

Mental Health Counseling in the Schools:
School Psychologists' Perceptions
And Current Practice

by

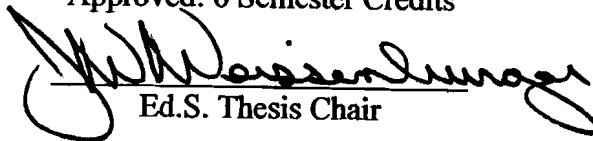
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A Research Paper

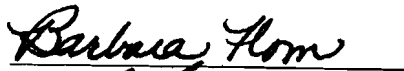

Submitted in Partial Fulfillment of the
Requirements for the
Education Specialist Degree
in

School Psychology

Approved: 6 Semester Credits


Ed.S. Thesis Chair

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The Graduate School
University of Wisconsin-Stout

May, 2008

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Title: *Mental Health Counseling in the Schools: School Psychologists' Perceptions and Current Practice*
Graduate Degree/ Major: Ed.S. in School Psychology
Research Adviser: Jacalyn W. Weissenburger, Ph.D.
Month/Year: May, 2008
Number of Pages: 28
Style Manual Used: American Psychological Association, 5th edition

ABSTRACT

Many students are affected by mental health problems. There is growing controversy of how best to serve these children while taking into consideration budget constraints and the role of the schools in this matter. This study reviewed the available literature on the provision of mental health services in the schools and examined current perceptions and practice through surveying a national sample of members of the National Association of School Psychologists (NASP) ($n = 825$). Results indicated that about half of the NASP members surveyed provide mental health counseling services in the schools. Statistical analysis also revealed that female school psychologists reported spending more time engaged in group mental health counseling service delivery, other results found male school psychologists have more years of experience, indicating male school psychologists are older as a group. School psychologists with more years of experience indicated greater perception of faculty support with regard to the provision of mental health services in the schools and asserted greater confidence in the adequacy of their

training as mental health counseling service providers. School psychologists in the northeast region reported lower student to school psychologist ratios and devoted more time to both individual and group mental health counseling service delivery. The study concludes with a discussion of the results and implications for training and future research.

Acknowledgements

This paper could not have been completed without the guidance and support of several people. Foremost, I would like to thank my research advisor, Jacalyn Weissenburger. She provided me with the knowledge and resources I needed to complete a well-researched and organized investigation of the provision of mental health services in the schools. Thank you for lending me your patience, grace, and expertise throughout this process.

Finally, I would like my wife Rachel. You have encouraged and supported me from the early stages of my graduate application process through the completion of this paper. Thank you for your unwavering support and understanding throughout my graduate education.

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CHAPTER I

INTRODUCTION

In America today, many students struggle with mental health concerns on a daily basis. Mental health problems among adolescents and children are fairly common, with the mean overall prevalence at 15.8% (Roberts, Attkisson, & Rosenblatt, 1998). According to the American Psychiatric Association (2000), mental health problems like mental retardation, learning disorders, attention-deficit disorder, disruptive behavioral disorders, elimination disorders, selective mutism, psychotic disorders such as schizophrenia, and mood disorders like depression or bipolar may occur as early as childhood or adolescence. Mental health concerns certainly are not limited to adults. The educational implications of mental health disorders for the students who struggle with them are vast and far-reaching. For instance, the Center for Disease Control and Prevention (CDC) found, in a 2001 study surveying adolescents in grades 9-12, that 28.3% of students display two of the most serious diagnostic hallmarks for depression (Grumbaum et al., 2002). The same study indicated that 8.8% of these students admitted to attempting suicide at least once in the previous 12 months. In today's society, social pressures on youth are unparalleled. Children are regularly exposed to multiple stressors in their homes due to child abuse, child neglect, substance abuse, rising rates of poverty, and violence in our communities (Heathfield & Clark, 2004). Policymakers have recognized the implications of realities like these as serious issues that require additional support in our communities and, more specifically, our schools.

Although students with academically based disorders like learning disabilities may qualify for special education services if certain criteria are met, many question

whether schools should provide mental health services for students who present mental health problems. School psychologists are at the forefront of the provision of mental health services in the schools; some school psychologists deliver mental health services directly to the students they serve, others take a more passive role and serve as the bridge between the schools and community-based agencies, while others provide a combination of both. Abrams, Flood, and Phelps (2006) saw broader implications for school psychologists: "School psychologists play a critical role in medication management by monitoring behavioral, social-emotional, and academic outcomes, coordinating the intervention team, interfacing with the prescribing physician, and providing psychosocial interventions" (p. 493). In spite of their crucial role in the provision and coordination of mental health services to our nation's youth, surprisingly little is known about the role that practicing school psychologists play in the provision of mental health services in the schools.

Those who disagree with the provision of mental health services in schools, however, point to the lack of funding in our schools (Adelman & Taylor, 1999). Most argue that students need the basics: reading, writing, and math. Reading, writing, and math are considered cultural imperatives in our society, and dissenters argue that counseling services and mental health interventions are the responsibility of families and the communities in which students live rather than the responsibility of the schools. Further, opponents of mental health services in schools worry that the provision of such services is often done without parental consent or knowledge, which can be a violation of parental rights.

Statement of the Problem

Given the large number of students affected by the decisions of our school personnel regarding the provision of mental health services and the growing scarcity of financial resources to address mental health needs, research regarding the provision of mental health services in schools is warranted. Moreover, given the paucity of data regarding the current practice of school psychologists with respect to the provision of mental health services, more research is needed to determine what role practicing school psychologists play in the evolving practice of the provision of mental health services in the schools.

Purpose of Study

The objectives of this research were: (a) to determine the current practice of practicing school psychologists in the United States regarding the provision of mental health counseling services in the schools, (b) to determine the level of satisfaction regarding the provision of mental health counseling services in the schools of practicing school psychologists in the United States, (c) to determine the perceived level of support from stakeholders in the schools regarding practicing school psychologists' provision of mental health counseling services, and (d) to determine school psychologists' perceptions of the adequacy of their training related to the provision of mental health services in the schools. Finally, this study sought to determine what influence, if any, the following variables had on school psychologist's perceptions of the aforementioned variables: gender, years practicing as a school psychologist, and geographic region.

Definitions

To further facilitate knowledge of mental health problems and concerns for America's students, the following definitions are provided:

The No Child Left Behind Act. An act of Congress, proposed by President G. W. Bush, which places accountability on student performance. Students' academic achievement is measured using standardized testing. Schools are held accountable for progress or underachievement with financial rewards and bonuses or disciplinary action. Further, vouchers may be given to students in failing schools (George W. Bush, 2003).

Mental Health. The successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity (Department of Health and Human Services, 1999).

Mental Illness. A term that refers collectively to all mental disorders, which are health conditions characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning (U.S. Department of Health and Human Services, 1999).

Mental Health Problems. A term that refers to signs and symptoms of sufficient intensity or duration to meet the criteria for any mental disorder (U.S. Department of Health and Human Services, 1999).

PL XX-XXX. The letters "PL" stand for public law and are followed by several numerals, a dash, and more numerals. The first numerals designate the session of

Congress in which the law was passed. The second set of numerals designate the position in the sequence of laws for that particular congressional session.

Passive consent. When parents are provided with information or notified that they have access to information about a service and have the right to object if they choose (Evans, 1999).

CHAPTER II

LITERATURE REVIEW

Introduction

Because reform movements like the No Child Left Behind Act (NCLB) have been instrumental in turning the attention of America's schools from services that provide socio-emotional and mental health support to more traditional academic services, this literature review will begin with a brief discussion on the NCLB. This chapter will then discuss the following in the context of the available literature: (a) the historical development of school-based mental health services, (b) the reasons for the provision of mental health services in the schools, (c) the reasons against the provision of mental health services in the schools, (d) the existing empirical evidence to support or deny the provision of mental health services in the schools, and finally, (e) the National Association of School Psychologists' stance on the provision of mental health services in the schools.

No Child Left Behind

With the advent of the No Child Left Behind Act, the concept of federal funding based on test scores has forced schools to narrow the focus of their financial and personnel resources to emphasize more traditional, academically-based services for students. The No Child Left Behind Act has placed an unprecedented importance on the academic performance of America's students, and the act has made overt connections between academic performance and much needed funding. In his executive summary, President George W. Bush outlined several policy changes as he implemented the act. First, schools must have annual, nationwide assessments of reading and math skills. As

such, students will be formally assessed at least once per year for the purpose of eventually formulating a report card for each school district and state (Bush, 2003).

The link between testing and funding has had a huge impact on our schools. James Green (2004) summed the effects of high stakes testing nicely when he said, “The current emphasis on high-stakes testing is leaving an unmistakable imprint on all aspects of education. Our curriculum, our instructional methods and materials and even our understanding of the purpose of public education are being reshaped by the standardized tests” (p. 30). Further, schools whose students are not meeting criteria set by the U.S. Department of Education will “first receive assistance, and then come under corrective action if they still fail to make progress” (Bush, 2003, p. 3). According to the President’s address, “The Secretary of Education will be authorized to reduce Federal funds available to a state for administrative expenses if a state fails to meet their performance objectives and demonstrate results in academic achievement” (Bush, 2003 p. 5). The implications of these policies as they relate to the provision of mental health services in schools are massive. States that once provided mental health services to students are now faced with reallocating resources to ensure high test scores by making academic improvements to meet the demands of the NCLB.

Proponents of school-based mental health services often argue that students who are unstable from a mental health perspective will struggle academically, socially, and emotionally, regardless of the quality of instruction, academic, or behavioral interventions provided (Adelman & Taylor, 1999). These mental health proponents take a more holistic approach to education, stating that for students to thrive academically, their physical and mental health needs must be met. Proponents argue that attempting to

teach students academics without first addressing their socio-emotional well-being is a lost cause.

History

To gain an understanding of the context surrounding the issue of the provision of mental health services in schools, it is helpful to first explore the historical development of mental health services in the public schools. Because a mental health disorder may be considered a disability under the Individuals with Disabilities Education Act (IDEA), much of the history of the provision of mental health services is intertwined with, and related to, the history of special education in the United States.

From a constitutional perspective, the primary power and responsibility for education is delegated to the states. The federal government had a laissez faire approach to education prior to the 1950s (Martin, Martin & Terman, 1996).

According to Martin, Martin, and Terman (1996), due to a perceived threat of Soviet intellectual superiority after the Soviet Union launched Sputnik, the National Defense Education Act (NDEA) was passed in 1958. Several days after the NDEA was signed, President Dwight Eisenhower signed an additional act that provided financial incentives to colleges and universities that trained people to teach children with mental retardation.

In 1965, the Elementary and Secondary Education Act (ESEA) (PL 89-10) was signed into law, marking the first major federal effort to provide direct monetary support to selected populations in public elementary and secondary schools (Martin, Martin, & Terman, 1996, p. 26). Although not directly pertaining to students with disabilities, the ESEA provided money to states to assist in educating students whose families were

below the poverty line. In 1966, an amendment to the ESEA (PL 89-313) was passed, and the Bureau of Education for the Handicapped in the Department of Health, Education, and Welfare was created (Katsiyannis, Yell, & Bradley, 2001).

In 1970, PL 91-230, or the Education of the Handicapped Act (EHA) was passed. EHA was the first law that exclusively addressed students with disabilities. It is important to note that prior to the mid 1970s, students with disabilities of any kind (mental health problems included) were inadequately served or overtly excluded from public education (Martin, Martin, & Terman, 1996). Students with severe physical or emotional disabilities were simply not allowed to attend school. Students who did not meet the criteria of being educable were excluded from public school. However, under the EHA, grants were offered to institutions to develop programs to train teachers who could teach students with disabilities. The EHA was amended in 1974 after the landmark court cases PARC (PARC v. Commonwealth of Pennsylvania, 1972) and Mills (Mills v. Board of Education of District of Columbia, 1972) were decided. The amendment included a requirement that all states receiving federal funds must adopt the goal of “full educational opportunity for students with disabilities” (Katsiyannis, Yell, and Bradley, 2001, p. 325).

In 1975, the Education for All Handicapped Children Act (EAHCA) (PL 94-142) was signed into law, marking the “most significant increase in the role of the federal government in special education to date” (Katsiyannis, Yell, & Bradley, 2001, p. 325). Many current students with emotional or mental health disorders qualify for special education services and are entitled, therefore, to the protection of these laws. The nomenclature for mental or emotional disability categories varies from state to

state. However, the President's New Freedom Commission on Mental Health (2002) defined children with these types of emotional and mental health problems as having a serious emotional disturbance (SED).

According to Katsiyannis, Yell, and Bradley (2001), under the EAHCA, disabled students were ensured a free and appropriate public education (FAPE), due process rights, and an individualized education plan (IEP). Special education students also were entitled to be educated in the least restrictive environment (LRE). In 1990, the title of the EAHCA was changed to the Individuals with Disabilities Education Act (IDEA).

In 1999, the U.S. Surgeon General issued a report on Mental Health in America that called for reforms in mental health systems (U.S. Department of Health and Human Services, 1999). Part of the report specifically addressed the needs of children's mental health. In response to the Surgeon General's report, George W. Bush issued an executive order in April 2002. The executive order authorized the establishment of "The President's New Commission on Mental Health" (Executive Order No. 13263, 2002). The commission proposed solutions to some of the problems outlined in the 1999 Surgeon General's Report on Mental Health. To meet the needs of children with mental health problems, schools were encouraged to partner with community-based mental health organizations. According to The President's New Freedom Commission on Mental Health (2002), past community and school partnerships have been successful. Such partnerships often improved school attendance and reduced discipline referrals. Further, preliminary evidence suggested standardized test scores have risen as a result of such partnerships (The President's New Freedom Commission on Mental Health 2002).

Upon examining of the history of the provision of services to students with mental health concerns and other disabilities, one may conclude that mental health services have become a national priority. However, in which context should the provision of these services take place, and should schools provide mental health services to students? The following discussion focuses on the literature from professionals who believe the responsibility of providing mental health services to our nation's youth rests on the schools.

Need

According to the Surgeon General's Report on Mental Health, approximately 20% of children and adolescents experience the symptoms of a diagnosable DSM-IV mental health disorder (U.S. Department of Health and Human Services, 1999). Unfortunately, it has been reported that well below 50% of children with mental health disorders receive any treatment to address their needs (U.S. Department of Health and Human Services, 1999). Neglecting the mental health needs of our children can have devastating consequences (Adelman & Taylor, 1999). The lack of mental health support for children can lead to more serious problems and the need for more expensive services in adolescence and adulthood. Additionally, failing to meet children's mental health needs can result in poor health outcomes when these children mature into adolescence and adulthood, thereby compromising the safety of families, communities, and societies (Power, 2003).

Access

An additional piece of the mental health puzzle is one of access. Of the small percentage of affected children who receive mental health services, 70-80% receive them

in a school (Burns et al., 1995). It seems schools have become the “front line” for efforts to systematically address the socio-emotional needs of children (Elias, Zins, Graczyk, & Weissberg, 2003). Some would say the use of schools as a vehicle for mental health services is only logical. The World Health Organization report (1994), *Mental Health Programs in Schools*, asserted: “Schools have a central position in many children’s lives and potentially in their development, especially when families are unable to assume a leading role. Therefore, schools, for many children, may be the most sensible point of intervention [for mental health services]” (as cited in Armbruster et al., 1999).

Although many children receive mental health services in schools, a large portion of these are qualified as special education students. Few schools provide services in the general education program for students with serious mental health needs (Dutchnowski, 1994). Moreover, children identified with mental health disorders are more likely to enter and receive intervention in a school than when services are offered in the community (Catron & Weiss, 1994). Schools often stand in the gap, with educational personnel advocating for students who would otherwise be left to struggle. According to Adelman and Taylor (1999), schools provide invaluable access to students with mental health needs and “unique opportunities for intensive, multifaceted approaches and are essential contexts for prevention and research activity” (p. 137).

Success

Proponents of school-based mental health services also address the perceived link between mental health and academic achievement. There is growing consensus among educators, health care professionals, child advocates, welfare reformers, and social policymakers who admit the interrelatedness of children’s overall health and their

achievement (Carlson, Paavole, & Talley, 1996). These advocates assert that children do not learn in a vacuum. Children are affected by their environment and the current state of their physical and mental health. Educators also have recognized that emotional, social, and physical health problems must be addressed so schools may function satisfactorily and students may learn and perform effectively (Adelman & Taylor, 1999). Although the primary concern of schools is education, it has been argued that mental health is crucial to learning as well as socio-emotional development (Executive Order No. 13263, 2002). When put into the greater context of life, schools are often the first structured environments for children with mental health disorders. Children learn training and coping skills in schools that will hopefully guide them the rest of their lives. Elias and colleagues stated it succinctly when they posited: "There is growing international recognition that education must include all of the elements needed for success in school and must refocus to prepare children for the tests of life, not for a life of tests" (2003, p. 304).

Upon an examination of the pros of providing mental health services in the schools and a review of the NCLB, one may see the need for the inclusion of mental health services. However, not all professionals agree about the necessity of providing mental health services in the schools. Although the literature on this topic is limited, the following discussion focuses on those who oppose the provision of school-based mental health services and why.

Philosophy and Money

For many, the aversion to the provision of mental health services in schools is largely a philosophical one. Many parents, teachers, and administrators see schools as

delivery systems for academic instruction and little more. Deviation from the provision of services which are strictly academic in nature can be an intrusion into the primary mission of schools: educational instruction. Adelman and Taylor (1999) captured this idea nicely when referring to those who disagree with the provision of mental health services in the schools when they said “. . . schools are not in the mental health business. Their mandate is to educate. Thus, they tend to see any activity not directly related to instruction as taking resources away from their primary mission” (p. 138). Mental health interventions could be seen as burdens on educational systems due to the reality of fixed resources that must be allocated across multiple needs with a priority on student achievement (Ringelisen, Henderson, & Hoagwood, 2003). Unfortunately, resources in schools are limited. When resources are increasingly limited with every failed referendum and every legislative session that works to trim the budgets of schools, priorities must be made. For many, mental health services are secondary to the academic mission of our public schools.

Consent

According to Evans (1999), “The issue of consent is central to the arguments of those who criticize school-based services” (p. 172). When a school counselor, social worker or psychologist begins seeing a student, there are many gray areas. Consistency on the consent for services varies from state to state. In some states, children are allowed to consent to services at the age of twelve. One state allows children to consent to services at any age if they are judged to be intelligent enough to understand what they are consenting to (DeKraai & Sales, 1991). With consent practices varying to such a great

degree from state-to-state, it behooves providers of mental health services in schools to become aware of the laws in their particular state to avoid litigation.

Problems with consent go deeper than state-to-state legislative differences, however. In states where consent rules are governed by strict guidelines, ambiguity and complications may arise. For instance, situations involving divorced parents, children in detention facilities, foster children, and married parents who disagree about the course of treatment for their children can lead to complications (Evans, 1999). Further, parental advocacy groups have raised questions about some decisions to utilize what is called passive consent. Referring to the integration of education and mental health services as education's ruin, the Citizens Commission on Human Rights (1995) asserted that the provision of mental health services is intrusive and in violation of parental rights. Furthermore, the Commonwealth of Pennsylvania House of Representative's Committee on Education (1996) argued that the school-based system of mental health lacks the privacy and safeguards available in a clinical setting.

Philosophy, a lack of funding, and issues with consent are central to arguments against the provision of mental health counseling services in the schools. In order to offer more objective analysis of this issue, studies involving the empirical effects of mental health counseling in the schools follow.

Empirical Effects of Mental Health Services in Schools

According to Adleman and Taylor, "It is not new insight that mental health and psychosocial problems must be addressed if schools are to function satisfactorily and if students are to learn and perform effectively" (1998, p. 136). Of the available empirical

research available on the effects of mental health services in schools, many studies show favorable results for such interventions.

In a longitudinal study, Rosenblatt and Attkisson (1997) examined adolescent (mean age = 12.4) students ($n = 41$) with severe emotional disturbance and mental health concerns in several counties in California. Students were given the Woodcock Johnson Tests of Achievement and the Wide Range Achievement Test-Revised (WRAT-R) to gauge their academic achievement level. At the conclusion of the study, students showed increases in grade-level achievement of as much as a year and strong student school attendance when extensive mental health programs were implemented over the course of that year. Rosenblatt and Attkisson (1993) reported similar results in an earlier study in California involving 237 students.

In a two-year longitudinal study that compared mental health concern symptoms of sadness and anger with GPA and school attendance, Roeser, Eccles, and Strobel (1998) conducted concurrent studies with 6th and 8th graders in California ($n = 97$) and Maryland ($n = 1071$). These researchers found that students who displayed sadness and anger had lower GPAs and poorer school attendance than students who did not report these symptoms. Further, Roeser et al. found that students who showed depressive symptoms in school were more likely to engage in classroom resistance behaviors like failing to complete assignments or missing class.

In a pilot study assessing treatment outcomes for high-school students enrolled in a school-based mental health clinic in Baltimore, Weist, Paskewitz, Warner, and Flaherty (1996) found that adolescent (mean age = 16) students ($n = 39$) who received therapy displayed improvements in their self-concept with decreases in their depression scores.

Conversely, students ($n = 34$) who received no services experienced an increase in depression and poorer self-concepts.

In a longitudinal study that examined early psychosocial predictors of academic achievement, Teo, Carlson, and Mathieu (1996) found that young children's psychological adjustment and psychosocial environment predicted later academic achievement. Students ($n = 174$) participated in the study from birth to sixteen years of age. Teo and colleagues found students with positive early mental health histories had higher scores on standardized tests of academic achievement in first grade, sixth grade, and at sixteen years of age.

Similarly, in another longitudinal study which assessed students from birth to eighteen years of age, Gutman, Sameroff, and Cole (2003) found that poor mental health among low-risk students ($n = 145$) was negatively related to students' average GPA, including the slope of their GPA from 1st grade to 12th grade.

In a longitudinal study that tracked high-risk students ($n = 174$) from birth to sixteen years of age, Jimerson, Egeland, and Teo (1999) found academic achievement spiraled downward in students with socioemotional and behavior problems. As a part of the study, students were administered the Peabody Individual Achievement Test (PIAT) and the Woodcock Johnson Test of Achievement- Revised (WJ-R) to assess their levels of academic achievement. Additionally, teachers were interviewed and given checklists to complete to determine the students' socioemotional functioning and behavior. Students who experienced problems in socioemotional functioning or behavior were reported to fall further and further behind their peers due to a lack of motivation, attention, concentration, and an inability to self-regulate their emotions and behavior.

In a study involving adolescents aged thirteen to eighteen years of age ($n = 383$), which assessed the efficacy of a school-based mental health center, Gall, Pagano, Desmond, Perrin, and Murphy (2000) administered the Pediatric Symptom Checklist (PSC-Y) to screen students for mental health problems. Qualifying students were identified and received services in the school. Two months later, the attendance records of students who received services were reviewed, and students' absences and tardiness were reported to have decreased significantly.

However, as limited as it may be, not all empirical research on the effects of mental health services is favorable. For instance, one study compared school district mean achievement scores in Oklahoma with predetermined expense categories (Jaques & Brorsen 2000). Jaques and Brorsen found that standardized test scores were positively related to expenditures toward instruction and instructional support. Conversely, they found that test scores were negatively related to expenditures on student support services such as counseling.

In another study, Gutman, Sameroff, and Cole (2003) found no significant relation for high-risk students ($n = 145$) between their mental health and their GPA or the slope of their GPA over the course of their K-12 schooling experience. The same study also found no relation between their mental health, IQ, and school attendance.

Although there seems to be more available research conveying favorable empirical results on the effects of providing mental health services, not all studies found positive outcomes for students. Because school psychologists play an integral role in the provision of mental health counseling services in the schools, the position of the National Association of School Psychologists (NASP) is offered.

NASP's View

The National Association of School Psychologists (NASP) published a brochure outlining its stance on the provision of mental health services in schools (National Association of School Psychologists, 2005). According to NASP, "Mental health is as important as physical health to our quality of life" (2005, ¶1). NASP policymakers contend that all children face mental health problems from time to time, ranging from problems with learning and development to problems with relationships and physical health as a result of mental health problems. School psychologists are trained to prevent and intervene related to a long list of mental health concerns. Examples of these concerns include: stress, anxiety, depression, loneliness, alienation, academic difficulties, substance abuse, and fears of terrorism or war, to name a few. According to NASP, schools are ideal settings for the provision of mental health services. Schools are particularly well suited to provide mental health services for several reasons: schools are geared toward learning and development, schools are a natural context for the intervention and prevention of mental health problems, schools are connected to various community resources and agencies, and educational staff are familiar with ways to communicate with parents. Additionally, school psychologists are trained to make links between mental health, learning, and behavior to promote good mental health and high academic achievement for students. The National Association of School Psychologists describes the role of the school psychologist regarding mental health as being one of prevention, intervention, assessment, collaboration, and advocacy.

In summary, this literature review focused on the historical development of school-based mental health services, the reasons for and against the provision of mental

health services in the schools, the empirical evidence regarding the provision of mental health services in the schools, and the National Association of School Psychologists' stance on the provision of mental health services in the schools. A summary of the methodology used in this empirical study will now be addressed.

CHAPTER III

METHODOLOGY

Introduction

This survey research was conducted to determine school psychologists' perceptions regarding current practices, support, satisfaction, and the adequacy of their own training related to the provision of mental health counseling services in the schools. This chapter will discuss the participants, survey instrument, procedures, and data analyses that were involved in the study.

Participants

A survey was distributed to a random, nationwide sample ($n = 825$) of practicing school psychologists. All school psychologists were registered members of the National Association of School Psychologists (NASP). A summary of the school psychologists' demographic characteristics is provided in Table 1. As indicated in Table 1, the majority of respondents were female ($n = 324$; 81%), Caucasian ($n = 362$; 91%), and employed full-time ($n = 354$; 89%). About half were nationally certified school psychologists ($n = 196$; 49%) and worked in suburban school districts ($n = 209$; 53%).

Survey Instrument

The Provision of Mental Health Services: Perceptions and Practice Survey for School Psychologists was developed by Jason Riebe, a graduate student, and Jackie Weissenburger, faculty advisor for this study (see survey in Appendix B).

The questionnaire consisted of 26 items with three sections: Current Practice, Perceptions of Practice, and Demographic Information. The Current Practice section contained six questions that sought to determine whether or not school psychologists

provide mental health services and the specifics of their service delivery for those who indicated they provide mental health services in the schools. In terms of formatting, the Current Practice questions included a mix of fill-in-the blank and checklist-style items. The Perceptions of Practice section was comprised of eight questions that focused on school psychologists' perceptions of level of support from various stakeholders in the schools, as well as their own level of satisfaction with the mental health counseling services provided in the schools. The first four questions in the Perceptions of Practice section pertained to level of satisfaction using five-point Likert-style ratings ranging from 1 = Very Unsatisfied to 5 = Very Satisfied. Two questions related to school psychologists' perceived level of support regarding the provision of mental health counseling services in the schools using five-point Likert-style ratings ranging from 1 = Very Unsupportive to 5 = Very Supportive. Two final questions in the Perceptions of Practice section focused on perceptions of professional preparation and the appropriateness of schools as mental health counseling service sites; answers utilized five-point Likert-style ratings ranging from 1 = Strongly Disagree to 5 = Strongly Agree. Finally, the Demographic Information section items addressed: gender, age, ethnicity, number of years practicing as a school psychologist, highest degree held, employment status, national certification status, characterization of school district (e.g., urban, suburban, rural), state of employment, grade levels served, number of schools served, and school psychologist to student ratio.

Procedures

The survey was mailed to a random sample of NASP members ($n = 825$) from the University of Wisconsin-Stout. Each packet contained a cover letter (see Appendix C), a

survey, and a postage-paid return envelope. To minimize the cost and interruption associated with the dissemination of follow up surveys, surveys were coded. Of the 825 surveys sent in the first mailing, 300 were returned, yielding a return rate of 36%. Follow up surveys were sent only to those who did not respond to the first mailing. Of the 525 surveys sent in the second mailing, 98 were returned, yielding total return rate of 48%. Between the two mailings, there were 29 surveys returned that were unusable or incomplete; these surveys were not included in calculating the total rate of return.

Data Analysis

The demographic information and responses to the Current Practice and Perceptions of practice section were analyzed by obtaining frequency counts, percentages, means, medians, and standard deviations when applicable. To determine any statistically significant differences between male and female school psychologists' responses to relevant items, individual t-test analyses were conducted. A one-way analysis of variance (ANOVA) was conducted to determine whether years of experience or geographic region had a statistically significant impact on perceptions of mental health support, training, and functioning. A $p < .05$ was adopted to determine whether statistically significant results were found.

CHAPTER FOUR

RESULTS

Introduction

This survey research was conducted to determine school psychologists' perceptions regarding current practices, support, satisfaction, and professional competence related to the provision of mental health counseling services in the schools. In this chapter, results are presented for these research questions. In addition, there will be a discussion exploring what effects gender, years practicing, and geographic region had on the variables under investigation.

Results

The first research question of this investigation sought to determine the current practice of practicing school psychologists regarding the provision of mental health counseling services. Fifty four percent of the respondents reported they provide mental health counseling services to students ($n = 217$), while 46% ($n = 181$) indicated that they do not. In terms of hours spent counseling, respondents were given two choices to indicate how many hours in a 40 hour workweek they devoted to mental health counseling services: individual counseling and group counseling. Participants reported a mean of 4.82 hours (standard deviation (SD) = 4.88) spent on individual counseling and a mean of 2.21 hours ($SD = 3.09$) spent on group counseling services. These results indicated participants reported spending more time on individual counseling services during a typical work week.

The respondents who indicated they provide mental health counseling services in the schools ($n = 217$; 54.5%) were asked to complete additional questions. These data

are provided in Table Five in Appendix A. The following options were offered regarding the use of a theoretical framework of counseling: cognitive-behavioral, eclectic, Adlerian, play, rational emotive, psychoanalytic, Gestalt, and solution focused therapies. A majority of respondents ($n = 166$; 76.5%) indicated that they use cognitive-behavioral therapy. Solution focused ($n = 104$; 47.9%), eclectic ($n = 90$; 41.5%), play ($n = 58$; 26.7%), and rational emotive ($n = 44$; 20.3%) therapies were reported moderately by some school psychologists, whereas psychoanalytic ($n = 7$; 3.2%), Adlerian ($n = 7$; 3.2%) and Gestalt ($n = 5$; 2.3%) therapies were reported less frequently.

All respondents, regardless of their own participation in the delivery of school-based mental health counseling services, were requested to answer the following question: Do other professionals provide school-based mental health counseling services to students in your school(s)? A majority of respondents (89%; $n = 355$) indicated that other professionals provide school-based mental health counseling services. School counselors ($n = 244$) and school social workers ($n = 183$) composed the majority of other professionals who were reported to provide mental health counseling services in their schools. Teachers of students with emotional and/or behavioral disabilities ($n = 64$), outside licensed psychologists or licensed counselors hired by the school district ($n = 49$), and outside licensed social workers hired by the school district ($n = 42$) were used less frequently. Further, ninety respondents endorsed the “other” category in this area. Please refer to table six in Appendix A for additional information about school-based mental health counseling service providers.

The second research question was intended to determine the level of satisfaction of practicing school psychologists related to the provision of school-based mental health

services. Three questions related to this area: (a) “How satisfied are you by your level of involvement in the provision of school-based mental health counseling to students in your school(s)?”, (b) “How satisfied are you by the level of involvement of other professionals regarding the provision of mental health counseling services to students in your school(s)?”; and (c) “How satisfied are you by the provision of community-based mental health counseling services to students in your school(s)?” Mean scores across these areas ranged from 2.77 to 3.23, indicating that school psychologists’ perceptions of satisfaction regarding the provision of mental health services in their schools ranged from unsatisfied to neutral. Please refer to table seven in Appendix A for specific means and standard deviations per item.

The third research question in this investigation addressed school psychologists’ perceived level of support from varying school personnel. Three questions were provided: (a) “What do you perceive as your principal’s level of support regarding the provision of school-based mental health counseling services to students in your school(s)?,” (b) “What do you perceive as your director of special education/director of pupil service’s level of support regarding the provision of school-based mental health counseling services to students in your school(s)?,” and (c) “What do you perceive as the non-administrative staffs’ (i.e., faculty and other support staff) level of support regarding the provision of school-based mental health counseling services to students in your school(s)?” Descriptive statistics reveal mean scores ranged from 3.84 to 3.93 across these three areas, indicating that school psychologists perceive that others are mostly supportive of the provision of school-based mental health counseling services in the schools.

The final two questions in the perceptions of practice section addressed questions related to the respondents' personal beliefs regarding school psychologists' role and the respondents' perceived adequacy in training related to the provision of school-based mental health counseling services. The two questions were: (a) "I believe the schools are appropriate places to provide mental health counseling services to students" and (b) "I believe I have been adequately trained to provide school-based mental health counseling services to students." The mean score on the first question was 4.13, indicating that most school psychologists agreed that the schools are appropriate places to provide mental health counseling services. The mean score on the second question, the fourth research question in this study, was 3.71, indicating that school psychologists are indifferent regarding their own training and professional competence related to the provision of school-based mental health counseling services.

The fifth and final research question in this investigation intended to determine what role, if any, demographic factors played in the responses of participants. The respondents' gender, years practicing, and geographic region were explored for this study and the results will be addressed by demographic area in the following sections.

Gender Effects

To examine the impact of gender on school psychologists' perceptions of mental health support, training, and functioning, independent *t*-test analyses were conducted by item. *T*-test results indicate that item #3B ($t(110) = -3.02, p = .003$), item #16 ($t(390) = 3.16, p = .002$), and item #18 ($t(94) = 4.74, p = .000$) were effected by school the psychologist's gender. While item #3B (i.e., How many hours do you devote to group counseling per week?) indicated that females reported spending more time providing

group counseling services than males, items #16 (i.e., What is your age?) and #18 (i.e., How many years have you been working as a school psychologist?) were endorsed by more males than females, indicating the male school psychologists were older as a group. Additional information regarding these data is provided in Table Two in Appendix A.

Effects by Years of Experience

A one-way analysis of variance (ANOVA) was conducted to evaluate the effects of experience on school psychologists' perceptions of mental health support, training, and functioning. One-way ANOVA results indicated that item #12 ($F(3) = 5.25, p = .001$), item #14 ($F(3) = 2.69, p = .046$), and item #16 ($F(3) = 2.37, p = .000$) were affected by number of years practicing as a school psychologist. All three items (i.e., I feel that faculty supports mental health counseling in my school; I am adequately prepared to provide mental health counseling services in my school; and What is your age?) generated higher ratings from school psychologists who had more years of experience. More information is provided in Table Four in Appendix A related to these findings.

Effects by Geographic Region

To evaluate the effects of geographic region had on school psychologists' perceptions of mental health support, training, and functioning, one-way ANOVA analyses were conducted. One way ANOVA results demonstrated that item #2 ($F(3) = 3.99, p = .009$), item #3B ($F(3) = 3.62, p = .014$), and item #26 ($F(3) = 10.45, p = .000$) were affected by geographic region. All three items were germane to school psychologists in the northeastern portion of the United States. School psychologists in the northeast reported devoting more hours toward the provision of mental health counseling and group counseling services than school psychologists in other geographic

regions. School psychologists in the northeast also reported lower school psychologist to student ratios than the other regions (see Table Three in Appendix A).

CHAPTER FIVE

CONCLUSIONS AND DISCUSSION

Introduction

This chapter will provide a discussion regarding the general findings of this research project. This will be followed by a discussion of implications for training, limitations of the study and directions for future research. Finally, a summary of this project will be provided.

General Findings

The purpose of this study was to investigate school psychologists' current practices and beliefs regarding the provision of mental health services and determine what effect, if any, gender, years practicing, and geographic region had on respondents' responses. Practicing school psychologists' perspectives on the provision of mental health services and current practices regarding the provision of mental health counseling services were examined.

Only half of practicing school psychologists reported providing mental health counseling services to students. This is surprising, considering that the National Association of School Psychologists (NASP) considers the provision of mental health counseling services to be an integral part the role of a school psychologist (NASP, 1997). A former president of NASP recently framed school psychologists' role as mental health service providers as a professional mandate (Pfohl, 2006). The NASP mission statement itself includes language related to school psychologists' role in ensuring the mental health competence of all children (Pfohl, 2006). Moreover, NASP's most recent publication that outlines criteria for school psychology training programs, *School Psychology: A*

Blueprint for Training and Practice II, calls for training in mental health interventions and service delivery for *all* school psychologists (NASP, 1997).

Participants reported spending more time engaged in individual mental health counseling than mental health group counseling. Cognitive-behavioral therapy (CBT) was reported to be used by a majority of respondents, while solution-focused, eclectic, play, and rational-emotive therapies were reported to be used moderately by some school psychologists. Psychoanalytic, Adlerian, and Gestalt therapies were reported to be used less frequently. These findings are not surprising due to widespread empirical support for CBT; further, CBT is known for demonstrating efficacy in a relatively limited time frame (Ledley, Marx, & Heinberg, 2005). This is clearly an attractive feature in an environment with increasingly limited financial resources and increased expectations for academic performance.

A majority of respondents indicated that other professionals provide school-based mental health counseling services. School counselors and school social workers comprised the majority of other professionals who were reported to provide mental health services to students in the schools. Other professionals like teachers of students with emotional and/or behavioral disabilities, outside licensed psychologists or licensed counselors hired by the school district, and outside licensed social workers hired by the school district were reported to provide school-based counseling services less frequently.

School psychologists reported being unsatisfied to neutral regarding their own involvement, the level of involvement of other professionals, and community-based mental health counseling services for students in their schools. The respondents generally perceived principals, directors of special education/directors of pupil services,

and non-administrative staff to be indifferent regarding the provision of mental health counseling in the schools.

Not surprisingly, school psychologists consistently agreed that the schools are appropriate places in which to provide mental health counseling services. However, with regard to the adequacy of their own training and professional competence related to the provision of mental health counseling in the schools, school psychologists appeared indifferent. Again, this suggests incongruence between the scope of school psychology from NASP's viewpoint and what is actually occurring in the field; this item also has obvious implications for school psychology training programs in terms of school psychologists' need for additional preparation to provide mental health counseling services in the schools.

The gender of school psychologists responding in this study had a statistically significant impact on several items. Female school psychologists reported spending more time engaged in group mental health counseling service delivery; male school psychologists reported having more years of experience, indicating male school psychologists are older as a group.

Years of experience had a statistically significant effect on several items. School psychologists with more years of experience indicated greater perception of faculty support with regard to the provision of mental health services in the schools. This seems logical as more years of experience would likely engender greater familiarity with school staff, thereby strengthening collaborative relationships and making them more aware of the areas of expertise of their school psychologist. More experienced school psychologists also asserted greater confidence in their own adequacy as mental health

counseling service providers. This finding is not surprising. Ostensibly, more years of experience would logically lead to greater feelings of confidence in one's own professional competence. As expected, school psychologists with greater years of experience reported being older.

Finally, the geographic region of school psychologists was found to have a statistically significant impact on several variables. Interestingly, differences in all three of the variables were due to practice differences attributable to the northeastern region of the United States. School psychologists in the northeast reported lower student to school psychologist ratios. Moreover, school psychologists in the northeast reported devoting more time to both individual and group mental health counseling service delivery. Having lower school psychologist to student ratios would likely result in less time spent on the due process paperwork and time consuming evaluations for which the field of school psychology is known. Having to devote less time to paperwork and evaluations due to working with fewer students would allow more time for the provision of individual and group mental health counseling services. Thus, it is logical to deduce that lower school psychologist to student ratios would create more opportunities for the provision of mental health counseling services in the schools.

Implications for training

Perhaps the most salient finding in this study was the overall perception of ambivalence of school psychologists regarding their perception of adequacy in providing mental health counseling services. While NASP clearly indicates that the provision of mental health counseling services is an integral piece of the role of the school psychologist, many respondents reported they are uncertain about their own level of

professional competence in this area. This information could provide an impetus for school psychology training programs nationwide to enhance the mental health counseling component of their programs.

Only about half of practicing school psychologists surveyed indicated they provide mental health services at all. It would seem that there is inconsistency in the message being sent by NASP and what is actually occurring in the field. Perhaps more discussion should occur among the leadership in the field of school psychology to address this discrepancy. If only about half of practicing school psychologists provide mental health counseling services, it would seem illogical to spend a significant volume of precious time addressing the skills associated with the provision of mental health counseling in training programs; particularly when considering the scope of knowledge required in the field of school psychology.

Another finding was that school psychologists reported being unsatisfied regarding their own involvement in the provision of mental health counseling services. Although such an investigation would be outside the scope of this research, it may be interesting to note what, if any, relationship exists between school psychologists' level of satisfaction and their perceptions of professional adequacy and level of training in the provision of mental health services.

Limitations and directions for future research

There are some limitations that emphasize the need to interpret the results of this study with caution. First, participants were limited to practicing school psychologists who were members of NASP. Therefore, the study did not include the significant number of school psychologists nationwide that are not NASP members. While this

study could be considered a valid estimate of NASP members' perceptions and current practice regarding the provision of mental health services in the schools, further generalization to school psychologists as a whole would be inappropriate. Moreover, respondents in this study could have been influenced by NASP's position statements or the other professional literature provided solely to NASP members. Nonmembers may have differing views and experiences than members.

A second limitation of this study is that only school psychologists' perspectives of the level of support and current practice were explored. Future research should examine other educational professionals' perspectives on the provision of mental health services. Because school administrators and directors of special education/pupil services play an integral role in the allocation of professional resources in this area, future research should consider the opinions and perceptions of these groups related to the provision of mental health services in the schools. The results of these investigations would be particularly interesting when viewed in lieu of the perceived relationship between students' mental health and academic achievement, especially with the relatively far reaching impact of NCLB in determining the allocation of educational resources.

Finally, this study only examined school psychologists' subjective perceptions of the level of support and current practice regarding the provision of mental health counseling services. A more objective examination would include direct observations or empirical experimentation.

Summary

Since the advent of NCLB, American schools have been compelled to place unprecedented emphasis on core academic areas due to the increased pressure from

standardized testing with consequences for schools that do not meet standards. While some contend that students' mental health needs must first be met in order for effective learning to occur, some assert that a more traditional emphasis on core academic areas is necessary.

Given school psychologists' integral role in the provision of mental health services in the schools, this survey research was conducted to determine their perceptions of satisfaction, competence, current practices, perceived level of support, and adequacy of training regarding mental health counseling services. In addition, this study sought to determine if gender, years of experience, and geographic region had any effect on respondents' answers. Results indicate that about half of school psychologists provide mental health counseling services to students in the schools. Other results found school psychologists reported having indifferent beliefs regarding the adequacy of their own training with regard to providing mental health services in the schools. Several other factors were found to be influenced by gender, years of experience, and geographic region.

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APPENDIX A

TABLES

Table 1

School Psychologists' Demographics

Characteristic	<i>N</i>	%
Gender		
Female	324	81.4
Male	74	18.6
Ethnicity		
White/Caucasian	362	91.2
Asian American	5	1.3
Native American	1	.30
African American	15	3.8
Hispanic/Latino	8	2.0
Other	1	.30
Multi-racial	5	1.3
Years of Experience		
1-5	97	24.7
6-10	98	25.0
11-20	102	26.0
21+	95	24.2

Table 1 (*continued*)*School Psychologists' Demographics*

Characteristic	<i>N</i>	%
Highest Degree Held		
M.S./M.A./M.Ed.	19	4.8
M.S./M.A + 15	16	4.0
M.S./M.A. + 30	137	34.4
Ed.S.	136	34.2
S.S.P	2	.50
Ph.D/Ed.D/Psy.D.	84	21.1
Certificate in Advanced Graduate Study (CAGS)	4	1.0
Employment Status		
Full-time	354	88.9
Part-time	42	10.6
Recent retire/consultant	2	.50
National Certification Status		
Nationally Certified	196	49.4
Not Nationally Certified	201	50.6

Table 1 (*continued*)*School Psychologists' Demographics*

Characteristic	<i>N</i>	%
<i>School District Characterization</i>		
Urban	91	22.9
Suburban	209	52.5
Rural	72	18.1
Urban/Suburban	9	2.3
Urban/Rural	3	.80
Suburban/Rural	9	2.3
Urban/Suburban/Rural	4	1.0

Table 2

Effects of Gender on School Psychologists' Perceptions of Support & Current Practice

Item	Male			Female		
	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>
Hours - mental health counseling	44	6.73	5.51	170	7.04	5.99
Hours - individual counseling	43	5.37	5.07	169	4.67	4.83
Hours - group counseling	43	1.28	1.93	172	2.45	3.28
Satisfaction with personal involvement	72	3.07	1.03	322	3.13	1.13
Satisfaction with involvement of others	72	3.19	1.02	321	3.24	1.14
Satisfaction with community mental health counseling services	72	2.75	1.03	318	2.78	1.03
Level of support from principal	72	3.92	.75	318	3.85	.97
Level of support from special education/pupil services director	71	3.82	.98	318	3.85	.97
Level of support from faculty	72	3.93	.66	319	3.93	.78
Belief that that schools should provide mental health counseling	73	4.04	.87	324	4.15	.73
Belief of training adequacy	73	3.81	1.14	323	3.68	1.08
Age of respondent	74	48.42	11.12	318	43.95	10.89

Table 2 (continued)

Effects of Gender on School Psychologists' Perceptions of Support & Current Practice

Item	Male			Female		
	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>
Years practicing	72	18.89	10.55	320	12.56	8.75
Number of schools	69	3.54	3.63	304	3.21	4.02
School psychologist to student ratio	68	1821	1676	300	1538	1305

Table 3

Effects of Region on School Psychologists' Perceptions of Support & Current Practice

Item	<i>Northeast</i>			<i>South</i>			<i>Midwest</i>			<i>West</i>		
	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>
Hours – mental health counseling	73	8.36	5.88	74	5.19	4.98	24	7.42	7.31	40	7.70	5.99
Hours – individual counseling	74	5.46	4.60	71	3.63	4.20	24	6.17	6.55	40	4.95	5.24
Hours – group counseling	75	2.93	3.63	73	1.59	2.25	24	1.25	1.73	40	2.75	3.66
Satisfaction – personal involvement	117	3.20	1.17	150	2.98	1.11	47	3.36	1.03	77	3.09	1.03
Satisfaction – involvement of others	117	3.36	1.20	149	3.13	1.10	47	3.40	1.08	77	3.09	1.04
Satisfaction – community services	116	2.78	1.04	148	2.75	1.02	45	2.80	1.04	78	2.78	1.05
Support – principal	117	3.84	.92	148	3.83	.74	45	3.87	.73	77	3.92	.89
Support – directors	112	3.89	1.00	149	3.85	.96	47	3.83	.82	78	3.73	1.03
Support – faculty	116	3.91	.73	148	3.99	.76	46	3.89	.67	78	3.87	.83

Table 3 (continued)

Effects of Region on School Psychologists' Perceptions of Support & Current Practice

Item	<i>Northeast</i>			<i>South</i>			<i>Midwest</i>			<i>West</i>		
	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>
Belief – schools should provide	118	4.07	.83	151	4.21	.75	47	4.11	.79	78	4.08	.64
Belief – adequately trained	117	3.67	1.21	151	3.67	1.09	47	3.85	.91	78	3.76	1.00
Age of respondent	117	46.3	11.2	147	43.9	11.1	47	42.2	9.8	78	45.7	11.3
Years of experience	117	14.1	9.1	151	14	10	46	12.3	7.8	75	13.4	9.5
Number of schools	113	2.45	2.20	143	3.73	4.74	43	3.30	2.34	71	3.61	4.96
School psychologist to student ratio	110	1003	720	141	1858	1291	43	1696	1461	71	1917	1949

Table 4

Effects of Years of Experience on School Psychologists' Perceptions of Support & Current Practice

Item	01-05 Years			06-10 Years			11-20 Years			21 Years plus		
	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>
Hours – mental health counseling	58	6.16	5.15	53	7.81	6.61	52	7.04	6.08	48	7.23	5.75
Hours – individual counseling	57	4.32	4.53	52	5.25	5.25	51	5.08	5.02	49	4.86	4.88
Hours – group counseling	58	1.91	2.40	53	2.66	4.17	52	2.10	2.82	49	2.27	2.83
Satisfaction – personal involvement	97	3.03	1.15	96	3.01	1.06	101	3.13	1.07	94	3.31	1.15
Satisfaction – involvement of others	96	3.19	1.17	96	3.17	1.08	101	3.22	1.09	94	3.36	1.14
Satisfaction – community services	96	2.83	1.08	94	2.83	1.02	101	2.54	.92	93	2.85	1.07
Support – principal	94	3.72	.82	95	3.84	.76	101	3.38	.92	94	4.04	.76
Support – directors	97	3.97	.87	95	3.77	1.04	100	3.68	1.04	91	3.96	.92
Support – faculty	96	3.75	.96	.78	96	.75	100	3.84	.80	93	4.15	.64

Table 4 (continued)

Effects of Years of Experience on School Psychologists' Perceptions of Support & Current Practice

Item	01-05 Years			06-10 Years			11-20 Years			21 Years plus		
	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>
Belief – schools should provide	97	4.09	.86	98	4.07	.82	102	4.10	.71	94	4.28	.66
Belief – adequately trained	97	3.77	1.07	97	3.75	1.10	102	3.45	1.14	94	3.86	1.04
Age of respondent	96	33.9	7.63	98	40.7	9.07	99	49.0	7.65	94	55.8	4.71
Number of schools	91	3.85	5.59	93	3.49	3.55	97	2.40	1.72	88	3.32	3.85
School psychologist to student ratio	88	1709	1892	92	1511	1079	94	1547	1437	90	1570	958

Table 5

Types of Mental Health Counseling Techniques Used

Item	N	%
Mental Health- Cognitive-Behavioral	166	76.5
Mental Health- Eclectic	90	41.5
Mental Health- Adlerian	7	3.2
Mental Health- Play Therapy	58	26.7
Mental Health- Rational Emotive	44	11.1
Mental Health- Psychoanalytic	7	3.2
Mental Health- Gestalt	5	2.3
Mental Health- Solution-Focused	104	47.9

Table 6

Other Types of Professionals Providing Student Mental Health Services

Item	<i>N</i>	%
Other professionals provide services	355	89.2
Professional- School Counselor	244	68.7
Professional- School Social Worker	183	51.5
Professional- EBD Teacher	64	18.0
Professional- Outside Social Worker	42	11.8
Professional- Outside Psychologist/Counselor	49	13.8
Professional- Other	90	25.4

Table 7

Perceptions of Practice

Item	<i>N</i>	<i>M</i>	<i>SD</i>
Satisfied- level of involvement	394	3.14	1.11
Satisfied- other's level of involvement	393	3.23	1.12
Satisfied- community involvement	390	2.77	1.03
Perception- principal's support	390	3.86	.82
Perception- special ed director/director of pupil services	389	3.84	.97
Perception- faculty support	391	3.93	.76
Belief- schools provide counseling	397	4.13	.76
Belief- Adequately trained	396	3.71	1.09

APPENDIX B
SURVEY INSTRUMENT

Insert IRB research .jpg here

RIEBE SCHOOL PSYCHOLOGY SURVEY

Please respond to the following questions or statements based upon the following definition of school based mental health counseling services:

Any counseling or socio-emotional supportive services in which a staff member of a school works with a student or group of students with the exclusive purpose of engendering social, emotional, behavioral or cognitive changes in functioning.

Current Practice Section

1. Do you, as a school psychologist, provide school-based mental health counseling services to students in your school(s)?
 Yes – continue with question #2
 No - skip to question #5

2. In your current job, how many hours do you devote to school-based mental health counseling per week (assuming a 40 hour work-week)? _____ hours per week

3. Please indicate the number of hours per week you devote to each of the following activities in the schools (assuming a 40 hour workweek):
 Individual counseling: _____ hours per week Group counseling: _____ hours per week

4. If you use specific mental health counseling techniques, which do you use? (Check all that apply)
 Cognitive-behavioral therapy Rational Emotive Behavioral Therapy
 Eclectic Psychoanalytic therapy
 Adlerian Therapy Gestalt Therapy
 Play therapy Solution Focused Therapy
 Other (please describe): _____

5. Do other professionals provide school-based mental health counseling services to students in your school(s)?
 Yes – continue with question #6
 No – skip to question #7

6. Please indicate those professionals who provide school-based mental health counseling in your school(s): (check all that apply)
 School Counselor
 School Social Worker
 Emotional-Behavioral Disorder Teacher
 Outside licensed social worker hired by your district
 Outside licensed psychologist or licensed counselor hired by your district

Perceptions of Practice Section

7. How satisfied are you by your level of involvement in the provision of school-based mental health counseling to students in your school(s)?
- | | | | | |
|---------------------|-------------|---------|-----------|-------------------|
| 1 | 2 | 3 | 4 | 5 |
| Very
Unsatisfied | Unsatisfied | Neutral | Satisfied | Very
Satisfied |
8. How satisfied are you by the level of involvement of other professionals regarding the provision of mental health counseling services to students in your school(s)?
- | | | | | |
|---------------------|-------------|---------|-----------|-------------------|
| 1 | 2 | 3 | 4 | 5 |
| Very
Unsatisfied | Unsatisfied | Neutral | Satisfied | Very
Satisfied |
9. How satisfied are you by the provision of *community-based* mental health counseling services to students in your school(s)?
- | | | | | |
|---------------------|-------------|---------|-----------|-------------------|
| 1 | 2 | 3 | 4 | 5 |
| Very
Unsatisfied | Unsatisfied | Neutral | Satisfied | Very
Satisfied |
10. What do you perceive as your principal's level of support regarding the provision of school-based mental health counseling services to students in your school(s)?
- | | | | | |
|----------------------|--------------|-------------|------------|--------------------|
| 1 | 2 | 3 | 4 | 5 |
| Very
Unsupportive | Unsupportive | Indifferent | Supportive | Very
Supportive |
11. What do you perceive as your director of special education/director of pupil service's level of support regarding the provision of school-based mental health counseling services to students in your school (s)?
- | | | | | |
|----------------------|--------------|-------------|------------|--------------------|
| 1 | 2 | 3 | 4 | 5 |
| Very
Unsupportive | Unsupportive | Indifferent | Supportive | Very
Supportive |
12. What do you perceive as the non-administrative staffs' (i.e., faculty and other support staff) level of support regarding the provision of school-based mental health counseling services to students in your school(s)?
- | | | | | |
|----------------------|--------------|-------------|------------|--------------------|
| 1 | 2 | 3 | 4 | 5 |
| Very
Unsupportive | Unsupportive | Indifferent | Supportive | Very
Supportive |
13. I believe the schools are appropriate places to provide mental health counseling services to students.
- | | | | | |
|----------------------|----------|-------------|-------|-------------------|
| 1 | 2 | 3 | 4 | 5 |
| Strongly
Disagree | Disagree | Indifferent | Agree | Strongly
Agree |
14. I believe I have been adequately trained to provide school-based mental health counseling services to students.
- | | | | | |
|----------------------|----------|-------------|-------|-------------------|
| 1 | 2 | 3 | 4 | 5 |
| Strongly
Disagree | Disagree | Indifferent | Agree | Strongly
Agree |

Demographic Section

15. Gender:
 male female
16. Age: _____ years old
17. Ethnicity (please check all that apply):
 White/Caucasian Pacific Islander
 Asian American Hispanic/Latino
 Native American Other (please describe): _____
 African American
18. Number of years as a school psychologist: _____ years
19. Highest degree held:
 M.S. M.S. + 15 M.S. + 30 Ed.S. Ph.D.
20. Employment status:
 full-time part-time
21. Are you a Nationally Certified School Psychologist?
 yes no
22. Please characterize the school district in which you work (please circle):
 Urban Suburban Rural
23. In which state do you work as a school psychologist? _____
28. What grade levels do you serve? (check all that apply)
 Elementary High School
 Intermediate K-12
 Middle/Jr. High Other (please describe)

29. How many schools do you serve?

30. What is the school psychologist to student ratio
 in your district or agency? One (1) school psychologist to _____ students

Please provide any additional comments you would like to make regarding the provision of mental health services in the schools:

Thank You!

APPENDIX C
COVER LETTER

Dear NASP member:

I am a school psychology graduate student studying at the University of Wisconsin-Stout. I am studying under the supervision of Dr. Jacalyn Weissenburger, Associate Professor.

I am interested in studying the perceptions and practice of school psychologists regarding the **provision of mental health counseling services** in the schools. Although much has been written regarding the provision of mental health services in the schools, little information has been solicited from practicing school psychologists. It is important to gain information from the “front-line workers” in the field . . . people like you!

Participation in this study is voluntary. To reduce the costs and interruption associated with the dissemination of follow-up questionnaires, your survey contains a coded number. All results will be kept confidential; only group results will be reported. You may refuse to participate or terminate your participation in this study at any time.

If you choose to participate, please read the enclosed questionnaire and answer the questions. The questionnaire is divided into three brief sections: current practice, perceptions of practice, and demographic information. This questionnaire should take 10 to 15 minutes to complete. After completion, you can return the questionnaire in the postage-paid envelope. If you wish to receive a summary of the results, please include a self-addressed stamped envelope with your survey.

If you have any questions regarding this study, please contact Jason Riebe at riebej@uwstout.edu or Dr. Jackie Weissenburger at (715) 232-1326. Any questions regarding your rights as a research subject may be directed to John Thompson, UW-Stout’s Research Coordinator, at (715) 232-2170.

Your response is very important to the success of this study. The information gleaned from this study will be used to inform future training and practice and provide valuable insight into the perceptions and current practice of school psychologists in different areas of the country. Thank you for your time and cooperation. Your participation is greatly appreciated!

Sincerely,

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