 104	.001	.48	.99
Illness prevention	48	3.48	.62	55	2.80	.84	28.87	1, 101	.001	.34	.93

with beliefs about providing mental health services in schools. None of the analyses were statistically significant.

The majority of the participants (76.5%) also responded positively about NASP promoting school psychologists as mental health service providers. About half of this group (34.2% of the whole sample) said that there needs to be changes in time, training, and supervision requirements if NASP continues promotion of school psychologists as providers.

Chi-square analyses were conducted to examine the associations of group status (i.e., years of practice, degree status, or NCSP) with beliefs about NASP's promotion of school psychologists as mental health service providers. Follow-up pairwise comparisons were conducted to examine the effects of each group on associations with beliefs. The Chi-square for years of practice was statistically significant, $\chi^2(N = 110, 6) = 13.68, p < .05$. Given a medium effect size ($w = .30$) and a sample size of 102, power was estimated to be low (.64). Therefore, these results should be interpreted with caution. A follow-up analysis showed that for those who have been practicing for 1 to 10 years, more participants than expected were positively disposed towards NASP's promotion ($n = 25$, $z = 2.80, p < .01$).

Because it was expected that the agreement that services should be provided in schools would be correlated with positive beliefs about NASP's promotion of school psychologists as providers, bivariate correlational analyses were conducted for each

group to examine the correlations between these two beliefs. In contrast to our predictions, there were no statistically significant correlations.

Beliefs About Appropriateness for Individual Services

Overall, the majority of the participants believed that each individual service should be provided by schools (ranging from 66.7% to 96.4%, see Table 9). Chi-square analyses were conducted to examine the associations of group status (i.e., years of practice, degree status, or NCSP) with beliefs about the provision of individual services. Follow-up pairwise comparisons were conducted to examine the effects of each group on associations with beliefs. The Chi-square for years of practice was statistically significant, $\chi^2(N = 108, 2) = 7.43, p < .05$. Given a medium effect size ($w = .30$) and a

Table 9. *Attitudes toward service provision: Appropriateness of individual services*

	%
Socio-emotional assessment	96.4
Individual counseling	91.0
Group counseling	86.5
Consultation for mental health concerns	94.6
Consultation for behavioral concerns	96.4
Crisis intervention	96.4
Crisis prevention	91.9
Screening	66.7
Illness prevention	91.0

Note. $N = 109$.

sample size of 108, power was estimated to be high (.80). Follow-up analysis showed that for those who have been practicing the longest, more participants than expected were in favor of group counseling being provided in schools ($n = 35, z = 2.68, p < .01$).

Importance

Overall, participants felt the reasons discussed in the methods section were all important reasons to provide mental health services in schools. Means and standard deviations for the sample as a whole are reported in Table 10. One-way ANOVAs were conducted in order to examine the effects of group status on ratings of importance. Due to the large number of statistical tests performed, a Bonferroni correction was applied yielding an alpha level of .007 (.05/7) for each group's ANOVA. None of these analyses were statistically significant, meaning that there were no significant group differences in ratings of importance.

Table 10. *Attitudes toward service provision: Importance of reasons for providing services*

	N	*M*	*SD*
High frequency	110	3.48	.62
Persistence	110	3.72	.51
Affects schools	110	3.86	.34
Linked to negative outcomes	107	3.85	.36
Difficult to recognize	107	3.01	.77
Low self-referral rates	108	3.15	.75
Large number of stressors	108	3.60	.56

Concerns

Means and standard deviations for participants' responses to level of concern are reported in Table 11. Participants' greatest concerns were limited funding (n = 109, M = 3.49, SD = .63), limited knowledge of costs of providing mental health services (n = 106, M = 2.83, SD = .75), lack of time available for school psychologists to provide these services (n = 108, M = 3.65, SD = .63), lack of training for school psychologists to provide these services (n = 108, M = 2.72, SD = .92).

Table 11. *Attitudes toward service provision: Concerns*

	N	*M*	*SD*
Funding	109	3.49	.63
Costs	106	2.83	.75
Outcomes	108	2.50	.84
Training	108	2.72	.92
Time	108	3.65	.63
Medication	107	1.77	.68
Stigma	109	1.87	.72
Consent	108	2.05	.93

One-way ANOVAs were conducted in order to examine the effects of group status on ratings of concern. Due to the large number of statistical tests performed, a Bonferroni correction was applied yielding an alpha level of .006 (.05/9) for each group's ANOVAs. Those without their NCSP certification (n = 39, M = 3.03, SD = .96) said that the lack of training was a greater concern than those with their NCSP certification (n =

61, $M = 2.51$, $SD = .85$, $F[1, 98] = 7.98$, $p < .01$, $f = .25$). With this medium effect size, power was estimated to be moderate (.71). Therefore these results should be interpreted with caution.

Willingness

Means and standard deviations for participants' responses to level of interest in serving in different roles are reported in Table 12. Participants were at least somewhat interested in writing grant proposals to get funding ($N = 108$, $M = 2.37$, $SD = 1.01$), but were otherwise interested in serving in these roles.

Table 12. *Attitudes toward service provision: Willingness to serve in mental health service programs*

	N	*M*	*SD*
Develop	109	3.00	.85
Train	108	2.98	.91
Write grant proposals	108	2.37	1.01
Evaluate programs	108	2.74	.89
Provide mental health services	108	3.39	.72
Educate others	108	3.37	.66
Serve as liaison	108	3.25	.77

One-way ANOVAs were conducted in order to examine the effects of group status on willingness to serve in the roles. Due to the large number of statistical tests performed, a Bonferroni correction was applied yielding an alpha level of .007 (.05/7) for each group's ANOVAs. Those participants with their nondoctoral degrees were less

interested in training school staff ($n = 80$, $M = 2.81$, $SD = .90$) and evaluating programs ($n = 80$, $M = 2.60$, $SD = .91$) than those with their doctoral degrees ($n = 28$, $M = 3.46$, $SD = .74$, $F[1, 106] = 11.80$, $p < .001$, $f = .28$; $n = 28$, $M = 3.14$, $SD = .71$, $F[1, 106] = 8.24$, $p < .01$, $f = .07$, respectively). Power was estimated to be high for the training ANOVA (.83) with a medium effect size, but low for the evaluating programs ANOVA (.68) with a small effect size. Results of this second ANOVA should be interpreted with caution due to the low power and small effect size.

CHAPTER 5

DISCUSSION

Overall, most of the participants said that mental health services are provided in their schools, but not all of the participants provide these services. The lowest percentages of provision were for group counseling, screening, and prevention. Those who have been practicing for the longest are more likely than others to provide crisis prevention and screening services.

Participants feel trained to provide the mental health services discussed in this study. For those practicing for 11 to 20 years, there is a dip in ratings of training adequacy for mental health screening in comparison to the other two groups for years of practice. Those with doctoral degrees also felt more well trained than those with nondoctoral degrees.

Overall, participants also feel comfortable providing these services. Those who have been practicing the longest are the most comfortable providing individual counseling, crisis prevention, and screening. For the most part, school psychologists with doctoral degrees also felt more comfortable providing services.

There was a strong positive correlation between ratings of training adequacy and ratings of comfort with provision of services. Also, those who provide the various mental health services rated training adequacy and comfort level higher than those who do not provide the various services.

The majority of participants said that school psychologists should provide mental health services. The majority also thought positively about NASP's promotion of school

psychologists as providers of mental health services, though some had stipulations. These stipulations include changes in training requirements, time requirements, and supervision requirements. The lack of correlation between these two could indicate that participants believe school psychologists should provide these services but that expectations for time and training need to change first.

The majority of the participants stated that all services included in this research should be provided in schools, with screening garnering the least support. Participants were knowledgeable about the reasons why mental health services are needed in schools. The largest concerns were funding, costs, time, and training. Participants were only somewhat interested in serving in mental health service programs, and are least interested in writing grant proposals for these programs.

Implications and Limitations

Given that the results show that those school psychologists with doctoral degrees feel more comfortable and more well trained than those school psychologists with nondoctoral degrees, I do not suggest that all school psychologists are required to have doctoral degrees. School psychologists in NASP-approved nondoctoral programs should receive training in the psychosocial factors of mental health, such as social skills and problem solving skills. Therefore, these school psychologists can still provide mental health services that focus more on prevention of mental illnesses than treatment.

Also, school psychologists in the school setting should consult with school psychologists or other psychologists who are in the clinical setting. There should be more collaboration and consultation for the more serious mental health problems. Practitioners

should regularly reflect on their abilities, making sure that they do not provide services for which they are not well trained or not comfortable providing. Reflective practice will help ensure that school psychologists are providing the best services for schools.

Analyses show that those who provide these mental health services feel more well trained and more comfortable than those who do not provide these services. It is possible that school psychologists, given opportunities to provide these services, will feel more well trained and at least more comfortable in regards to the provision of these services, regardless of degree status.

Provision often depends on the amount of time school psychologists have available. If school psychologists are to be mental health service providers, requirements of time need to change. With time available as a constraint, school psychologists should refer students with more serious mental health problems to psychologists whose sole job description is to provide such services (i.e., psychologists in the clinical setting).

In addition, training programs need to provide more classes on mental health and related services. Training programs should also continue to focus on psychosocial factors. Those school psychologists with nondoctoral degrees should seek more training for diagnoses and treatment before providing these services, although this depends on the program from which they received their school psychology degree. Ongoing training can help alleviate the concern about lack of training and ratings of comfort level. This will also help reduce the dip that occurs in the middle years of practice.

School psychologists who have been practicing the longest or who have doctoral degrees may be the best prepared to provide mental health services. Recruiting school

psychologists with doctoral degrees to help with the training of staff and the evaluation of mental health service programs could help garner support for mental health services in the schools. School psychologists could also advocate for a mental health physician or clinical psychologist to be involved in a mental health service program. This would integrate professionals, and possibly alleviate concerns about lack of training.

Screening continues to be controversial. Fewer agree that it should be provided and there are issues with adequacy of training and comfort level regarding screening. Further research is needed to examine the reasons for the above.

Funding and costs are important concerns. More mental health service programs in schools should report their avenues of funding and their costs. School psychologists can help schools report their data along with analyzing the data.

Further research on school psychologists' current practice, preparedness, and attitudes needs to be conducted. This study provides a snapshot of these constructs across only a small sample of school psychologists who are NASP members nationwide. There is great variety in the job duties of school psychologists across the United States. This sample consists of only a small number of school psychologists with very little representation from each state. To have a truly representative sample of school psychologists across the U.S., a larger sample size is needed.

Also, the participants in this study are all members of NASP. Because NASP promotes school psychologists as mental health providers, it is possible that more participants were in support of mental health service programs in schools than a non-NASP affiliated group. However, a large number of school psychologists are members of

NASP; therefore the sample has a high likelihood of representing school psychologists nationwide.

Finally, this study provided a definition of mental health services in schools. There is great variety in the literature and among school psychologists as to what school-based mental health services actually include. It would be interesting to assess school psychologists' personal definitions. Doing so would help to create a common language in the field in terms of mental health services in the schools.

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APPENDIX A

SURVEY COVER LETTER

Mental Health Services in Schools: School Psychologists' Current Practices and Perspectives

Nicole Carlson, MAE, & Kimberly Knesting, Ph.D.

University of Northern Iowa

Dear School Psychologist:

As part of my training to become a school psychologist, I am conducting a study to assess the current practices and perspectives of school psychologists regarding mental health services in schools. You are invited to participate in this research project conducted through the University of Northern Iowa.

As the need for mental health services and the desire to provide such services in schools increases, it becomes more important for a clear picture of current practices and perspectives to be drawn. It is necessary to understand how school psychologists function as mental health providers to ensure that students are receiving the best services possible. An understanding of school psychologists' concerns regarding mental health services in schools, such as their feelings about training issues and funding issues, is needed. Knowing this could allow schools to develop and implement more effective mental health service programs. Despite the need for such information, no research has been published concerning school psychologists' perspectives. This study aims to provide insight into these areas.

This survey is confidential – we do not ask for your name and no one aside from the researchers will view your answers. Your participation is completely voluntary. If you do not wish to participate, you may choose not to do so. Because the survey is confidential, we hope that you will feel comfortable being completely honest when answering the questions. There are no foreseeable risks and no direct benefits to participation in this study. Information obtained during this study which could identify you will be kept confidential. Surveys will be coded and this code will be matched with your name and address. The codes will be used to provide a means of sending reminders to complete the survey, but will be destroyed later. The summarized findings with no identifying information may be published in an academic journal or presented at a scholarly conference.

If you have questions about the study or desire information in the future regarding your participation or the study generally, you can contact Nicole Carlson at 319-273-2694 or Dr. Kimberly Knesting at the Department of Educational Psychology and Foundations, University of Northern Iowa, 319-273-3840. You can also contact the office of the IRB Administrator, University of Northern Iowa, at 319-273-6148, for answers to questions about rights of research participants and the participant review process.

The survey will take 10 to 15 minutes to complete. By completing the survey you are agreeing to participate in this project. You are acknowledging the nature and extent of your participation in this project as stated above and the possible risks arising from it.

Please complete the enclosed survey and return it in the enclosed envelope. Thank you in advance for participating in our survey.

Sincerely,

Nicole Carlson, MAE
Kimberly Knesting, Ph.D.

APPENDIX B

SURVEY

Mental Health Services in Schools: School Psychologists' Current Practices and Perspectives

Nicole Carlson, MAE, & Kimberly Knesting, Ph.D.
University of Northern Iowa

Demographics

Age _____ Gender _____

Years of Practice (Circle one; in years)

1-5 6-10 11-15 16-20 21-25 26-30 31>

Which of the following degrees have you received? (Check all that apply)

Non-Doctoral		Doctoral	
Ed.S.	_____	Ph.D.	_____
M.A.	_____	Ed.D.	_____
M.S.	_____	Psy. D.	_____
M. Ed.	_____		
S.S.P.	_____		
C.A.S.	_____		
C.A.G.S.	_____		
Other:	_____		

In which of the following areas do you have other graduate degrees or certifications? (Check all that apply)

____ Counseling ____ Clinical Psychology

____ Social Work ____ Other _____

Do you have your NCSP? Yes No

Mental health services in schools promote the socio-emotional well being of students. These services could include the following: socio-emotional assessment, individual or group counseling, consultation regarding mental health and behavioral concerns, crisis intervention and prevention, mental health screening (identifying at-risk students in need of further assessment), and mental illness prevention programs (i.e., social skills, friendship groups, or anti-bullying groups).

Current Practice

1. Which of the following mental health services are available at one or more of your schools, and which of the following mental health services do you provide at one or more of your schools?

	Available		Provide	
Socio-emotional assessment	Yes	No	Yes	No
Individual counseling	Yes	No	Yes	No
Group counseling	Yes	No	Yes	No
Consultation regarding mental health concerns	Yes	No	Yes	No
Consultation regarding behavioral concerns	Yes	No	Yes	No
Crisis intervention	Yes	No	Yes	No
Crisis prevention	Yes	No	Yes	No
Mental health screening	Yes	No	Yes	No
Mental illness prevention (i.e., social skills groups or anti-bullying groups)	Yes	No	Yes	No

2. To the best of your knowledge, are federal monies available to fund mental health services in schools?
   Yes No

Preparedness for Service Delivery

3. How adequately do you think that you are trained to provide each of the following services:

	Very well trained			Not well trained
Socio-emotional assessment?	4	3	2	1
Individual counseling?	4	3	2	1
Group counseling?	4	3	2	1

Consultation regarding mental health concerns?	4	3	2	1
Consultation regarding behavioral concerns?	4	3	2	1
Crisis intervention?	4	3	2	1
Crisis prevention?	4	3	2	1
Mental health screening?	4	3	2	1
Mental illness prevention programs (i.e., social skills groups or anti-bullying groups)?	4	3	2	1

4. How comfortable are you providing the following services:

	Very comfortable			Not comfortable
Socio-emotional assessment?	4	3	2	1
Individual counseling?	4	3	2	1
Group counseling?	4	3	2	1
Consultation regarding mental health concerns?	4	3	2	1
Consultation regarding behavioral concerns?	4	3	2	1
Crisis intervention?	4	3	2	1
Crisis prevention?	4	3	2	1
Mental health screening?	4	3	2	1
Mental illness prevention programs (i.e., social skills groups or anti-bullying groups)?	4	3	2	1

Provision of Services

5. Should school psychologists provide mental health services in schools?

Yes No

6. How important do you believe each of the following reasons is for providing mental health services to students?

	Very important			Not at all important
There is a high frequency of children and teens with mental illnesses.	4	3	2	1
Untreated mental health problems persist into adulthood.	4	3	2	1
Mental illnesses affect students' ability to do well in school.	4	3	2	1
Mental illness is linked to a number of negative outcomes (i.e. drop out, behavior problems, and substance abuse).	4	3	2	1
Most mental illnesses are internal and difficult to recognize.	4	3	2	1
Children and adolescents have low self-referral rates.	4	3	2	1
Children and adolescents face a large number of stressors.	4	3	2	1

7. When it comes to mental health services in the schools, how concerned are you with each of the following?

	Very concerned			Not at all concerned
There is limited funding to provide mental health services.	4	3	2	1
It is unclear how much providing the necessary services will actually cost school districts.	4	3	2	1
There is a lack of time available for school psychologists to provide mental health services.	4	3	2	1
School psychologists are not adequately trained to provide mental health services.	4	3	2	1
There is a lack of conclusive research on the outcomes of providing mental health services to students.	4	3	2	1
Providing mental health services to students will lead to students being unnecessarily medicated.	4	3	2	1

Providing mental health services to students will lead to students being stigmatized by a label of mental illness.	4	3	2	1
Students will be provided mental health services without parental consent.	4	3	2	1

8. How interested are you in doing each of the following activities related to mental health services in schools:

	Very interested			Not at all interested
Developing a mental health service program for your school?	4	3	2	1
Training school staff involved in a mental health service program?	4	3	2	1
Writing grants to get funds for a mental health service program for your school?	4	3	2	1
Evaluating a mental health service program in a school?	4	3	2	1
Providing mental health services in a school?	4	3	2	1
Educating others (staff, community) on mental health and mental illness?	4	3	2	1
Serving as a liaison between schools and mental health clinics?	4	3	2	1

9. Which of the following services do you think your school(s) should provide? Check all that apply.

____ Socio-emotional assessment

____ Individual counseling

____ Group counseling

____ Consultation regarding mental health concerns

____ Consultation regarding behavioral concerns

____ Crisis intervention

____ Crisis prevention

____ Mental health screening

____ Mental illness prevention (i.e., social skills groups or anti-bullying groups)

____ Other _____

10. What do you think about NASP promoting school psychologists as mental health service providers?

Thank you for your time and input.

APPENDIX C

FOLLOW-UP COVER LETTER

Mental Health Services in Schools: School Psychologists' Current Practices and Perspectives

Nicole Carlson, MAE, & Kimberly Knesting, Ph.D.

University of Northern Iowa

Dear School Psychologist:

About a month ago you received a letter from me requesting that you complete a survey. As part of my training for becoming a school psychologist, I am conducting a study to assess the current practices and perspectives of school psychologists regarding mental health services in schools. I would like to give you another opportunity to participate in this research project conducted through the University of Northern Iowa.

As the need for mental health services and the desire to provide such services in schools increases, it becomes more important for a clear picture of current practices and perspectives to be drawn. It is necessary to understand how school psychologists function as mental health providers to ensure that students are receiving the best services possible. An understanding of school psychologists' concerns regarding mental health services in schools, such as their feelings about training and funding issues, is needed. Knowing this could allow schools to develop and implement more effective mental health service programs. Despite the need for such information, I was unable to find published research concerning school psychologists' perspectives. This study aims to provide insight into these areas.

This survey is confidential – we do not ask for your name and no one aside from the researchers will view your answers. Your participation is also completely voluntary. If you do not wish to participate, you are welcome to choose not to do so. Because the survey is confidential, we hope that you will feel comfortable being completely honest when answering the questions. There are no foreseeable risks and no direct benefits to participation in this study. Information obtained during this study that could identify you will be kept confidential. Surveys will be coded and this code will be matched with your name and address. The codes will be used to provide a means of sending reminders to complete the survey, but will be destroyed later. The summarized findings with no identifying information may be published in an academic journal or presented at a scholarly conference.

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Sincerely,

Nicole Carlson, MAE
Kimberly Knesting, Ph.D.