September 2018

Recommendations for the Role and Responsibilities of School-Based Mental Health Counselors

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Abstract

School counselors (SCs) are tasked with addressing the academic, career, and personal/social development of all students. As mental health issues experienced by school-aged children have increased, SCs have been unable to provide adequate mental health services. Because of barriers to receiving community-based mental health services, school-based services are becoming increasingly necessary. In this article we propose that School-Based Mental Health Counselors (SBMHCs), specifically trained to work with school-aged children and placed within a school setting, are appropriate for meeting students' mental health needs. Although SBMHCs are not new to counseling, we make specific recommendations and suggestions for the training and practice of SBMHCs so that they can collaborate with SCs to meet the mental health needs of all students.

Keywords: School-based mental health counseling, school counseling, mental health counseling, student mental health

Introduction

School-aged children are experiencing an increase in issues warranting mental health services. Although school counselors (SC) are tasked with addressing the mental health needs of all students, their role and responsibilities, as outlined by the American School Counselor Association (ASCA, 2012a), and time and training limitations prevent them from meeting the mental health needs of all students. In this case, SCs provide referrals to services provided by community-based clinical mental health counselors (CMHC). Although CMHCs are equipped to provide the necessary therapeutic services, barriers often prevent students from receiving the help they need (Adelman & Taylor, 2010; Becker, Buckingham, & Brandt, 2015; Center for Disease Control and Prevention [CDC], 2017a; DeKruyf, Auger, & Trice-Black, 2013; Kaffenberger & O'Rorke-Trigiani, 2013; Owens et al., 2002; Patel, Flisher, Hetrick, & McGorry, 2007). To ensure students receive appropriate services, some schools collaborate with CMHCs to provide mental health counseling on campus. We will refer to these providers as school-based mental health counselors (SBMHC).

For this paper, SBMHCs are trained and credentialed CMHCs, addressing the mental health needs of school-aged children on a school campus through evidence-based practices (EBP) in their provision of mental health services (ASCA, 2012b; Stephan, Sugai, Level, & Connors, 2015). Some SBMHCs are school-employed while others are contracted through community agencies (Doll, Nastasi, Cornell, & Song, 2017). Existing literature on the use of non-school credential mental health professions to meet students' mental health needs in schools fails to address SBMHCs and their relationship to SCs specifically (Becker et al., 2015; Doll et al., 2017; Stephan et al., 2015). The purpose of this article is to provide recommendations for the role and responsibilities of SBMHCs based on historical developments and current needs that can be used to inform policy related to mental health.

Mental Health of School-Aged Children

Data indicate that approximately 14-20% of all school-aged children struggle with mental health issues (Adelman & Taylor, 2010; CDC, 2013). Roll, Kennedy, Tran, and Howell (2013) reported that, from National Health Interview Survey data, these numbers are increasing. According to the same data, Simon, Pastor, Reuben, Huang, and Goldstrom (2015) reported that approximately 23% of children ages 6-11 have some form of mental health issue. In 2013, the CDC released a report describing the current state of mental health of children ages 3-17 in the United States (US). Children across the US have been diagnosed with anxiety, depression, ADHD, and other childhood mental disorders. According to a report released by the National Research Council and Institute of Medicine (2009), approximately 13-20% of children experience symptoms of a mental disorder each year, costing $247 billion to treat. Moreover, 6.8% of children aged 3-17 have been diagnosed with ADHD, 3.5% with behavioral or conduct problems, 3% with anxiety, 2.1% with depression, and 1.1% with autism spectrum disorder (CDC, 2013). Regarding substance use disorders, in youth aged 12-17, 4.7% have an illicit drug use disorder, 4.2% have alcohol use disorder, and 2.8% reported cigarette dependence (CDC, 2013). As of 2015, suicide, often a result of both mental illness and substance abuse, was the third leading cause of death for US youth aged 10-14 and

the second leading cause of death for youth aged 15-24 (CDC, 2015).

International statistics are similar, with Patel et al. (2007) noting that "mental disorders account for a large proportion of the disease burden in young people in all societies" (p. 1302). According to the World Health Organization (WHO, 2017), 10-20% of children and adolescents experience symptoms of mental illness. Patel et al. (2007) reported that the prevalence of school-aged children diagnosed with mental health disorders ranged from 8% in the Netherlands, 12% in the United Kingdom, 13% in Brazil and India, 14% in Australia, 15% in South Africa, and 21% in the US. Mental disorders most prevalent worldwide were depression, substance abuse disorders, and self-injurious behaviors (Patel et al., 2007). Like the US, suicide is the second leading cause of death for youth internationally (Hawton, Saunders, & O'Connor, 2012). Clearly, mental disorders in school-aged children are an international issue that needs to be addressed.

According to the CDC (2013), early identification of mental health issues is important for school success. ASCA (2009) also acknowledges that unmet mental health needs can impede the academic, career, and personal/social development of students. Students with mental health diagnoses typically have worse academic outcomes (Auger, 2011), and over half of all students who drop out have a diagnosed mental disorder (Vander Stoep, Weiss, Kuo, Cheney, & Cohen, 2003). Kelly (2013) noted that, although not all issues school-aged children face warrant a mental health diagnosis, the issues often affect academic and personal/social development. Finally, Reback (2010) noted that improved mental health can improve academic performance and career achievement.

According to the CDC (2017a) "schools can be a convenient setting for children and families to access health care, especially in rural or isolated areas" (para. 7). Simon et al. (2015) reported in 2010-2012 that, of the 23% of children ages 6-11 identified with mental illness, only 53% received treatment. Of those receiving treatment, 18.6 % of students exclusively received school-based services, 11.4% of students exclusively received non-school-based services, and 17.3% received both (Simon et al., 2015). Atkins, Hoagwood, Kutash, and Siedman (2010) reported that 70-80% of school-aged children receiving mental health services do so at school. Kolbert, Williams, Morgan, Crothers, and Hughes (2017) reported that, although school counselors are directed to refer school-aged children requiring mental health services to appropriate resources, few families follow through with seeking services outside of the school building. Research indicates that providing mental health services at school can lead to improved academic performance and personal/social functioning

(Carrell & Carrell, 2006; Reback, 2010; Whiston, Tai, Rahardja, & Eder, 2011).

From this data, school-based treatment is an important avenue for addressing students' mental health needs. To ensure school-aged children receive appropriate mental health services, the CDC (2017a) encourages inter-professional collaboration between mental health care providers and SCs. For this article, we propose that SBMHCs, specifically trained to work with school-aged children and placed within a school setting, are appropriate for meeting students' mental health needs. We offer specific recommendations and suggestions for the training and practice of SBMHCs to encourage collaboration with SCs and inform policy.

School Counseling
History of School Counseling

Throughout its 110-year history, school counseling in the US has experienced changes related to name, role and responsibility, and focus due to political and social forces (Kolbert et al., 2017). In the late 19th and early 20th centuries, a need for vocational guidance arose from division of labor, technological innovation, increased post-secondary training options, and increased choice regarding career direction (Brewer, 1942; Kolbert et al., 2017). As both education and work options increased, students needed help exploring and choosing a career path (Gysbers, 2010). Because of this focus on vocational guidance, the professionals providing those services were considered vocational or guidance counselors. Although the training for guidance services appeared as early as 1911, and by 1928, there were approximately 70 colleges offering training, there were still few trained guidance counselors employed within school settings (Kolbert et al., 2017). By the mid-20th century, many vocational and personal issues were addressed predominantly by educators in the classroom, emphasizing the vocational and educational focus of guidance services provided within a school (Kolbert et al., 2017). Because of this initial educational focus, state departments of education often oversaw credentialing for SCs, and early on a requirement for credentialing often included prior experience as a classroom teacher (Kolbert et al., 2017).

Over time, guidance counselors received training emphasizing a psychological orientation from faculty with CMHC backgrounds (Kolbert et al., 2017). This training paradigm shift likely caused the change in focus from vocation to personal/social development noted by Gysbers (2010). During this time, many states removed the teaching requirement for becoming a SC and, as of 2015, only eight states require teaching experience for credentialing: Kansas, Kentucky, Louisiana, Nebraska, North Dakota, Oregon, and Texas (Kolbert et al., 2017). Along with this reconceptualization of role and focus came the call for a new name; in 1993, ASCA

called for guidance counselors to become known as professional school counselors or school counselors (Kolbert et al., 2017).

In 1988, ASCA adopted a recently-revised position statement requesting the creation of comprehensive school counseling programs that are "preventive in design and developmental in nature" (2017, p. 17) and address the academic, career, and personal/social needs of all students. In 1997, Campbell and Dahir published *Sharing the Vision: The National Standards for School Counseling Programs* that would lead to the 2003 publication of the *ASCA National Model: A Framework for School Counseling Programs*, now in its third edition (ASCA, 2012a). ASCA's model and call for comprehensive school counseling programs that address the needs of all students have been pivotal in the training of SCs and the role SCs play in schools.

Training of School Counselors

The training of SCs in the US has undergone various changes over the past 110 years. A field once dominated by vocational guidance has become a field seeking to train future SCs with a balance of knowledge and skills to address the academic, career, and personal/social needs of all students. The Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016) has an established, standardized curriculum designed to prepare SCs. According to CACREP, "students who are preparing to specialize as school counselors will demonstrate the professional knowledge and skills necessary to promote the academic, career, and personal/social development of all P–12 students through data-informed school counseling programs" (CACREP, 2016, p. 33). Graduates of a CACREP-accredited school counseling program must complete a master's degree comprised of a minimum of 48 credit hours covering 8 common core counseling areas and school counseling specific standards. School counseling standards are related to the foundation of school counseling, contextual dimensions of school counseling, and the practice of school counseling. Finally, all students in a CACREP-accredited school counseling program must complete supervised professional practice where they provide direct services (e.g. assessment, counseling, psycho-educational activities, and consultation) to students and families. The initial professional practice, or practicum experience, totals a minimum of 100 clock hours (40 hours of direct services) and must be completed before a 600 clock hour (240 hours of direct services) supervised internship experience. Based on the common core areas, school counseling specific standards, and supervised professional practice requirements, CACREP views SCs as psychological, not educational, in nature. To ensure a psychological and educational balance, training programs can use the ASCA School Counselor

Competencies (ASCA, 2012a) so that SCs "are equipped to establish, maintain and enhance a comprehensive school counseling program addressing academic achievement, career planning and personal/social development" (p. 1) of all students.

Role of School Counselors

To clarify the role of SCs, ASCA introduced the *ASCA National Model: A Framework for School Counseling Programs* (ASCA, 2012a). According to the model, school counselors are tasked with creating comprehensive and developmentally-appropriate counseling programs that are preventative in nature and address the academic, career, and personal/social development of all students (ASCA, 2012a). SCs engage in leadership, advocacy, collaboration, and systemic change (ASCA, 2012a), intending to remove barriers to educational access. SCs believe that their programs are vital to the development of all students and play an integral role in student success (DeKruyf et al., 2013).

School counselors implement their comprehensive school counseling programs using direct and indirect services with the overall goal of removing barriers to education access. Direct services include delivering core curriculum through classroom and small group lessons, engaging in individual planning with students, and providing responsive services through individual or small-group counseling and crisis response (ASCA, 2012a). Indirect services, such as referrals, consultation, and collaboration directly affect students via the work of people other than SCs (ASCA, 2012a). For this article, it is important to note that ASCA stipulates that, although it is appropriate to address issues that impede achievement through short-term counseling (Kolbert et al., 2017), SCs "do not provide therapy or long-term counseling in schools to address psychological disorders" (ASCA, 2012a, p. 86). Instead, when SCs determine that long-term counseling is required, they refer students to appropriate mental health resources (ASCA, 2009). After SCs make referrals, the level of consultation and/or collaboration between the SC and the other mental health provider depends on the specifics of the situation.

Limitations of School Counselors

As previously mentioned, the emphasis of school counseling has oscillated between an educational focus and a psychological focus (Gysbers, 2010; Kolbert et al., 2017). Due to the current emphasis on academic accountability, SCs face pressure, from administrators and other stakeholders, to focus more time and attention on data-driven interventions that impact academic success (DeKruyf et al., 2013; Dimmitt, Carey, & Hatch, 2007); this leaves less time to address students' mental health needs. Brown, Dahlbeck, and Sparkman-Barnes (2006) reported that, although most school counselors

believe they should be providing counseling services to students with mental health needs, the lack of time and support limited their ability to do so.

DeKruyf et al. (2013) stated that "it may be time to affirm a vision of school counselor identity with an increased focus on meeting the mental health needs of students, and embrace an identity in which school counselors can view themselves as both educational leaders and mental health professional" (p. 272). It is true that SCs have an intimate knowledge of school climate, student behavior, teacher personality, and the daily functioning of schools (Maag & Katsiyannis, 2010). It is also true that "school counselors are uniquely qualified and solely eligible to meet the requirements of designing and implementing" comprehensive school counseling programs (ASCA, 2012b, p. 64) and these programs benefit students in various was (Kaffenberger & O'Rorke-Trigiani, 2013; Reback, 2010). However, school counselors are often limited in their ability to meet the mental health needs of students due to insufficient time and insufficient training (Carlson & Kees, 2013; Kaffenberger, 2011). Each of these limitations is described in detail below.

Insufficient time. As of 2013-2014, the average student-to-counselor ratio in the US was 491:1 (ASCA, n.d.). The recommended ratio to achieve maximum program effectiveness is 250:1 (ASCA, 2012a). On average, SCs have a caseload twice the size recommended by ASCA. To understand how such a large caseload affects the ability for SCs to meet the mental health needs of their students, it is necessary to explore further the mental health needs of their 490 students. Using aforementioned data, approximately 17% of school-aged children need mental health services. That means that the average SC has approximately 83 students on their caseload in need of services. Further, approximately 75% of school-aged students in need of mental health services receive those services at school; on average, approximately 62 students on every SC's caseload would likely benefit from receiving mental health services on campus. There are simply not enough hours in the week for SCs to provide mental health counseling to all of their students in need, let alone provide those services on top of the other direct and indirect student services prescribed by the ASCA model (2012a). Kolbert et al. (2017) noted that, as school counseling has shifted from being an intervention-based model, focused on at-risk students, to a prevention-based model, focused on all students, SCs have been discouraged to work with individual students as it is not the most efficient use of time.

Insufficient training. Although CACREP standards ensure a certain level of quality and rigor regarding the training of SCs, closer inspection to determine if the training provided by counselor education programs prepare SCs to address the mental health needs of their students is warranted. Kaffenberger and O'Rorke-Trigiani (2013) reported that a major training deficit is that CACREP does not require SCs to take any courses related to psychopathology. This remains true with the 2016 Standards (CACREP, 2016). In addition, the SC specialty area has significantly more area standards than CMHC, often resulting in more time being spent on those specific standards and less time being spent on standards related to addressing the mental health needs of students. Carlson and Kees (2013) reported that school counselors who took courses related to counseling skills, child and adolescent, couples, and family counseling, psychopathology and diagnostic criteria, school counseling, and substance use appeared to be more confident working with students with mental health diagnoses. Finally, although students in SC programs are required to be able to identify warning signs of mental health issues, they are only required to be able to utilize techniques to foster personal/social growth (CACREP, 2016). Alternatively, CMHC students are not only required to understand the etiology, risk factors, and warning signs related to mental health issues; they are also required to be able to address a "broad range of mental health issues" (CACREP, 2016, p. 25). Clearly, the training SCs receive is insufficient to address the mental health needs of all students.

Recommendations

Although we agree with previous literature calling for SCs to recognize their role as mental health experts in schools (ASCA, 2009) and provide more mental health services to their students (DeKruyf et al., 2013; Kaffenberger & O'Rorke-Trigiani, 2013; Keys, Bemak, & Lockhart, 1998), we also recognize that, due to the previously-mentioned limitations, as well as ASCA's (2012a, 2012b) recommendations, SCs must utilize other mental health professionals to meet the mental health needs of students. Further, ethical guidelines mandate SCs provide appropriate referrals as well as ensure transition of services with minimal interruption (ASCA, 2016). Therefore, we recommend that SCs strive to implement comprehensive school counseling programs that are preventive in nature, but responsive when necessary (ASCA, 2012a). As mental health professionals in schools, SCs address any mental health issues that impede the academic, career, and personal/social success of all students (Kaffenberger & O'Rorke-Trigiani, 2013), while knowing the limitations of their training as well as time constraints. To meet their students' needs, SCs should serve as a type of mental health triage, assessing the type of services required (Kolbert et al., 2017) and referring students to CMHCs when necessary (ASCA, 2012a).

Clinical Mental Health Counseling

History of Clinical Mental Health Counseling

The American Mental Health Counselors Association (AMHCA) was created to recognize and support non-school counselors in community and agency settings and, in 1979, established the standards for certification through examination of CMHCs (Weikel, 1985). CMHCs serve in a range of clinical practice that includes "diagnosis and treatment of mental and emotional disorders, psychoeducational techniques aimed at the prevention of mental and emotional disorders, consultations to individuals, couples, families, groups, organizations and communities, and clinical research into more effective psychotherapeutic treatment modalities" (AMHCA, 2016, p. 2).

Training of Clinical Mental Health Counselors

According to CACREP, "students who are preparing to specialize as clinical mental health counselors will demonstrate the knowledge and skills necessary to address a wide variety of circumstances within the context of clinical mental health counseling." (CACREP, 2016, p. 24). Graduates of a CACREP-accredited CMHC program must complete a master's degree comprised of 60 credit hours, covering the same eight common core counseling areas as SCs in training. CMHC programs must also provide students with coursework related to the foundation, contextual dimensions, and practice of mental health counseling. Students in the CMHC program also complete supervised professional practice consisting of a 100 clock hour (40 hours of direct services) practicum and a 600 clock hour (240 hours of direct services) supervised internship experience.

Role of Clinical Mental Health Counselors

According to Mobley (2016), the term "clinical mental health counselor" describes all licensed individuals practicing in a clinical health care environment. CMHCs are "trained to use helping skills to build a relationship, address needs of the whole person from a wellness perspective, and focus on clients' empowerment within their cultural context" (Mobley, 2016, p. 2). According to AMHCA (2016), counseling services involve the provision of developmentally appropriate psychotherapy to individuals, couples, families, and groups, to promote mental health and wellness.

Most CMHCs are licensed within their practicing state as licensed professional counselors (LPC) or similar licensure and provide mental health services to individuals, families, and groups. Most LPCs are employed in non-school settings such as community mental health centers and hospitals, non-profit and for-profit agencies, and organizations covered by managed care and health plans (ACA, 2011). Current research indicates that as demands for mental health services have risen, CMHCs are providing services in schools with increasing frequency (Becker et al., 2015).

Limitations of Clinical Mental Health Counselors

As school-aged children exhibit increasingly complex mental health issues in schools (DeKruyf et al., 2013; Lambie, 2011), SCs recognize that students' mental health needs are best addressed through collaboration with other school professionals and community agencies (ASCA, 2012b; Kaffenberger & O'Rorke-Trigiani, 2013). Following the suggestion of the ASCA model (2012a), SCs often assess students' needs, determine if short-term counseling will adequately address the issue, and refer students and families to community-based CMHCs when necessary. However, there are limitations to providing community referrals.

Accessibility. Unfortunately, both American and international youth struggling with mental health issues often fail to receive the services they need (CDC, 2017a; WHO, 2013). Of the school-aged children in the US with a diagnosed mental illness, approximately 70-80% are not receiving treatment (Greenberg et al., 2003; Mendez, Carpenter, LaForett, & Cohen, 2009). Barriers to mental health services include shortage of mental health professionals (Becker et al., 2015; CDC, 2017a), as well as inadequate finances, location of services, and stigma related to mental health (Becker et al., 2015; Owens et al., 2002). Kaffenberger and O'Rorke-Trigiani (2013) reported that lack of access to mental health professionals is a major reason why school-aged children are not receiving appropriate mental health services. Adelman and Taylor (2010) reported that many parents lack necessary resources to seek counseling services for their children outside of school. Occasionally, a combination of multiple factors might impede access. Becker et al. (2015) highlighted adolescents' perceptions of assuming responsibility for managing their mental health needs, failing to recognize the benefits of treatment, and increased worry of stigmatization, privacy, and confidentiality as barriers to services. Additionally, rural settings account for 61% of the areas reporting mental health provider shortages (CDC, 2017b), have a larger population living at or below the poverty level, and are likely to ascribe stigma to mental health issues (Robinson et al., 2017). Patel et al. (2007) reported similar barriers to access being pervasive across the globe. The WHO (2013) reported that in low-income and middle-income countries, approximately 76-85% of people with a mental health issue receive no treatment. In high-income countries, approximately 35-50% receive no mental health services (WHO, 2013).

Insufficient training. Clinical Mental Health Counselors are often trained as general practitioners to support a broad range of clientele with diverse mental

health issues (CACREP, 2016). Within this model, many CMHCs obtain additional training in specialized areas of practice such as animal assisted therapy, play therapy, neuro-/biofeedback, art therapy, and adventure therapy to meet the unique needs of specific populations served. Additionally, although CACREP (2016) standards ensure a certain level of quality and rigor regarding the training of CMHCs, a major training deficit is that they do not require any school-related courses. Therefore, most CMHCs are limited in school-based experience, training, and credentialing (Crespi, Nissen, & Lopez, 2000). Finally, without appropriate training specific to working in schools, CMHCs violate their ethical code by practicing without "appropriate education, training, and supervised experience" (ACA, 2014, p. 8).

Recommendations

Although school-aged children need mental health services that CMHCs are uniquely qualified to provide, issues related to accessibility and training limit their ability to do so. Because school-aged children are more likely to receive mental health services provided in schools than community mental health agencies (Kaffenberger & O'Rorke-Trigiani, 2013), a trend likely to continue in the future (Crespi et al., 2000; Maag & Katsiyannis, 2010), we make the following recommendations. A unique type of CMHC that we will call a school-based mental health counselor (SBMHC) is needed to meet the mental health needs of students in a school setting. Although SBMHCs already exist, there is ambiguity regarding their role and responsibilities in addressing the mental health needs of school-aged children. The remainder of this article is dedicated to clarifying the role and responsibilities of SBMHCs.

School-Based Mental Health Counseling

History of School-Based Mental Health Counseling

DeKruyf et al. (2013) noted that "relying primarily on referrals to outside resources to address the needs of students with mental health problems will leave some needy students unserved" (p. 274). As early as 1994, ASCA addressed the use of non-school-counseling credentialed personnel, such as SBMHCs, to meet the mental health needs of students in schools (ASCA, 2012b). In 1995, Dykeman published an article exploring the privatization of services provided by SCs where schools contracted with outside agencies to provide mental health services within the school. In a position statement, ASCA (2012b) outlined the rationale and offered role clarification for utilizing SBMHCs in schools.

Crespi et al. (2000) postulated that, as schools become primary sites for the provision of healthcare services, CMHCs will increasingly seek to provide

services in school settings. Although the use of contracted SBMHCs appears to be common and increasing, (Crespi et al., 2000) there is a dearth of information documenting its effectiveness (Dykeman, 1995). Recent research indicates that school-based mental health services increase access to and reduce stigma associated with mental health counseling (Becker et al., 2015; Bringewatt & Gershoff, 2010; Stephan et al., 2015). Bringewatt and Gershoff (2010) identified fear of experiencing mental health stigma such as prejudicial assumptions and discrimination as a major barrier to children receiving services. To counter this barrier, they recommended "better access to stable service (including long-term interventions) in schools, which are considered less stigmatizing than other treatment settings" (Bringewatt & Gershoff, 2010, p. 1297). However, Stephan et al. (2015) reported that long-term efforts to implement school-based counseling services are often derailed due to lack of sustainability, limited funding, inadequate or disorganized community partnerships, lack of training and leadership, low priority, and tensions between SCs and SBMHCs. This tension likely results from the different perspectives regarding the roles and responsibilities of SBMHCs and SCs (Crespi et al., 2000). Although there is ample literature related to school-based mental health providers, much of it discusses mental health providers in general (Becker et al., 2015; Doll et al., 2017; Stephan et al., 2015), without a specific focus on the counseling profession. As of 2015, the School-Based Health Alliance reported 49 of 50 states had school-based health centers, which often include the use of mental health professionals. Literature also indicates the use of school-based mental health interventions in Canada (Mental Health Commission of Canada, 2013), Australia, and the United Kingdom (Fazel, Hoagwood, Stephan, & Ford, 2014) as well as countries in the Asia, Africa, Eastern Europe, the Middle East, and South America (Fazel, Patel, Thomas, & Tol, 2014). The remainder of this article is dedicated to the discussion of SBMHCs role and responsibilities and suggestions for improved school-based mental health services.

Role of School-Based Mental Health Counselors

Generally, SBMHCs are tasked with addressing the mental health needs of school-aged children on a school campus. They are typically trained as CMHCs and credentialed by their state as such. Doll et al. (2017) described school-based providers as being both school-employed and contracted through community agencies. However, a common problem is that schools and community agencies exist as separate entities with little communication between them (Doll et al., 2017). It is important to note that SBMHCs are not always contract counselors. In some districts, SBMHCs are school-employees who happen to be trained and licensed as

CMHCs instead of SCs. Currently there is no professional association or division, ethical code, or credentialing body dedicated to SBMHCs. Counselor education programs have no CACREP standards to guide how they train SBMHCs. Thus, the role and responsibilities of SBMHCs remains ambiguous and often defined by the employing district or agency. Although SBMHCs should utilize evidence-based practices (EBP), they often fail to do so due to lack of training, funding, support, and unique obstacles associated with a school environment (Stephan et al., 2015). Stephan et al. (2015) noted that the actual EBPs implemented are less important than the model SBMHCs use to select and implement the interventions. Suggestions for this practice are provided below.

Recommendations

Using existing literature, we have constructed a list of recommendations regarding training and credentials, clarity of roles and responsibilities, communication, scheduling sessions, funding services, selecting and implementing EBPs, and evaluating efficacy. We have also relied on our own experiences as a SC (first author) and SBMHC (second author) to create these recommendations.

Training and credentials. We recommend the creation of training standards and credentialing for SBMHCs due to their ever-increasing role in delivering mental health services to school-aged children. Currently there are no clearly defined training standards (CACREP, 2016) or credentialing bodies (Dykeman, 1995) for SBMHCs. SBMHCs are encouraged to obtain training and supervision working with children in the school setting since most mental health providers are not trained to practice in schools (Crespi et al., 2000; Doll et al., 2017; Stephan et al., 2015). Even with the best intentions, SBMHCs lacking the training and skills to work with school-aged children in a school setting are violating their ethical code (ACA, 2014) and might provide inappropriate services (ASCA, 2012b).

Counselor education programs are advised to expose future and potential SBMHCs to how mental health issues affect behavior in schools and how mental health services can be delivered in a school. Until specific standards are created, we suggest SBMHCs follow the CMHC specialization area, but take additional courses and engage in additional clinical experiences that expose them to counseling students in schools. Although the content of typical SC courses might be inappropriate for SBMHCs, some type of cross-pollination of CMHC and SC courses is warranted. Topics that SBMHCs need exposure to during training include the role of the school counselor, school culture and climate, goal of the public education system, developmentally appropriate behavior within a school and classroom setting, academic scheduling, school policy, privacy and confidentiality

within a school setting, FERPA, mental health interventions appropriate for a school setting, and general constructs of a comprehensive school counseling program. As for specific standards and credentialing, wit would benefit SBMHCs and their clientele if CACREP created training standards and state credentialing bodies or the National Board for Certified Counselors created credentials specifically for SBMHCs. These could be standalone credentials or specializations that counselors can add to the state issued school or mental health credentials. Finally, we suggest creating a School-Based Mental Health Counseling division of ACA to help train and support SBMHCs. See Table 1 for a detailed comparison of the training and credentialing of SCs and CMHCs as well as our SBMHCs recommendations.

Clarity of roles and responsibilities. With the increase in SBMHCs (Brown et al., 2006), SCs and SBMHCs must clearly define their roles and responsibilities in meeting the needs of students (ASCA, 2012b). Both parties need to know whether their school operates under a school-employed or contracted model and how this affects implementation of services (Dykeman, 1995). For example, school-employed SBMHCs would follow school guidelines and rules while contracted SBMHCs would follow the guidelines and rules set by their agency's agreement with the school.

As previously stated, SCs primary responsibility is the creation and implementation of comprehensive school counseling programs that address the academic, career, and personal/social needs of all students (ASCA, 2012a). SCs are also tasked with identifying risk factors and warning signs for mental health and behavioral disorders (CACREP, 2016), providing responsive services in the forms of short-term individual and group counseling (ASCA, 2012a). When additional counseling is required, SCs collaborate with SBMHCs to ensure students' mental health needs are met (Kaffenberger & O'Rorke-Trigiani, 2013).

Whereas SCs clearly fall under ASCA's Ethical Standards (2016) and the legal codes outlined by their states, SBMHCs ethical and legal obligations are less clear. We recommend that SBMHCs be familiar with the ASCA Ethical Standards (2016), but adhere to the ACA Code of Ethics (2014) and guidelines/codes/laws connected to their state's credentialing body. SBMHCs utilize various developmentally and contextually appropriate interventions to improve the mental health and wellness of school-aged children such as intake and assessment services, treatment plans and goals, emergency/crisis response, and individual and group counseling. They are not limited to short-term interventions nor are they responsible for all students in the school. SBMHCs are encouraged to communicate and collaborate throughout this process with SCs to eliminate barriers to academic achievement, such as missed class time.

Communication. Collaboration between SCs and SBMHCs is essential to identifying and addressing the needs of at-risk students. Therefore, we recommend that SCs continue to serve as the primary point of contact to assess students' needs and, if needed, refer to SBMHCs for additional services (ASCA, 2009; Keys et al., 1998). SBMHCs should only provide prevention and intervention activities within their training and scope of practice (ASCA, 2012b). SCs and SBMHCs also collaborate "with administrators, teachers, and staff to establish appropriate guidelines, responsibilities, and supervision" for SBMHCs (ASCA, 2012b, p. 64). SCs and SBMHCs should communicate regarding student referrals, counseling progress, and treatment interventions as they relate to academic achievement. When working with contracted SBMHCs, SCs must ensure the information they share with SBMHCs contributes to the counseling process while protecting student confidentiality.

Maag and Katsiyannis (2010) emphasized that of the greatest challenges for school personnel is ensuring the privacy and confidentiality of students and families. Schools must obtain parental consent for providing mental health services and avoid violating parental rights by forcing school-based mental health services upon students and parents (Maag & Katsiyannis, 2010). Therefore, we recommend that school personnel, such as SCs, contact parents and inform them of available school-based services and additional resources if requested. Also, SCs should make the initial contact with parents regarding SBMHCs role within school, services offered, scope of practice, and education and credentials (ASCA, 2012b). When contacting parents about potential mental health services, SBMHCs must allow parents the right to reject school-based services and instead provide them with other resources (Maag & Katsiyannis, 2010). School-employed SBMHCs must understand school policy regarding confidentiality, parent contact, and release of information. Contract SBMHCs must understand agency policy and guidelines of the agency/school agreement.

Scheduling sessions. Time spent outside of the classroom to receive mental health services is a barrier to the primary goal of being in school, which is to attain an education (Kolbert et al., 2017). Whereas SCs understand this goal and focus their comprehensive programs to assist in achieving it, SBMHCs may lack the clarity regarding this goal, leading them to focus exclusively on providing regular counseling services aimed at helping clients achieve treatment goals. These discrepancies can cause barriers to both student success and collaboration between SBMHCs and SCs (Crespi et al., 2000). We recommend that SBMHCs establish a set day and time to provide counseling to students by reviewing class schedules to minimize missed academic instruction. This task will likely be easier for school-employed SBMHCs as they can access student academic records such as course schedules. Although likely more challenging for contracted SBMHCs, they can collaborate with SCs to get the needed information to minimize impact on academic performance.

Although SBMHCs predominately work with individual or small groups of students, we recommend they extend their services to a broader range of students through collaboration with SCs and other school personnel. Specifically, as schools create comprehensive school counseling programs, they should use SBMHCs' knowledge and skills to ensure all students are receiving appropriate preventative mental health services rather than just intervention for a select few (Stephan et al., 2015). One way to accomplish this goal is through SC and SBMHC collaboration to provide classroom lessons with mental health and wellness foci.

Funding services. Crespi et al. (2000) highlighted that schools have a unique opportunity to meet the mental health needs of students and families that might go unserved due to financial barriers. However, a major barrier to providing school-based mental health services is affordability (Maag & Katsiyannis, 2010). To navigate financial barriers, we recommend that schools explore state and federal funding opportunities (Cooper, 2008; Maag & Katsiyannis, 2010). Schools should explore several federal funding sources connected to legislation and programs, like the Social Security Act, The IDEA and Section 504, Public Health Service Act, Patient Protection and Affordable Care Act of 2010, and Medicaid (Maag & Katsiyannis, 2010). Schools should also explore using private insurance plans and third-party reimbursement (Maag & Katsiyannis, 2010). When pursuing external sources of funding, schools should consider training and credentialing requirements necessary for reimbursement of services provided by SBMHCs (Crespi et al., 2000). For example, if a school, located near a military base, planned to use Tricare to fund their SBMHC position, they would need to know that only licensed professional counselors who graduated from CACREP accredited programs with the CMHC specialization would be eligible for reimbursement.

Selecting and implementing EBPs. Doll et al. (2017) suggested using various services that are child-centered, family focused, and culturally competent. In addition, it is important that SBMHCs utilize evidence-based practices (EBP) when providing mental health services in schools (Stephan et al., 2015). To implement sustainable services, we encourage SBMHCs to collaborate with SCs and other personnel to identify EBPs appropriate for their population and that align with the goals and intended outcomes of their services (Stephan et al., 2015). SBMHCs can use databases located at SAMHSA.gov, youth.gov, and the *What Works Clearinghouse* as well as consult professional

journals for information regarding EBPs. After selecting an EBP, SBMHCs must secure necessary funding, receive appropriate training, and collaborate with SCs to avoid duplication of services (Stephan et al., 2015).

Evaluation. Finally, it is imperative that SBMHCs use data to inform their practice and evaluate the efficacy of their services. We recommend SBMHCs that lack the competence or confidence to collect, analyze, and synthesize data partner with SCs, who have the requisite knowledge and skills to use data to inform practice (ASCA, 2012a). SBMHCs can use data to support the effectiveness of the implemented EBPs as well as advocate for the continuation of the positions. We also recommend SMBHCs partner with counselor educators to conduct research evaluating school-based services that can be used to inform policy.
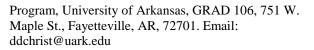
Conclusion

School-aged children are experiencing increased issues that warrant mental health services. Unfortunately, most of these children are not receiving adequate services. Literature and previous research suggests that school-based mental health services are an appropriate way to meet school-aged children's mental health needs. As mental health professionals in schools, SCs are in a prime position to help. Unfortunately, due to limited training in mental health therapy as well as time constraints due to large caseloads and increasing responsibilities, SCs cannot meet the ever-increasing mental health needs of all students. Although CMHCs have the training to meet a variety of mental health needs, limitations regarding their training to work with students in a school setting as well as accessibility issues keep them from adequately meeting the mental health needs of school-aged children. What is needed is a specially trained and strategically placed type of CMHC. We proposed that SBMHCs, specifically trained to work with school-aged children and placed within a school setting, are appropriate for meeting students' mental health needs. We also offered specific recommendations and suggestions for the training and practice of SBMHCs so that they can collaborate with SCs to meet the mental health needs of all students. Although this article informs school-based mental health training, practice, and policy, additional evaluation of SBMHC services as well as an ACA division would increase the ability to advocate for the placement of more SBMHCs in schools.

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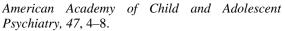Correspondence concerning this article should be addressed to David D. Christian, Counselor Education Program, University of Arkansas, GRAD 106, 751 W. Maple St., Fayetteville, AR, 72701. Email: ddchrist@uark.edu

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Table 1

Comparison of Professional School Counselors, Clinical Mental Health Counselors, and School-Based Mental Health Counselors

	Professional School Counselors	**Clinical Mental Health Counselors**	**School-Based Mental Health Counselor**
Professional Association:	Clear: American Counseling Association	Clear: American Counseling Association	Recommendation: *American Counseling Association*
Division:	Clear: American School Counselor Association (ASCA)	Clear: American Mental Health Counselors Association (AMHCA)	Recommendation: *School-Based Mental Health Counseling division of ACA*
Ethical Standards:	Clear:2016 Ethical Standards for School Counselors	Clear: 2014 ACA Code of Ethics	Recommendation: *Be familiar with both; Follow ACA Code of Ethics and guidelines/codes/laws connected to state's credentialing body*
Credentials	Licensed or Certified School Counselor	Licensed Professional Counselor	Recommendation: *LPC or Create SBMHC Credential*
CACREP Core:	Clear: 8 Core Curriculum Areas	Clear: 8 Core Curriculum Areas	Recommendation: *8 Core Curriculum Areas*
CACREP Foundations:	Clear focus: Foundational concepts related to SC. Key Concepts: • History and development • Models of Counseling, career development, collaboration and consultation, and assessment in P-12 schools	Clear focus: Foundational concepts related to CMHC Key Concepts • History, development, theories, and models • Biopsychosocial case conceptualization and treatment planning • Psychological testing and assessment • Etiology of addiction and co-occurring disorders	Recommendation: Additional Key Concepts: • *SBMHC specific training standards and credentialing* • *Follow CMHC specialization area, cross-pollinate with SC info*
CACREP Contextual Dimensions:	Clear focus: Role responsibilities and knowledge specific to SC Key Concepts: • SC role as leader, advocate, change agent, and consultant • College and career readiness • Crisis, disaster, and trauma counseling;	Clear focus: Role responsibilities, knowledge, and skills specific to CMHC Key Concepts: • Roles and settings of CMHCs • Etiology (biological and neurological), nomenclature, treatment, referral, and prevention of mental and emotional disorders	Recommendation: Role responsibilities, knowledge, and skills specific to CMHC with additional exposure: • Role of the school counselor • School culture and climate • Goal of the public education system • Developmentally appropriate behavior

	- emergency management planning. - Risk factors for and warning signs of mental health and behavioral disorders - Common medications that affect learning, behavior, and mood - Signs and symptoms of substance abuse in children and adolescents; signs and symptoms of living in a home where substance use occurs - Community resources and referral sources - Professional organizations, preparation standards, and credentials relevant to the practice of SC - Policy relevant to SC - Legal and ethical considerations for SC	- Mental health service delivery modalities within the continuum of care - Diagnosis using the DSM and ICD - Substance use disorders relationship to neurological, medical, and psychological disorders - Impact of crisis and trauma on individuals with mental health diagnoses - Use, classification, and prescription of Psychopharmaceuticals - Policy relevant to CMHC - Cultural factors relevant to CMHC - Professional organizations, preparation standards, and credentials relevant to the practice of CMHC - CMHC Legal and ethical considerations - Record keeping, third party reimbursement, and issues in CMHC	- within a school and classroom setting - Academic scheduling - School policy - Privacy and confidentiality within a school setting - FERPA - Mental health interventions appropriate for a school setting - General constructs of a comprehensive school counseling program
CACREP Practice:	Clear focus: Skills, strategies, approaches, and techniques specific to SC Ability to: - Develop SC program mission statements and objectives - Design and evaluate SC programs - Design and implementation core curriculum - Promote academic development - Implement career counseling interventions and assessments - Utilize school appropriate Personal/social counseling techniques	Clear focus: Skills, strategies, approaches, and techniques specific to CMHC Ability to: - Complete intake interview, mental status evaluation, biopsychosocial history, mental health history, and psychological assessment for treatment planning and caseload management - Implement techniques and interventions for prevention and treatment of a broad range of mental health issues	Recommendation: Skills, strategies, approaches, and techniques specific to SBMHC Ability to: - Identify as Organic or Contract SBMHC - Apply skills relevant to working with children in a school setting - Engage in open and ongoing communication with SCs - Engage in open and ongoing communication with students and parents - Schedule counseling sessions in a way that limits disruption of academic instruction

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• Implement transition strategies • Critically examine the connections between systems, behavior, and academic achievement • Increase promotion and graduation rates • Promote college & career readiness & access • Promote equity in student achievement • Foster collaboration and teamwork • Implement peer intervention programs • Use data to inform decision making • Use data to advocate for program	• Interface with the legal system regarding court-referred clients • Interface with integrated behavioral healthcare professionals • Advocate for persons with mental health issues	• Identify sources of funding for SBMHC position

Note. Clear = information or guidance clearly stated or widely known and accepted by the counseling profession. Recommendation = recommendations for the counseling profession due to the lack of information or guidance clearly stated or widely known and accepted.