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School psychologists' provision of school-based mental health interventions: A qualitative study of perceived barriers

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School Psychologists' Provision of School-Based Mental Health Interventions:

A Qualitative Study of Perceived Barriers

by

Allison A. Friedrich

A thesis submitted in partial fulfillment
of the requirements for the degree of
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Dedication

This manuscript is dedicated to my father, James Friedrich, my mother, Leslie Friedrich, and my dear sister, Lindsey Friedrich, for their continual support, love, and care throughout my educational career. Special thanks to my mentor, Dr. Shannon Suldo. Without her support, guidance, and continual efforts this work would not have been possible.

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ABSTRACT

The primary purpose of this study was to elucidate factors that school psychologists perceive inhibit them from providing more mental health interventions within their professional roles. School psychologists' dual training in mental health and education renders them the logical choice to provide tier II and tier III interventions in schools (National Association of School Psychologists [NASP], 2003). School psychologists appear to be in agreement, as they indicate a desire to spend more time in the provision of roles such as counseling and consultation (e.g., Prout, Alexander, Fletcher, Memis, & Miller, 1993). However, school psychologists currently spend relatively little time in the provision of such services (e.g., Curtis, Hunley, Walker, & Baker, 1999). Although this contradiction provides a rationale for further investigation, previous lines of research have not fully identified why school psychologists are not providing their desired levels of time in the provision of mental health services. Research also suggests that significant differences exist among school psychologists of different ages and levels of experience pertaining to their roles within the school system (e.g., Curtis, Hunley, & Grier, 2002). Therefore, factors such as years of experience also

should be considered when studying school psychologists' roles in the provision of mental health services. Thus, an additional purpose of the current study was to examine the frequency of the themes elucidated across each research question as a function of practitioners' levels of experience.

Participants were 39 school psychology practitioners from two geographical locations, ranging in age from 26 to 61 years old ($M = 41.92$, $SD = 11.22$) and had from 1 to 32 years of experience ($M = 11.89$, $SD = 10.49$). Eleven focus groups, composed of two to five members each, were conducted. Participants responded to a set of open-ended questions, and the discussions were audiotaped and then transcribed verbatim. Within each question, several common themes emerged across the focus groups; however, differences between practitioners' level of experience was noted on several occasions. Implications for future research and practice are presented, specifically related to the training and professional development needs of school psychologists.

Chapter 1

Introduction

Statement of the Problem

Mental health in childhood and adolescence is defined by the achievement of expected developmental, cognitive, social, and emotional milestones and by establishing effective coping skills, secure attachments, and positive social relationships (US Department of Health and Human Services [US DHHS], 1999). Mentally healthy children and adolescents enjoy a positive quality of life; function well at home, in school, and in their communities; and are free of disabling symptoms of psychopathology (Hoagwood, Jensen, Petti, & Burns, 1996). As summarized in the Surgeon General's Report (US DHHS, 1999), psychopathology in childhood arises from:

...the complex interactions of specific characteristics of the child (including biological, psychological, and genetic factors), his or her environment (including parent, sibling, and family relations, peer and neighborhood factors, school and community factors, and the larger social-cultural context), and the specific manner in which these factors interact with and shape each other over the course of development. (p. 7)

Many children have mental health problems that interfere with normal development and functioning. According to a recent report, almost 21% of U.S. children aged 9 to 17 years had a diagnosable mental or addictive disorder associated with at least

minimum impairment (US DHHS, 1999). In order to prevent and reduce symptoms of psychopathology, mental health services must be provided (Ollendick, King, & Chorpita, 2005). Support for the use of mental health services for children has been evidenced through countless studies and four major meta-analyses that examined the effects of child therapy (Ollendick et al., 2005). In 1995 the Society of Clinical Psychology Task Force on Promotion and Dissemination of Psychological Procedures published a comprehensive review of empirically validated psychological treatments, identifying three well-established treatments and one probably efficacious treatment for children (Ollendick et al., 2005). Since this report was published, additional task forces have been established by the Society of Clinical Psychology and the Society of Clinical Child and Adolescent Psychology and have identified additional effective psychosocial treatments for high-frequency problems encountered in clinical and other settings serving children with mental health problems (Ollendick et al., 2005).

A number of societal problems (Crocket, 2004) and legislative initiatives (e.g., Individuals with Disabilities Education Improvement Act) have resulted in more children in need of mental health services and, consequently, more children who go without treatment. Yet, studies across the decades illustrate that the majority of children and adolescents with a psychological disorder never receive mental health services (Burns et al., 1995; Farmer, Burns, Philip, Angold, & Costello, 2003; Kataoka, Zhang, & Wells, 2002; Leaf et al., 1996; Pandiani, Banks, Simon, Van Vleck, & Pomeroy, 2005; Stiffman, Earls, Robins, & Jung, 1988).

The provision of mental health services to children and adolescents is dispersed across multiple systems and professions: schools, primary care, the juvenile justice

system, child welfare, and substance abuse treatment centers (Satcher, 2000). Over the years, a complex system for providing mental health services to children has evolved, driven by the multiple government initiatives and advocates for more comprehensive mental health services for children (Brown, 2002). Within this complex system, the education (i.e., school-based) system has emerged as the foremost provider of mental health services to children (Burns et al., 1995; Farmer et al., 2003). School-based mental health services are provided by a range of personnel, including school psychologists.

An original intent of the school psychologist role within the school system was to conduct psychoeducational assessments for placement in special education (Fagan & Wise, 2000). Although this assessment role has been the primary function of school psychologists for decades, leaders in the field have advocated for role expansion and respecialization (cf. Crespi & Politikos, 2004) to include additional roles such as the provision of mental health services. While the assessment role has persisted across the twenty-first century, two additional major roles for school psychologists have emerged: intervention and consultation.

Assessment, as defined by the National Association of School Psychologists (NASP), is "the process of gathering information from a variety of sources, using a variety of methods that best address the reason for evaluation; and is contrasted to *testing* which is limited to administration and scoring of tests" (NASP, 2003, ¶ 1). The definition used by NASP places an emphasis on the difference between assessment and testing. Interventions may be directed toward promoting well being and preventing the onset of problems (i.e., primary prevention), minimizing difficulties once they occur (i.e., secondary prevention), and stabilizing disabilities and working to ensure basic and

needed services are provided to those who can be expected to manifest one or more disabling conditions over some years (i.e., tertiary prevention) (NASP, 2003).

Consultation generally refers to the provision of school psychological services using indirect methods to deliver services. Consultation services may be offered to teachers and other educational personnel, other professionals, religious and other community leaders, parents, and government officials; consultation often involves school psychologists participating as members of a team. Consultation services also may be directed toward enhancing the understanding and ability of teachers, administrators, and parents to promote development (NASP, 2003).

School psychologists should receive graduate training that provides the knowledge and skills necessary to perform the aforementioned functions, as well as less-frequently provided roles such as research and supervision (American Psychological Association, 2005; NASP, 2000a). Given their broad training and experience, school psychologists are well-qualified to provide comprehensive and effective mental health services. In recent years, school psychology literature has been inundated with a call for school psychologists to respond proactively with respect to providing mental health services to children in schools (Nastasi, 2000). Despite compelling factors, such as (a) the need for mental health services in the schools, (b) school psychologists' expertise in mental health and education, and (c) calls for the expansion of school psychologists' professional roles into additional involvement in mental health services, school psychologists currently spend less than one-quarter of their time in the provision of mental health services (Curtis, Hunley, Walker, & Baker, 1999; Hosp & Reschly, 2002; Reschly & Wilson, 1995; Yates, 2003). Yet, the majority of school psychologists desire

to provide more mental health services within their roles in the school system (Prout et al., 1993; Reschly & Wilson, 1995; Yates, 2003).

Given school psychologists' desire to spend more time in the provision of mental health services and the still unmet need for treatment of children's mental health problems, barriers must exist that prohibit school psychologists from intervening with these children. Through a survey response form, Yates (2003) provided one of the few studies to examine barriers to the provision of one type of mental health service, counseling, by school psychologists. Yates found that respondents endorsed a heavy emphasis on assessment (68.2%) and the fact that counseling was not part of their roles in the school (52.5%) as two common barriers. An additional barrier endorsed by a number of respondents was that counseling is not currently part of their identified/written job responsibilities (26.4%). Other barriers elicited through an "other" choice category included insufficient training in counseling, other job responsibilities, and the perception that their school district does not view counseling as a necessity. While this study is notable in that it provides an in-depth examination of barriers, the research is limited by (a) a narrow definition of mental health (i.e., "counseling services"; mental-health-related services as consultation were not examined), (b) use of a questionnaire that consisted of only closed and partially closed-ended questions, and (c) a finite list of response options that limited participants to responding to their perception of only six barriers. Initial exploratory research is needed using qualitative methods that allows respondents to identify the range of factors they perceive prohibit their provision of mental health services in schools is needed.

Additional research is needed to address factors that moderate school psychologists' involvement in mental health services. Preliminary research suggests significant differences exist among school psychologists of different ages and experiences pertaining to their roles within the school system (Curtis, Hunley, & Grier, 2002). Therefore, demographic factors such as years of experience also should be considered when studying school psychologists' roles in the provision of mental health services. In recent years, school psychology has witnessed a "graying of the field" (Curtis, Grier, & Hunley, 2004, p. 7) in which the average age (and corresponding years of experience) of school psychologists is significantly older than in past years. Therefore, the gap in years of experience between new graduates/recent hires and experienced practitioners is widening. Because of the recency of calls to expand the school psychologist's role into mental health services, school psychologists' beliefs regarding their roles in providing mental health services may vary according to the number of years they have worked in the field. Years of experience also may be relevant to school psychologists' provision of mental health services due to changes over time in school psychology graduate training.

Conceptual Framework

NASP, founded in 1969, is a not-for-profit association representing more than 23,500 school psychologists from across the United States and other countries (NASP, 2000a). The mission of NASP is to represent and support school psychology with leadership to enhance the mental health and educational competence of all children. Consistent with this mission, NASP promotes educationally and psychologically healthy environments for all children and youth through the implementation of research-based,

effective programs that prevent various problems and promotes optimal learning. This is accomplished through up-to-date research and training, advocacy, continual program evaluation, and caring professional service. Consistent with its mission, NASP has adopted and promotes an integrated set of comprehensive standards for preparation, credentialing, and professional practice in school psychology. NASP has been influential in setting the standards for school psychology practice in the United States since the first development of its first training guidelines in 1972 (NASP, 2000a). The *Standards for Training and Field Placement Programs in School Psychology* (NASP, 2000b), its most recent training guideline, contributes to the development of effective services through the identification of critical training experiences and competencies needed by candidates preparing for careers in school psychology. The *Standards* serve to guide the design of school psychology graduate education by providing a basis for program evaluation and a foundation for the recognition of programs that meet national quality standards through the NASP program approval process (NASP, 2000b).

The procedural standards supporting the comprehensive training of school psychologists identified within the *Standards* include providing school psychology candidates with the knowledge and skills needed to demonstrate entry-level competency in a number of domains of professional practice. Within the domain of Prevention, Crisis Intervention, and Mental Health, school psychologists should be trained to provide or contribute to prevention and intervention programs that promote the mental health and overall well-being of students (NASP, 2000b). In addition to the identification of mental health training standards within the *Standards for Training and Field Placement Programs in School Psychology*, NASP has published a position statement on the

provision of mental health services in the schools. Within this position paper NASP advocates for the implementation of school-based comprehensive mental health services in order to help students overcome barriers to learning (NASP, 2003). Given the standings of NASP within the field of school psychology and its influence on school psychology training programs, school psychologists should not only be providing mental health services within the schools but they should also be adequately trained and competent in providing such services.

Purpose of the Current Study

While most school psychologists express a desire to provide more mental health services to children in schools, little is known about why they are unable to provide these services. There is currently insufficient information regarding the types of barriers that school psychologists perceive prohibit them from providing more mental health services. In addition, there have been no peer-reviewed published studies that have explored this area of research. An additional gap in the literature pertains to the significance of demographic characteristics (e.g., years of experience) in factors that prohibit mental health service delivery. The current study addressed these needs by expanding and improving upon the aforementioned research of Yates (2003), who examined the barriers to the provision of counseling services by school psychologists primarily using a forced-choice survey response form. Specifically, the current study aimed to expand upon the list of factors that keep school psychologists from providing additional mental health interventions through the use of qualitative research in which participants (school psychologists) identified perceived barriers.

Educational Significance

This study is significant to the field of school psychology as it contributes to the literature pertinent to school-based mental health service delivery. Findings provide a current and comprehensive overview of school-based mental health service provision by school psychologists and a comprehensive list of factors that inhibit their ability to provide additional mental health interventions. Because of the study's focus on the training needs of current practitioners, it was expected that this study would aid trainers in determining the current need for additional education in mental health service assessment and intervention. Rich, descriptive qualitative comparisons provide information about the significance of demographic characteristics in the provision of mental health interventions. This study also is noteworthy to the field of school psychology as there is a paucity of qualitative research (Powell, Mihalas, Onwuegbuzie, Suldo, & Daley, in press).

Research Questions

To generate information regarding factors that prohibit the delivery of school-based mental health interventions, the following research questions were addressed through collecting and analyzing data from focus groups in which new and experienced school psychologists participated.

1. For which types of problems (e.g., anxiety, depression) are students referred for mental health assessment and intervention?
2. Which mental health assessment and interventions have school psychologists provided during their past few years of practice in the schools?

- a. What is the role that year of experience plays in mental health services provided by school psychologists?
3. Which factors prevent school psychologists from providing additional mental health assessment and intervention?
 - a. What is the role that year of experience plays in the barriers perceived by school psychologists?
4. In which specific knowledge and skill areas would additional training be helpful in enabling school psychologists to provide additional mental health assessment and intervention?
 - a. What is the role that year of experience plays in the training needs of school psychologists?

Definition of Terms

Mental Health Problem

A mental health problem is defined as an environmental situation or within-child symptom(s) that is likely to prevent (or has already inhibited) a given child from achieving expected developmental, cognitive, social, and emotional milestones or from establishing effective coping skills, secure attachments, and positive social relationships (US DHHS, 1999); this includes psychiatric mental illnesses and mental disorders.

Mental Health Assessment and Intervention

Mental health assessment and intervention is defined as, following the identification of a given child at-risk for, suspected of, or diagnosed as having a mental health problem, any activity in which school psychologists purposefully engage in an effort to ameliorate the mental health problem(s) within the identified child. Such

activities include the following: clinical or behavioral assessment with intent to intervene; individual, group, or family counseling/psychotherapy; case management; consultation with adults including educational personnel and family members; crisis intervention; and mediation management/coordination of care with physicians. The following activities are excluded: assessment for special educational eligibility (without intent to provide interventions after placement); academic assessment/intervention for children without mental health problems; school-wide or classroom counseling; and school-level research and evaluation.

Delimitations of the Study

The proposed research design incorporated deliberate limitations. One of the delimitations of this study included the differentiation of the focus groups based upon years of experience. Practitioners with 0-5 years of experience and 17 or more years of experience were included while practitioners with 6-16 years of experience were not the focus of the primary research questions. Practitioners with 6-16 years of experience were excluded in comparative analyses in order to provide two distinct groups of practitioners. Another delimitation of the study was the sole use of school psychologists from only two school districts in a single state (Florida).

Limitations of the Study

For this study, several potential threats to the validity of the findings exist. Thus, limitations pertinent to this study are presented. Instrumentation was a potential threat to internal validity (Gay & Airasian, 2003). Instrumentation included data entry errors (i.e., errors occurring during the process of transcription) by the research group and data not reported or incorrectly reported by the participants. Threats to descriptive validity, the

ability to record accurately what was stated during the focus group sessions, threatened the internal validity of the findings. For example, the taped recordings may not have captured all of the comments made by participants. To diminish this threat, the researcher utilized a tape recorder complemented by the field note taker who was responsible for recording the dialogue of the participants. Another potential threat to validity involved the interpretation of the data obtained from the focus groups (Maxwell, 2005). Therefore, the researcher exerted a conscious effort to avoid imposing her personal bias to the data. To complement this effort, open-ended questions were asked during the focus groups. The utilization of focus groups and the differential selection of participants also threatened the credibility of the results (Maxwell, 2005). Finally, theoretical validity, the lack of collection of or perception of discrepant data, was a potential threat to the findings (Maxwell, 2005).

Several issues influenced the external validity of the findings. In this study, limited sampling potentially limited the ecological validity of these results (Johnson & Christenson, 2004). Because this study recruited participants from only two school districts within Florida, the ecological validity of the results are limited. The limited sample size and the exclusion of a random sample within the study also impacted the generalizability of the findings via population validity. Given these limitations, the results from this study should be generalized with caution. Findings apply only to the school psychologists involved within the study and are not representative of all school psychology practitioners.

Organization of Remaining Chapters

The remaining chapters are organized to provide information pertaining to the proposed study as well as previous research regarding mental health service needs and the provision of such services. Chapter 2 includes a review of the current literature relevant to this research study. Chapter 3 includes a description of the design and procedures used in this study. Chapter 4 provides an overview of the qualitative results. Chapter 5 presents a discussion of the implications of the research.

Chapter Two

Review of the Literature

This chapter provides a review of the frequency of mental health problems in children and adolescents and the insufficient mental health services available to address children's social and emotional concerns. The provision of mental health services to children and adolescents is dispersed across multiple systems and professions: schools, primary care, the juvenile justice system, child welfare, and substance abuse treatment. In recent years, a growing school-based mental health movement has emerged, largely to overcome barriers to access to children's services. To this end, a comprehensive review of the mental health services provided through the school system is presented in the chapter. Additionally, this chapter contains a discussion of the expansion of the school psychologist's role and function, barriers to the provision of mental health services in the schools, and a summary of the current status of school psychology graduate training. A summary will conclude this chapter.

Prevalence of Mental Health Problems in Children and Adolescents

Fostering social and emotional health in children is a critical element in healthy child development. Many children have mental health problems that interfere with normal development and functioning. In the United States, 1 in 10 children and adolescents suffer from mental illness severe enough to cause some level of impairment (Burns et al., 1995; Shaffer, Fisher, Dulcan, & Davies, 1996). Both the treatment of

mental disorders and the promotion of mental health in children are therefore essential pieces of providing comprehensive services to children. Recent data that illustrate the alarming prevalence of mental disorders in youth support the need for increased attention to children's mental health.

Sources of Information on Prevalence Rates of Mental Disorders in Youth

With a growing awareness in the United States regarding the immense burden of disability associated with mental illnesses, government agencies have become advocates of mental health awareness, research, and interventions. Case in point, in the past decade a collaboration was formed between two Federal agencies, The Substance Abuse and Mental Health Services Administration (SAMHSA) and The National Institutes of Health (NIH), and through this collaboration the Surgeon General's Report on Mental Health (US DHHS, 1999) was published. The Surgeon General's Report on Mental Health provided an up-to-date, extensive scientific literature review of the prevalence of mental health problems and mental illnesses. The authors of the literature review indicated that almost 21% of U.S. children aged 9 to 17 years had a diagnosable mental or addictive disorder associated with at least minimum impairment. In the Surgeon General's Report on Mental Health, it was also suggested that approximately 6 million to 9 million children and adolescents in the United States had serious emotional disturbances (Lavigne et al., 1996).

In addition to this comprehensive review of literature, information regarding the prevalence of mental health problems in youth can be gleaned from the annual Youth Risk Behavior Surveillance System (YRBSS), a national school-based survey conducted by the Center for Disease Control (CDC) (U.S. Department of Health and Human

Services Center for Disease Control [US DHHS CDC], 2006). The YRBSS involves state and local school-based surveys conducted by state and local education and health services (US DHHS CDC, 2006). The YRBSS monitors categories of priority health-risk behaviors, including behaviors associated with mental health problems.

Other prevalence rate studies have focused on smaller geographical areas within the United States and within specific mental health service modalities. For instance, The Great Smoky Mountain Study of Youth (Costello et al., 1996) used a multistage, overlapping cohorts design, in which 4,500 of 11,758 children aged 9, 11, and 13 years in an 11-county area of the Southern Appalachian mountain region of North Carolina were randomly selected for screening for psychiatric symptoms using the Child Behavior Checklist Parent Report (Achenbach & Edelbrock, 1983). A final sample of 1,015 participants completed the Child and Adolescent Psychiatric Assessment (CAPA; Angold et al., 1995), an interview that elicits information about symptoms that contribute to a wide range of DSM-III-R (American Psychiatric Association, 1987) diagnoses in order to determine the prevalence of psychiatric disorders and mental health impairment. The researchers found that 27% of children 9, 11, and 13 years of age have mental health impairments and 20% have a diagnosable mental health condition.

Several studies of childhood mental health problems have relied on reports from primary care physicians in the pediatric setting, particularly studies that focus on children younger than 5 years of age. Kelleher, McInerney, Gardner, Childs, and Wasserman (2000) utilized data from a 1979 study called the Monroe County Study (MCS), which included a sample of 9,612 4-to 15-year-old children who had visited a random sample of 30 pediatricians in Rochester, New York. These data were compared to a more recent

dataset collected from the Child Behavior Study (CBS), a study supported by NIMH and conducted in the Pediatric Research in Office Settings network (PROS) and the Ambulatory Sentinel Practice Network (ASPN), during 1995, 1996, and the first part of 1997. According to their results, the proportion of pediatric patients in which psychosocial problems are seen in primary care has increased from 7% to 19% over the past 20 years. This more recent estimate (19%) is consistent with Lavigne et al. (1996), who found that 21.4% of children aged two to five years seen by pediatricians in Chicago met criteria for an Axis I disorder. Briggs-Gowan et al. (2003) conducted a similar study of 5- to 9-year-old children seen in pediatric settings in the greater New Haven, Connecticut area, in which the weighted estimate for any child psychiatric disorder was 16.8%.

Taken together, the aforementioned studies have indicated that between 16.8% and 27% of youth have mental health problems. As pointed out by Robert, Attkisson, and Rosenblatt (1998), the body of literature on the prevalence of mental health problems is limited by differences in sampling (representativeness, sample size), data analyses, case ascertainment, case definition, and presentation. Representativeness is problematic because the samples studied often do not represent the diversity of the child and adolescent populations. In addition, most prevalence studies focus on either a narrow age range (middle school, high school) or a specific age (e.g., age 3, age 8, age 11). In addition, prevalence studies use a range of assessment methods to determine the prevalence of mental disorders (e.g., syndrome scales such as the Child Behavior Checklist, DSM-IV checklists of symptoms).

Given the various studies in which researchers have attempted to estimate the prevalence of mental health problems, it is difficult to determine if these findings have been consistent across studies. Therefore, estimates of the prevalence of the most common mental health problems and specific disorders in youth from the two government-funded large-scale sources of information (US DHHS, 1999; US DHHS CDC, 2006), as well as studies conducted by independent researchers, are summarized in the following sections.

Anxiety disorders. According to research in the Surgeon General's Report on Mental Health (US DHHS, 1999), the combined prevalence of the group of disorders known as anxiety disorders is higher than that of virtually all other mental disorders of childhood and adolescence. The 1-year prevalence of anxiety disorders in children aged 9 to 17 years is 13%. Approximately 5.7% of children in the Great Smoky Mountain Youth Survey (Costello et al., 1996) exhibited an anxiety disorder, the most common diagnosis among the sample. One of the most common anxiety disorders is separation anxiety disorder, which occurs in approximately 4% of children and young adolescents (American Psychiatric Association, 1994). The 1-year prevalence rate for all generalized anxiety disorder sufferers of all ages is approximately 3%. Social phobia is another commonly diagnosed anxiety disorder, with lifetime prevalence rates ranging from 3% to 13%, depending on how many different situations induce anxiety and the level of fear (American Psychiatric Association, 1994).

Mood disorders. The synthesis of literature indicates that the most frequently diagnosed mood disorders in youth are major depressive disorder, dysthymic disorder, and bipolar disorder (US DHHS, 1999). At any one time, between 10% and 15% of the

child and adolescent population exhibits symptoms of depression (Smucker, Craighead, Craighead, & Green, 1986). The prevalence of major depression among all children aged 9 to 17 years has been estimated at 5% (Shaffer et al., 1996). Estimates of 1-year prevalence in children range between 0.4% and 2.5%; and in adolescents, prevalence rates are as high as 8.3% (Garrison et al., 1997; Kessler & Walters, 1998). The prevalence of dysthymic disorder in adolescents is around 3% (Garrison et al., 1997).

Mood disorders substantially increase the risk of suicide, which is a matter of serious concern for professionals who provide mental health services to children and adolescents. The YRBSS indicated that 16.9% of students had seriously considered attempting suicide during the 12 months preceding the survey (US DHHS CDC, 2006). Regarding suicidal behaviors, 8.4% of students reported actually attempting to commit suicide one or more times during the 12 months preceding the survey. Some states and cities conducted a school-based Youth Risk Behavior Survey (YRBS) among middle school students (Whalen et al., 2005). In 2003, the proportion of middle school students who reported suicidal ideation ranged from 8.5% to 11.8% for sixth-grade students, 10.0% to 15.9% for seventh-grade students, and 14.0% to 19.8% for eighth-grade students. Of note, this study was conducted on a much smaller scale than the nationwide YRBSS survey. Although the statewide samples were relatively large (1,179 to 7,709), the states and cities selected were not necessarily representative of the population.

Behavior disorders. In a national sample of 21,065 4-to 15-year-old children included in the Child Behavior Study (CBS), a prevalence rate of 4.4% for behavioral/conduct problems was found (Kelleher et al., 2000). In Lavigne et al.'s (1996) dataset of 510 children aged 2 through 5 years from the Chicagoland area, the

prevalence of behavior problems was 8.3%. As summarized in the Surgeon General's Report (US DHHS, 1999), prevalence rates of oppositional defiance disorder range from 1% to 6%, depending on the population sampled and the way the disorder is evaluated; rates are lower when impairment criteria are more strict and when information is obtained from teachers and parents rather than from the children alone (Shaffer et al., 1996). The prevalence of conduct disorder in 9- to 17- year-olds varies from 1% to 4%, depending on how the disorder is defined (Shaffer et al., 1996). The Great Smoky Mountain Youth Survey found the prevalence rates of conduct disorders and oppositional defiance disorder were 3.3% and 2.7%, respectively (Costello et al., 1996).

Eating disorders. As summarized in the Surgeon General's Report (US DHHS, 1999), eating disorders are serious, at times life-threatening, conditions that arise most often in adolescence and disproportionately affect the female population. Approximately 3% of young women have one of the three main eating disorders: anorexia nervosa, bulimia nervosa, or binge-eating disorder (Becker, Grinspoon, Klibanski, & Herzog, 1999). Anorexia nervosa has the most severe consequence, with a mortality rate of 0.56% per year (Sullivan, 1995).

Substance use disorders. Substance abuse disorders are of particular concern because of their link with other mental disorders. Approximately 51% of those with one or more lifetime mental disorders also have a lifetime history of at least one substance use disorder (US DHHS, 1999). The rate of substance abuse disorder is highest in the older adolescents, particularly within the 15- to 24-year-old age group (Kessler et al., 1994). According to the National Survey on Drug Use and Health (Substance Abuse and Mental Health Service Administration, 2006), in 2005 youth aged 12 to 17 years had a

rate of substance dependence or abuse of 8.0%. Approximately 10% of youth aged 12 to 17 years were current illicit drug users: 6.8% used marijuana, 3.3% used prescription-type drugs nonmedically, 1.2% used inhalants, 0.8% used hallucinogens, and 0.6% used cocaine. The rates of alcohol dependence or abuse for youth aged 12 to 17 years was approximately 5.5% (SAMHSA, 2006). In sum, a sizeable number of children are diagnosed with mental health problems and disorders. Numerous studies consistently have estimated the prevalence of mental health problems in children and adolescents at approximately 20%. These findings support the essential need for mental health treatment for youth. Therefore, important lines of research are those that examine the proportion of children receiving mental health services and the common modalities for treatment.

Child and Adolescent Mental Health Services

Just as there is evidence for the alarming prevalence of mental health problems in children and adolescents and the corresponding need for mental health treatment, evidence also supports the efficaciousness of providing such services to children. Support for the use of child psychotherapy has been evidenced through countless studies and four major meta-analyses that examined the effects of child therapy (Ollendick et al., 2005). A thorough review of the literature consistently shows that therapy for children results in beneficial impacts on the lives of children and their families. In recent years a shift has occurred towards identifying efficacious treatments for children who present with specific behavioral, emotional, and social problems.

The movement towards evidence-based practice in child psychotherapy led to the Society of Clinical Psychology Task Force on Promotion and Dissemination of

Psychological Procedures publishing a comprehensive review of empirically validated psychological treatments in 1995 (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). In this report, three categories of treatment efficacy were defined: 1) well-established treatments, 2) probably efficacious treatments, and 3) experimental treatments. The criteria for classification as a well-established treatment specified that the treatment should be shown to be superior to a psychological placebo, pill, or other treatment. Additionally, effects supporting a well-established treatment should be demonstrated by at least two different investigatory teams. To be classified within the probably efficacious treatment category, the specified treatment should be shown to be superior to a wait-list or no-treatment control condition. For both of these categories, characteristics of the clients should be well specified and the clinical trials were to be conducted with treatment manuals. The final requirement was that the outcomes of treatment should be demonstrated in “good” group design studies (i.e., reasonable to conclude benefits observed due to effects of treatment and not due to chance) or a series of controlled single-case design studies. The third category, experimental treatments, included treatments not yet shown to be at least probably efficacious. The purpose of this category was to include treatments frequently used in clinical practice or newly developed treatments that had not yet been fully evaluated (Ollendick et al., 2005).

Using the aforementioned criteria for the three categories of treatment, the 1995 Task Force Report identified three well-established treatments and one probably efficacious treatment for children. The three well-established treatments for children included behavior modification for developmentally disabled individuals, behavior

modification for enuresis and encopresis, and parent training programs for children with oppositional behavior. The one probably efficacious treatment identified was habit reversal and control techniques for children with tics and related disorders. Since this report was published, additional task forces have been established by the Society of Clinical Psychology and the Society of Clinical Child and Adolescent Psychology to identify effective psychosocial treatments for high-frequency problems encountered in clinical and other settings serving children with mental health problems. Together they published a review of empirically supported treatment for children with autism, anxiety disorders, attention-deficit/hyperactivity disorder (ADHD), depression, and oppositional and conduct problem disorders in the *Journal of Clinical Child Psychology* (Ollendick et al., 2005). In summary, the movement towards evidence-based practice has led to the identification of a number of empirically validated psychological treatments that can be utilized across the multiple systems that currently provide mental health services to children and adolescents.

The provision of mental health services to children and adolescents is dispersed across multiple systems and professions: schools, primary care, the juvenile justice system, child welfare, and substance abuse treatment centers (Satcher, 2000). Prior to the 1980's, the traditional model of mental health services for children and adolescents consisted of office-based outpatient therapy and psychiatric residential placement, which were handled primarily through the medical and mental health systems (Satcher, 2000). Over the years, a much more complex system for providing services has evolved, driven by the multiple government initiatives and advocates for more comprehensive mental health services for children (Brown, 2002). Nevertheless, almost 20 years after Knitzer's

(1982) landmark publication, *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services*, the delivery of mental health services remains complicated and services continue to be inaccessible to children (Brown, 2002).

Proportion of Children Receiving Services From Various Sectors

Several recent studies have attempted to estimate the number of children receiving mental health services. This is an important area of inquiry given that in earlier studies researchers have suggested that at least two-thirds of the 20% of all children and adolescents with a mental health disorder never received mental health services (Stiffman et al., 1988). Follow-up studies have provided professionals with a complex picture of the status of those children in need of receiving mental health service.

Kataoka et al. (2002) examined the rates of mental health services in three cross-sectional nationally representative samples of more than 11,500 households with 3- to 17-year-old children. The most knowledgeable adult in the household (95% were parents) provided information about the sampled child. Between 6.0% and 7.5% of youth across data sets reportedly received some type of mental health service; rates were consistently lower for preschool children (2%–3% for children 3–5 years old). Across the data sets, a higher percentage of children with public insurance (e.g., Medicare, Medicaid) used services (9%–13%) than did the privately insured (5%–7%) and uninsured (4%–5%) children. The authors suggest that the lower differences by insurance status among children could be partly due to the high level of unmet need across insurance groups among children.

The percentages of 6- to 17-year-olds with mental health problems ranged from 15.2% to 20.8% across datasets. Thus, only 29% to 49% of children with mental health problems receive any treatment. Data from all three national surveys showed that greater levels of mental health need were associated with higher rates of receiving any mental health care among children, suggesting that children do not receive care until they are very symptomatic. Controlling for other factors, the authors concluded that the rate of unmet need was greater among Latino than White children and among uninsured than publicly insured children. Caution should be used when interpreting the data for children under age 6 year, because the sample size was relatively small ($n= 131$ children).

Data from the first wave of the Great Smoky Mountains Study of Youth (GSMS) were utilized to examine the number of children receiving mental health services and the role of other child service sectors in providing mental health care to children (Farmer et al., 2003). Clinical status was determined by whether or not a child met the diagnostic criteria for a mental disorder using the psychiatric classification system DSM III-R, (American Psychiatric Association, 1987) and whether or not he or she exhibited impaired functioning (inability to function in developmentally appropriate ways at school, at home, and with peers) related to the reported symptoms. The diagnosis/no impairment category (9.1%) included children who met diagnostic criteria for at least one DSM-III-R condition but did not display impaired functioning. Children with both a diagnosis and impairment (11.1%) constituted the most severely affected category. Five sectors of mental health service use were included in this study: mental health (e.g., psychiatric hospital, residential treatment center, group home, detoxification unit, and private mental health professional); education (e.g., guidance counselor/ school

psychologist, and special class); health (e.g., medical inpatient unit, family doctor/ other nonpsychiatric physician); child welfare (e.g., social services counseling); and juvenile justice (e.g., detention center/ jail). The likelihood of a child having used mental health services within the three months preceding the initial interviews was strongly linked to the child's clinical status. Of children without a diagnosis or impairment (63.7% of the sample), only 1.6% reported using specialty mental health services during the three months prior to the interview, compared with 3.3% with a diagnosis but no impairment, 6.0% of children with an impairment but no diagnosis, and 21.6% with both a diagnosis and impairment. Among the 16% of children in the sample who reported receiving mental health care in any sector, 13% (81% of those served) received care in only one sector, and 3% (19% of those served) received care in more than one sector. Between 70% and 80% of children who received services for a mental health problem were seen by providers working within the education sector (mostly guidance counselors and school psychologists). For the majority of children who received any mental health care, the education sector was the sole source of care. Approximately 11% to 13% of children receiving any mental health services reported use of the general medical sector for these services, with little differentiation by clinical status. The child welfare and juvenile justice sectors provided mental health services to relatively few children in the sample. Because the Smoky Mountain and Blue Ridge Area Programs are recognized throughout the state for their well-developed, up-to-date services for children and their families, the proportion of children receiving services may be higher in this sample than in other regions.

A follow-up study was conducted with the GSMS participants to determine the persistence of use of mental health services (Farmer, Stangl, Burns, Costello, & Angold, 1999). Fewer than 10% of children in the sample persisted in service use across multiple 3-month follow-ups. Among those who used specialty mental health services, nearly one-half (47.3%) used services during at least two of the 3-month periods. For education services persistence was much less common, with only 20% using services during more than one 3-month period. Importantly, the education sector was the point of entry into mental health services that was least likely to be followed by involvement with other sectors. In addition, the majority of youths who entered services through the specialty mental health sector (62%) used services from additional sectors, including education (57.5%), general medicine (29.8%), and child welfare (20.6%).

Leaf et al. (1996) conducted a similar study with the four community sites included in the National Institute of Mental Health (NIMH) Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) Study. The study consisted of 1,285 adult-child pairs, with youths aged 9 through 17 years surveyed concerning the existence of psychiatric symptoms, level of functioning, and risk factors for psychiatric disorders. Both parents and youths were interviewed with the NIMH Diagnostic Interview Schedule for Children (DISC), a highly structured diagnostic instrument (Shaffer et al., 1996). During the interview, parents were provided lists of service settings and potential service providers and asked to indicate (a) whether the youth had ever been brought to any of these settings because of an emotional, behavior, drug, or alcohol problem, and (b) the youth's contacts related to an emotional, behavior, drug, or alcohol problem. Using the reports of specific services and providers utilized by

the youth, outpatient service utilization was categorized into six types of services: (a) mental health specialty sector (e.g., contacts with a psychiatrist, psychologist, social worker, or counselor in a private office or psychiatric outpatient facility), (b) medical services from a nonpsychiatrist physician or a nurse; (c) school-based services; (d) clergy; (e) social services; and (f) other or classification unknown (e.g., spiritualists, herbalists, or faith healers). One-quarter of the children reported some mental health service contact during their lifetimes; 36.5% of youth who met criteria for a psychiatric disorder reported use of a mental health service. In the past year, utilization of mental health services averaged 14.9% across community sites. Of those children who received services in the past year, 8.1% received services from a mental health specialist, 2.9% received services from a medical professional, 8.1% received services from the school system, 1.2% received services from the clergy, and 1.6% of children received services from the social service system. Of note, reports of parents and their youths regarding the use of mental health and substance abuse services showed considerable inconsistencies, and parents and children frequently differed in their reports about the use of mental health services.

Pandiani et al. (2005) conducted a comprehensive study of the utilization of mental health services within Vermont. Results reported in the study were based entirely on analysis of existing administrative databases, such as the state Department of Education (DOE). Eight special populations were examined, including three groups defined by school program participation or performance: students with an Individualized Education Plan (IEP) for an emotional/behavioral disorder, students with an IEP due to another disability, and students with poor school performance. Data for these groups were

obtained from the state DOE. Two groups were defined by participation in economic programs, specifically the state Medicaid and welfare programs, with data being obtained from the relevant state agency. Two groups were defined by indication of social or emotional trauma with data obtained from state child protection agency and the state Office of Child Support. One group was defined by criminal/juvenile justice involvement, with data obtained from state juvenile justice agency, courts, and the Departments of Public Safety and Corrections. Measures of utilization rates for young people in the eight special populations were based on information from additional public education and social service agencies. For each of these eight special groups, the proportion of children in the special population who received community mental health services was determined by probabilistic population estimation (Banks & Pandiani, 2001). Overall, more than 1 in 20 children and adolescents were served by a public mental health children's services program during 2002. Among the eight special populations, young people with an IEP for an emotional/behavioral disorder had the highest community mental health utilization rate (44%), followed by youth with a history of abuse/neglect (30%), and youth involved in the criminal/juvenile justice system (28%). Children with poor school performance and children enrolled in the state Medicaid program had the lowest community mental health utilization rates (6% and 8%). In the combined sample, mental health service utilization by young people increased with increasing age from 2% of children under 7 years of age, to 6% in the 7–12 age group, and 8% in the 13–17 age group. Of note, Vermont's system of care for young people with emotional or behavioral disorders is exceptional in many ways, resulting in a rate of utilization of public mental health services that may exceed that of most states. Therefore,

the data presented in this study may overestimate the utilization rate of children in other geographic locations. Nevertheless, this study's findings that only 44% of children who receive special education services due to severe emotional or behavior problems actually receive treatment is remarkable because, by definition, 100% of this group needs mental health services. A similar argument for the extensive need for services could be made for most of the other seven special populations studied in this research.

In conclusion, the studies reviewed above support the notion that few children who have a mental health need actually receive psychological treatment. Studies across the decades illustrate that the majority of children and adolescents with a psychological disorder never receive mental health services (Burns et al., 1995; Farmer et al., 2003; Kataoka et al., 2002; Leaf et al., 1996; Pandiani et al., 2005; Stiffman et al., 1988). Variability in the methods used to identify (a) youth with mental health problems and (b) types of mental health services provided, prohibits comparisons across similar research. Nevertheless, the studies are consistent in the finding that of those children who do receive treatment, the majority receive services through the education system (Burns et al., 1995; Farmer et al., 2003). The following section provides a review of mental health services provided within the education system.

Mental Health Services in the Schools

In recent years, a growing school-based mental health movement has emerged, essentially to overcome access barriers to children's services (Flaherty, Weist, & Warner, 1999; Hunter, 2004). A survey of school-based health clinics in 1998–1999 indicated that 57% offered mental health services as compared to only 30% seven years earlier (Brindis, Klein, Santelli, Juszczak, & Nystrom, 2003). In fact, in recent years schools have been

come to be regarded as the de facto providers of mental health services for children and youth (Farmer et al., 2003), providing an estimated 70% to 80% of psychosocial services to those children who receive them (Rones & Hoagwood, 2000).

Mental Health Problems Referred for Treatment in Schools

Mental Health Services in the United States (Foster et al., 2005) is one of the most comprehensive examinations of the provision of mental health services within the educational system. A representative random sample of 1,147 schools in 1,064 districts across the country responded to a survey about the problems most frequently presented by students in their schools. Respondents ranked the three most frequently seen problems for male and for female students out of a broad list of 14 psychosocial or mental health problems. For both male and female students, the mental health problem category most frequently endorsed was social, interpersonal, or family problems (73% male, 80% female). The second and third most frequently cited concerns differed for males and females. Anxiety (41%) and adjustment issues (36%) were cited as the second and third most frequent problems, respectively, for females. Aggression or disruptive behavior (63%) and behavior problems associated with neurological disorders (42%) were cited as the second and third most frequent problems for males. For both boys and girls, depression and substance use/abuse were reported more frequently as school level increased. The frequency of citing substance abuse as a major problem jumped sharply from middle school to high school for both males and females (for males, from 4% of middle schools to 34% of high schools; for females, from 3% of middle schools to 19% of high schools).

Repie (2005) examined the perceptions of regular and special education teachers, school counselors, and school psychologists on presenting problems of students. The School Mental Health Issue Survey (Weist, Myers, Danforth, McNeil, Ollendick, & Hawkins, 2000) was mailed to a random sample of school counselors, school psychologists, regular teachers, and special education teachers, yielding a final sample of 413 respondents from all 50 states. Respondents rated the types of problems that were most critical in their schools, or most in need of services to be provided. Respondents rated impaired self-esteem, attention deficit/hyperactivity, and peer relationship problems as the most critical emotional and behavioral problems of students in their schools. They viewed suicidal thoughts and/or behaviors, inappropriate sexual behaviors, and alcohol/drug abuse as least critical. Consistent with previous research (US DHHS, 1999), high school respondents rated depression significantly higher than did their elementary school counterparts. In addition, high school and multiple grade level respondents rated suicidal thoughts significantly higher than elementary persons.

Whitmore (2004) surveyed a random sample of 241 school psychologists on the types of referral problems that they encounter in the schools. The problems identified as occurring most frequently across all grade levels included academic problems, externalizing issues (e.g., ADHD, anger, conduct), peer problems, and self-esteem issues. Respondents serving Grades 6-12 reported a high occurrence of problems also related to depression, motivation, school phobia, substance abuse, and truancy.

In conclusion, the most commonly referred mental health problems within schools include impaired self-esteem, interpersonal problems, family problems, and disruptive behavior problems. Because of the varying categories used to define the types of mental

health problems referred, it is difficult to compare studies with similar intent.

Preliminary findings support differences in referral concerns across school level. With such a breadth of mental health problems being referred for intervention within schools, it is important to know which school personnel provide the appropriate mental health services.

School Personnel Providing Mental Health Services

In the Mental Health Services in the United States study (Foster et al., 2005), about one-third of school districts reported that they exclusively utilized school- or district-based staff to provide mental health services, which the researchers defined as those services and supports delivered to individual students who have been referred and identified as having psychosocial or mental health problems. Approximately one-quarter of school districts only contracted with outside providers for mental health services provided through the district, and approximately one-third of schools combined school- and district-based staff with outside providers. Approximately one-half of all districts (49%) used contracts or other formal agreements with community-based organizations and/or individuals to provide mental health services to students. The most common types of district-based staff providing mental health services in schools were school counselors (77%), followed by nurses (69%), school psychologists (68%), and social workers (44%). Three-quarters of schools had at least one school counselor on staff, more than two-thirds had a school psychologist and/or nurse, and 44% had a school social worker. School counselors reported spending 52% of their time providing mental health services, compared to 48% for school psychologists. School social workers reported spending 57% of their time providing mental health services and school nurses reported spending

32% of their time providing mental health services. Most schools had between two and five staff providing mental health services, but the distribution was broad, from no staff (3%) to 10 or more staff (6%). The most commonly reported number of staff was three (20% of schools). Of note, detailed information on which specific services each staff member (e.g., school psychologist) provided was not sought. Therefore, it is impossible to determine whether school psychologists were providing mental health services in the form of emotional/behavioral assessment, for example, or group counseling.

Types of Mental Health Services in the Schools

Significant variation exists in the nature and types of mental health services (e.g., parent training, individual counseling, group counseling) delivered within the school system and by organizations closely affiliated with schools. This diversity of services is partially because of the multiple objectives of mental health services provided across the entire continuum of prevention, education, and treatment (Adelman & Taylor, 2000). Individual school sites also have unique features, such as the socioeconomic background of their students, that have to be considered when planning and evaluating mental health services (Ringeisen, Henderson, & Hoagwood, 2003).

In the School Mental Health Services in Foster et al.'s (2005) United States study, respondents reported the types of services provided to students in their schools, either directly by the school or district or through community-based organizations with which the school or district had formal arrangements. A high percentage of schools provided assessment for mental health problems (87%), behavior management consultation (87%), and crisis intervention (87%), as well as referrals to specialized programs (84%). Individual counseling, case management, and group counseling also

were frequently provided (by 76%, 71%, and 68% of schools, respectively). In general, short-term interventions were more commonly provided than were services that tended to be longer term (e.g., counseling). Less than one-half of all schools reported that they provided substance abuse counseling (43%), and medication/medication management was the least likely of all services to be provided (34%). Schools also indicated that some services were more difficult to deliver than others. The service most frequently ranked as “difficult” or “very difficult” to deliver was family support services, followed by medication management, substance abuse counseling, and referral to specialized program or services. The services most frequently ranked as “not difficult” or only “somewhat difficult” to deliver were individual and group counseling, followed by behavior management and crisis intervention.

Heneghan and Malakoff (1997) reported the types of services provided within a sample of schools throughout the United States. A survey was mailed to a sample of 221 principals or program directors from elementary and middle schools, with some respondents representing affiliated preschool programs. All targeted schools had established at least one component of the School of the 21st Century model, a movement to provide integrated services to children in the schools, and/or anticipated implementing new components. Of the 221 surveys mailed, 126 were returned (57% response rate). The survey classified mental health services as "short-term," defined as psychological testing or crisis counseling; or "chronic," defined as long-term counseling or psychiatric care. Fifty-one percent of schools provided short-term mental health services, whereas only 19% provided chronic mental health services. Twenty-six percent reported that psychological counseling was available on a daily basis; 51% on a weekly or bi-weekly

basis; and 10% on a monthly basis. Because the schools that participated in the survey were part of the Schools of the 21st Century, this sample may over-represent the range of services provided; thus, findings should not be generalized to less progressive schools.

An analysis of data from the 1994–1995 National Longitudinal Study of Adolescent Health (Add Health) is one of a few studies that compares the types of mental health services provided across geographic locations (Slade, 2003). This study aimed to estimate the proportion of middle and high schools that offer school-based mental health counseling, physical examinations, and substance abuse services. The Add Health is a nationally representative survey of students in Grades 7 through 12 in the United States. Administrators from 125 schools were asked about the availability of a range of health services either at school or at another school within the same district. Overall, nearly one-half of schools offered on-site mental health counseling and approximately 40% offered on-site substance abuse counseling. Larger schools were more likely to offer all three health services on-site. There were significant regional variations in the on-site availability of mental health counseling. More than two-thirds of schools in the Northeast (86.1%) and West (68.5%) offered counseling on-site, whereas less than one-half of schools in the South and less than one-third of schools in the Midwest offered mental health counseling on-site. Schools with greater percentages of students from minority race and ethnic group backgrounds were significantly less likely to offer all three health services on-site.

The School Health Policies and Programs Study (SHPPS) 2000 assessed mental health and social services at the state, district, and school levels (Brener, Martindale, & Weist, 2001). State-level data were collected from all 50 states plus the District of

Columbia. District-level data were collected from a nationally representative sample of public school districts and from dioceses of Catholic schools included in the school sample (513 of 734 districts). School-level data were collected from a nationally representative sample of public and private elementary, middle/junior high, and senior high schools. State- and district-level data were collected by self-administered questionnaires completed by designated respondents for each of seven school health program components. School-level data were collected by computer-assisted personal interviews with respondents from 876 schools. The most common respondents were guidance counselors, psychologists, social workers, and principals. Results indicated that the three most common forms of mental health service delivery were individual counseling, case management, and evaluation/testing. Almost two-thirds (62.8%) of schools offered a student assistance program (SAP), which provide services designed to assist students experiencing personal or social problems that can affect school performance, physical health, or overall well-being. More than three-fourths of schools provided each of the following services: crisis intervention for personal problems; identification of or counseling for mental or emotional disorders; identification of or referral for physical, sexual or emotional abuse; and stress management services. In addition, more than three-fourths of schools provided alcohol and other drug use prevention, suicide prevention, and violence prevention in one-on-one or small group discussions, and more than three-fourths provided case management for students with behavioral or social problems, as well as group and individual counseling. Approximately 1 in 10 schools (10.4%) had a school-based health center (SBHC) that provided mental health and social services to students. In addition, 51.6% of schools had

a contract, memorandum of agreement, or other similar arrangement with organizations or professionals to provide mental health or social services to students.

In a survey of a national representative sample of school psychologists, special and regular education teachers, and school counselors, Repie (2005) found that the most commonly cited services available as part of the school program were evaluation of emotional/behavioral problems (91%), individual counseling services (84%), and crisis intervention services (81%). The most infrequently available services were family counseling services (28%), substance abuse services (38%), and education presentations to students on mental health (51%).

The infrequency of family counseling services was further illustrated in Whitmore's (2004) comprehensive study of the family counseling practices of school counselors, school psychologists, and school social workers. A random sample ($n = 538$) was obtained through each profession's national organization; the overall response rate was 62.9%. Only 10.9% to 12.7% of the three groups of school practitioners reported providing school-based family counseling. Eighteen percent of respondents reported that family counseling was offered as a school-based service in their school districts. In the school districts providing family counseling, 34.9% of respondents reported that the service was provided by school counselors, 28.6% reported that the service was provided by school psychologists, and 44.4% reported that the service was provided by social workers.

In addition to the provision of mental health services within a school by individual personnel, comprehensive mental health programs, such as student assistance programs (SAP), and school based health centers (SBHC) are becoming common modes

of providing mental health services in the school. With the recent increase in the number of SBHC within the U.S., the system in which mental health services are being provided has broadened. To this end, a discussion of school-based health centers and the types of services provided within these programs is provided.

School-Based Health Centers (SBHC)

Over the past two decades, the number of SBHCs has grown rapidly. The movement towards more comprehensive school-based health and mental health services began in the 1980's and was driven by several national policy initiatives. According to Flaherty et al. (1999), in 1987 there were approximately 2,150 SBHCs nationwide. In 1993, the number had more than doubled to 5,000 SBHCs nationwide. Although the SBHCs were initially developed to provide primary health services, the provision of mental health services quickly became an essential component of these clinics. In a national survey of school-based health centers in 1998, mental health issues were reported as the second most frequently cited reason for visits to a SBHC (Flaherty et al., 1999). Given the prevalence of mental health needs among children, many school districts began to implement SBHCs.

SBHCs provide some type of treatment and assessment to all children within a school. Assessment may include mental health evaluations, diagnostic interviews, classroom behavior observation, and screening for emotional or behavioral problems. SBMH programs may offer individual therapy, group therapy, or preventive services. One of the primary goals of a SBHC includes increasing access to mental health services and improving psychosocial functioning (Hunter, 2004).

The 1998-99 Census of School Health Centers provided information about the types of mental health services provided in SBHCs (National Assembly for School-Based Health Care, 2000). Data were collected through a questionnaire that was mailed to health centers; 806 school-based health centers (centers located in a school or on a school campus) responded, representing a 70% response rate. Ninety-two percent of the health centers employed a combination of physicians, physician assistants, or nurse practitioners to provide physical health services. Physical health services staff collectively averaged 27 hours per week on-site. Mental health professionals were part of the clinical team in 57% of the health centers for an average of 33 hours a week. Mental health and counseling services provided by health centers included crisis intervention (79%), case management (70%), comprehensive evaluation and treatment (69%), substance abuse (57%), and the assessment and treatment of learning problems (39%). Group counseling was used by health centers to offer peer support (59%), grief counseling (53%), classroom behavior modification (49%), substance use prevention and treatment (41%), and gang intervention (26%).

Taken together, the aforementioned studies have found that schools often offer a breadth of mental health services to their students, ranging from individual counseling to crisis intervention. The body of literature on the types of mental health services provided in schools is limited by differences in the definition of mental health services utilized in each study. In particular, studies vary across the types of mental health services included and the degree to which each service is detailed into a comprehensive list (i.e., counseling: substance abuse vs. family). A consistent finding across studies is that school psychologists often have a role in the provision of mental health services in the

schools. However, a more thorough review of the professional practices of school psychologists within the schools reveals they spend relatively little time in the role of interventionist (Curtis et al., 2004).

School Psychologists Role and Function

With the recognition of the importance of providing mental health services to children, including studies portraying a vast discrepancy between the number of children with mental health problems and those actually receiving services, schools increasingly have become the most common means by which children are provided mental health services. Accordingly, the field of school psychology has recognized the importance of the provision of mental health services in the schools as well as the major role that school psychologists can play in providing these services. To this end, a review of school psychologists' role in the schools is provided, particularly in the provision of mental health services, as well as the amount of time currently spent and desired to be spent in the provision of mental health services.

Expectations for School Psychologists' Involvement in Mental Health Services

Several sources provide direction regarding the present and future courses of the field of school psychology, including the potential and essential roles that should be performed by school psychologists. Professional organizations and the school psychology literature are two such sources of direction. Professional organizations provide practitioners with a framework of their roles within the school system through position statements. School psychology literature commonly provides the field with a research-based synthesis of how school psychologists can expand their roles within the school system.

National Association of School Psychologists. The National Association of School Psychologists (NASP) is an international organization with more than 22,000 members that has been influential in setting the standards for school psychology programs and practice in the United States (NASP, 2000b). NASP publishes position statements that describe the ideal functions and roles of school psychologists, including a statement on providing mental health services in the schools. As summarized in this statement, NASP acknowledges the importance of such factors in students' lives as psychological health, supportive social relationships, positive health behaviors, and schools free of drugs and violence in facilitating success in school (NASP, 2003). NASP advocates for the implementation of comprehensive mental health services in the schools in order to help students overcome barriers to learning, often stemming from poverty, family difficulties, and/or emotional and social needs. Regarding the professional role of the school psychologist, NASP (2003) states the following:

School psychologists are at the forefront of mental health service delivery in the schools. School psychologists are uniquely trained to integrate the knowledge and skill base of psychology with their specific training in learning, child development, and educational systems. Given this broad training and experience, school psychologists are well-qualified to provide comprehensive, cost-effective mental health services. (p. 1)

Regarding specific activities provided through comprehensive mental health services, NASP notes school psychologists currently provide such services as assessment, counseling, implementation of prevention programs, behavioral consultation services, and crisis intervention. NASP states that “school psychologists serve students directly

through individual and group counseling/therapy services, and as members of comprehensive school based mental health programs” (2003, p. 1). Of note, out of NASP, the American Psychological Association Division of School Psychology, and the Florida Association of School Psychologists (FASP), NASP was the only professional organization to provide a position statement on the provision of mental health services.

School psychology literature. Similarly, calls for the expansion of the role of the school psychologist through the delivery of mental health services have been made in the school psychology literature. For instance, Ehrhardt-Padgett, Hatzichristou, Kitson, and Meyer (2004) argued that no matter what role a school psychologist currently has—practitioner, trainer, or student—they must begin to conceptualize their roles in service delivery differently. They call for school psychologists to take action by promoting the need for comprehensive mental health services in the schools and to offer opportunities for professional development related to consultation, intervention, and mental health.

Moreover, because school psychologists possess expertise and experience in mental health and education, they have been recognized as being uniquely qualified to fill the position of school-based mental health specialists (Nastasi, 2000; NASP, 2003). For example, Nastasi (2004) highlights school psychologists’ intervention skills as a facilitator in developing and implementing classroom-based programs, and small-group and individual interventions, and in developing educational programs for teachers, parents, students, and community members. In addition to possessing the skills required to provide mental health services, school psychologists have consistently voiced a desire to spend more time providing these services and less time in their current major functions, as discussed in the following sections.

School Psychologists' Major Functions

Despite calls to spend increased time in activities relevant to mental health intervention, the typical school psychologist spends more than one-half of his or her time in assessment activities related to special education eligibility decisions (Curtis et al., 2004). Indeed, the establishment of the school psychologist as a practitioner within the school system was founded on the function of psychoeducational assessment for special education placement (Fagan & Wise, 2000). Although this has been the primary function of a school psychologist, for the past few decades leaders in the field have advocated for role expansion and respecialization (Crespi & Politikos, 2004). Even with repeated calls for increased services over the past decades, the foundation of the assessment role has continued across the century but also has yielded to two other major roles for school psychologists: direct intervention and consultation, with the earliest mentions of intervention occurring in the 1930's (Fagan & Wise, 2000). Across the decades, these three roles have accounted for most of the school psychologist's time (Crespi & Politikos, 2004). In addition, the traditional assessment role itself has broadened in scope as additional factors, such as environmental (e.g., home environment, classroom environment), have been acknowledged to contribute to the problems of children and their education (Fagan & Wise, 2000).

Since 1970, social and educational movements have strengthened the school psychologist's identity and supported more expanded services and functions. For example, since the 1970s, practice has been largely defined by special education legislation and funding (Fagan, 1992). During this time period, a number of legal challenges to special education occurred and a number of legislative acts were passed, the

most important being PL 94-142 (Education for All Handicapped Children Act) in 1975 (United States Senate and House of Representatives, 1975). Most recently the Individuals with Disabilities Education Improvement Act (United States Senate and House of Representatives, 2004) was issued, which may change the assessment role of the school psychologist (Fagan, 2002). In the field of special education, towards the end of the 1980's the focus shifted to another target group, "children at risk." With this shift, changes occurred in the provision of related services and instruction, and more recently toward functional assessment. A shift in the school psychologist's role towards pre-referral assessment, intervention, and secondary prevention for at-risk groups are additional potential indicators of changes in role and function (Furlong, Morrison, & Pavelski, 2000). More recently, there has been a resurgence of interest in consultation and an ecological approach to family assessment and intervention, including communication and collaboration between the home and the school (Fagan & Wise, 2000). Due to these various external forces (i.e., legislation, social changes), a greater potential for school psychologists to broaden their roles within the school system has emerged. Importantly, job-site characteristics (e.g., school psychologist: student ratio; school system expectations) and what the person brings to the job (e.g., professional skills and personal characteristics) also are influential factors in determining the role of each individual school psychologist (Fagan & Wise, 2000).

Time school psychologists spend in each major function. In general, school psychologists spend more than two-thirds of their time in activities related to students who have identified disabilities and are part of the special education system (Hosp & Reschly, 2002; Reschly & Connolly, 1990). The services that school psychologists

deliver are significantly oriented toward assessment, with an average of 52% to 55% of their time spent in psychoeducational assessment, 21% to 26% in direct interventions (e.g., counseling), 19% to 22% in consultation, and 1% to 2% in research and evaluation (Bramlett, Murphy, Johnson, Wallingsford, & Hall, 2002; Curtis et al., 1999; Hosp & Reschly, 2002). For example, a 1991-1992 survey of 1,089 NASP members and practitioners showed that school psychologists devoted more than one-half of their time to psychoeducational assessment (55%), with considerably less time devoted to direct intervention (20%), problem-solving consultation (16%), and systems-organizational consultation and research-evaluation (5% or less) (Reschly & Wilson, 1995).

Studies published in recent years show a similar allocation of time across the school psychologist's roles, although many recent surveys included an expanded, comprehensive survey of school psychologists' roles and functions. Bramlett et al. (2002) solicited participation from 800 randomly-selected members of NASP during the Spring of 1999, with a final sample of 370 school psychologists from 40 states. A similar pattern of role functions was evidenced, as respondents indicated spending the majority of their time in assessment (46%), followed by consultation (16%), direct interventions (13%), counseling (8%), conferencing (7%), supervision (3%), inservices (2%), research (1%), parent training (1%), and other (3%). Taken together, up to 22% of school psychologists' time is spent delivering mental health treatment, assuming that all interventions, counseling, and parent training services are targeted at assisting children with mental health needs. A smaller proportion was obtained in survey research by Hosp and Reschly (2002), which indicated that school psychologists spent 6.5 hours per week on direct interventions (16.3% of a 40-hour work week).

Collectively, a consistent pattern with respect to the school psychologist's role within the school system has sustained over the last 20 years (Bramlett et al., 2002; Curtis et al., 1999; Fagan & Wise, 2000; Hosp & Reschly, 2002; Reschly & Wilson, 1995). School psychologists spend the majority of their time in assessment-related duties, and substantially less of their time involved in direct intervention and consultation. Studies are limited by designs that preclude making statements specific to the provision of various and specific mental health services. Although the professional practices of school psychologist have remained constant, some factors significantly influence the proportion of time spent in various roles.

Geographic differences in functions. Historically, researchers have found that the types of roles in which school psychologists engage vary according to the location and setting of their school districts. As summarized by Curtis et al. (2004), in general, the rural school psychologist historically provided a wider array of services and was more likely to be involved in activities at the systems level. For example, 20 years ago rural school psychologists were more likely to be involved in such activities as consulting with board members, conducting home visits, and designing school-wide programs than were school psychologists located in urban and suburban locations. There was also a greater tendency for consultation to occur in suburban school districts (Curtis et al., 2004). Differences in the definition utilized in studies pertaining to the geographic location of practitioners have made it difficult to compare early studies with more recent research. For example, Smith (1984) defined locations by regions of the U.S., as opposed to defining location by rural, suburban, and urban settings, and found that the average role

in the Northeast NASP region (NE and MA census regions) involved more time allocated to direct interventions than assessment.

Hosp and Reschly (2002) surveyed a random sample of 1,056 practicing school psychologists from the 1997 NASP membership list. Respondents were categorized into region on the basis of the state where they received NASP correspondence, with a total of nine census regions (Northeast, Mid-Atlantic, South Atlantic, East South Central, East North Central, West South Central, West North Central, Mountain, and Pacific). All census regions were represented by at least 44 respondents. The researchers found significant differences between regions in current hours spent in psychoeducational assessment. Number of hours ranged from just under 19 hours per week (Northeast and Mid-Atlantic) to more than 26 hours per week (East South Central). Differences also were found among regions for hours spent providing direct interventions, with the highest average in the Mid-Atlantic region (9.9 hours), which was more than all other regions except for the Northeast. The regions with the most hours spent in psychoeducational assessment generally had the least amount of hours per week spent providing direct interventions.

Taken together, recent studies suggest that school psychologists on the East coast and those who serve urban and suburban populations are more likely to spend more of their workday providing direct interventions to students, interventions that may include mental health services. School psychologists in rural areas and in the central and western parts of the USA are more likely involved in conducting assessments for special education eligibility, which limits the time they have available to provide interventions. Rural school psychologists' relatively limited provision of direct interventions also may

be due to more involvement in systems-level activities (Curtis et al., 2004). Notably, a call for frequently updated studies has been made (cf., Reschly & Wilson, 1995) due to shifts in employment setting, with an increase in the percentage of school psychologists working in urban school districts. The current body of literature also is limited by the lack of a common definition of geography.

Trends in School Psychologists' Roles Specific to Mental Health Services

School psychologists have been concerned with the mental health of school children since the beginning of the field, evidenced by the efforts of early school psychologists to establish comprehensive services for children (Fagan & Wise, 2000). Federal law has mandated school psychologists' involvement. Specifically, in PL 94-142, counseling is specified as a related service that must be provided by a qualified social worker, school psychologist, or guidance counselor when deemed necessary by a student's IEP (United States Senate and House of Representatives, 2004). According to IDEA, such services may be necessary to assist a child with a disability to benefit from special education. In addition to government policies, increased societal stressors have been identified that impact children's mental health and subsequently the learning environment of children. Most recently, Crocket (2004) summarized the critical issues facing children in the 21st century, which included poverty, violence, and serious behavioral and emotional issues. School psychology literature has published calls for school psychologists to respond proactively with respect to providing mental health services to children in schools (Nastasi, Varjas, Bernstein, & Pluymert, 1998) and to provide a continuum of mental health services in schools, addressing primary prevention

as well implementation of secondary and tertiary services that treat mental health needs in school children.

Surveys suggest that some change in school psychology practice has occurred, although not among all practitioners. A 1994-1995 survey of NASP school psychologists revealed that the majority of the sample of 1,414 school-based practitioners provided a range of services, including psychoeducational assessment (97% of respondents), consultation (97%), individual and group counseling (82% and 53%, respectively), and educational programs for parents, teachers, and others (78%) (Curtis et al., 1999). Similarly, a survey of 273 doctoral-level school psychologists who were members of the American Psychological Association indicated that most of the responding practitioners provided an array of services, including assessment (63% of the respondents), counseling (64%), and consultation (59%) (Short & Rosenthal, 1995).

In addition to providing more mental health services within the traditional role in the school system, the shift occurring within the field has allowed many school psychologists to carve out their own roles as a mental health provider within the school system. Nastasi et al. (1998) surveyed school psychologists who were engaged in a mental health program that had been identified as exemplary by NASP. Surveys were returned by 87 programs (representing 36 states), with 90% of the 87 mental health programs providing services in public schools. With regard to responsibilities in general, the 87 school psychologists spent 21% of their time in assessment, 20% in counseling, 27% in consultation, 16% in prevention, and 6% in research. These school psychologists devoted almost one-half (48%) of their total work time to the specific mental health program. Of note, the difference in amount of time spent in providing mental health

services in this study compared to previous studies mentioned may be due to the school environment and attitude towards the provision of mental health services. Despite small movements towards an expanded role for the school psychologist, a review of the literature demonstrates that school psychologists currently voice discontent over the amount of time currently spent providing mental health services.

Discrepancy Between Actual and Desired Involvement in Mental Health Services

Early studies show that a majority of school psychologists provide at least some direct mental health services, and that most practitioners wish to increase their time spent in such activities. Smith (1984) found that practitioners spent approximately 11% of their time providing counseling services (7.3% of services provided to students and 3.8% to parents), but desired to spend approximately 18% of their time providing counseling services. Yoshida, Maher, and Hawryluk (1984) found that 60% of school psychologists that they surveyed reported providing individual counseling services (37% for 1-5 hours per week, 16% for 6-10 hours, and 7% for 11 hours or more per week) and 46% of the school psychologists reported provided parent counseling (41% for 1-5 hours per week, 4% for 6-10 hours, and 2% spent for 11 hours or more). When participants were asked to indicate to which of several activities they wished to devote more time, the two highest rated were counseling pupils (66%) and counseling parents (43%).

A 1991-1992 survey of 1,089 NASP members and practitioners focused on their current and desired roles within the school system (Reschly & Wilson, 1995). These practitioners indicated a desire for reallocation of their time, including a decrease in psychoeducational assessment to a preferred level of 32% of their time. Respondents indicated that they would like to increase their time spent in the following roles to the

following percentages: direct intervention, 28%; problem-solving consultation, 23%; organizational-systems consultation, 10%; and research and evaluation, 7%.

A similar study specific to counseling was conducted with 178 members of NASP (Prout et al., 1993). In regards to their professional roles, 70% of the respondents indicated that counseling/therapy services were specifically included in their job description. Respondents spent an average of 17% of their time providing counseling/psychotherapy services; 100% of respondents indicated provision of at least some services in this area. Respondents reported seeing an average of 6.4 students weekly for individual counseling and 10.3 students weekly in group sessions. Of note, 53.9% of the respondents indicated that they would like to undertake more counseling, whereas 43.7% indicated that they would like to undertake about the same amount of counseling.

A recent replication was conducted by Yates (2003) via survey of 500 randomly selected NASP members. The majority of respondents was from the Northeast (41.9%) and worked in a suburban school district. Approximately 72% of respondents indicated that they provided counseling. Respondents indicated spending 17.2% of their time in counseling (vs. 49.8% in assessment, 9.4% prevention, 18.5% consultation, 17.7% administration, and 4.6% research). Respondents indicated a desire to spend 22.0% of their time providing counseling services.

In conclusion, the majority of researchers over the decades have found that school psychologists wish to spend more time in the provision of mental health services. Given that researchers have found that problems commonly referred within schools relate to mental health service needs (e.g., interpersonal problems, family problems), it is plausible

that practitioners desire to spend more time providing mental health services because they recognize the need for these services. Although the most recent study was conducted in 2003, the study focused on the provision of counseling services and did not examine other modes of mental health services, such as consultation with teachers and family members. Additional research is needed using an expanded definition of mental health. To this end, the type of mental health services currently being provided by school psychologists is an important area of research.

Specific Mental Health Services Provided by School Psychologists

Pryzwansky, Harris, and Jackson (1984) surveyed school psychologists in 18 Milwaukee schools. Fifty-eight percent of the 146 respondents provided some form of direct interventions in their schools. Of those school psychologists providing direct intervention services, 92% reported students as their client group, 52% reported working with parents, 27% reported working with families, and 30% reported working with teachers. Individual plus group sessions was the most common format used for counseling/therapy (47%), followed by individual sessions (20%). Of note, this study was published more than two decades ago and the amount of time spent in direct interventions may have changed slightly in line with findings from national surveys (e.g., Curtis et al., 1999). This study also was limited by its use of participants from only one region, because roles and functions for school psychologists vary somewhat by geography. Finally, the sample consisted of some school psychologists who had a degree specialization in counseling psychology (12%). Hence, the results may have been skewed by both the sample's demographics and degree specialization.

Recent research sheds light on the details of counseling services provided by school psychologists. Of the 72% of school psychologists who reported providing counseling services in Yates' (2003) study, the most commonly cited theoretical orientations used in treatment were behavioral/cognitive behavioral therapy (36.5%) and solution-focused behavior therapy (18.6%), whereas the use of Adlerian (1.2%), gestalt (1.2%), or psychodynamic (3.3%) approaches were least common. Regarding frequency of mental health services, approximately 62% reported providing individual counseling on a regular basis whereas 34.7% provided it at least on an occasional basis. Most individual sessions occurred weekly (54.4%), lasted from 30-45 minutes (73.3%), and involved five or more sessions (39.6%). Approximately 41.1% of the subset who endorsed individual counseling reported that they provided group counseling for students on a regular basis and 32.9% indicated providing group counseling at least on an occasional basis. Most student group sessions occurred weekly (79.5%), with 1-5 groups (77.5%), and involved 5-16 sessions (54.2%). Approximately 18.2% provided classroom counseling (e.g., social skills training) and 19.1% provided family counseling. Although this study has been the most comprehensive one to focus on the provision of mental health services, the focus is on the provision of counseling services. Additional information gathered on the different forms of interventions (i.e., behavior management consultation, behavior intervention plans) would be beneficial. In addition, because this study relied solely on a survey, forced-choice answers were the mode by which participants gave information. Open-ended survey questions and/or interviews, which would allow participants to provide in-depth answers to questions, would be helpful.

Another gap in research involves the lack of examination of the types of mental health services provided in relation to school psychologists' years of experience.

Role of Years of Experience on Professional Practices

Due to societal, legal, educational, and professional trends, the role of the school psychologist has expanded and the field of school psychology continues to challenge practitioners to provide more comprehensive services. In response, changes have been made in graduate school training and more opportunities exist for continuing education. Importantly, the standards set by school psychology organizations have expanded to match both legislative changes and societal changes. It is therefore plausible that each generation of school psychologists has received slightly different training, corresponding to different philosophies of professional roles. In particular, because of the recent trend towards the expansion of the school psychologist's role into the provision of mental health services, school psychologists' beliefs regarding their roles in providing mental health services in schools may vary according to the number of years they have been in the field. It may also be difficult for school psychologists who have been practicing for several years to change their established roles within the school, particularly if the change requires extensive training.

Over the past decade research has shown a steady increase in the average age of school psychologists resulting in a growing age gap between most practitioners and new graduates. Between 1980-1981 and 1999-2000, the mean age of school psychologists increased from 38.8 years (Smith, 1984) to 45.2 years (Curtis et al., 2002). In only 20 years the percentage of school psychologists 40 years of age or younger has declined from 43.2% to 31.2%, whereas those over 50 years of age increased from 20.2% to

32.8%. Almost one out of three school psychologists is now over the age of 50 (Curtis et al., 2004).

In general, older practitioners have greater years of experience. Whereas the mean total experience (i.e., years of experience in school psychology and education combined) in 1980-1981 was 10.9 years, it increased to 16.7 years in 1998-1999. A survey of 370 practitioners conducted in 1999 found that the mean length of experience as a school psychologist was 18 years (Bramlett et al., 2002). Ten percent of the sample had been engaged in school psychology for less than 10 years, 43% for 11–20 years, and 46% for more than 20 years. Between 1989-1990 and 1999-2000, the percentage of school psychologists with 20 or more years of total experience more than doubled, increasing from 10.2% to 20.7% (Curtis et al., 2004).

These trends in age and experience may contribute to increased variability in the professional roles of school psychologists due to the aforementioned changes in the field. However, an initial study conducted before the graying of our field and the push for expanded mental health services found that differences between recent and more experienced graduates were negligible with respect to specific skills and role functions for the conditions of actual and preferred job characteristics (Fisher, Jenkins, & Crumbley, 1986).

A more recent study examining experience as a variable influencing school psychologists' role and function was conducted using data from the 1994-1995 school year (Curtis et al., 2002). Survey responses from 1,411 practicing school psychologists were analyzed to examine the association between nine professional practice factors, including experience, and each of the professional practices. The number of years of

experience as a school psychologist was significantly related to some professional practice activities. Specifically, school psychologists with more years of experience conducted more special education reevaluations, served more students through consultation, and conducted more in-service programs than did their less-experienced peers (Curtis et al., 2002). This study did not find a relationship between years of experience and practitioners' reports of the number of students they served through individual counseling or through group counseling. Although this study was published recently, the data analyzed are more than a decade old. As has been noted, the age of school psychologists has increased markedly in recent years and, therefore, a sample of school psychologists today may differ greatly from a sample in 1994. Differences also may be larger in current years due to the continuing push for school mental health services.

Yates (2003) examined relationships between those spending a high (more than 25%), medium (10% to 24%), or low (1% to 9%) percentage of their time in counseling (individual, group, family, and classroom) and the following demographic characteristics: degree level, grade level served, school psychologist/student ratio, type of school, number of buildings worked in, *years of experience*, region of the country, and the number of assessments completed per year. Time spent in counseling was inversely associated with the following three demographic factors: number of assessments completed per year, psychologist/student ratio, and number of buildings served; a positive association between grade level served and time spent in counseling was identified. Years of experience were unrelated to the amount of time spent in counseling.

In sum, few researchers have examined the relationship between provision of

mental health services and the number of years that a practitioner has been in the field. While Yates' (2003) study is commendable as one of the few to examine this relationship, this study is limited by a narrow definition of mental health (i.e., "counseling services" and did not include such services as consultation). The body of literature also is limited by a reliance on survey data; it is difficult to draw conclusions from forced-choice surveys because of the limited range of items/choices often included within the survey. Other methods of collecting data, such as focus groups or the use of open-ended questions in surveys, would allow researchers to identify the common themes that emerge with respect to types of mental health services provided and barriers to the provision of such services. Such barriers must exist given the still unmet need for treatment of children's mental health problems and school psychologists' clearly expressed desire to spend more time in providing psychotherapeutic services. Preliminary quantitative studies have identified such barriers to the provision of mental health services in the schools.

Barriers to the Provision of Mental Health Services in Schools

A review of the existing literature identified only a handful of articles that have examined barriers that prevent school psychologists from providing the range and frequency of mental health services they desire to provide. Out of these studies, only one directly addressed school psychologists' perceived barriers to mental health services. Additionally, there have been no qualitative studies conducted to explore this topic.

Meyers and Swerdlik (2003) discussed a number of external and internal barriers school psychologists may face in working in a school-based health center (SBHC). A potential barrier may involve the confusion that arises over the various terminology used

to refer to SBHCs, which could potentially negatively impact development, implementation, and research. Cultural and attitudinal factors, such as the stigma associated with mental health problems, may obstruct the development of SBHCs. Related to this, cultural, religious, or political climate of a given community may stand in the way of a SBHC's effort to implement effective preventive interventions that address sensitive issues (e.g., adolescent sexuality, substance abuse). Limited funding also could be a barrier, because very few schools have adequate resources to deal with the large number of students with mental health problems. A lack of integration and coordination of current school-based programs may inhibit effective implementation of services. Finally, two barriers are identified in relation to the school psychologist's role within the school. First, a narrow role of the school psychologist as the sole provider of assessment may inhibit them from providing mental health services. Second, in an effort to provide comprehensive services to all students, schools and practitioners may find themselves overextended and experiencing role strain. For any school psychologist, the expanded role opportunities in SBHCs provides an avenue for professional development, but may also be overwhelming, leading to feelings of stress and exhaustion.

In the SAMHSA survey (US DHHS, 1999), schools ranked the extent to which 10 factors were barriers to the delivery of mental health services, using a scale of 1 ("not a barrier") to 4 ("serious barrier"). Financial constraint of families (58%) and insufficient school and community-based resources (49%) were the factors most often reported as barriers or serious barriers. In open-ended comments, respondents discussed the financial constraints faced by students and their families in attempting to obtain medical health services. Explanations ranged from inadequate Medicaid reimbursement to limitations in

benefits for those who are privately insured and a dearth of mental health services for the uninsured. Competing priorities for use of funds (46%), difficulties with transportation (45%), and inadequate community mental health services (44%) also were considered barriers. Least often reported as serious barriers were protection of student confidentiality (8%) and language and cultural barriers (20%). A limitation of this study includes the use of forced-choice in responding to the items pertaining to this topic within the survey. Of those barriers listed, most reflected external, systems-level barriers (e.g., funding) to the exclusion of internal, within-person barriers (e.g., practitioners' skill level). Because of the newness of this topic, the types of barriers included in the survey may not necessarily represent the entire range of factors that practitioners consider barriers to represent. In addition, respondents were grouped into one large sample for this analysis. Because administrators, school counselors, and school psychologists' responses were collapsed, it is impossible to determine which group of professionals viewed which barrier as being the greatest, which is unfortunate because school psychologists' and administrators' perceptions may vary significantly.

Participants in Yates' (2003) survey of school psychologists from preschool, elementary, middle, and high schools responded to a series of statements that listed factors that either facilitated more time spent on counseling or presented barriers to spending more time in the counseling role. The list of barriers included six categories and an "other" choice category which also provided space for additional comments and the words "please elaborate." Participants were asked to check all that they perceived as representing barriers. The barriers rated as most preventing practitioners from spending more time in counseling pertained to role responsibility. Specifically, respondents

endorsed a heavy emphasis on assessment (68.2%) and the fact that counseling was not part of their roles in the school (52.5%) as two common barriers. An additional barrier endorsed by a number of respondents was that counseling is not currently part of their identified/written job responsibilities (26.4%). Relatively few respondents indicated that low interest (6.6%), belief that counseling should be provided outside of school (3.7%), or a low number of referrals (5.4%) were significant reasons preventing them from spending additional time on counseling. Other barriers elicited through the “other” choice included insufficient training in counseling, other job responsibilities, parent/student issues, and the perception that their school district does not view counseling as a necessity. A number of participants elaborated on barriers they listed in the “other” category in order to describe what prevents them from spending more time in counseling. Responses included the following: (a) “I don’t feel that I have received adequate training/supervision to provide counseling services in the schools,” (b) “school psychologists need more practicum experience rather than workshops on theory,” and (c) “close supervision or training specific to the school setting would have increased my confidence.” When asked to respond to time barriers, respondents replied that (a) “case management and assessment impact my ability to provide counseling” and (b) “I have a large number of assessments that cause counseling to take a back seat.” When asked to respond to district perception as a barrier, respondents indicated that (a) “counseling is a huge area of need, but budgets are tight,” (b) “my district is not pro mental health,” and (c) “my state does not encourage school psychologists to provide counseling.” While this is one of the few studies to focus on barriers specific to school psychologists, the questionnaire utilized consisted of only closed-ended and partially closed-ended

questions and a minimal list of six barriers. Because so little research has been conducted on this topic, it is difficult to know what are the most common barriers to the provision of mental health services. For example, in this particular study insufficient training was not listed as a barrier, yet it was noted by multiple respondents in the “other” category. Therefore, a more appropriate method of studying this issue would be in the form of open-ended questions that would allow respondents to identify the range of barriers in order to gather information on emerging themes. Of note, although this sample was fairly representative of the field of school psychologists at that time, respondents who worked within only one school (31.5%) were over-sampled.

In sum, only a few studies have examined what prevents school psychologists from providing needed and desired mental health services. Only one study (Yates, 2003) has examined why the gap between the amount of time school psychologists currently spend providing mental health services and their desired amount of involvement is occurring. Due to limitations of this pioneering study, there is insufficient information about the types of barriers that school psychologists perceive inhibit them from providing more mental health services within their roles. An additional gap in the literature pertains to the relationship between school psychologists’ demographic characteristics and the types of barriers that they may perceive. As mentioned earlier, researchers have found significant differences among school psychologists of different ages and levels of experience pertaining to their roles within the school system. Therefore, additional research is needed on how years of experience impact either the perceptions of, or reactions to, barriers. A practitioner’s level of experience is potentially relevant due to changes that occur in school psychology graduate training. Additionally, Yates (2003)

identified that the type and amount of training received by school psychologist are perceived barriers and facilitators in the provision of school mental health services. To this end, a review of the mental health training required for accreditation and a review of current research on the amount of mental health training school psychologists currently receive is discussed in an effort to identify variability in training that would support Yates' preliminary findings.

School Psychology Graduate Training

There are currently approximately 22,000 school psychologists working nationwide in the field and approximately 200 school psychology training programs (NASP, 2000b). Most school psychologists have been trained at the 60-hour educational specialist level or beyond, with approximately 20% of practitioners attaining the doctoral degree (Curtis et al., 2004). Both NASP and the American Psychological Association Division 16 (School Psychology) provide standards that guide the training and practice of school psychology, with a rigorous accreditation process for program approval.

National Association of School Psychologists

While it is impossible to list exact courses school psychologists take because programs are permitted great variability, accredited programs do have to address standards. In order to become a NASP-accredited program in school psychology, a program has to provide knowledge and training in a number of domains of professional practice as indicated in the *NASP Standards for Training and Field Placement Programs in School Psychology* (NASP, 2000a). Programs must ensure that their students have a foundation in the knowledge base for psychology and education, including theories, models, empirical findings, and techniques in each domain. Pertaining to the provision of

mental health services, NASP requires programs to provide training in the domains of “prevention, crisis intervention, and mental health” (NASP, 2000a, p. 30). This domain includes the following:

School psychologists have knowledge of current theory and research about child and adolescent development; psychopathology; human diversity; biological, cultural, and social influences on behavior; societal stressors; crises in schools and communities; and other factors. They apply their knowledge of these factors to the identification and recognition of behaviors that are precursors to academic, behavioral, and serious personal difficulties (e.g., conduct disorders, internalizing disorders, drug and alcohol abuse, etc.). They have knowledge of effective prevention strategies and develop, implement, and evaluate programs based on recognition of the precursors that lead to children’s severe learning and behavior problems. School psychologists have knowledge of crisis intervention and collaborate with school personnel, parents, and the community in the aftermath of crises (e.g., suicide, death, natural disasters, murder, bombs or bomb threats, extraordinary violence, sexual harassment, etc.). School psychologists provide or contribute to prevention and intervention programs that promote the mental health and physical wellbeing of students. (pp. 30-31)

Division 16 (School Psychology) of the American Psychological Association

The American Psychological Association provides accreditation of education and training programs in professional psychology, including school psychology, consistent with their recognized scope of accreditation practice, and their published policies, procedures, and criteria. Similar to NASP program accreditation process, to become an

American Psychological Association-approved program each program must fulfill certain requirements. Because of the breadth of professional psychology, accreditation guidelines are broader than NASP's guidelines. According to the Guidelines and Principles for Accreditation of Programs in Professional Psychology (American Psychological Association, 2005), programs must provide knowledge and training in the following:

... the breadth of scientific psychology, its history of thought and development, its research methods, and its applications; the scientific, methodological, and theoretical foundations of practice in the substantive area(s) of professional psychology in which the program has its training emphasis; and diagnosing or defining problems through psychological assessment and measurement and formulating and implementing intervention strategies (including training in empirically supported procedures). (p. 14)

In sum, all graduates of NASP or American Psychological Association-accredited programs should, by definition, receive training in mental health services. However, the amount and intensity of experiences is quite variable. A sample of school psychology training programs conducted via the Internet on training sequences shows that some programs, for instance, University of Texas-Austin, require up to eight courses and practicum in mental health interventions (University of Texas-Austin, 2005). Other programs, such as the University of Florida, require students to take just one class in psychological counseling (University of Florida, 2005). Studies in the school psychology literature provide additional information on the range of mental health intervention training school psychology graduate students receive.

Training in Mental Health Interventions During Graduate School

In a survey of 146 school psychologists, Pryzwansky et al. (1984) found that the sample had taken a relatively large number of courses in therapy and counseling. More than one-half of the participants had completed more than three courses in therapy and counseling and 36% had logged more than 100 hours of practicum experience in the psychological counseling or therapy areas. Prout et al. (1993) reported that in a random sample of 178 school psychologists, the average number of courses in counseling or psychotherapy was 5.6 ($SD = 5.00$).

More recently, Whitmore (2004) surveyed a national sample of school psychologists, school counselors, and school social workers. When the 74 school psychologists were asked to indicate whether or not they had received university-level training in five topics related to family work and family counseling, 80.5% indicated that they had received training. When asked if they had received training in family systems intervention, 63.5% of school psychologists indicated that they had received training and approximately 55% of school psychologists reported taking a family therapy survey course. Approximately 30% of school psychologists reported having advanced family counseling coursework and 23.8% reported having supervised practica in family counseling. School psychologists who reported practicing family counseling in the schools were asked what type of training they had received specifically in family counseling. Nearly 68% reported receiving training from seminars, workshops, or trainings sponsored by the school system, 53.3% reported receiving training from their university program, 40.0% received training from post-degree university coursework in family therapy, 20.0% received training from a family therapist apart from the school

system, and 13.3% received training from a free standing family therapy institute.

Notably, this study is limited by its focus on family therapy and its small sample size (i.e., $n = 74$). Current data on other modalities of psychotherapeutic interventions (e.g., individual and group counseling) would be helpful.

In Yates' (2003) survey of 500 school psychologists, participants responded to a series of questions concerning the type of training they had received in foundations of mental health problems and in counseling interventions. The greatest proportion (45.0%) of the respondents took between three and five graduate "counseling" courses; the remaining 27.5% indicated taking one to two courses, 12.7% indicated taking six to eight courses, and 14.8% indicated taking more than eight classes. Courses frequently (more than 70%) noted in the counseling area included: Behavioral Interventions (89.9%), Counseling Children (78.6%), Developmental Psychology (88.2%), Psychological Theories (92.0%), Personality (82.4%), and Psychopathology (70.6%). Much less frequently (less than 50%) did respondents note coursework in Multicultural Counseling (42.0%), Psychotherapy (45.8%), and Counseling Children with Developmental Disabilities (30.3%). Approximately one-half (54.4%) stated that they had enrolled in a continuing education counseling workshop within the last five years. Respondents most often indicated spending 1% to 24% of their time in supervision discussing their counseling cases (57.9%), with 11.1% indicating no time in supervision spent on counseling cases, 19.3% indicating 25% to 49% of their time, 8.2% indicating 50% to 75% of their time, and 3.4% indicating spending more than 75% of their time on counseling cases. Direct supervision most often included audio/video taping (56.4%), with one-way viewing (i.e., supervision through a one-way mirror) being the least

common (39.0%) When asked about the satisfaction of the graduate training they had received in counseling, 65.5% indicated that insufficient time was spent on counseling during their training. This finding is of particular importance, because it shows that school psychologists do not feel adequately trained despite the majority of respondents taking four courses or more in foundations of mental health problems and in counseling interventions. More research is needed to determine the type and amount of coursework and the type and amount of training experiences (e.g., didactic content, practica experience, live supervision during training) necessary for school psychologists to feel prepared to provide mental health services. Taken together, research indicates the amount of training in mental health services varies across training programs. This research is limited by a lack of consistency across studies in defining “mental health coursework” and “mental health training.” Additional research needs to determine which specific content areas and experiences will allow school psychologists to feel sufficiently prepared to provide mental health services in the schools. Such training could be provided during graduate school but also implemented in continued education courses, particularly in light of data illustrating practitioners’ reliance on post-graduate seminars to receive additional training in mental health services (e.g., Whitmore, 2004; Yates, 2003). An additional gap in research involves the variability in training throughout the country and across time in the area of mental health.

Conclusions

The common path through which children and adolescents receive mental health services is through the education system (Burns et al., 1995; Farmer et al., 2003). Changes in government policy and societal initiatives have underscored the need for

school psychologists to provide school-based mental health services. However, school psychologists currently spend relatively little time in the provision of such services (Curtis et al., 1999; Fagan & Wise, 2000; Hosp & Reschly, 2002, Reschly & Wilson, 1995). The majority of researchers over the decades have found that school psychologists wish to spend more time in direct intervention with children with mental health needs (Prout et al., 1993; Reschly & Wilson, 1995; Smith, 1984; Yates, 2003). Therefore, it is important to identify why school psychologists are not providing the desired and needed level of mental health services.

One purpose of the current study was to elucidate factors that school psychologists perceive inhibit them from providing more mental health interventions within their professional roles. This current study expanded on the research of Yates (2003), a study limited by a list of barriers in which response options did not appear sufficient given that themes such as knowledge/skill/training deficits emerged following examination of responses to the “other” option (i.e., other barriers other than those listed). To date, no published qualitative research has identified barriers perceived by school psychology practitioners.

Existing research has not sufficiently explored the kinds of content knowledge areas and training experiences that would allow school psychologists to feel sufficiently prepared to provide mental health services in the schools. Identifying barriers related to knowledge and skill deficits may ultimately aid in the design and implementation of effective mental health training in school psychology programs. Thus, the current study purposefully queried practitioners about desired didactic and practical experiences in school-based mental health interventions.

Research also suggests that significant differences exist among school psychologists of different ages and levels of experience pertaining to their roles within the school system (e.g., Curtis et al., 2002). Therefore, factors such as years of experience also should be considered when studying school psychologists' roles in the provision of mental health services. There is a growing age gap between most practitioners and new graduates (Curtis et al., 2004). Identifying differences between new graduates' and experienced practitioners' needs and perceptions may ultimately aid in the design of specific and deliberate professional development services for practicing school psychologists. Thus, an additional purpose of the current study was to examine perceived barriers as a function of practitioners' levels of experience.

Chapter 3

Method

Research Paradigm

Creswell (1998) defines qualitative research as “an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or humanistic problem” (p. 15). Qualitative research methods are typically designed with the objective of making generalizations about some social phenomena, creating predictions regarding those phenomena, and providing contributory explanations (Glesne, 2006). A valuable use for qualitative research is as a means for exploring a topic or problem that has not been previously researched (Glesne, 2006). According to Strauss and Corbin (1990), qualitative methods can be used to unearth and provide understanding about a phenomenon about which little is yet known. Additionally, Creswell (1998) has identified a number of rationales for choosing a qualitative study. His justifications include such reasons as a topic needs to be explored, a need to present a detailed view of the topic, or to emphasize the research’s role as an active learner who can tell the story from the participants’ view. Onwuegbuzie and Leech (2007) have identified qualitative research as particularly appealing to the field of school psychology given that it is useful for obtaining insights into regular or problematic experiences and the meaning attached to these experiences of selected individuals and groups. Given the nature of the research

problem, qualitative research methodology was used to address the expressed purpose and corresponding research questions for this study.

Research Design

Collective case study was the framework for understanding and interpreting the information obtained from this study (Stake, 1995). Case study research is used to explore real life experiences and situations, when the researcher is interested in both the phenomenon and the context in which it occurs. Case study research seeks out rich, in-depth information and it aims to investigate a particular topic in its context from multiple viewpoints through multiple methods and multiple data sources (Stake, 1995). Golby (1993) has pointed out that case study research can be a useful approach when studying professional practice and problems of practical significance. Case study research can suggest to readers what to do, especially if they are in a similar situation (Merriam, 1998), and enable practitioners to re-conceptualize a practical problem and to understand more fully, that is, to relate theory and practice (Golby, 1993). In a case study, the case can be a person or several persons, an institution, an innovation, a process, a service, a program, an event or an activity (Creswell, 1998). When a researcher decides to study a number of cases to gain a better understanding of a phenomenon, the study is defined as a *collective case study* (Creswell, 1998). Stake (1995) defines a study as a collective case study when the researcher utilizes a number of cases that are studied jointly in order to investigate a phenomenon, population, or general condition.

Only one published study (Yates, 2003) has attempted to explain why the gap between the frequency with which school psychologists currently provide mental health services and their desired amount of involvement is occurring. In this study, the response

options did not appear sufficient, given that themes such as knowledge/skill/training deficits emerged following examination of responses to the “other” option (i.e., other barriers other than those listed) after multiple respondents identified common barriers. Thus, currently the professional literature contains insufficient information about the types of barriers that school psychologists perceive inhibit them from providing more mental health services within their professional roles. Given the limited understanding of the research problem, collective case study provided the means to derive inductively the greatest amount of information for why a gap currently exists between the amount of time school psychologists currently provide mental health interventions and their desired amount of involvement.

Participants

Selection of Participants

In case study, achieving the greatest understanding of the critical phenomena depends on choosing the case(s) well (Patton, 1990). The case(s) are often representative of some population of cases. For qualitative fieldwork, a purposive sample is drawn, building in variety and acknowledging opportunities for intensive study. Even though the case is decided in advance, there are subsequent choices to make about persons, places, and events to observe. Creswell (1998) identifies the purposeful selection of participants as a key decision point in a qualitative study. Within this study, the type of purposeful sampling utilized was stratified purposeful sampling. The purpose of stratified purposeful sampling is to illustrate subgroups and to facilitate comparisons (Miles & Huberman, 1994). The rationale for using this sampling scheme was to illustrate the subgroups of practitioners utilized within the study as well as to facilitate the

comparisons needed between two subgroups, based upon the research questions of the study. Inclusion criteria were identified to facilitate the selection of participants.

School Psychologists

Inclusion criteria for participation included the following:

1. Participants were required to have a graduate degree and professional credentials (e.g., National Certification of School Psychology [NCSP], Florida Department of Education [FL DOE] certification) in school psychology
2. Participants had to be practitioners within a school setting
3. Participants had to be within the years of experience parameters described below
4. Participants had to sign a consent form (Appendix A) before data collection

The participants used in the current study were part of a larger study investigating the perception of barriers by school psychologists in the provision of mental health interventions in the schools (Suldo, 2006). In April of 2006, The Southern Florida County School District granted permission for school psychologists to participate in the study. Approval to conduct the study was obtained from the Middle Florida County School District and the University of South Florida (USF) Institutional Review Board in September of 2006. Data were collected in October of 2006 by graduate students in the USF Department of Psychological and Social Foundations, under the supervision of the principal investigator (PI), a faculty member from the USF School Psychology Program. The author of this proposal was the coordinator of the PI's research team.

Recruitment of participants began with a phone call to the director of psychological services in both counties. Given that the two directors had already

provided written letters of support for the larger project from which these data were taken, the phone call consisted of a review of the purpose of the study and a description of the inclusion criteria for participants. The directors then provided a list of the names and e-mail addresses of the school psychologists working within their district who met the inclusion criteria. These school psychologists were sent an e-mail that included a description of the study, information on incentives, details regarding the amount of time requested, and contact information for those who were interested in participating (see Appendix B). Those who expressed an interest in participating received a follow-up e-mail that asked them to indicate multiple time frames during which they could participate in the focus groups. After a sufficient number of individuals expressed preliminary interest in participating, four to seven focus groups were scheduled within each county. All participants were sent an e-mail the day before the scheduled focus group to remind them of the session and to confirm their intention to attend.

To compensate participants for their time, incentives for participation were offered. Incentives were paid for by funds from the award granted to conduct the larger study. Each participant received a \$25 gift card to one of several stores, provided in one disbursement after the focus groups had been conducted. Information about incentives was shared with prospective participants during the recruitment process and was included in the initial e-mail to potential participants (see Appendix B).

Demographics

Participants in the larger study consisted of 39 school psychology practitioners from two school districts in Florida. Data from the larger sample were utilized throughout the data analysis process and in the development of themes that recurred in

response to the research questions. To address the research questions in the current study, data from only two subgroups of participants, the experienced and new practitioner subgroups, were compared. Given the nature of the research questions, stratification of the participants into subgroups occurred using the participants' years of experience. Years of experience was differentiated by those practitioners who had been practicing for up to 5 years (i.e., new practitioners) and those who had been practicing for 17 or more years (i.e., experienced practitioners). The differentiation of the two groups was determined by research previously conducted on school psychologists' demographic characteristics and the recent trend in school psychology literature related to school-mental health services. Previous research has indicated that the mean total experience was 16.7 years in 1998-1999 (Curtis et al., 2004) and 18 years in 1999 (Bramlett et al., 2002). Therefore, the average was taken between these two studies, indicating a break at 17 years of experience. In a review of the published articles in the field, the majority of articles on the provision of mental health services has been written in the last 5 years, including the aforementioned NASP mental health service position statement. Therefore, in order to differentiate between those practitioners who have experienced the societal and legal changes due to the mental health trend and those practitioners who have been in the field for a number of years, two definitive groups were established. The new practitioner subgroup contained a total of 15 participants and the experienced practitioner subgroup contained a total of 13 participants.

As shown in Table 1, the majority of the participants in the larger study were female ($n = 29$), had a specialist degree in school psychology ($n = 19$), and were from

Table 1

Descriptive Statistics for Participants in the Focus Groups

Variable	Early school psychologists <i>n</i> = 15		Mid-range school psychologists <i>n</i> = 11		Experienced school psychologists <i>n</i> = 13		Total sample <i>N</i> = 39	
	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%
Gender								
Male	2	13	3	27	5	39	10	26
Female	13	87	8	73	8	61	29	74
Degree level								
Masters	1	7	3	30	4	31	8	21
Ed.S.	11	73	4	40	5	38	20	53
Ph.D.	3	20	3	30	4	31	10	26
School district								
Middle	12	80	4	36	9	69	25	64
Southern	3	20	7	64	4	31	14	36
School psychologist to student ratio								
1: < 500	1	7	0	0	0	0	1	3
1: 500-999	4	27	1	10	2	17	7	19
1:1000-1499	5	32	1	10	1	8	7	19
1: 1500-1999	0	0	4	40	4	33	8	22

1: 2000-2499	4	27	3	30	2	17	9	24
1: >2500	1	7	1	10	3	23	5	13

the Middle Florida County School District ($n = 25$). Participants in the larger study were 26 to 61 years old ($M = 41.92$, $SD = 11.22$) and had from 1 to 32 years of experience ($M = 11.89$, $SD = 10.49$). The average number of mental health courses taken was 8.54 ($SD = 4.02$). The majority of participants in the larger study felt that their graduate school training sufficiently prepared them to provide mental health assessment and interventions (53.2%). In the new practitioner subgroup, the average age of participants was 32 years old ($SD = 7.4$) and participants had an average of 2.4 years of experience ($SD = 1.79$). The majority of new practitioners felt that their graduate training sufficiently prepared them to provide school-based mental health services (57%). In the experienced practitioner subgroup, the average age of participants was 52.92 years old ($SD = 4.42$) and participants had an average of 25.23 years of experience ($SD = 3.83$). The majority of experienced practitioners also felt that their graduate training sufficiently prepared them to provide mental health services (54%).

Composition of the Focus Group

In the context of the present study, the purpose of the focus group was to obtain a comprehensive understanding of school psychologists' perceptions of mental health interventions in the schools, barriers to providing these interventions, and mental health training issues. According to Kreuger (2000), focus groups should be considered when the purpose of a study is to uncover factors relating to complex behaviors or motivation.

When an area of concern relates to behavior or motivation, focus groups can provide the insight into these complex topics (Krueger, 2000).

According to Krueger (2000), a focus group is characterized by homogeneity, but also needs a sufficient amount of variability among participants to allow for contrasting options. Krueger (2000) recommends seeking homogeneity in terms of such characteristics as occupation, past use of a program or service, educational level, age, gender, education, or family characteristics. Given that all of the participants held the same occupation and similar educational levels, homogeneity of the participant group as a whole already was established. Given the nature of the research questions, stratification of focus groups occurred using the participants' years of experience to yield specific subgroups of participants (i.e., new practitioners and experienced practitioners). In order to gather information related to school psychologists at all levels of experience currently practicing in education, additional focus groups containing practitioners who had between 6 and 16 years of practice were conducted as part of the larger grant-funded study. One focus group in the Southern Florida County contained only experienced practitioners (17 or more years), one group contained only recent graduates, and two contained only the mid-range group of practitioners (6-16 years of experience). Three focus groups in the Middle Florida County contained only experienced practitioners (17 or more years), three focus groups contained only recent graduates (0-5 years of experience), and one group contained only the mid-range group of practitioners (6-16 years of experience). Of note, only data from the recent graduates focus groups and the experienced practitioners focus groups were used in comparisons made in the current study.

Krueger (2000) recommends that when dealing with complicated topics or with knowledgeable participants, the ideal size of a focus group typically falls between 6 and 9 participants. Krueger further recommends utilizing smaller focus groups (between 4 and 6) when working with participants who are specialized in the topic area, when the intent is to get more in-depth insights, and when participants have a great deal to share about the topic. Given the specialization of participants, desire for in-depth insights from participants, and that the focus groups call for discussions about their daily work experiences, smaller focus groups, containing three to five participants, were conducted. One focus group consisting of two participants was conducted on a unique occasion due to time and planning constraints related to practitioners' availability.

A total of 11 focus groups were held, with four focus groups in the Southern Florida County and seven focus groups in the Middle Florida County. According to Krueger (2000), in focus group interviews, the first two focus groups held provide a considerable amount of new information, but by the third or fourth session a fair amount of information typically already has been covered. Therefore, theoretical saturation has often occurred by the third session. Theoretical saturation, a concept from grounded theory, occurs when the information-gathering sessions (e.g., focus groups) yield no new relevant data regarding a category, the category development is dense, and the relationship between categories is authenticated (Strauss & Corbin, 1990). Although the recommended rule of thumb by Krueger is three focus groups, he also advises following this rule conditionally, depending on the nature of the study. Therefore, because of the diversity of exposure by participants to the issue of investigation, the number of focus groups held with each level of experience under study was four to five.

Setting

Middle Florida County

The Middle Florida County Public Schools contains a total of 197 schools consisting of one more grades from K-12. Of those schools, 130 are elementary schools, 41 are middle schools, 3 are Grades K-8, 23 are high schools, and 73 represent additional educational centers (Charter, Early Child, ESE, etc). In the 2005-2006 school year, the Middle County Public Schools consisted of the following ethnic breakdown: 43.97% White, 22.36% Black, 25.90% Hispanic, 3.1% Indian, 2.70% Asian, and 4.77% Multi Racial. The total number of students enrolled in the school system during that year was 202,240. The Middle Florida County is considered to be an urban/big city environment.

Southern Florida County

The Southern Florida County Schools contains a total of 67 schools consisting of one or more grades from Grades K-12. Of those schools, 46 are elementary schools, 12 are middle schools, 9 are high schools, and 15 are additional educational centers (e.g., Charter, Alternative, ESE). In the 2005-2006 school year, The Southern Florida County Public Schools consisted of the following ethnic breakdown: 67.0% White, 14.6% Black, 13.4% Hispanic, 1.4% Asian/Pacific Islander, 3.4% Multiracial, and 0.2% American Indian/Native American. The total number of students enrolled in the school system during that year was 65,407. The Southern Florida County is considered a suburban environment. Compared to the urban environment of the Middle Florida County, the Southern Florida County contains a much smaller student population, less diversity among the student population, and a smaller number of schools within the district. Two

distinctly different settings were selected to address the fact that school psychologists' professional practices can vary by type of setting.

Data Collection Setting

In deciding upon the location of the focus group interviews, Krueger (2000) recommends choosing a location that is easy to find. Sessions should be conducted in a private room free from outside distractions. Focus groups were therefore conducted on a school campus in each county in a conference room location that was private and convenient to the participants. This allowed the participants easy access to the location given that it was within their school district, and the room provided an environment free from distractions.

Measures

Demographic Questionnaire

The demographic questionnaire (see Appendix C) contained questions regarding the type of school served, university attended, amount of training received, the types of courses available in mental health services at their university, additional experiences available in mental health services (e.g., practica, assistantships), and types of (and frequency of involvement in) various mental health services. The demographic questionnaire was modeled after Yates' (2003) survey of school psychology counseling practices and was modified to include additional information related to the broadened definition of mental health interventions. The demographic questionnaire was included in a pilot study of the focus group. Two questions at the end of the pilot focus group pertained to the demographic questionnaire and changes were made following a conference with other members of the research group. During the study, the

demographic questionnaire was given to participants at the beginning of the focus group sessions immediately after they had provided consent. The demographic questionnaire took approximately 10 minutes to complete and was immediately collected.

Procedures

Prior to commencing formal data collection, a pilot study of the focus group protocol was conducted. This provided a “test-run” of the focus group protocol, allowing for modification, removal, and additions of questions as necessary before beginning official data collection. In particular, the pilot focus group allowed the author of the thesis and other members of the research team to verify that the questions in the protocol elicited the information that they intended to gather. The focus group protocol (see Appendix D) was tested by the author of this thesis proposal and other members of the research team during a mock focus group with a convenience sample of five school psychologists in the Tampa Bay area. The five school psychologists were recruited through an internship seminar class being conducted at a large southern university. After the research questions had been asked, pilot participants were asked a list of predetermined questions that addressed such issues as the clarity of the questions. Following completion of the pilot focus group, modifications to the focus group protocol and demographic form were made before formal data collection began.

Each of the 11 focus groups that were held took place for approximately 30 to 60 minutes. As participants arrived at the setting where the focus group occurred, members of the research team secured informed consent and administered the demographic questionnaire individually. The focus group protocol (see Appendix D) was used to move the group from a general discussion of mental health interventions to more specific

questions about barriers and the type of mental health training participants received. Specifically, the moderator defined mental health intervention services and then asked a standard set of open-ended questions regarding (a) current provision of mental health interventions to students, (b) barriers to the provision of such interventions, and (c) perceptions of knowledge and skill deficits that contribute to the training/qualification(s) barriers. A single moderator (the author of this thesis) led all 11 focus groups to ensure a standardized questioning procedure. The moderator's role included monitoring of the group, including allowing all participants an equal chance to participate in the focus group. The field note taker was responsible for recording the dialogue of the participants, what order the participants answered each question, and when each participant spoke. Please refer to Appendix E for a sample of the form that the field note taker utilized to document participants' answers.

Ethical Considerations

Several precautions were taken to protect the participants. First, the Principal Investigator (PI) of the larger study obtained approval from the Institutional Review Board (IRB) at the University of South Florida, the Middle Florida County Public Schools, and the Southern Florida County Public Schools to conduct this research. Documentation of all possible precautions taken to protect human research participants were submitted prior to conducting any aspects of data collection. A participant consent form was administered to participants upon arrival at the data collection setting. The participant consent form outlined the purpose of the study, the risks and benefits of the study, data collection methods (i.e., use of a tape recorder), and allowed practitioners to

decline or agree to participate. The consent form contained contact information for the research team in order for participants to ask any follow-up questions.

Protection of participant identity was upheld to the fullest extent throughout the study. During the recruitment, data collection, and analysis phases, participants were assigned a code number rather than identifying them by name. All interview summaries, audiotapes, and any other supporting documentation were labeled using this code number so as to protect the confidentiality and identity of all participants. Participants were informed of the use of an audiotape through the signed consent form and during the beginning of the focus group (see focus group protocol in Appendix D). Only the PI of the larger study had access to the locked file cabinet that was being used to store documents linking code numbers to participant names and any other personally identifiable information.

Data Analysis

As defined by Creswell (1998), two basic types of information were collected in this study. Data were generated through the following two types of information: (a) field notes taken during focus groups by the field note taker (see sample form in Appendix E) and (b) the completion of focus group interviews that were audiotaped, documenting the exact comments and interactions that occurred during the focus group sessions. Field notes documented participants' responses to questions and were recorded as faithfully as possible during the interview session, with no interpretation or themes noted on the interview protocol. After the focus groups were conducted, the resulting audiotapes were transcribed verbatim. Master copies of the transcriptions were kept in the aforementioned locked file cabinet. To address the research questions of this study, data

were analyzed from Question 1, Question 2, Question 4, Question 5, and Question 6 from the focus group protocol. The remaining question was asked during the focus group sessions for the purpose of the larger study. Additionally, only the information obtained from the nine focus groups containing either (a) practitioners with 0-5 years of experience, or (b) practitioners with 17 or more years of experience, were analyzed during comparisons reported in Chapter 4. All 11 focus groups sessions were utilized in the development of themes reported.

The data analyses strategies utilized in this study were based on the recommendations of Creswell (1998). Creswell described the data analysis process as a progression that involves moving in analytical circles rather than a fixed, linear approach. This process can be represented in a spiral image, a data analysis spiral, represented by Figure 1.

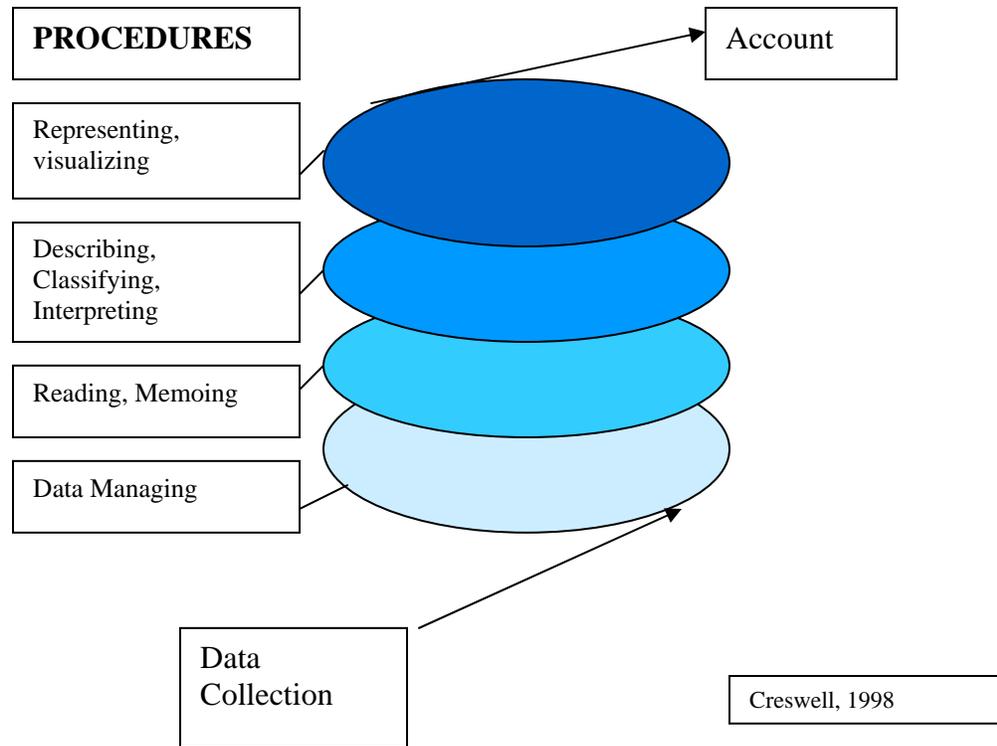


Figure 1. The Data Analysis Spiral

Creswell describes qualitative data analysis as the process of a researcher moving through four different procedures within the data analysis spiral. Each of the four data analysis procedures is represented by a separate spiral within the complete data analysis spiral. Creswell (1998) describes the data management procedure of the first data analysis spiral as the researcher entering with data of text and exiting with an account or a narrative. Throughout this process the researcher touches on several facets of analysis and circles around and around (Creswell, 1998). The data management spiral in this study involved the process of transferring raw data, or the focus group audiotapes, into a narrative of written words. Focus group audiotapes were transcribed verbatim into written documents in Microsoft Word. Following completed transcriptions of the 11

focus groups, the transcripts were printed and reviewed to get a “first impression” of the data, emerging themes, and to make preliminary notes. This procedure is defined as reading and memoing, the second loop of the data analysis spiral. In a general review of all the information, the author thoroughly read the transcripts and field notes from the study.

Following this step, the procedure that reduces the data began through *describing, classifying, and interpreting the data* (Creswell, 1998). Creswell (1998) describes this third loop of the data analysis spiral as the process of describing the data in detail, developing themes or dimensions through some classification system, and providing an interpretation in light of their own view or views of perspective in the literature. Within this spiral classifying of the data occurs, which involves taking the text apart, looking for categories, themes, or dimensions information (Creswell, 1998). This process, defined as coding, represents the process by which the information obtained was broken down, conceptualized, and put back together in a novel way (Strauss & Corbin, 1990). Specifically, three members of the research team were involved in the third loop of the data analysis spiral. Within this stage of the data analysis spiral, three members of the research group engaged in several careful readings of three transcripts and developed a short list of tentative codes for each of the research questions that matched text segments within the transcript. Investigative perspective was used in the creation of categories and codes as the source of names used to identify given sets of categories and codes (Constas, 1992). All three members of the research group read through the same three transcripts and developed a short list of tentative codes for each of the research questions that matched text segments within the transcript. These codes were expanded upon as the

three members of the research team reviewed and re-reviewed the focus group transcriptions. Categorical aggregation occurred through this process, as research team members sought a collection of instances from the data (Stake, 1995).

The three researchers then met to reach a consensus regarding the major and minor themes identified in the transcripts and to develop a codebook that would organize participant responses into discrete categories. Each member served to cross-check and validate the codes identified by the other two members. In the event of a disagreement, all three members traced the segment of text back to its original location and determined the appropriate code after conducting a more thorough review of the transcript and the context in which the comment was made. This procedure was an additional means to ensure the rigor of the methods used in this study.

Following the development of a codebook, a total of six research assistants applied the codebook to all 11 transcripts; each transcript was analyzed by at least two researchers. The method of constant comparison, or constant comparative analysis, was also utilized to compare the themes mentioned within each of the focus groups (Glaser & Strauss, 1967). Constant comparison analysis is often used when the researcher wants to answer general questions of the data (Leech & Onwuegbuzie, in press). Constant comparison was undertaken inductively, or as codes were identified when they emerged from the data. During constant comparison, one focus group was analyzed at a time and then compared to the next focus group. This process allows for the examination of new themes as they emerged. When new themes no longer emerged from the transcripts read by each researcher, theoretical saturation had been reached. Throughout this stage, focus group transcripts were analyzed in a systematic, sequential, and verifiable process such

that the location of any given theme could be traced (Patton, 1990). This allowed for comparability among researchers when there were differences of opinion about the codes assigned. If both research team members traced the segment of text back to its original location and were unable to agree upon the appropriate code after conducting a more thorough review of the transcript, an additional opinion was solicited from a third researcher. Researchers then entered the consensus of the coding into a qualitative software program (Atlas.ti), which provided a tool for organizing questions, codes, quotations, and groups of school psychologists. ATLAS/ti is a qualitative data assessment computer software package that assists in the process of coding and analysis of datasets such as transcribed focus groups (Muhr & Friese, 2004).

In the final procedure of the data analysis spiral, researchers present the data, a packaging of what was found in text, tabular, or figural form (Creswell, 1998). This final spiral is described as the process of representing or visualizing the data. Within this study, data are presented in text and tabular form. Data in text form included the representative quotes of the various themes that emerged within the study. Data in tabular form were represented through comparison tables for each of the research questions. Comparison tables present the data in quantitative form through comparative data representing the themes in the study differentiated through the category of experienced practitioners or new practitioners. To provide an understanding of the frequency with which the themes were used by new and experienced practitioners, the number of times each them and subtheme was described by participants was counted. These frequency counts represent the number of times participants in each group provided a sentiment (i.e., quotation) that expressed the coded theme or subtheme. A

total index of the frequency with which the coded themes and subthemes were mentioned was created by summing the total number of times a strategy was mentioned in the total sample (i.e., 11 focus groups) as well as broken down into total mentions for the four focus groups of experienced practitioners and the four focus groups of new practitioners. To control for the fact that a few verbose participants could artificially inflate the frequency of a given them or sub-theme, a second index of frequency was created by calculating the proportion of groups in which a given them or sub-theme was mentioned at least once. Finally, naturalistic generalizations were developed, generalizations that people can learn from the case either for themselves or for applying it to a population of cases (Creswell, 1998).

Credibility Measures

In approaching reliability and validity issues in qualitative research, Merrick (1999) recommended following Lincoln and Guba's (1985) delineation of "parallel criteria," four criteria, which are discussed below, that parallel those of quantitative methods. These criteria, which increase the likelihood that credible findings and interpretations will be proposed, can be met through the use of several techniques. Through the use of these techniques, the trustworthiness of the research can be established. A number of the suggested techniques to meet the "parallel criteria" established by Lincoln and Guba (1985) were utilized within the study to establish the trustworthiness of the research.

As summarized by Merrick (1999), the concept of internal validity is paralleled by internal credibility. To increase the likelihood of credibility, the technique of prolonged engagement and persistent observation was utilized within the study. Through

the use of 11 focus groups, the researchers extended their time in the field. Triangulation, or the use of different sources, was utilized in this study (Merrick, 1999). Field notes were taken during the focus groups in addition to taping, so as to provide two different sources of data through two observers. In addition, because this research is part of a larger study, collaborative work occurred throughout the entire research process, which increased the likelihood that analyses and interpretations were not biased.

The concept of external validity is parallel to transferability (Merrick, 1999). Transferability is defined as the researcher's responsibility to provide "the thick description necessary to enable someone interested in making a transfer to reach a conclusion about whether transfer can be contemplated as a possibility" (Lincoln & Guba, 1985, p. 316). Transferability was reached through the collection of sufficiently detailed descriptions of data within the context of the study and through the report of sufficient detail and precision to allow judgments about transferability to be made by the readers of the study. Examining two different locations also increases the trustworthiness of the common themes that emerged within the study (Glesne, 2006).

The concept of reliability is parallel to dependability (Merrick, 1999). The latter is to be achieved by using an "inquiry audit," which involves the examination of the process and product of the inquiry. To address the issue of dependability, triangulation, the use of multiple data-collection methods, was utilized. In addition, an external audit occurred with a professor in the USF School Psychology Program. An external audit involves an outside person examining the research process and product through "auditing" the field notes, research journal, and analytical coding scheme (Merrick, 1999).

Finally, the concept of objectivity is paralleled to that of confirmability. Confirmability refers to the degree to which the product is accurate and unbiased. It is the “extent to which the auditor examines the product and attests that it is supported by data and is internally coherent so that the ‘bottom line’ may be accepted” and is known as leaving an audit trail (Lincoln & Guba, 1985, p.318). The research team left a trail of raw data through the documentation of identifiable raw data (e.g., field notes), data reduction and analysis products, process notes, data reconstruction and synthesis products, and instrument development information (Lincoln & Guba, 1985). Peer review and debriefing was also utilized, which allowed for external reflection and external input into the work that had been completed in the research process (Merrick, 1999).

Limitations of the Current Study

In this study, limited sampling may potentially limit the ecological validity of the results. Ecological validity is the ability of the researcher to generalize the results of a study across settings (Johnson & Christenson, 2004). Violations to ecological validity include the tendency of the researcher to draw erroneous conclusions to populations in different settings than the population under study. Because this study recruited participants from only two school districts within Florida, the external validity is limited. In addition, because of the relatively small size, participants are not likely to represent equally elementary, middle, and high schools. Each individual holds different views and values and employs them differently when working within his/her role in a school. As a result of this sampling, a considerable amount of variability in attitudes, beliefs, and practices may have gone unexamined.

Focus group questions may have elicited ideas and thoughts that might not be suggestive of “real life” or may not have prompted participants to think about the issues to be considered. Questions may not have served their purpose in prompting participants and eliciting answers related to the questions. Participants may have added information that might not otherwise have been considered. Finally, it is possible that individuals within the focus groups may have altered their attitudes and beliefs based upon other participants’ responses. Results from this study, therefore, should be interpreted with caution.

Contributions to the Literature

Although there exists a need for school psychologists to expand their involvement in the provision of mental health services, information regarding the specific barriers that they perceive prohibit the implementation of mental health services is insufficient. If school psychologists are to respond to the challenges posed by the prevalence of mental disorders and psychopathology in youth, the factors that impede the provision of mental health services must be identified. The proposed study attempted to identify the barriers perceived by school psychologists. In addition, because of the recent trend towards increased expansion of the school psychologist’s role in the provision of mental health services, school psychologists’ beliefs regarding their professional roles and their corresponding training may vary according to the number of years they have been away from the university setting. It was expected that an understanding of the relationship between the barriers perceived by practitioners and the number of years they have been in the field would provide a more complete picture relating to the problem.

Chapter Four

Results

The primary purpose of this study was to elucidate factors that school psychologists perceive inhibit them from providing more mental health interventions within their professional roles. In an effort to identify training-related barriers related to knowledge and skill deficits, the current study also purposefully queried practitioners about desired didactic and practical experiences in school-based mental health interventions. Research also suggests that significant differences exist among school psychologists of different ages and levels of experience pertaining to their roles within the school system (e.g., Curtis et al., 2002). Therefore, factors such as years of experience also should be considered when studying school psychologists' roles in the provision of mental health services. Thus, an additional purpose of the current study was to examine the frequency of the themes elucidated across each research question as a function of practitioners' levels of experience.

Seven main questions were asked of the participants in the 11 focus group sessions to gain their thoughts and feelings about providing mental health interventions within their professional roles; five of these questions were analyzed for the current study. Within each question, several common themes emerged across the focus groups; however, differences between practitioners' level of experience was noted on several occasions. The five main questions were as follows: (a) For which type of problems are

students referred for mental health assessment and intervention to either you or other school personnel?, (b) Which mental health assessment and interventions have you provided during their past few years of practice in the schools?, (c) Which factors prevent you from providing additional mental health assessment and intervention?, (d) Which specific content areas that were taught in your graduate school or continuing education training most enable you to provide mental health assessment and intervention?, and (e) What types of training experiences (beyond class work) that were included in your graduate school or continuing education training most enable you to provide mental health assessment and intervention?

Importantly, the analyses of responses from participants within the current study indicate that both consensus within the focus groups and theoretical saturation across all five research questions was reached. In general, consensus was reached in each of the focus groups, as participants exhibited a state of mutual agreement with all legitimate concerns of individuals having been addressed to the satisfaction of the group.

Furthermore, analyses of transcribed focus groups indicated that participants did not exhibit negative responses nor was there the presence of any negative cases. Theoretical saturation occurred during the analysis of text when no new themes were identified, the themes were dense enough to cover variations and process, and relationships between themes were delineated during text analysis (Strauss & Corbin, 1990). Theoretical saturation was achieved after eight focus groups, as no new themes emerged during the analysis of the 9th, 10th, and 11th transcripts. Substantiation of theoretical saturation was also evidenced through the use of two investigators in the process of examining each of the 11 transcripts.

The purpose of this chapter is to present the themes that emerged from the analysis of the 11 focus group transcripts. The chapter is organized in relation to the specific research questions previously presented in Chapter 1. After the initial coding process of all 11 transcripts from the larger study had been completed, this graduate student and two additional researchers from the research team collapsed codes into thematic families. The following section will provide a description of the (a) themes and subthemes related to problems referred, (b) themes and subthemes related to mental health services provided, (c) themes and subthemes related to barriers to the provision of psychotherapeutic services, and (d) themes and subthemes related to training needs and experiences. Below is a description of the salient themes, including representative quotations, and paraphrased statements; focus group numbers (FG) of the transcribed data are indicated as well. Table 2 presents the composition of the focus groups within the current study.

Research Questions

Focus group data obtained in this study were transcribed and analyzed relative to the four main research questions. Patterns and trends are discussed below, with sample quotes provided to illustrate specific experiences. Following a discussion of the general findings of each research question, frequency of themes is compared as a function of practitioners' levels of experience for Research Questions 2, 3, and 4. Research Question 1 is not part of this secondary analysis process given that the referring agent has

Table 2

Composition of Focus Groups

Focus group (FG)	Number of participants	Level of school psychologist
FG 1	3	Mid-range
FG 2	4	Experienced
FG 3	4	Mid-range
FG 4	3	New
FG 5	4	Experienced
FG 6	4	Mid-range
FG 7	5	New
FG 8	2	Experienced
FG 9	3	New
FG 10	4	New
FG 11	3	Experienced

no real control over which types of problems are referred to school personnel; hence, referral problems should be similar across practitioners' levels of experience. However, the school psychologists receiving the referrals do have control over the types of services they provide, what they perceive are barriers to psychotherapeutic service provision, and personal perceptions of the mental health training needs of school psychologists.

Types of Problems for which Students are Referred for Mental Health Assessment and Intervention

The following section will provide a description of the (a) themes related to problems referred and (b) subthemes within each category. Below is a description of all salient themes, including representative quotations and paraphrased statements; focus group numbers (FG) assigned are indicated as well. Table 3 presents a summary of themes and subthemes.

Anxiety. The theme anxiety refers to students who exhibit irrational fear or worry characterized by physical symptoms and feelings of stress that interfere with a student's ability to carry out normal or desired activities. Although anxiety is a diagnosable DSM disorder, the next theme to be discussed, participants described this referral problem as encompassing a variety of separate forms of anxiety-related issues. This theme included three subthemes from participants' conversations: general anxiety or other clinical anxiety disorder, test anxiety, and school phobia. General anxiety and other clinical anxiety disorder refers to those sentiments that indicated "anxiety" (FG 8) as a referral problem but were minimally described as well as descriptions of other anxiety problems, such as "severe panic attacks" (FG 9). Test anxiety refers to those sentiments that indicated receiving referrals for students anxious over testing situations. School phobia was identified as students who "refuse to come to school, very anxious about coming to school" (FG 2).

Table 3

Themes and Subthemes Related to the Common Types of Problems Referred for Mental Health Assessment and Intervention

Theme	Sub-themes (when applicable)
Anxiety	General anxiety or other clinical anxiety disorder; school phobia; test anxiety
DSM disorders	Oppositional/defiant symptoms or behaviors; attention-deficit hyperactivity disorder symptoms or behaviors; bipolar symptoms or behaviors; depressive symptoms or behaviors, autism/Aspergers
Anger	The expressed emotion of anger, behaviors that convey aggression and violence
Isolated behavioral or emotional symptoms	Bullying; lack of empathy; self-esteem; cutting; interpersonal problems; eating problems; isolated internalizing symptoms; isolated externalizing symptoms; health concerns
Atypical/bizarre behaviors	
Learning problems	Work completion; study skills; motivation
Crisis situations	Suicidality; threat to harm others; grief or loss; school-wide tragedy
Trauma	Child abuse; sexual abuse

Adolescent issues	Romantic relationship problems; teenage sexuality; gender/sexual identity; substance abuse
Family issues	Divorce; foster care situations; parent absent from home; conflict with parent
Adults' mental health problems	

DSM disorders. The theme of DSM disorders refers to those referral problems that can be characterized as a specific mental disorder including a cluster of distinct signs and symptoms as described in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000). This theme comprised five subthemes generated from school psychologists' conversations: oppositional/defiant symptoms or behaviors, attention-deficit hyperactivity disorder (ADHD) symptoms or behaviors, bipolar symptoms or behaviors, depressive symptoms or behaviors, and autism/aspergers. Within the subtheme of oppositional/defiant symptoms, students were described as exhibiting such behaviors as "noncompliance" (FG 1), "trouble problem solving and taking ownership for behavior" (FG 2), and "not following directions" (FG 3). One participant described the common types of ADHD behaviors teachers indicate when referring a student, including "out of their seat, not following directions, inattentive, can't focus, is easily distracted, distracts others, moving about the classroom, constantly going to the restroom,...all those kinds of behaviors" (FG 1). Many participants noted the prevalence of this referral problem, highlighted by the following statement: "I would just say that in my short time I have seen a lot of attention issues and inattention" (FG 4).

Similarly, the prevalence of students with bipolar disorder was also noted by one participant: “those [bipolar disorder and cutting] are two big areas that I’m seeing too” (FG 2). The complexity of identifying children with depression was noted by a number of participants, as one participant described receiving “a lot for depression, but a lot of times, it’s manifested in different ways” (FG 8). Another participant indicated that “...it usually comes out later. Like a lot of the aggression that is stemming from possible depression...” (FG 5).

Similar to ADHD, multiple participants who discussed referrals for autism spectrum disorders (ASD) noted the prevalence of this problem:

I have a lot of what have later become either diagnosed or we all think and it is undiagnosed autistic or Aspergers....the teachers describe them as socially detached, inappropriate, just wandering. All those kinds of things. And later on through the process we’ve found that out. Higher than normal [referrals for ASD] I think. (FG 3)

Anger. The theme of anger refers to students who exhibit an emotional state that varies in intensity from mild irritation to intense fury and rage, commonly coexistent with a behavioral reaction by the student. The category of anger emerged and was coded as a distinct theme because anger can be a symptom of many DSM disorders. This theme included two subthemes generated from participants’ conversations: the expressed emotion of anger and behaviors that convey violence. Students who expressed emotions of anger were described as having “explosive behaviors...volatile behavior”(FG 2), “angry outbursts in the classroom” (FG 7), and “when they get mad they ...disrupt the classroom, throw things, and the teachers don’t know how to deal with that in their

general classrooms” (FG 4). Behaviors that convey violence included “five or six year old kids who have battered a teacher or another kid” (FG 2) and students having “weapon at school” (FG 2).

Isolated behavioral or emotional symptoms. The theme of specific, isolated behavioral or emotional symptoms refers to those mental health problems that were mentioned by participants that are related to a distinctive characteristic/symptom exhibited by a student. In particular, these symptoms did not, by themselves, constitute diagnosable DSM disorders. This theme included nine subthemes from participants’ conversations: bullying, lack of empathy, self-esteem, cutting, interpersonal problems, eating problems, isolated internalizing symptoms, isolated externalizing symptoms, and health concerns. Bullying problems included referrals for students who were victims of bullying as well as those who were the aggressors. Participants described bullying referrals covering both physical and verbal bullying within the schools. A lack of empathy was described by one participant: “I’ve had a lot of kids...they either fail to develop it or have lost like the empathic complex you know, they really just don’t seem to have that emotional connection, that empathy for other people” (FG 2).

Self-esteem issues included such problems as low self-concept and low self-esteem. Participants described cutting with the following sentiment, “cutting...is basically (one of) the two big things...that seem to generate the most business” (FG 5). Regarding referrals for interpersonal problems, participants described students as lacking social skills, having difficulty with peer relations, and experiencing social isolation and/or peer rejection.

Participants discussed referrals for eating problems in general terms by simply

reporting “eating problems” (FG 11) and not expanding on specific behaviors such as bingeing and purging. Isolated internalizing symptoms refers to students experiencing problems within the self (i.e., deal with problems internally) that do not meet all criteria for internalizing disorder diagnoses, such as mood or anxiety disorders. Referral problems within this sub-theme included students who appeared withdrawn, students who do not want to express feeling or emotion, and students who do not speak. Similarly, participants also described receiving referrals for students who displayed isolated externalizing problems, or behaviors directed outward (i.e., externally), that did not meet all criteria for a disruptive behavior disorder diagnosis, such as conduct disorder. Participants described problems related to disruptive classroom behavior including off-task behaviors and acting out behaviors. One participant described such behaviors as “disruptive, disrespectful, talking back, screaming, crying, yelling, things like that” (FG 9). Referral concerns were also mentioned for health-related issues, as one participant noted receiving a referral for a student who “has a condition where he...defecates on himself” (FG 7).

Atypical/bizarre behavior. The theme of atypical/bizarre behavior refers to student behavior that deviates from what is usual or common or what is to be expected. Participants indicated that sometimes these problems were referred to them in broad terms, such as “unusual and odd behaviors” (FG 6) or as described by one participant, “kids that are saying or doing things that are different than same-aged peers and what the teacher expects” (FG 2). Other participants indicated specific behaviors, such as “saying inappropriate comments that are sexual in nature” (FG 7), drawing “pictures with inappropriate content” (FG 5), and “eating non-nutritive items” (FG 3).

Learning problems. The theme of learning problems refers to a heterogeneous group of problems manifested by difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning, or subject-related skills. This theme consisted of three subthemes generated from participants' conversations: problems related to work completion, study skills, and motivation. Participants indicated receiving referrals for students who were "not completing work" (FG 3) and needed help with "organizational skills" (FG 2). Motivation issues were described as students no longer caring about school, bright students failing their classes, and students just not wanting to do their work.

Crisis situations. The theme of crisis situations encompasses the circumstances under which student(s) perceive a sudden loss of ability to use effective coping skills. This theme included four sub-themes from participants' conversations: suicidality, threat to harm others, grief or loss, and school-wide tragedy. A number of suicidal behaviors were identified as a reason for students being referred, including "suicidal ideation" (FG 8) and "writing something or saying something that makes somebody nervous about their intentions of hurting...themselves" (FG 11). Situations in which a student threatened to harm someone else were described by participants: "a student threatened to kill somebody and then drew a picture of it with the knife and everything" (FG 5) and a "student brought a knife to school" (FG 5). When discussing referrals related to grief and loss, participants noted the prevalence of such problems: "quite a few kids...have lost parents" (FG 2) and "we deal with a lot of children who have been impacted or affected by family member, friend, sibling,...parent that...committed suicide" (FG 2). School-

wide tragedies included such situations as when “a child...was hit and killed” (FG 1) and “a beloved teacher dies” (FG 8).

Trauma. The theme of trauma refers to problems that arise because a student has experienced something that is emotionally painful, distressful, or shocking, which can result in mental and physical problems. This theme contained two subthemes generated from participants’ conversations: child abuse and sexual abuse. Neither child abuse nor sexual abuse was elaborated upon by participants during the focus groups; instead they discussed referrals for these situations in general terms.

Adolescent issues. The theme of adolescent issues refers to problems that occur during the time of adolescent development that are often triggered by physical, mental, and/or school changes. This theme included four subthemes generated from participants’ conversations: romantic relationship problems, teenage sexuality, gender/sexual identity, and substance abuse. Problems surrounding romantic relationships included such sentiments as “problems with boyfriend/girlfriend” (FG 8) and “dating” (FG 7). Teenage sexuality was described as problems related to “pregnancy” (FG 11). Gender/sexual identity issues were described as “...gender problems, how to do that, the issues...” (FG 5). Regarding substance abuse, participants indicated receiving referrals for students who were “intoxicated or using drugs” (FG 11).

Family issues. The theme of family issues refers to student problems that arise due to problems occurring within the family and/or home environment. This theme included four subthemes generated from participants’ conversations: divorce, foster care situations, parent absent from home, and conflict with parent. Divorce includes issues that may arise because of a current or past family situation involving parental separation.

One participant described how this can become a problem in the schools, with those students whose "...mom and dad have just divorced or mom has just remarried...all those other issues kinda come into play" (FG 8). The subtheme of foster care situations refers to student issues that arise when they are moved to out-of-home placements. One participant indicated that "a large number of the referrals that I'm getting are like emergency related referrals, these kids are in a temporary foster home" (FG 8) or students who has "some problems with adjusting to being in a foster care situation" (FG 7). Participants described receiving referrals because a parent is absent from the home: "I have a lot of children whose one parent is incarcerated or both parents are incarcerated" (FG 2) and "parental rights were severed" (FG 5). Discussions of students having conflicts with parents included such sentiments as "his mother never listened to him, felt like his mother never believed him, was always yelling at him" (FG 5).

Adults' mental health problems. The theme of adults' mental health problems refers to problems brought to the attention of school psychologists that are related to the personal problems that school personnel experience. The following participant described her experience with this problem:

...it's the working with adult staff that are having major issues from principal, custodian, to the teachers...not only about necessarily their personal issues but after you've been there awhile you become very accessible to them and they feel very comfortable coming to you (FG 5).

Participants did not indicate a particular group of school personnel that they often encountered, as noted in the previous quotation.

Although this research question was not part of the secondary analysis of the frequency of themes compared as a function of practitioners' levels of experience, a total index of the frequency with which the mental health problems were mentioned was created by summing the total number of times a problem was mentioned in the total sample (i.e., 11 focus groups). See Table 4 for a summary of the frequency with which specific referral problems were discussed within the current study and Figure 2 for a graphic representation the percentage of times with which each specific theme was discussed within the current study.

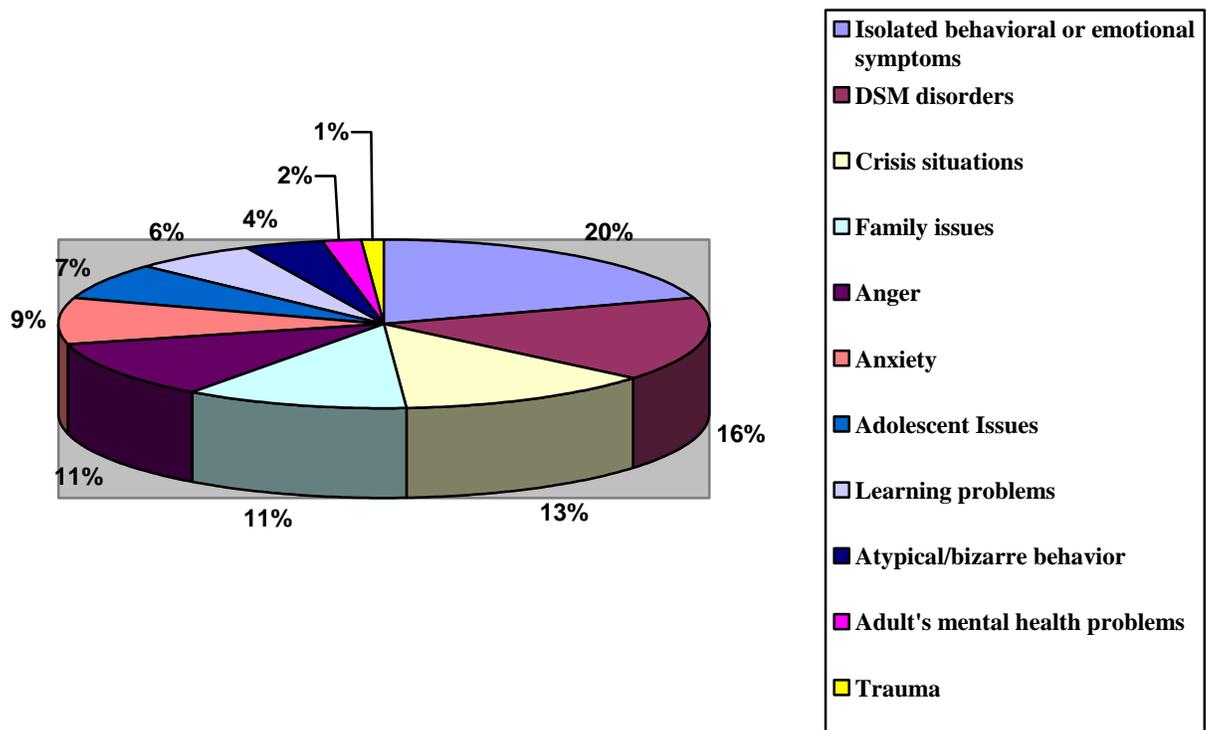


Figure 2. Percentage of times with which each specific referral problem theme was mentioned by participants

Table 4

Frequency School Psychologists Mentioned Specific Referral Problem

Referral Problem	Total (n =39)	
	N	%
Family issues	28	73
Divorce	8	55
Foster care situations	3	25
Parent absent from home	3	18
Conflict with parent	3	18
Trauma	2	18
Child abuse	1	9
Sexual abuse	1	9
Adult's mental health problems	4	9
Learning problems	15	55
Work completion	3	27
Study skills	2	9
Motivation	8	55
Atypical/bizarre behavior	9	55
Anger	28	73
The expressed emotion of anger	15	64
Behaviors that convey aggression and violence	13	45
Adolescent issues	16	64
Romantic relationship problems	2	18
Teenage sexuality	2	18
Gender/sexual identity	2	18
Substance abuse	8	55

DSM disorders	38	91
Oppositional, defiant symptoms or behaviors	6	45
ADHD symptoms or behaviors	10	45
Bipolar symptoms or behaviors	3	18
Depression symptoms or behaviors	16	82
Autism/Aspergers	3	18
Anxiety	22	82
General anxiety or other clinical anxiety disorder	16	82
School phobia	5	36
Test anxiety	1	9
Crisis situations	32	73
Suicidality	12	55
Threat to harm others	7	36
Grief or loss	10	64
School-wide tragedy	3	18
Isolated behavioral or emotional symptoms	48	100
Bullying	5	36
Lack of empathy	1	9
Self-esteem	4	27
Cutting	7	45
Interpersonal problems	7	45
Eating problems	3	27
Isolated internalizing symptoms	8	45
Isolated externalizing symptoms	13	55
Health concerns	1	9

Note. N = number of times referral problem was mentioned across groups; % = proportion of groups in which the problem domain was mentioned at least one time.

Mental Health Assessment and Interventions School Psychologists have Provided During Their Recent Practice in the Schools

The following section will provide a description of the (a) themes related to the types of mental health assessment and intervention services provided by participants and (b) subthemes within each category. Below is a description of all salient themes, including representative quotations and paraphrased statements; focus group numbers (FG) assigned are indicated as well. See Table 5 for a summary of themes and subthemes. Themes will be presented in order of the frequency with which they were mentioned. Following a discussion of the general findings of the research question, themes are compared as a function of participants' levels of experience.

Group counseling. The theme of group counseling refers to a form of psychotherapy in which a small, selected group of individuals meet with a school psychologist to discuss issues related to a particular problem area. This theme included nine subthemes generated from participants' conversations: social skills group, study skills group, organization skills group, anger management group, motivation group, divorce group, anxiety group, grief group, and unspecified group. Participants described how social skills groups can be tailored to specific populations of students:

I've done some social skills groups...I'll do a lot of [groups for] relational aggression in girls. So, I do a lot of skill building with girls as far as how to make and maintain friendships and how to get along with peers and how to handle when other kids aren't nice to you and when they put you down or they exclude you from group. (FG 9)

Table 5

Themes and Sub-themes Related to the Common Types of Mental Health Assessment and Intervention Services Provided by School Psychologists

Theme	Sub-themes (when applicable)
Group counseling	Social skills group; study skills group; organization skills group; anger management group; motivation group; divorce group; anxiety group; grief group; unspecified group
Individual counseling	
Crisis intervention	Suicide assessment and immediate intervention; threat assessment; de-escalation of individual problem; unspecified crisis intervention activity
Consultation to individuals	Parent consultation; school-staff consultation; problem-solving team consultation
Behavioral interventions	
Case management	Consultation with psychiatrist; consultation with outside therapist; referral to outside agencies/follow-up care; unspecified case management; consultation with police
Social-emotional behavioral assessment	
Inservices (consultation to group)	Presentation to educational staff; presentation to parents

Counseling adults

Prevention

School or class-wide screening; drug education

Family services

Parent support groups

Similarly, study skill groups, organization skills groups, anger management groups, motivation groups, and divorce groups were all mentioned as different types of group counseling interventions provided, although additional details regarding the content of or rationales behind the provision of the group were not provided. Participants described providing group interventions to treat general anxiety and specific anxiety-related concerns, such as “text anxiety” (FG 1). The sub-theme of unspecified group included statements made by participants that did not indicate the specific problem for which group counseling was being provided. For example, one participant said, “I’ll run groups, so if there seems to be a certain issue that’s coming up a lot, then I’ll do some groups” (FG 9).

Individual counseling. The theme of individual counseling refers to a form of psychotherapy in which an individual meets with a school psychologist on an ongoing basis to discuss current or past problems. Participants indicated providing individual counseling for students with specific needs/concerns and for students who may just be having difficulty in school. For example, one participant described, “right at phase one...I dealt with a couple of cases last year where [we] pulled them outside kind of like a pre-intervention...and I did counseling with both of them...like six sessions” (FG 1).

Contrastingly, another participant described a more structured and formal process: “I

actually do one-on-one individual therapy with kids. I have four kids that I see weekly and...it is written in their IEP that they have counseling goals” (FG 6).

Similarly, participants described using both informal and formal processes during individual counseling sessions. A more informal process was described by one participant: “Usually we just talk about things that are going on at school and home that they want to talk about. It is very low key...because we do not have a prescribed mental health model that we follow” (FG 2). Other participants indicated using a specific counseling process such as client-centered therapy or reality therapy. Following a specific program as part of individual therapy was also elaborated upon by a participant:

Prepare Curriculum, I use that a lot. Typically, what I do...is focused on teaching a skill within a content of a role play, you know, the Skill Streaming format. And then...following it up with some kind of contingency, some monitoring system, classroom. (FG 9)

Participants also described using individual counseling services as a method to treat a variety of problems, ranging from ongoing suicidality to motivational issues.

Crisis intervention services. The theme of crisis intervention services can be described as immediate, short-term help provided to individuals who experience an event that produces emotional, mental, physical, and behavioral distress or problems. This theme included four sub-themes generated from participants’ conversations: suicide assessment and immediate intervention, threat assessment, de-escalation of individual problems, and unspecified crisis intervention activities. The provision of suicide assessment and immediate intervention encompasses a variety of services, including risk-to-harm-self assessments, administration of suicidal ideation questionnaires, no suicide

contracts, contacting school resource officers and hospitalizing a student, referrals to and consultation with crisis centers, consultation with parents, and short-term follow-up with the referred student. Threat assessment involves assessing a student's risk for harming another person. One participant elaborated on the varying degrees with which this service may be needed, stating that "I have to, sometimes, do an informal threat assessment and if I'm picking up vibes that this kid is a threat to himself or others, I will pose a more formal threat assessment, but sometimes it ends right there" (FG 8). The sub-theme of de-escalation of individual problems involves those services provided by school psychologists on a short-term and immediate basis in an effort to work with a student having problems at that moment in the school environment. As one participant described, "they'll be lots of more short-term referral types of things, have a kid sent down because...[they need] somebody that can take a kid on a short-term, maybe just for that period and then deal with some of those issues" (FG 2). Similarly, another participant described providing such services as "a lot of just getting to class and trying to put out the little fire at the moment, kind of crisis management" (FG 9). The final sub-theme, unspecified crisis intervention activities, includes statements made by participants that were related to crisis intervention activities that were broad and ambiguous, such as stating that they provide "crisis intervention."

Consultation (to individuals). The theme of consultation refers to a conference between two or more people to consider a particular problem. This theme comprised three sub-themes generated from participants' conversations: parent consultation, school-staff consultation, and problem-solving team consultation. Participants described parent consultation across a broad range of discussion topics. One participant indicated that

“I’ve had a lot of interaction with parents, and helping them understand their child’s needs and, looking at strategies, you know, that they can try, resources that they have available to them” (FG 2). Regarding school-staff consultation, participants described the process as “...someone is coming and saying what do I do about this, so you are really using your expertise in response to an issue” (FG 11). Some commonly shared ideas also emerged within this sub-theme, such as the use of consultation with school-staff to emphasize the positive qualities within a student. As described by one school psychologist:

Sometimes what I am really trying to do is really more therapeutic with the teacher to get the teacher to see a different side of the kid, to get the teacher to listen to the positive qualities that reinforce the kid, and then the teacher’s attitude turns around and then she likes the kid. (FG 6)

School staff with whom participants mentioned consulting included teachers and guidance counselors. The subtheme of problem-solving team consultation involves school psychologists working as part of an educational support team to determine a referred student’s problem, determine the types of services needed, and implement interventions.

Behavioral interventions. The theme of behavioral interventions refers to creating and/or implementing an informal or formal plan to reduce problem behaviors or increase desired behaviors. One participant elaborated on the types of services provided, describing that they were “putting kids on behavior contracts for some of those issues they are having; especially aggression, the acting out, or just completing work. The

motivational issues so...writing behavior plans for kids” (FG 7). Others indicated participating in “FBAs and behavioral intervention plans” (FG 9).

Case management. The theme of case management can be described as a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s mental health needs through communication and maximum utilization of available resources. This theme included five subthemes generated from participants’ conversations: consultation with psychiatrist, consultation with outside therapist, consultation with police, referral to outside agencies/follow-up care, and unspecified case management. Regarding consultation with psychiatrists, participants indicated sharing information for “students that are on medication” (FG 5) or if “we can give them feedback about how the child is doing or what concerns we might see” (FG 5). Participants did not elaborate on consultation with outside therapists and consultation with police, indicating only that they provided such services. The sub-theme of referral to outside agencies/follow-up care includes those efforts made by school psychologists in order to provide the referred students with appropriate services. Participants indicated making outside referrals for family therapy services and counseling, as well as continuing to keep in touch with the referred service provider. The final sub-theme of unspecified case management included those services that were mentioned only as “case management,” with no further description of activities.

Social-emotional-behavioral assessment. The theme of social-emotional-behavioral assessment refers to the process of gathering and discussing information from often multiple and diverse sources in order to develop a deep understanding of which factors contribute to and maintain an operationally defined referral concern; all

assessment activities are conducted with the intent to provide interventions after the assessment phase. Participants described a number of services provided under this theme, including administering pre- and post-tests, behavior rating scales, and projective measures, as well as conducting behavioral observations, clinical interviews, and teacher, parent, and student interviews. Participants discussed administering measures to teacher, parent, and student and using a variety of assessment tools as part of the assessment process, including the use of broad indicators (e.g., ask the parents a few questions) and narrow measures of problems (e.g., depression rating scales).

Inservices (consultation to groups). The theme of inservices refers to training(s) provided for the purpose of educating individuals on a wide variety of topics. This theme included two sub-themes generated from participants' conversations: presentation to educational staff and presentation to parents. In describing presentations to educational staff, participants discussed broad topics, such as "helping the faculty with professional development in terms of how they can help foster the mental health needs of children" (FG 2), whereas others focused on specific mental health issues, such as "...maybe the teacher doesn't know about Aspergers or whatever the mental health issue may be..." (FG 9). One participant elaborated on presentation to parents, indicating that they were "asked to come to parent meetings sometimes, PTA, and present on...a myriad of different topics" (FG 5).

Counseling adults. The theme of counseling adults refers to an informal and brief form of psychotherapy in which a school psychologist discusses current or past problems with school personnel. One participant elaborated on how school psychologists are involved in providing counseling to adults:

Whether it is for a teacher who's going through an emotional time, you know, or a student. I, last year, I had to collect some data and stuff, you know I went through my notes on how many, how many teachers I had seen, and here it was like, wow. I really didn't think that I, you know, had seen that many teachers, who were dealing with boyfriend issues and boyfriends who were psychotic and you know, things like that, and they didn't know what to do and other teachers have, you know, emotional needs. (FG 8)

Although counseling adults is not a direct service provided to students, participants discussed the indirect impact counseling adults can have on students. As one participant described, "I still just feel like I'm indirectly helping the kids by helping the staff sometimes" (FG 10).

Prevention. The theme of prevention refers to the proactive provision of services that promote the well-being of students in a school environment. This theme contained two subthemes generated from participants' conversations: school or class-wide screening and drug education. The subtheme of school or class-wide screening was described as a specified method that school psychologists implement in order to identify students at-risk, or in need of mental health services, within their school. As one participant described, "I generally worked with principals to find out which group of children they were most concerned about and then what particular skills those children need" (FG 2). Participants did not provide further specification of activities under the subtheme of drug education services.

Family services. The theme of family services refers to interventions provided to families and/or significant others to address family relationship issues. This theme

included parent support groups. One participant described providing “parents group, for...supporting the mental health needs of your child” (FG 2). No participants reported providing family therapy.

The role of years of experience in the provision of mental health services by school psychologists. To provide a better understanding of the differences that emerged in relation to the types of mental health services provided by school psychologists as a function of practitioners’ levels of experience, the number of times each mental health service was described by a participant was counted. These frequency counts represent the number of times participants in each group provided a sentiment (i.e., quotation) that expressed the coded mental health service. A total index of the frequency with which the mental health service was mentioned was created by summing the total number of times a service was mentioned in the total sample (i.e., 11 focus groups) as well as broken down into total mentions for the four groups of experienced school psychologists and the four groups of new school psychologists (see Table 6) in an effort to compare frequency of responses between the two groups. Figure 3 provides a graphic representation of the percentage of times with which each barrier theme was discussed within the current study.

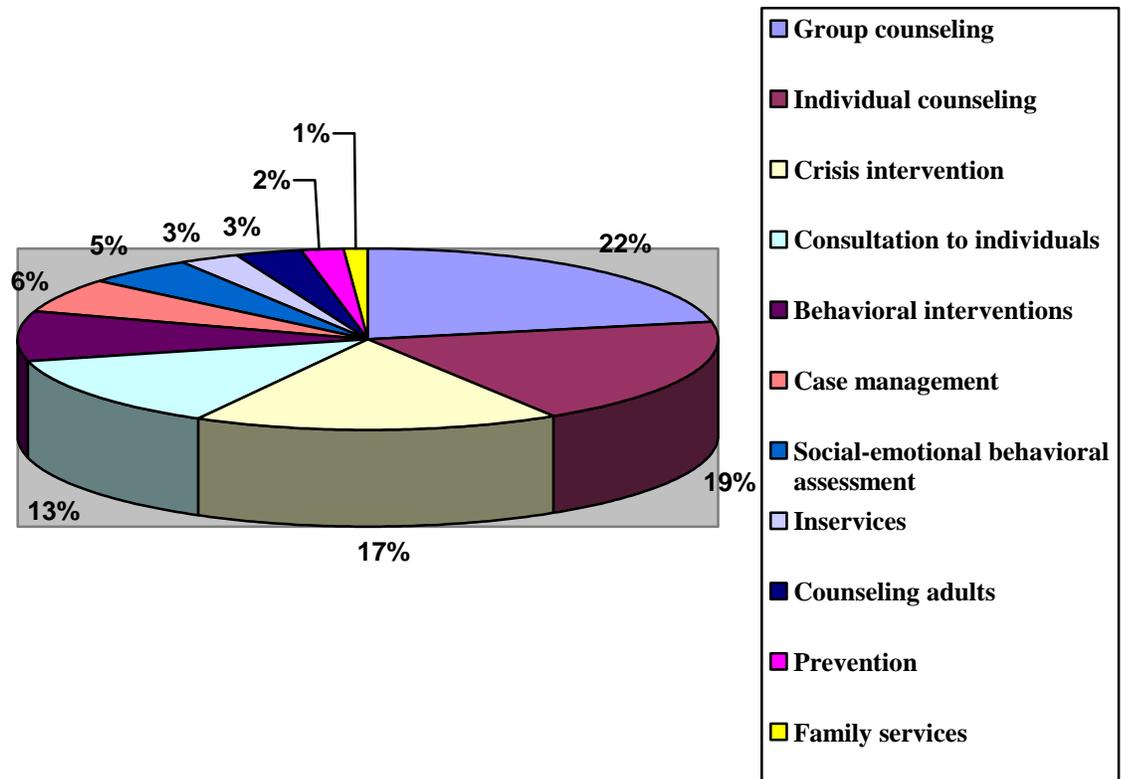


Figure 3. Percentage of times with which each mental health service theme was mentioned by participants

As shown in Table 6, participants in both the new and experienced school psychologist groups reported the provision of four mental health service themes at a relatively similar rate: individual counseling services, group counseling services, counseling adults, social-emotional-behavior assessment, consultation to individuals, and crisis intervention services. Participants in the new school psychologist groups were more likely to provide behavioral interventions (8 times, 75% of groups) than participants in the experienced school psychologist groups (2 times, 50% of groups). On the other hand, participants in the experienced school psychologist groups were more frequently

Table 6

Frequency each Group of School Psychologists Provided Specified Services by Level of Experience

Services provided	New school psychologists (n =15)		Mid-Range school psychologists (n =11)		Experienced school psychologists (n =13)		Total (N =39)	
	N	%	N	%	N	%	N	%
	Individual counseling	10	100	10	100	12	100	32
Group counseling	10	100	17	100	11	75	38	91
Social skills group	3	75	3	66	3	25	8	55
Study skills group	1	25	2	33	1	25	4	27
Organizational skills group	1	25	0	0	1	25	2	18
Anger management group	2	25	3	66	1	25	6	36
Motivation group	0	0	0	0	1	25	1	9
Divorce group	1	25	0	0	0	0	1	9
Anxiety group	0	0	3	66	0	0	3	18
Grief group	0	0	0	0	2	25	2	9
Unspecified group	2	50	7	100	2	50	11	55
Family services:								
Parent support groups	0	0	0	0	1	25	1	9
Prevention	1	25	0	0	2	25	3	27
School or class-wide screening	1	25	0	0	1	25	2	18
Drug education	0	0	0	0	1	25	1	9
Counseling adults	3	25	0	0	2	50	5	27
Social-emotional behavioral assessment	3	25	3	33	3	50	9	45

Consultation (to individuals)	8	75	2	33	12	100	22	73
Parent consultation	2	50	1	33	4	100	7	55
School-staff consultation	6	75	1	33	3	75	10	64
Problem-solving team consultation	0	0	0	0	5	50	5	18
Inservices (Consultation to groups)	1	25	0	0	4	50	5	37
Presentation to school staff	1	25	0	0	3	50	4	27
Presentation to parents	0	0	0	0	1	25	1	9
Crisis Intervention	9	100	8	100	13	100	30	100
Suicide assessment and immediate intervention	3	50	1	33	4	50	8	45
Threat assessment	1	25	2	33	3	25	6	27
De-escalation of individual problem	2	50	0	0	3	50	5	36
Unspecified crisis intervention activity	3	75	5	66	3	75	11	73
Behavioral Interventions	8	75	5	100	2	50	15	73
Case management	2	25	2	66	6	75	10	66
Consult with psychiatrist	1	25	1	33	2	25	4	27
Consult with outside therapist	1	25	0	0	0	0	1	9
Referral to outside agencies, follow-up on care	0	0	0	0	3	75	3	55
Unspecified case management	0	0	0	0	1	25	1	9
Consultation with police	0	0	1	33	0	0	1	9

Note. N = number of times service was mentioned in each group; % = proportion of groups in which the service domain was mentioned at least one time.

involved in the provision of inservices (4 times, 50% of groups) than participants in the new school psychologist groups (1 times, 25% of groups), with an emphasis on presentations to educational staff. Experienced school psychologist groups also indicated more frequent involvement in case management activities (6 times, 75% of groups) when compared to new school psychologist groups (2 times, 25% of groups). Only participants in the experienced school psychologist groups indicated involvement in family services (1 time, 25% of groups).

Factors that Prevent School Psychologists from Providing Additional Mental Health Assessment and Intervention

The following section will provide a description of the (a) themes related to barriers to providing mental health assessment and intervention and (b) subthemes within each category. Below is a description of all salient themes, including representative quotations and paraphrased statements; focus group numbers (FG) assigned is indicated as well. Table 7 presents a summary of themes and subthemes. Themes will be presented in order of the frequency with which they were mentioned. Following a discussion of the general findings of the research question, themes are compared as a function of practitioners' levels of experience.

Table 7

Themes and Sub-themes Related to Barriers to the Provision of Mental Health

Assessment and Intervention Identified by School Psychologists

Theme	Sub-themes (when applicable)
Problems inherent to using schools as site for service delivery	Scheduling problems; space constraints; inconsistent treatment; termination; student attrition; maintaining student privacy; accountability for academic success only; overlapping responsibility among mental health care providers
Insufficient support from the department and district administration	Department assigned roles and responsibilities; department procedural requirements; department liability and legal concerns; lack of support from district-level administration
Problems with school personnel	Lack of support from building-level administration; teachers not supportive of counseling; teachers unaware of school psychologists' mental health services; frustration with teachers
Insufficient training	Lack of confidence; lack of knowledge; inexperience
Insufficient time and integration into the	

school site

Personal characteristics

Burn out; apathy towards their job as a school psychologist; personal mental health problems; personal desire to provide traditional services rather than interventions

Caseload at school

overwhelming caseload; too many children in need of assessment

Student factors

Negative student characteristics; low parent support

Role strain

Problems inherent to using schools as site for service delivery. The theme of problems inherent to using schools as site for service delivery refers to the logistical and physical problems that arise related to the use of the school environment as the location of mental health service provision. This theme consisted of eight subthemes from school psychologists' conversations: scheduling problems, space constraints, inconsistent treatment, termination, student attrition, maintaining student privacy, accountability for academic success only, and overlapping responsibility among mental health care providers. Regarding scheduling problems, one participant described a common conflict:

The problem I'm having is at the elementary school and the Middle school - the academic time. You can't go in during the academic time, which leaves a very limited amount of time to do this [provide direct mental health services], and yet

it takes a lot of time, it takes a lot of time. (FG 2)

Other participants indicated how it is often difficult to get students together at the same time to run groups, particularly at schools that adhere to a block schedule. With respect to space constraints, one participant noted, “you have to have the right environment, and sometimes schools are not conducive no matter what; there is no space in some places, period” (FG 5). Others indicated the need for space due to safety, “when you are counseling with a kid...I’m not going to be in a room where people cannot see in because I want people to be able to see in” (FG 5), and in order to run group therapy sessions, “what prevents me is, is space. If I wanted to do a group, I wouldn’t have the space to do it” (FG 8).

Participants described how the probability of inconsistent treatment led them to be less likely to provide mental health services:

It’s hard...when you have...an emergency test and you have to change your day, it’s the most horrible thing in the world because the kids are used to you on Monday at 10 o’clock and they’re like, ‘where are ‘ya?’ (FG 2).

Participants indicated that the inability to provide consistent treatment alone meant that they would not provide mental health services: “to be able to provide long-term or something [mental health service] that is in depth, it is just not feasible. It is absolutely not feasible.” (FG 3)

Factors relevant to termination include the concern over determining when to end therapy: “to do comprehensive on-going, lengthy interventions: do you cut them loose after a half-dozen sessions, give or take?” (FG 8). Participants indicated that student attrition, or the loss of clients throughout the school year, was a barrier to providing

services: “so, I have a lot of that, where they start in a group and they change schools three weeks into it...that’s not only me being consistent but consistently getting that child here” (FG 10). Maintaining privacy was another concern raised by participants: “I was doing my [group] in the cafeteria at the Middle school...sitting there having a group with four kids talking about personal things and the people going to the clinic are stopping in and listening” (FG 2). Regarding the issue of accountability for academic success only within the schools, one participant noted, “and we keep putting a lot into academics and a lot of our goals focus on academics...and job roles are based on academics, not necessarily mental health needs of children” (FG 2). Overlapping responsibilities among mental health care providers involved participants feeling uncomfortable when there was an overlap between the services they provided and the services provided by another person employed by their school. Participants indicated concern with stepping on others’ toes and crossing informal territorial boundaries.

Insufficient support from the department and district administration. The theme of insufficient support from the department and district administration refers to specific actions and/or behaviors exhibited by the department or district administration that school psychologists’ perceive indicates a lack of support for providing psychotherapeutic services. This theme comprised four subthemes generated from participants’ conversations: department assigned roles and responsibilities, department procedures and requirements, department-level liability and legal concerns, and lack of support from district-level administration. Department assigned roles and responsibilities refers to the professional practices that a school psychologist provides in a school, practices that are based upon the departmental definition of school psychological services and the

responsibilities assigned to school psychologists. Participants discussed the ambiguity of their department's definition of their roles as a mental health service provider and the exclusion of the role of mental health service provider as part of the district's definition. As one participant described, it is "the job description itself" (FG 2) that is a primary barrier. Another participant elaborated on the ambiguity of her role in mental health service provision, stating "Do you ever feel like sometimes our roles are a little bit unclear when it comes to mental health? I find that's kind of sometimes the gray area in my role...when it comes to mental health things" (FG 10).

Participants also discussed how having assigned responsibilities within a school can limit their ability to provide SBMH services:

I mean right away I could see that student services and the special education were the ones that dictated and therefore were impediments to...different roles...In other words, they defined and therefore limited...or expanded all the different roles. And I noticed that...right from the moment I got here.... as far as counseling...unless you just said, 'look I want to do this' nobody was asking you to. (FG 1)

Regarding department procedures and requirements, participants indicated that departments require cumbersome paperwork to be completed when providing psychotherapeutic services. Additionally, participants described how the current evaluation procedures conflict with their abilities to provide SBMH service: "We spend so much time doing evaluations that have...little direct link to actual interventions...when you go down the list of evaluation requirements...you get this big report and the recommendations are not related to anything" (FG 9).

Liability and legal issues refers to the legal responsibilities that come with providing psychotherapeutic services and the fear of causing legal problems for an individual or the department. As one participant reported, “you not only [increase] your personal liability but the district’s liability if you start working with kids that are suicidal...sex offenders, homicidal, depressed. I mean you...open up a whole new liability issue” (FG 3).

The barrier of insufficient support from district-level administration often related to budget decisions made by the district: “district administrators who are making decisions about budgets and dollars and human resources and staffing...and we keep putting a lot into academics...and our budgetary purchases go towards academics” (FG 2). Another participant discussed how a general lack of funding for mental health services can prevent the provision of specific services:

I...started an anger management group at my school...and I needed curriculum, and...I found something I really wanted...and [we] then had to try to scrape-up the money and...go to different people, and beg...I mean, you need materials, you need things...so money’s not always readily available. (FG 10)

Problems with school personnel. The theme of problems with school personnel refers to the problems that arise because of the need for support from and collaboration with other school employees in order to provide SBMH services. This theme included four subthemes generated from participants’ conversations: lack of support from building-level administration, teachers not supportive of counseling, teachers unaware of school psychologists’ mental health services, and frustration with teachers. Regarding insufficient support from administration, some participants mentioned a general need for “administrative support within your school” (FG 5), whereas others elaborated on how

building-level administration are not supportive of the provision of SBMH services. For instance, one participant discussed the barrier of building administration's focus on testing: "people are still holding on to that old thinking and still want that test them, test them, test them...It is more like 'no, we need to test them. That is an ESE kid'" (FG 3). Another participant described the pressure that often comes from building administration to provide services other than mental health interventions: "administration...you got the bad kid, they want him out, they want him evaluated and we don't have them the time to give them the four week of STAT counseling that you want to" (FG 7).

Participants described how teachers may not be supportive of counseling services "because the kids see me as an ally sometimes the teacher find that to be a negative thing because they feel like the kids are running to me" (FG 7). Others indicated that "teachers...feel like its enabling the kids because they see them as socially maladjusted kids that are bad and they feel like they shouldn't have that support" (FG 7). Participants indicated that teachers often wish to have a student removed from their classroom or made eligible for services, as it places the responsibility outside of their hands. Challenges related to teachers' lack of awareness of school psychologists' mental health services was also described by participants:

We have the school psychologist just testing for years and years and years....and then [the] next generation comes and it's the same thing...so then the perception of all those other support services that work with you in ESE, departments and all like that is, 'oh, that's what they do, they're not experienced in this.' So, then...they start asking for a behavior specialist to come in to do something that we very well could do...(FG 1).

A number of teacher behaviors (e.g., treatment integrity when implementing interventions in the classroom, classroom management issues, lack of concern for procedures) was described by participants that led them to feel a general frustration with teachers.

Insufficient training. The theme of insufficient training refers to a paucity of training in psychotherapeutic interventions that then hinders a school psychologist from providing SBMH services. This theme included three subthemes from participants' conversations: lack of confidence, lack of knowledge, and inexperience. Regarding a lack of confidence, one participant stated:

I do think fear sometimes kind of gets in the way or lack of confidence. I mean...I'm affecting children's lives...maybe I take it...too seriously, but that's me and I...have to be able to go to sleep at night [feeling] that I have not done anything in any way...to affect this child. (FG 5)

Insufficient training involved statements pertaining to participants' beliefs that he/she had too little exposure to important topics relevant to SBMH during graduate school. As one participant stated: "well, without the training, I mean, it's tough" (FG 6). Similar sentiments were expressed by another participant in regards to a lack of training opportunities as a barrier to providing mental health services:

We just don't have that...leadership that's providing the training. We have leadership right now that's assessing it, looking at it, studying it, but as far as moving forward, someone that's actually doing it on a regular basis and saying, here I'll train you, or let me work with you or let me refresh those skills and so forth. That's an impediment to me, the fact that it's just not there yet. (FG 1)

In addition to insufficient didactic content, participants also voiced dissatisfaction with their opportunities to apply psychotherapeutic interventions, resulting in uncertainty during practice: “I am thinking, am I allowed to? Do I need to get consent first? Do I need to call the parent? So, yeah I am a little you know that is where I do get a little hesitant” (FG 4). Likewise, another participant voiced how inexperience can lead to uncertainty: “So...I am interested in it but...because I don’t feel like I have enough...experience, I am a little hesitant in moving forward” (FG 4).

Insufficient time and integration into the school site. The theme of insufficient time and integration into the school site refers to participants’ frustration with schedules that prevented them from being known by, visible to, and accessible to school employees and students. The issue of not having enough time in their day was elaborated upon by one participant: “it’s definitely a balancing act, finding the time to actually do the counseling...or to make extra time for a specific kid for a specific reason” (FG 6). Other participants described how working in their school only a few days a week can lead to a lack of integration into their school site: “and not being there enough: you are in a school two days a week [and] you cannot schedule someone’s crisis on Monday because you are not there on Monday” (FG 7). Similarly, others voiced how a lack of integration into schools can lead to school personnel being unaware of both who they were and what types of services they can provide:

I don’t think a lot of people know what I do, what I can do...I don’t think the kids know who I am until I work with them or go in their classroom enough till they start to say, hey, you were in here the other day. (FG 9)

Personal characteristics. The theme of personal characteristics refers to characteristics internal to a school psychologist. This theme included four subthemes from participants' conversations: burn out, apathy towards job, personal mental health problems, and personal desire to provide traditional services rather than interventions. Burn out refers to the physical and emotional toll that providing mental health services often has on school psychologists. Participants indicated that "it takes a big chunk out of you...physically and emotionally, to do the counseling" (FG 2) and that sometimes they just become exhausted and need to take a break. Apathy towards one's job included sentiments like, "you know another thing is the sense of urgency and I don't find that I have that sense of urgency as much as I used to" (FG 5). Barriers related to personal mental health problems was described by one participant as, "you may not be in a space to take on a serious long-term kind of counseling kind of relationship" (FG 5). In describing school psychologists' personal preference to provide traditional services, one participant stated that, "they [school psychologists] enjoy the profession the way it is, the way it was...that's part of why they don't want to change" (FG 1). Other participants described how providing traditional services is perceived as being easier than providing mental health services.

Caseload at school. The needs of the students at a school psychologist's school became a barrier when it resulted in an overwhelming caseload for the practitioner and/or caused too many children to be in need of assessment. Participants indicated that they were often overwhelmed by the sheer number of students in need of mental health services:

Once I got the permission slips in, there were so many children who really wanted to participate...I found that I've had to break it down now until it's individual. I'm seeing them all individually from...12:25 to 3:30 I have individual sessions and it's still not enough. (FG 2)

Others described how their current case load inhibited their ability to provide services: "and a lot of times we handle crises because there are 2,800 students...to counsel is very rare" (FG 7) and another elaborated, stating, "volume of referrals for me, sheer volume...with two schools, my ratio is above 3,700 kids" (FG 8). Regarding a large assessment case load, one participant expressed, "if you have 30 pending referrals you don't have time to do much of anything else" (FG 5).

Student factors. The theme of student factors refers to the characteristics of a referred student that cause a school psychologist to be less inclined to provide SBMH services. This theme included two subthemes from participants' conversations: negative student characteristics and low parent support. Regarding the role of negative student characteristics, one participant noted: "I tend to like the ones that are the victims of that as opposed to working with the ones that are the aggressors because they're so...hard to work with, because they have no reason to change" (FG 9). Other student characteristics perceived as being aversive included poor hygiene and immature behavior. Participants indicated two particular parent behaviors that portrayed a lack of support for mental health service provision: parents' resistance to students receiving mental health treatment and how low parent involvement can lead to ineffective service provision. One participant described the crucial need for parent involvement: "but at the elementary school I don't think that you can do effective treatment without a family being involved"

(FG 3). Another participant elaborated on perceived parent resistance: “I can think of one girl that was referred to me this year for me this year....but the parent said absolutely not...you’re not going to meet with her” (FG 10).

Role strain. Role strain refers to the numerous roles that a school psychologist holds within a school that can inhibit their ability to provide mental health services. As one school psychologist described, “this is your school and...you have to be an expert in everything and that’s not the reality” (FG 5). Another school psychologist elaborated on the role strain that can occur in schools:

I think that is one of the factors that hinder us or are a barrier for providing counseling because we...wear so many hats in the school...we end up having to pick up the slack from somebody else... we are so well-trained that we can fit into that mold and they know that so they...push us there. (FG 7)

The role of years of experience in barriers perceived by school psychologists. To provide a better understanding of the differences that emerged in relation to the types of barriers perceived by school psychologists as a function of practitioners’ levels of experience, the number of times each barrier was described by a participant was counted. These frequency counts represent the number of times participants in each group provided a sentiment (i.e., quotation) that expressed the coded barrier. A total index of the frequency with which the barrier was mentioned was created by summing the total number of times a service was mentioned in the total sample (i.e., 11 focus groups) as well as broken down into total mentions for the four groups of experienced school psychologists and the four groups of new school psychologists (see Table 8) in an effort to differentiate responses between the two groups. Figure 4 provides a graphic

representation the percentage of times with which each specific training theme was discussed within the current study.

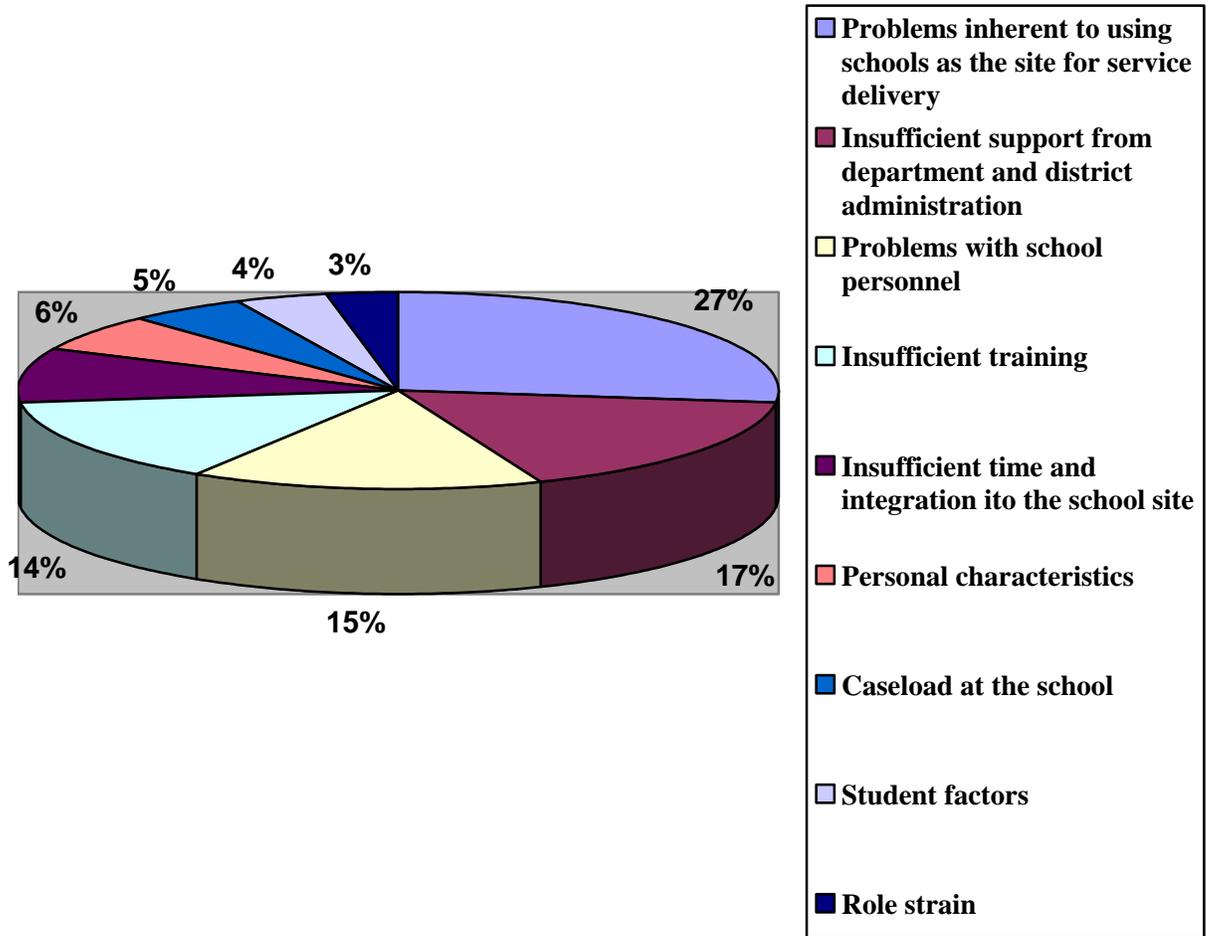


Figure 4. Percentage of times with which each barrier theme was mentioned by participants

As shown in Table 8, new and experienced school psychologists were equally as likely to perceive the five following themes as barriers to mental health service provision: insufficient support from district and department administration, role strain, caseload at the school, insufficient time and integration into the school site, and insufficient training. Participants in the new school psychologists groups were particularly concerned with

Table 8

Frequency each Group of School Psychologists Identified Barriers by Level of Experience

Barriers	New school psychologists (n =15)		Mid-Range school psychologists (n =11)		Experienced school psychologists (n =13)		Total (N = 39)	
	N	%	N	%	N	%	N	%
	Insufficient support from department and district administration	13	75	13	100	12	50	38
Department assigned role and responsibilities	6	50	11	100	7	50	24	64
Department procedures and requirements	3	50	0	0	1	25	4	27
Department liability and legal concerns	1	25	2	33	0	0	3	18
Insufficient support from district-level administration	3	50	0	0	4	50	7	36
Problems with school personnel	25	100	5	100	3	50	33	81
Lack of support from building-level administration	5	75	3	100	1	25	9	64
Teachers not supportive of counseling	6	50	0	0	0	0	6	18
Teachers unaware of school psychologist mental health services	7	100	2	33	0	0	9	45
Frustration with teachers	7	75	0	0	2	25	9	36

Role strain	3	50	0	0	4	50	7	36
Caseload at the school	6	75	0	0	6	75	12	55
Overwhelming caseload	2	50	0	0	4	50	6	36
Too many children in need of assessment	4	25	0	0	2	25	6	18
Problems inherent to using schools as the site for service delivery	12	100	14	100	36	100	62	100
Scheduling problems	0	0	2	33	7	75	9	36
Space constraints	2	25	1	33	11	100	14	55
Inconsistent treatment	3	50	1	33	8	75	12	55
Termination	0	0	0	0	5	50	5	18
Student attrition	2	50	0	0	0	0	2	18
Maintaining student privacy	0	0	0	0	3	50	3	18
Accountability for academic success only	3	50	3	66	2	25	8	45
Overlapping responsibility among mental health providers	2	50	7	100	0	0	9	45
Insufficient time and integration into the school site	6	100	5	100	10	100	21	100
Insufficient training	8	50	16	100	8	75	32	73
Lack of confidence	2	50	2	66	2	50	6	55
Lack of knowledge	3	50	11	100	5	50	19	64
Inexperience	3	25	3	66	1	25	7	36
Personal characteristics	0	0	4	66	10	75	14	45
Burn out	0	0	0	0	3	75	3	27
Apathy toward job	0	0	0	0	2	25	2	9
Personal mental health problems	0	0	0	0	2	25	2	9

Personal desire to provide traditional services rather than interventions	0	0	4	66	3	25	7	27
Student factors	6	100	2	33	2	50	10	64
Negative student characteristics	4	50	0	0	0	0	4	18
Low parent support	2	50	2	33	2	50	6	45

Note. N = number of times barrier was mentioned in each group; % = proportion of groups in which the barrier was mentioned at least one time.

problems that arise when working with school personnel (25 times; 100% of groups) when compared to participants in the experienced school psychologists groups (3 times; 50% of groups), with more frequent indications of concern across all four subthemes. Participants in the new school psychologists groups also indicated more concern over student factors (6 times; 100% of groups) when compared to participants in the experienced school psychologist groups (2 times; 50% of groups). On the other hand, participants in the experienced school psychologist groups were particularly concerned with the problems that arise when using schools as the site for service delivery (36 times, 100% of groups) when compared to participants in the new school psychologist groups (12 times, 100% of groups), with more frequent indications of concern across five of the seven subthemes. Participants in the experienced school psychologist group more frequently indicated concerns over personal characteristics that interfere with providing SBMH services (10 times; 75% of groups) as compared to participants in the new school psychologist groups (0 times; 0% of groups), with more frequent indications of concern across all four subthemes.

Specific Knowledge and Skill Areas in Which Additional Training Would be Helpful in Enabling School Psychologists to Provide Mental Health Assessment and Interventions

The following section will provide a description of the (a) themes related to training needs and (b) subthemes within each category. Below is a description of all salient themes, including representative quotations and paraphrased statements; focus group numbers (FG) assigned is indicated as well. Table 9 provides a summary of themes and subthemes. Themes are discussed in order of the frequency with which they were mentioned. Following a discussion of the general findings of the research question, themes are compared as a function of practitioners' levels of experience.

Course-work training needs. The theme of course-work training needs refers to the specific content and didactic areas that school psychologists identified as relevant to their ability to provide SBMH services. This theme includes 24 subthemes generated from participants' conversations: ethics and law, developmental psychology, personality, psychopathology, psychopharmacology, multicultural education, behavior interventions, empirically supported treatments, consultation, systems consultation, interpersonal and listening skills, crisis intervention, social-emotional-behavior assessment, advanced psychotherapy, advanced study of single orientation, survey of multiple orientations, group therapy, family therapy, treatment planning, case documentation, counseling adults, social work/services, life-long learning, and working in schools.

Table 9

Themes and Sub-themes Related to Identified Training Needs

Theme	Sub-themes (when applicable)
Course-work training needs	Ethics and law; developmental psychology; personality; psychopathology; psychopharmacology; multicultural education; behavior interventions; empirically supported treatments; consultation; systems consultation; interpersonal and listening skills; crisis intervention; social-emotional-behavior assessment; advanced psychotherapy; advanced study of single orientation; survey of multiple orientations; group therapy; family therapy; treatment planning; case documentation; counseling adults; social work services; life-long learning; working in schools
Experiential activities	observing a master therapist; supervised practicum; in-class role plays; co-leading a group; self-review and critique of counseling; receiving personal counseling; working on a multidisciplinary team
Professional development	applied experiences; supervision; consultation with peer colleague; working with interns;

participation in a professional organization; in-
services

Ethics and law addresses the need for coursework that attends to the legal issues that arise when providing mental health services in the school setting. One participant stated that "...you need to look at things like HIPPA, risk management" (FG 3). Participants described coursework covering developmental psychology as "a good foundation" (FG 11), particularly because "we need to look at a kid and say...what developmental task is he at right now" (FG 6). Personality coursework included content related to theories of personality.

Regarding psychopathology, participants described how "knowing the DSM front to back has been extremely helpful" (FG 3) and the importance of acquiring "information...about the disorders, internalizing disorders, anxiety disorders ...and just knowing what I'm seeing" (FG 11). The benefit of psychopharmacology coursework was described by one participant: "It really allowed me to understand how the whole medication piece fit in" (FG 9). Participants emphasized the importance of including multicultural education within school psychology graduate training:

I think that we don't understand cultural differences and I think that is so critical...in everything we do, I think that one thing that I may see as deviant may not be deviant to another person and...it's critical that we understand differences that we don't condemn, that we understand, and that we go from there. (FG 11)

Participants recognized the importance of learning about behavior interventions: "I've been doing coursework and training...in behavior analysis...and it's really exposed me to

some more behaviorally based strategies” (FG 9). Other beneficial coursework mentioned under this subtheme included “relaxation training” “role playing,” “skill streaming,” and “how to observe” (FG 6). One participant illustrated the need for coursework on empirically supported treatments: “I think an emphasis on specific programs that are successful...having courses that would say, here’s an excellent program for folks with this issue, here’s an excellent program for this and we actually get training in that program” (FG 1).

Coursework subthemes emerged that emphasized content covering communication skills, including courses in individual consultation, systems consultation, and interpersonal and listening skills. Systems consultation coursework was described as providing school psychologists with knowledge of “how long it takes for things in the system to change” (FG 7), “just knowing systems and knowing how systems work,” and “how to enter a place and be successful” (FG 11). With respect to interpersonal/listening skills, one participant noted the need for content covering “the dos and don’ts of communication” (FG 11). Consultation coursework was identified as important as teachers “are looking at us to help them.” Hence, there is a need for school psychologist to know “how to help them (teachers) not pull their hair out and how to help them make it through the day” (FG 3).

Regarding the need for coursework on crisis intervention, participants focused on the need for training in “suicide and threat assessment...like how to assess” (FG 9). Participants recalled important skills learned within social-emotional-behavior assessment coursework, including “techniques in interviewing” (FG 3), “RQC” (FG 7), and “rating scales” (FG 7). The need for coursework in advanced psychotherapy, the

study of how to conduct individual psychotherapy, was indicated as well: “I had really excellent training... we did...not only group process but we did individual and we would...take them and video and critique them...and we had a lot of courses that were real hands on...not just theory and models” (FG 1). In describing didactic training in an advanced study of a single orientation, one practitioner provided the following suggestion: “I think that you could even have people who were really expert in certain fields come in and do modules of training” (FG 5).

Contrastingly, participants deemed coursework on a survey of multiple orientations as essential to increasing their ability to provide SBMH services: “if there was someone in another department who...could share that kind of knowledge...just so you are exposed to more than just one orientation...if you could at least have access to...play therapy, sand play therapy,... gestalt therapy” (FG 5).

Specific courses in group therapy and family therapy were mentioned as important training needs. Regarding the benefit of having a course in group therapy, one participant indicated that “I really just had one course that was solely dedicated and that was really for group counseling” (FG 1). Coursework covering case documentation was described as covering “counseling notes” and “how would you document it, those kinds of things, the nuts and bolts of it” (FG 4).

Regarding the need for courses that included training in treatment planning, one participant described the following:

In terms of training...we're doing a lot with CBM, CBA, where we can measure progress. I think with the counseling...in terms of your progress notes, your goal, what are you doing, how do you measure that? I think...training in those kinds of

areas would help us because then you can go in and feel with confidence I am making a difference or I'm not (FG2).

The need for coursework covering content about counseling adults in a school setting was indicated by participants, as “people bring all their problems to you. And what to do with that?” (FG 7). The desire for information on social work services addresses the need for content covering mental health agencies and resources within communities: “and another thing I think we need to learn in our program is more about community agencies--what is out in the community” (FG 7). Working in the schools addresses the need for content covering how to navigate working in the school environment. This content area includes knowledge related to the functions of the teacher, functions of various school personnel, and a better understanding of the classroom and school environment. One participant, for example, elaborated upon such coursework:

I think we need a little bit more of the education component classes in terms of what to expect of teachers, what to expect of administrators, things like that. If they could include at least one strong education class...I think we need some, a little bit of education component (FG 7).

Life-long learning refers to content covered in courses that would provide school psychologists with the essential skills needed to continually acquire new information. One participant mentioned the need for “guidance on where you are going to find a lot of it [interventions]” and the need for “some guidance on where we could find things that are teacher-friendly” (FG 7). The last subtheme identified as “other coursework” includes specific content areas mentioned only once during the focus groups. For instance, single participants discussed the importance of coursework covering

neuropsychology, educational psychology, learning theories, and children with disabilities.

Experiential Activities. The theme of experiential activities refers to those activities within a training program that involve the students in actively practicing or observing a skill needed for mental health service provision. Six subthemes were identified within the focus groups as increasing participants' ability to provide SBMH service: observing a master therapist, supervised practicum, in-class role plays, co-leading a group, self-review and critique of counseling, receiving their own counseling, and working on a multidisciplinary team.

Co-leading groups refers to the experience of trainees actively facilitating a mental health group with an experienced practitioner. Experienced practitioners identified by participants included school-based counselors, psychiatrists, and practicum supervisors. One participant elaborated upon the benefits of this training experience:

I have done some co-group situations with them [guidance counselors]. And that really helped a lot because...their skills are much sharper in that area...I kind of felt like the tin man; I just needed to be oiled. So that helped a lot. It was a real positive thing. (FG 3)

Other benefits of co-leading were described by participants: "I like to co-lead.... because I like to watch their techniques and it really does help a whole lot. They know what works" (FG 3).

Participating in in-class role plays during school psychology training was another applied experiences identified as helpful:

I can make a suggestion for programs that was helpful in my training. In one course in advanced therapy techniques we did mock therapy with each other, we had a partner, and we worked with each other...and you taped it and transcribed it and it was critiqued by either the professor or TA...that was pretty intense. (FG 6)

With respect to the training benefits of receiving their own counseling, both individual counseling experiences and group counseling experiences were discussed as helping school psychologists feel sufficiently-prepared to provide SBMH services. One participant elaborated on the process:

I remember in one class we actually had to work with the folks ready to graduate from ...the counseling psych program, and we had to be the counselees. It was neat to go through the other side of that process and kind of go through that and feel that. (FG 3)

Other participants indicated similar beneficial experiences to receiving their own counseling:

I think that was interesting that they [professors] focused so much on looking at yourself as the instrument but also looking at whether you bring the good things and maybe the not so good things that you bring to anything you do as a school psychologist and that was very powerful experience that I really went through there. (FG 5)

A number of methods for observing master therapists were identified by participants, including “seeing films about different counseling and observing someone” (FG 3) and “shadowing” (FG 1). The benefits of observing a master therapist was discussed in detail:

You really need to go out there and get with someone who is really doing it and really watch them and see someone who is...doing good counseling, good mental health services, and has a good system in place because that is the only reason that I have been able to do half the things with this new intervention process at my school. (FG 7)

Self-review and critique of counseling encompasses a number of activities, including watching a tape of an applied experience, listening to a tape, critique of personal skills by either the trainee or a supervisor, critique of another student's skills, and discussing recommendations for future applied experiences with either other students or supervisors. One participant described a self-review as involving "the constant video taping, the watching of the videotape, listening to audiotapes" (FG 5). Another described this experience as "we also taped counseling sessions with kids...and then we viewed those tapes in class and what we were doing and what skills we needed to work on. It was very, very helpful" (FG 6).

Participants advocated for the inclusion of a supervised practicum as part of the school psychology training program: "I had a great supervisor and so...that was a wonderful experience. It just pushed me to do all sorts of things...I don't feel like I could...do now had I not had that training" (FG 10).

Working on a multidisciplinary team was described as a beneficial experiential activity:

One thing that was really beneficial, is working on multidisciplinary, interdisciplinary teams...I felt like that at those meetings, when we were discussing a case, I learned more then I felt I was ever contributing and I still feel

like that today but every time I go in a meeting with different people, I'm like, oh, you know, just absorb it, try and absorb everything I can. (FG 9)

Professional development. The theme of professional development refers to those activities that occur after a school psychologist has graduated from a training program. Six subthemes emerged within the professional development theme: inservices, applied experiences, supervision, consultation with peer colleagues, working with interns, and participation in a professional organization.

The benefit of attending in-services was described as a beneficial professional development activity:

When people come in and, I think it's really great and it's kind of that they do bring in good people and they come in with programs and things that can be implemented...They [department administration personnel] have brought in some good people with good training modules that...we're encouraged to go to trainings. (FG 2)

A second participant elaborated on the inclusion of specific activities and information within in-services that they have found to be beneficial:

They [department administration personnel] bring in a lot of different...trainings based on a lot of different theories and the training really helps, when they bring people in and we can go in and get training and they provide real-life experiences, hands-on type things, activities that we can do in the trainings that we can go out into the schools and do. (FG 2)

Applied experiences refer to the school-based experiences that involve the application of recently acquired knowledge relevant to the provision of SBMH services.

Applied experiences require the school psychologist to go beyond just learning a specific skill to actually practicing it. One participant described the possible benefits of having an applied experience in the school setting:

Having the opportunity to go back and apply that...where you have a group or individuals where you're practicing the strategies, being able to come back and say, '...this is what's happening...how can I improve it?'...things like that where you can get some feedback. (FG 2)

Participants indicated a need for accountability and follow-up as part of the applied experience. For example, one participant identified the need for "a performance-based activity that goes along with the professional development activities" (FG 2).

Supervision was described as "actually seeing someone who...comes out and...observes you in action" (FG 5). The importance of supervision was identified through one participants' description of the lack of such experiences: "In twenty seven years, I have never had one day of supervision from anybody....the lack of supervision once we are school psychologists and once we are off the leash is incredible" (FG 5).

Another valuable professional development activity for participants involved consultation with peers:

We have such a wealth of knowledge in our staff because you can go to someone on the staff ...or someone else knows something about what I need and we work well together for the most part. I can call and say hey, I need help and vice versa. (FG 11)

Throughout the focus groups, participants identified the benefit of consulting with fellow school psychologists, psychiatrists, and other school based staff (i.e., counselors).

Participating in a professional organization was one of the few individualized professional development activities mentioned. One participant indicated that “I...joined...NASP this year and....the online stuff that they have ...it’s been well worth it already” (FG 10).

Working with interns was mentioned as a means through which practicing school psychologists can acquire novel skills and knowledge from school psychology students that will increase their ability to provide SBMH services:

I supervised a group of students so...I learned a lot from them, I learned a lot by showing them how to do it and what to do, so demonstrating and making sure that I was doing it right because I knew they were learning and I wanted them to learn it correctly and learning from them because students always...know what is new...that was really helpful to me. (FG 5)

The role that year of experience plays in the training needs of school psychologists. To provide a better understanding of the differences that emerged in relation to the training needs of school psychologists as a function of practitioners’ levels of experience, the number of times each training need was described by a participant was counted. These frequency counts represent the number of times participants in each group provided a sentiment (i.e., quotation) that expressed the training need. A total index of the frequency with which the training need was mentioned was created by summing the total number of times a service was mentioned in the total sample (i.e., 11 focus groups) as well as broken down into total mentions for the four groups of experienced school psychologists and the four groups of new school psychologists (see Table 10) in an effort to differentiate responses between the two groups. Figure 5

provides a graphic representation the percentage of times with which each specific training theme was discussed within the current study.

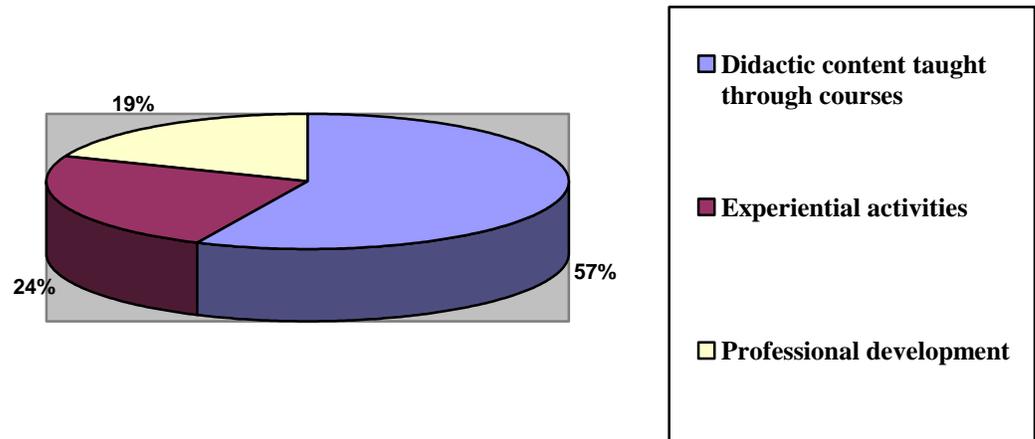


Figure 5. Percentage of times with which each training theme was mentioned by participants

As shown in Table 10, participants from both the new and experienced school psychologists groups were equally as likely to indicate a desire for training in didactic content taught through courses, experiential activities, and professional development. However, differences in responses emerged between the participants in the experienced and new school psychologists groups in relation to the types of content in coursework identified as beneficial. New school psychologists emphasized the need for coursework covering crisis intervention (7 times; 75% of groups), consultation (6 times; 75% of groups), systems consultation (3 times; 25% of groups),

Table 10

Frequency each Group of School Psychologists Identified Training Needs by Level of Experience

Training needs	Mid-Range				Experienced		Total	
	New school		school		school		Total	
	psychologists		psychologists		psychologists		(n =39)	
	(n =15)		(n =11)		(n =13)			
	N	%	N	%	N	%	N	%
Didactic content taught through courses	69	100	51	100	40	100	160	100
Advanced study of single orientation	3	50	2	66	7	75	12	64
Survey of multiple orientations	5	75	3	66	5	100	13	82
Crisis intervention	7	75	0	0	2	25	9	36
Interpersonal/listening skills	1	25	1	33	1	25	3	27
Systems consultation	3	25	1	33	1	25	5	27
Psychopathology	9	100	7	100	4	50	20	82
Advanced psychotherapy	2	50	4	100	1	25	7	55
Family therapy	3	50	1	25	0	0	4	27
Group therapy	2	25	5	100	3	50	10	55
Developmental psychology	0	0	3	33	2	25	5	18
Psychopharmacology	3	50	0	0	0	0	3	18
Treatment planning	2	50	1	33	2	25	5	36
Social-emotional-behavioral assessment	3	50	1	33	1	25	5	36
Counseling adults	3	25	0	0	0	0	3	9
Working in schools	3	25	2	33	0	0	5	18
Behavior interventions	5	75	3	66	2	25	10	55

Life-long learning	2	25	2	33	0	0	4	18
Social work/services	3	50	2	33	0	0	5	27
Ethics/law	0	0	3	33	0	0	3	9
Empirically-supported treatments	0	0	3	33	3	50	6	27
Multicultural education	3	50	0	0	2	25	5	27
Case documentation	1	25	1	33	1	25	3	27
Other coursework	0	0	2	66	2	50	4	36
Personality	0	0	2	66	1	25	3	18
Consultation	6	75	2	33	0	0	8	36
Experiential activities	28	100	21	100	18	100	67	100
In-class role plays	5	75	3	33	4	50	12	55
Supervised practicum	15	100	5	66	6	100	26	91
Observe master therapist	3	75	4	66	2	50	9	64
Co-lead groups	1	25	3	66	2	25	6	36
Self-review and critique of counseling	2	25	4	66	2	25	8	36
Receive own counseling	0	0	2	33	2	50	4	27
Work on multidisciplinary team	2	25	0	0	0	0	2	9
Professional development	17	100	8	100	27	100	52	100
In-services offered through the district	11	100	4	66	12	100	27	91
Applied experiences following inservices	1	25	1	33	3	50	5	36
Work with interns	0	0	0	0	2	25	2	9
Participation in professional organizations	2	25	0	0	0	0	2	9
Formal supervision of services	0	0	2	33	2	25	4	18
Consultation with peer colleagues	3	50	1	33	8	50	12	45

Note. N = number of times training course or experience was mentioned in each group; % = proportion of groups in which the training/coursework domain was mentioned at least one time

behavior interventions (5 times ; 75% of groups), life-long learning (2 times; 25% of groups), family therapy, psychopharmacology, counseling adults, working in schools, and social/work services (3 times; 20-75% of groups), psychopathology (9 times; 100% of groups), and social-emotional-behavioral assessment (3 times; 50% of groups) . Under the theme of experiential activities, participants in the new school psychologist groups more frequently mentioned the need for supervised practicum (15 times; 100% of groups) as compared to responses from experienced school psychologist groups (6 times; 100% of groups) and working on an interdisciplinary team (2 times; 25% of groups) as compared to responses from the experienced school psychologist groups (0 times; 0% of groups). Under the theme of professional development activities, participants in the new school psychologist groups more frequently mentioned the training need of participation in a professional organization (2 times; 25% of groups) than did the experienced school psychologist groups (0 times; 0% of groups).

Participants in the experienced school psychology groups emphasized the need for coursework covering the advanced study of a single orientation (7 times; 75% of groups), developmental psychology (2 times; 25% of groups), and empirically supported treatment (3 times; 50% of groups). Specific experiential activities that participants in the experienced school psychologist groups more frequently mentioned included the need of receiving their own counseling (2 times; 50% of groups) as compared to new school psychologist groups (0 times; 0% of groups). Participants in the experienced school psychologist groups more frequently indicated the benefits of four professional development activities. Participants in the experienced school psychologist groups more

frequently indicated the need for applied experiences following inservices (3 times; 50% of groups) as compared to participants in the new school psychologist groups (1 time; 25% of groups). Similarly, experienced school psychologist groups more frequently indicated the importance of consulting with peer colleagues (8 times; 50% of groups) as compared to new school psychologist groups (3 times; 50% of groups). Participants in the experienced school psychologist groups were the only participants to indicate working with interns (2 times; 25% of groups), and formal supervision of services (2 times; 25% of groups).

Chapter 5

Discussion

The purpose of the current study was to provide the first qualitative examination of school psychologists' provision of psychotherapeutic services in the schools. The study aimed to explore those factors that school psychologists perceive inhibit them from providing more mental health interventions within their professional roles. An additional purpose of the current study was to examine activities and attitudes related to mental health service provision as a function of practitioners' levels of experience. A focus group method was selected as a preliminary means to gather the important information that is lacking in the existing literature. As the participants explored their thoughts about mental health service provision in the schools, several themes emerged across the focus groups, with some differences between the new and experienced practitioners.

This chapter summarizes the results of the current study and integrates findings with existing literature review presented in Chapter 2. The chapter is organized by the research questions addressed within the research study. Following the examination of results and presentation of notable findings, implications of the results for school psychologists are examined, limitations of the research study are reviewed, and suggestions for future research are discussed.

Examination of Results

Problems Referred

The purpose of this first research question was to gain a greater understanding of the types of mental health problems that are commonly referred for mental health services in school settings. Unique to this study was the use of qualitative methods to elicit the types of common referral problems seen in schools. Responses from focus groups indicated that school psychologists receive a diverse array of referral problems. The student problems mentioned most frequently by participants were isolated behavioral or emotional symptoms (e.g., lack of empathy, cutting, low self-esteem). Other common referral problems included DSM disorders, family issues, crisis situations, and anger. Although not as prevalent within the focus groups, participants also discussed receiving referrals for adolescent issues, learning problems, atypical/bizarre behaviors, and adults' mental health problems.

These findings corroborate previous researchers' findings that have indicated that the types of problems referred within a school setting include but are not limited to diagnosable mental or addictive disorders (Foster et al., 2005; Repie, 2005; Whitmore, 2004). The implication of this finding (i.e., that specific symptoms are seen more often than full DSM disorders) are important to consider. Current prevalence data on the mental health problems of children and adolescents have been limited by the type of data collection method utilized within the research studies. As described in Chapter 2, the definition of what constitutes a "mental health problem" is limited by case ascertainment, case definition, and presentation. Furthermore, prevalence studies use a range of assessment methods to determine the prevalence of mental disorders (e.g., syndrome

scales such as the Child Behavior Checklist, DSM-IV checklists). As the results of this study indicate, many prevalence studies would not tap the types of problems that participants discussed as the common mental health problems that are referred for SBMH services (e.g., divorce, isolated externalizing symptoms) in that isolated symptoms would not be counted but are important enough to warrant psychologists' attention.

Several of the student mental health problems reported by participants in the current study are consistent with those identified in previous research. Similar to Foster et al.'s (2005) and Whitmore's (2004) findings, anger/aggression was identified as a reason students were often referred to school psychologists. Results from this study also corroborate the findings of Foster et al. (2005), in which a representative sample of 1,147 schools in 1,064 districts across the country responded to a survey about the problems most frequently presented by students in their schools. Foster et al. (2005) found that the mental health categories frequently endorsed related to family problems, anxiety, depression, and substance abuse. The finding of referrals related to learning problems, which participants described as issues related to work completion, motivation, and study, skills, is consistent with the findings of Whitmore (2004), in which a national sample of school psychologists identified academic problems as a frequently occurring referral problem. Additionally, the referral of students with problems related to trauma corroborates the findings of Slade (2003), in which a national sample of school administrators identified that schools receive referrals for physical, sexual, or emotional abuse and they help the referral student select outside services for ongoing care.

With the exceptions of the aforementioned similarities, the majority of referral problems that emerged from the current study were contradictory to previous findings.

Previous studies have consistently identified interpersonal problems and self-esteem as representing common referral concerns (Foster et al., 2005; Repie, 2005; Whitmore, 2004), and although both referral concerns were mentioned by some participants in the current study, they were not emphasized (i.e., mentioned frequently or elaborated on to a degree). Whereas earlier research with teachers, counselors, and school psychologists suggested that suicidality and substance use were among the least critical issues in schools (Repie, 2005), participants from the current study frequently identified suicidality and substance use as reasons why students were referred for mental health services. One hypothesis for why these differences emerged relates to the sample utilized in each study. Given the severity of issues surrounding suicidality and substance use, these referrals may bypass teachers and counselors and be directly sent to school psychologists; hence, teachers and counselors would be less likely to be aware of such issues. More research is needed to flesh out the specific reasons why such differences emerged. In one of the few studies that exclusively studied school psychologists (Whitmore, 2004), three out of the four most frequently identified referral concerns (academic problems, peer problems and self-esteem issues) were not emphasized by participants in the present study.

A number of unique responses were noted by participants in the current study. Given that most research studying the types of problems referred to school psychologists were based on forced-choice survey responses, it was not surprising that a number of referral problems that have not been noted in the existing literature emerged when participants were provided the opportunity to identify the types of referral concerns that they received—that is, to construct their own responses. For example, participants described how referral problems regarding family issues involved dealing with parental

divorce, placement in foster care, and conflicts with parents. Understanding the divergent issues that fall under the category of “family issues” is crucial to determining what relevant kinds of content knowledge areas and training experiences would allow school psychologists to feel sufficiently prepared to treat the broader referral problem of “family issues.”

Participants in the current study differentiated between referral problems that could be characterized as representing a diagnosable mental disorder and those referral problems that were isolated behavioral or emotional symptoms that could not by themselves constitute a diagnosable DSM disorder. Thus, such issues as bullying, cutting, and eating issues emerged from participants’ responses. Similarly, several participants described isolated internalizing symptoms such as a student appearing “withdrawn” or “not wanting to express emotion.” Participants expanded upon previous studies that had identified school-based referrals for students diagnosed with depression and ADHD (Foster et al., 2005; Repie, 2005) to include the following DSM disorders: oppositional defiant disorder, bipolar disorder, and ASD. Statements made by participants helped to provide information regarding the complexity of receiving referrals for problems related to a DSM diagnosis. Participants indicated that, for example, depression “often comes out later” and when referred, “can be manifested in different ways.” Similarly, participants described the referral problem of anxiety as encompassing a variety of separate forms of anxiety-related issues. While previous studies have noted the prevalence of school-based referrals regarding anxiety (Foster et al., 2005), statements made by the present participants helped to provide information about the variety of forms of anxiety, namely test anxiety and school phobia, that are referred for

mental health services. Participants' responses also contributed to a greater understanding of the types of adolescent issues that are referred for services within schools. Issues related to romantic relationship problems, teenage sexuality, and gender/sexual identity were all mentioned as referral problems by focus group participants. Similarly, participants provided a greater understanding of the types of atypical and bizarre behaviors referred for mental health services that have previously been noted in the literature (Repie, 2005).

While not seen in previous research, participants in the current study emphasized referral problems related to crisis situations, including threats of harm to others, personal grief, and school-wide tragedies. Participants' discussion of referrals due to adult mental health problems was also unique to the current study. In particular, participants described how they were sometimes faced with school personnel eliciting their guidance in regards to personal issues. Importantly, this is the first time that it has been noted that school psychologists also play a role in working with adults in a school setting.

In general, these results attest to the importance of conducting research on students' mental health by interviewing front-line service providers. The breadth of responses within the current study, and the unique referral problems that are currently not attended to in epidemiology studies, suggests that the topic of children's mental health concerns should be addressed further in future studies. Knowledge of the common referral problems within schools is needed to develop and implement mental health services, including prevention programs, family support services, and therapeutic interventions that meet the needs of children in modern society.

Mental Health Services Provided

The purpose of the second research question was to gain a greater understanding of the various types of mental health services that school psychologists currently provide. Unique to this study was the use of qualitative methods to elicit participants' answers. Responses from focus groups indicated that school psychologists provide a diverse array of mental health services. The activities identified most frequently by participants included group counseling, individual counseling, and crisis intervention services, followed by consultation, behavioral interventions, case management, and social-emotional behavioral assessment. Although not discussed as often, some participants also reported counseling adults, as well as providing inservices, prevention services, and family services. These findings are consistent with previous research demonstrating that school psychologists offer a breadth of mental health services to their students, ranging from individual counseling to crisis intervention (Pryzwansky et al., 1984; Repie, 2005; Yates, 2003).

Of note, it is challenging to integrate previous research on services provided due to the diverse definitions of mental health services utilized in each study. With that caveat, findings in the current study can be compared with studies that queried an assortment of school personnel on the provision of psychotherapeutic services (Brener et al., 2001; Foster et al., 2005; Repie, 2005; Slade, 2003; Whitmore, 2004) and studies that focused solely on the provision of psychotherapeutic services by school psychologists (Pryzwansky et al.; Smith, 1984; Yates, 2003; Yoshida et al., 1984). In general, the emphasis participants in the current study placed on the provision of crisis intervention services--individual counseling, group counseling, case management, and social-

emotional behavioral assessment--corroborate the previous research of Foster et al. (2005), Whitmore (2004), Slade (2003), and Brener et al. (2001), who also identified these services as some of the more frequently provided mental health services in schools. Regarding research examining psychotherapeutic services provided specifically by school psychologists, the results from this study are consistent with earlier studies that highlighted the provision of individual and group counseling services (Prout et al., 1993; Smith, 1984; Yates, 2003; Yoshida et al., 1984). Unique to the current study were participants' statements that clarified the process of individual counseling in the schools and the different types of group counseling provided. Specifically, individual counseling services ranged from addressing a targeted behavior to a "general issue in school." Group counseling services addressed a variety of specific problems, ranging from organizational skills to grief.

Consistent with previous research was the notable absence of the provision of family services. For instance, a national sample of school psychologists (Whitmore, 2004) and regular and special education teachers, school counselors, and school psychologists (Repie, 2005) indicated that the mental health service that they provided least often in school settings was the provision of family counseling services. Possible explanations for the limited provision of family services may be gleaned from previous research that found family support services was the mental health service most frequently ranked as "difficult" or "very difficult" to deliver (Foster et al., 2005). This may be a relatively recent phenomenon, as some studies conducted in the 1980's using a sample of school psychologists from a northern state (Pryzawansky et al., 1984) and a national sample of school psychologists (Yoshida et al., 1984) identified family services as a

common mental health service provided. Nevertheless, the paucity of family services discussed in the current study is in line with results of a more current study of school psychologists (cf. Yates, 2003).

Participants in the current study also did not report much provision of substance abuse services and prevention services (e.g., drug education), consistent with previous research suggesting that substance abuse services and prevention services were not services commonly provided in the schools (Foster et al., 2005; Repie, 2005). Perhaps other educational personnel are addressing such needs, as a national sample of guidance counselors, psychologists, social workers, and principals surveyed reported that many of their schools provided alcohol and other drug use prevention, suicide prevention, and violence prevention (Brener et al., 2001).

Notably, participants within the current study did not emphasize the provision of social-emotional behavioral assessment, which contradicts the large body of existing research that has consistently identified assessment/testing as a mental health service frequently provided in schools (Foster et al., 2005; Repie, 2005; Slade, 2003). One hypothesis for this inconsistency pertains to the current study's definition of mental health assessment and intervention. Participants received a detailed definition of mental health assessment and intervention that included the following: "clinical or behavioral assessment with intent to intervene." Excluded from the definition of mental health assessment and intervention, and provided as a non-example of a mental health service for participants, was the following: "assessment for special educational eligibility (without intent to personally provide interventions after placement)." Hence, assessment solely for the purpose of determining special education eligibility may be the type of

service in which respondents in previous studies were engaged, suggesting that assessment with intent to place in special education is more commonly provided in schools than assessment with intent to intervene.

Given that most previous studies of the types of mental health services provided by school psychologists were based on forced-choice survey responses and were often exclusive to a specific mode of services (e.g., individual counseling), it was not surprising that a number of mental health services emerged from the current study that are absent from existing literature. For instance, participants in the current study emphasized the provision of crisis intervention services, including threat assessments and de-escalation of individual problems that arose in class. These activities are in line with participants' reports regarding the frequency with which they receive referrals for crisis situations. Participants also emphasized their roles in providing consultative services to educational staff. Pryzwansky et al. (1984) and Yates (2003) had previously identified the role of school psychologists in working with teachers; however, the current study elaborated on a variety of services that were being provided as consultation to individuals, including consultation to parents and participation on problem-solving teams. Other unique mental health services described by participants included counseling adults in students' lives, providing behavioral interventions, and offering inservices. This new knowledge that school psychologists engage in such activities broadens the range of mental health services that school psychologists are known to provide.

Notable group differences. An additional purpose of the current study was to examine mental health service provision as a function of practitioners' levels of experience. Identifying differences between the types of services that new graduates and

experienced practitioners provide can ultimately aide in determining where additional training may be needed for either new or experienced practitioners. Responses from focus groups in the current study indicated that differences do indeed exist between new and experienced practitioners in regards to the types of mental health services they provide, although there are a number of mental health services that they provide at a similar rate.

New and experienced school psychologist groups reported the provision of individual counseling, group counseling, and consultation to individuals at a similar rate. These findings corroborate Yates' (2003) findings that years of experience were unrelated to school psychologists' roles in providing individual and group counseling and in providing consultation to individuals (Yates, 2003). However, Curtis et al. (2002) found that more experienced school psychologists indicated more frequent involvement in the provision of consultation services. Consistent with previous research (Curtis et al., 2002) in which a national sample of school psychologists completed a survey regarding their professional roles in the schools, participants in the experienced school psychologist groups indicated more frequent involvement in the provision of in-service programs than did their less experienced peer groups.

New and experienced participants in the current study reported the provision of social-emotional-behavior assessment at a relatively similar rate. These findings are inconsistent with previous researcher's findings that years of experience were related to school psychologists' roles in providing assessment services (Curtis et al., 2002). However, Curtis et al's (2002) findings were specific to conducting special education re-evaluations, which may account for the discrepancy noted in the current study.

Findings indicated that differences also exist between new and experienced practitioners in regards to the range of mental health services they provide. New school psychologists revealed that they were more likely to provide behavioral interventions than were experienced school psychologists. On the other hand, experienced school psychologists were more frequently involved in the provision of case management activities and family services when compared to new school psychologists. One hypothesis for why these differences emerged within the current study but not in previous research relates to the breadth of mental health services identified by participants within the current study. Previous research was limited to a forced-choice survey method that was not inclusive of such mental health services as behavioral interventions and case management.

Implications of these differences in mental health service provision by level of experience pertains to the design of deliberate professional development services that are tailored to the specific knowledge and training needs of new graduates and experienced practitioners. Such targeted trainings may increase practitioners' capacity to provide mental health services that they are currently not providing as frequently as are their peers.

Barriers to Psychotherapeutic Service Provision

The purpose of this research question was to determine the specific factors that could be addressed so as to increase the likelihood that a school psychologist would provide mental health services. Unique to this study was the use of qualitative methods to elicit participants' answers. Responses from focus groups indicated that school psychologists perceive problems inherent to using schools as the site for service delivery,

insufficient support from department and district administration, problems with school personnel, and insufficient training as most inhibiting their ability to provide mental health services. Other commonly identified barriers include insufficient time and integration in the school site, a large caseload at their schools, and challenges inherent to the referred student. Although not as prevalent within the focus groups, participants also discussed barriers related to role strain.

These findings corroborate previous researchers' findings that school psychologists perceive both external (i.e., due to the systems in which the practitioner works and internal (i.e., specific to an individual practitioner's experiences and attitudes) barriers to the provision of school-based mental health services. Although some unique barriers emerged from participants' statements, many of the external and internal barriers within this study corresponded with those found in the existing literature (Yates, 2003). Participants in the current study emphasized how department-assigned roles and responsibilities (external barriers) limited their abilities to provide psychotherapeutic service provision. In particular, participants described how the "job description itself" is a primary barrier, particularly due to their responsibilities for fulfilling assessment duties within a school. This is consistent with Yates' (2003) dissertation in which a national sample of school psychologists endorsed which of six factors presented barriers to spending more time providing counseling, as respondents most endorsed a heavy emphasis on assessment (68.2%), the fact that counseling was not part of their roles in the school (52.5%), and the fact that counseling was not currently part of their identified/written job responsibilities (26.4%). Two other department-level factors that were unique to participants' responses in the current study include the department's and

district's roles in creating cumbersome procedures and requirements as well as their roles in raising liability and legality issues. Taken together, these results underscore the significant role that the department plays in preventing school psychologists from providing mental health services. Notably, participants in the current study did not emphasize the barriers of role strain and burn out to the same extent as Meyers and Swerdlik (2003) had previously identified, suggesting that current practitioners may be more adept at balancing the districts' mandates for their involvement in traditional roles (i.e., assessment) with their personal conviction to provide direct intervention services.

Participants' responses regarding the barriers related to insufficient support from district administration are consistent with prior research in which school psychologists lamented a perceived lack of attention to student mental health at the district and state levels (Yates, 2003). Another systems-level barrier that emerged in the current study involved insufficient support from department and district administration in regards to a lack of funding for mental health services, which confirms findings from the SAMHSA survey in which schools ranked the extent to which certain factors were barriers to the delivery of mental health services, using a scale of 1 ("not a barrier") to 4 ("serious barrier") (US DHHS, 1999). In contrast, whereas the SAMHSA study (US DHHS, 1999) indicated that the financial constraint of families and difficulties with transportation were two of the most frequently indicated barriers to mental health care, neither of these factors were mentioned by school psychologists in the current study.

One of the most notable differences between the current study and previous research was the emphasis participants placed on the logistical and physical problems that arise related to the use of the school environment as the location of mental health service

provision. Participants described how issues such as space constraints, difficulty scheduling meetings with students, inconsistent treatment largely related to school psychologists' competing responsibilities, and the exclusive focus of the school on academic success prevents them from providing additional mental health assessment and intervention. Another notable systems-level theme that permeated throughout participants' responses regarded problems that arise because of the need for support from and collaboration with other school employees. Similar to the sentiments regarding insufficient support from the department and district, participants described how insufficient support from building-level administration and teachers can lead school psychologists to provide fewer mental health services. School psychologists in the current study provided a greater understanding of how teachers and building administrators convey a lack of support. For example, participants discussed how administrators focus on testing students suggests this service is a priority over mental health service provision. Two notable school-based barriers were related to not having enough time and integration into the school site and the caseloads they carried at their schools. Participants felt that they did not have enough days at their school and on those days that they were there were on site they were overwhelmed by the number of students they needed to serve with both academic and mental health concerns, consistent with prior research in which virtually no school psychologists (only 5.4% of those surveyed) cited a low number of referrals as a reason they could not spend additional time on counseling (Yates, 2003).

This study also elucidated factors internal to school psychologists that limit their provision of mental health services. Previous research had stumbled upon the important

role of professional training through providing an opportunity for participants to provide open-ended comments about “other” barriers to providing counseling services not purposefully assessed in the study (Yates, 2003). The current investigation provided insight into how inadequate training can lead school psychologists to feel unprepared to provide mental health services. In particular, participants noted that insufficient training includes not only inadequate foundational content knowledge and applied experiences, but also contributes to a lack of confidence. Insufficient training was the primary internal barrier that emerged in the current study. Regarding other internal barriers, although some participants mentioned their own personal characteristics (e.g., burn out) and their perceptions of specific referred children as preventing them from providing mental health services, these themes were not emphasized. For instance, just as less than 7% of school psychologists endorsed not having an interest in providing mental health services in Yates (2003) research, a preference for providing traditional services (e.g., assessment) rather than direct interventions was mentioned only on seven occasions in slightly more than one-quarter of the focus groups in the current study. The belief that counseling should be provided outside of school did not emerge in the current study, consistent with a survey in which only 3.7% of school psychologists endorsed such an attitude (Yates, 2003).

Taken together, this study suggests that barriers to mental health service provision exist across multiple levels and systems within education, as well as relate to the training experiences that individual practitioners possess. Relatively infrequent but nonetheless important internal barriers such as school psychologists’ apathy towards their profession (i.e., to help children) or a preference in providing traditional services, can further lead

school psychologists to provide fewer school-based mental health services. Working with others on an individual level, particularly teachers and students, can lead to frustration that diminishes the likelihood of school psychologists providing mental health services. At the school level, participants described issues ranging from logistical concerns to the emphasis on academic success only. At the district and department level participants voiced feeling a lack of support through such actions as not providing enough funding for school psychologists to provide mental health services.

Notable group differences. An additional purpose of the current study was to examine perceived barriers as a function of practitioners' levels of experience. Identifying differences between new graduates' and experienced practitioners' needs and perceptions may ultimately aid in determining the specific and deliberate actions that schools, departments, and districts can initiate to increase *both* new and experienced school psychologists' provision of mental health services. Responses from focus groups indicate that some differences do indeed exist between new and experienced practitioners in regards to the factors they perceive inhibit them from providing more mental health interventions within their professional roles.

In general, findings were unique to the current study because no previous research has examined perceived barriers as a function of practitioners' levels of experience. Regarding differences that emerged, new school psychologists voiced particular concern with problems that arise when working with school personnel as well as challenging student characteristics. New school psychologist also voiced concerns over a lack of support from building-level administration and a lack of support from teachers with respect to providing counseling services. One hypothesis for why new school

psychologists were more likely to feel unsupported by teachers and building administrators relates to the limited amount of time they have spent in a school; therefore, the amount of time spent building rapport with teachers and administrators would have been limited. However, there were no differences between new and experienced school psychologists in regards to the barrier of insufficient time and integration into their school site. More research is needed to identify the specific reasons why new school psychologists perceive such a lack of support. Other concerns related to the fact that teachers were unaware of their ability to provide mental health services and that because of certain teacher behaviors, they felt frustrated when trying to work with teachers. Experienced practitioners did not discuss such barriers as often, perhaps due to their additional time and experience working with school personnel. As practitioners spend more time in schools, one would expect that their ability to collaborate with school personnel and deal with frustrating school-related issues would increase with experience. This hypothesis is consistent with results from the current study that indicated that new school psychologists were the only participants to mention the value of a course covering content related to working in schools. Similarly, new school psychologists may have voiced more concern over challenging student characteristics because they have had limited time and experience in working with aversive issues that arise when providing services to a student, such as negative behaviors.

Participants in the experienced school psychologist groups were particularly concerned with the problems that arise related to using schools as the site for service delivery, as well as their personal characteristics. Given that many of the personal characteristics described by participants included such things as burn out, apathy towards

their profession, and personal desire to provide traditional services rather than interventions, this result is in line with the number of years the experienced school psychologists have been entrenched in their roles. In regards to problems related to providing services in schools, the sheer number of schools with which experienced school psychologists have practiced may negatively affect their perceptions. The number of schools to deal with which may increase linearly with the number of problems associated with space and scheduling.

Considering the findings of this study, it is clear that a practitioner's years of experience do play some role in their perception of barriers to mental health service provision. In particular, new school psychologists groups voiced greater concern over the lack of support from building administration and teachers, whereas experienced school psychologists groups voiced greater concern over problems inherent to using schools as the site for service delivery. These findings can ultimately aid in determining the specific and deliberate actions that schools, departments, and districts can initiate to increase *both* new and experienced school psychologists' provision of mental health services.

Training Needs of School Psychologists

The purpose of this research question was to determine the specific training activities that may ultimately aid in the design and implementation of effective mental health training in school psychology programs. Unique to this study was the use of qualitative methods to elicit participants' answers. Responses from focus groups indicated that school psychologists emphasized a desire to receive training in didactic content taught through courses, experiential activities, and professional development activities. Given that participants in this study emphasized the barrier of insufficient

training, the breadth and depth of participant responses to questions regarding training needs is not surprising. These results corroborate the findings of Yates' (2003) dissertation in which 65.6% of a national sample of school psychologists surveyed identified that insufficient time was spent on counseling during their training, despite the majority of respondents taking four or more courses in foundations of mental health problems and in counseling interventions.

Many of the didactic content areas, experiential activities, and professional development activities identified within the current study correspond with those found in the existing literature (Whitmore, 2004; Yates, 2003). However previous studies queried practitioners in regards to what type of mental health training experiences they had received from their school psychology programs and from their time practicing as a school psychologist. The current study expanded upon this area by querying participants regarding the type of coursework and the type of training experiences that they feel are essential for school psychologists to feel prepared to provide mental health services. In other words, whereas other studies have identified the current status of training in mental health (but no differentiation as to their utility in providing mental health services), the current study identified those areas of coursework and experiential activities that would be most beneficial to provide to school psychologists so as to increase their ability to provide mental health services.

Many of the didactic areas mentioned by participants in the current study have been noted in the previous literature examining university-level training of school psychologists (Whitmore, 2004; Yates, 2003). This is an encouraging finding given that at least some of the beneficial coursework identified by participants within the current

study were recently noted as part of practitioners' training. Participants' responses regarding coursework covering behavioral interventions, developmental psychology, personality, group counseling, neuropsychology, multicultural education, and psychotherapy is consistent with prior research in which a national sample of school psychologists responded to a series of questions concerning the type of training they had received in foundations of mental health problems and in counseling interventions (Yates, 2003). However, participants within the current study placed a greater emphasis on the importance of coursework covering psychopathology, behavioral interventions, and group counseling.

In regards to experiential activities, the current results are in line with prior research that identified such training experiences as observations of a trainer in a counseling session, supervision, and one-way viewing as part of mental health training (Yates, 2003). Participants in the current study expanded upon Yates' (2003) research by providing a comprehensive and detailed understanding of the processes that can occur within each of the experiential activities. For example, participants indicated that it was beneficial to observe a master therapist during a counseling session. Similarly, one-way viewing was encompassed within a broader training experience of self review and critique of counseling, which included activities as receiving feedback from supervisors and trainees in addition to watching videos of oneself providing counseling. Under professional development activities, a finding consistent with previous research was the advantage of attending in-services offered through school districts (Whitmore, 2004; Yates, 2003). Notably, the professional development activity of attending in-services

was emphasized by participants within the current study more than any of the other professional development opportunities that emerged.

A number of unique responses regarding training needs were noted by participants in the current study. Given that most research studying the types of mental health training school psychologists receive have been based on forced-choice survey responses and were often exclusive to one type of counseling (e.g., Whitmore, 2003), it was not surprising that a number of content areas emerged that have not yet been noted in the existing literature. In particular, participants within the current study emphasized the need for coursework inclusive of a survey of multiple counseling orientations, advanced study of a single counseling orientation, crisis intervention, and consultation. Similarly, participants emphasized the need for experiential activities that involved in-class role plays and co-leading group counseling sessions. Although not as prevalent within the focus groups, additional experiential activities that emerged include receiving one's own counseling and working on a multidisciplinary team. Unique responses in regards to professional development activities included consultation with peer colleagues, engaging in applied experiences following inservices, receiving formal supervision of services, working with interns, and participating in professional organizations. It is notable that participants placed a great deal of emphasis on having the ability to consult with peer colleagues.

The implications of these findings are important to consider given that participants indicated that both graduate school and school districts can play a significant role in providing the content knowledge and training experiences that would allow them to feel sufficiently prepared to provide mental health services in the schools. Indeed,

such training could be provided during graduate school but also implemented in continued education courses, particularly in light of consistent findings illustrating practitioners' reliance on post-graduate seminars to receive additional training in mental health services.

Notable group differences. An additional purpose of the current study was to examine training needs as a function of practitioners' levels of experience. Identifying differences between new graduates' and experienced practitioners' needs will ultimately aid in the design of specific and deliberate professional development services for experienced practitioners and new practitioners based upon their individualized needs. Responses from some focus groups indicate that differences do indeed exist between new and experienced practitioners in regards to the kinds of content knowledge areas and training experiences that would allow them to feel sufficiently prepared to provide mental health services in the schools.

In general, findings were unique to the current study because no other studies have examined training needs as a function of practitioners' levels of experience. Interestingly, new school psychologists indicated the need for coursework covering a variety of topics (e.g., crisis intervention, consultation, behavior interventions, family therapy) when compared to experienced school psychologists. One hypothesis for finding pertains to the changes that have occurred in school psychology training programs. Because practitioners are provided with more opportunities to take courses covering a variety of topics, they may become more aware of the benefit of knowledge in such areas. In respect to experiential activities, new school psychologists more

frequently mentioned the need for supervised practicum, working on an interdisciplinary team, and participating in a professional organization.

Experienced school psychologists indicated the need for coursework covering advanced study of a single orientation, developmental psychology, empirically supported treatments, and the experiential activities of receiving their own counseling more often than did new school psychologists. Experienced school psychologists placed greater emphasis on professional development activities, including applying experiences following in-services, working with interns, receiving formal supervision of services, and consulting with peer colleagues. One hypothesis for this finding relates to the type of resource each group currently relies on to receive the skills and knowledge needed to provide mental health services. At this point in their professional careers, it could be that new school psychologists have relied primarily on their formal coursework to provide them with the skills and knowledge necessary to provide SBMH services. In contrast, because experienced practitioners' graduate training occurred more than 17 years ago they may rely more heavily on professional development activities to enhance their ability to provide SBMH services. Therefore, each group would tend identify a different form of training that would allow school psychologists to feel sufficiently prepared to provide mental health services in the schools.

Taken together, it is clear that a practitioner's level does play a role in the types of training that would enable him or her to feel sufficiently prepared to provide mental health services. In particular, new school psychologists voiced a greater desire to receive additional training in a variety of didactic content areas and in such experiential activities as supervised practicum. Experienced school psychologists voiced a greater desire to

receive additional training in some didactic content areas, such experiential activities as co-leading counseling groups, and multiple professional development activities. These findings can ultimately aid in determining the specific, individualized training provided to new and experienced practitioners based upon their fully recognized perception of training needs.

Implications of Results for School Psychologists

School psychologists are currently receiving referrals for students with a diverse set of problems. Thus, mental health professionals working with youth in diverse age groups must be knowledgeable of the etiology of a variety of mental health conditions in order to address students' needs. It is not sufficient only to train students to understand and treat diagnosable disorders; students must also be prepared to deal with discrete symptoms and crisis situations. School psychology graduate training programs and key stakeholders (e.g., department administrators) must address the need for practitioners' knowledge of the variety of mental health conditions identified in the current study.

Furthermore, results from this study indicate that it is not sufficient to train school psychologists to provide only one modality of psychotherapeutic service (e.g., individual counseling), as participants indicated providing a broad array of school-based mental health services, from group counseling to crisis intervention. In order to ensure that effective and evidence-based services are being provided, graduate training programs and district-level trainers must fully prepare practitioners to provide the most effective approaches to treatment. Importantly, participants indicated a minimal role in the provision of certain mental health services, such as family services and prevention services. If school psychologists are to fully realize their roles in providing

comprehensive mental health services, they must be provided with the training opportunities and knowledge needed to provide such important modalities of treatment.

If school psychologists are to fully embrace their roles as mental health service providers, the factors affecting their ability to provide such services must be addressed. Participants described barriers to mental health service provision that exist across multiple levels and systems within education, as well as have to do with the personal training experiences that individual practitioners possess. Therefore, school psychologists must be prepared to problem-solve systems-level issues. Although school psychologists must be prepared to manage systems-level barriers due to such things as department-level decisions and/or a lack of support from building-level administration, results from this study indicate that it may be equally important to recognize the role that school, district, and department administration should play in ameliorating such barriers. Problem-solving efforts will need to be made regarding systemic issues, with involvement from administrators at all levels. Thus, these key stakeholders will need to be apprised of the results from the current study in order for them to understand fully their role in affecting school psychologists' ability to provide mental health services as well as to address the differing needs of new and experienced practitioners. In regards to notable group differences, in-services regarding the purpose of counseling and the types of mental health services school psychologists' could be provided to address the problems that new school psychologists discussed regarding school personnel's lack of support and lack of awareness. Similarly, providing experienced school psychologists with "mental health" days to address the problem of burn out that experienced school

psychologists discussed may ultimately lead to increased mental health service provision by this group.

Regarding the training needs of modern school psychologists, the implications of these findings are twofold: (a) how can training programs provide the content knowledge and experiences necessary for a school psychologist to enter a school prepared to provide comprehensive mental health services? and (b) how can administrators provide continuing education training to practicing school psychologists that will enhance the knowledge and skills necessary for mental health service provision in schools? Trainers might consider recognizing the need for comprehensive didactic coursework covering content that not only enhances their knowledge of mental health (e.g., psychopathology) but also their knowledge and skills at providing school-based mental health treatments (e.g., group therapy, behavior interventions). Essential to the training experience are experiential activities that allow students actively to practice and/or observe a skill needed for mental health service provision. In particular, the benefits of supervised practicum, in-class role plays, and observing a master therapist were recognized within the current study.

In terms of continuing education training, school districts might consider recognizing the need for continual training on didactic content areas. Such topics could be covered during in-services offered through the district, particularly in light of consistent findings illustrating practitioners' reliance on in-services to receive additional training in mental health services (Yates, 2003). Continuing education training also needs to involve experiential activities, such as role plays and observing a master therapist. In regards to professional development activities, experienced practitioners

noted the benefits of having the ability to consult with peer colleagues. Setting up a network within the district through e-mail or regularly-scheduled meetings to discuss mental health related-issues could offer practitioners the opportunities needed to enhance the knowledge and skills necessary for mental health service provision in schools.

Limitations of the Current Study

Through the focus group method, several research questions were asked of 39 practicing school psychologists during 11 focus groups. Participants responded to questions regarding their personal experiences in the provision of psychotherapeutic services in the schools and provided their perceptions of the barriers to providing such services. Although several precautions were taken to increase the likelihood that credible findings and interpretations were advanced, not all threats to the trustworthiness of the research can be controlled. Therefore, several limitations to the present study warrant consideration when interpreting the results and making suggestions for future research and practice.

First, there is limited generalizability of the results due to the relatively small sample size and the geographic limitations of the population sampled (i.e., only two school districts in Florida). Additionally, because participation in the study was voluntary, it is possible that voices heard in each school district reflect the activities and perceptions of a subgroup of practitioners with a particular interest in providing psychotherapeutic services to students. An additional limitation resulted from the small number of participants in one focus group, which meant that theoretical saturation was not guaranteed in this focus group. Although efforts were made to recruit an appropriate minimum number of participants for each focus group, the researchers could not control

for unexpected circumstances. However, although the limited number of participants in that focus group may have reduced the breadth of information obtained because there were fewer voices heard, the small number of participants translated into more on-task conversation and greater depth of responses because more time was provided for each participant's response.

Limitations exist in regards to errors associated with bias and subjectivity.

Krueger (2000) pointed out that data analysis of focus groups is often difficult because it is based on the subjective interpretation of the research. In order to improve the reliability of the coding of the themes and lessen the impact of research bias, multiple members of the research team coded the results separately, with two researchers assigned to each transcript. In doing this, inter-rater reliability was computed in which the average agreement between the two members was approximately 95%. Also notable, an issue pertaining to transcription may also limit the findings of this study. Specifically, interviews were audio taped and then transcribed for subsequent data analysis. Although trained research assistants transcribed diligently, some degree of error could be attributed to occasional deteriorations in the quality of audiotape playback (e.g., background noise) which is a threat to the descriptive validity of the findings.

Similar to research bias, a limitation of the current study is related to the subjectivity of the responses from the participants. No methods were employed in this study to ascertain the truthfulness of the information given by the participants. However, an advantage of focus groups is that the participants are placed in a more naturalistic setting to facilitate discussion and to allow for the group members to interact with one

another (Krueger, 2000). Additionally, efforts were made to homogenize groups through the characteristic of practitioners' years of experience.

Suggestions for Future Research

The purpose of the current study was to elucidate factors that school psychologists perceive inhibit them from providing more mental health interventions within their professional roles and the kinds of content knowledge areas and training experiences that would allow school psychologists to feel sufficiently prepared to provide mental health services in the schools. An additional purpose of the current study was to examine perceived barriers as a function of practitioners' levels of experience. It is hoped that the results of this study can be used to guide future research and practice and contribute to a better understanding of the mental health training needs of school psychologists. Several implications for future research are noted below.

This study was the first qualitative study to investigate school psychologists' role in the provision of psychotherapeutic services and identify barriers perceived by school psychology practitioners. Although the findings of this study yield a great deal of potential for training efforts in school psychology programs and district programs, it is necessary to replicate these findings with a nationally representative sample of school psychologists before broad generalizations can be made about the barriers to mental health service provision and specific content knowledge areas and training experiences that would allow practitioners to feel sufficiently prepared to provide mental health services. Because this study was conducted at only two school districts within the state of Florida, school psychologists who work in these districts may not be representative of all school psychologists in the state of Florida. Replication of these findings in practicing

school psychologists throughout Florida would confirm these results. Furthermore, research should be extended to other regions of the country, particularly given that regional differences are present in school assessment practices (Hosp & Reschly, 2002). It is suggested that a survey method may more effectively allow researchers to access information from a larger, more geographically diverse sample of school psychology practitioners.

This study highlighted several significant differences between new school psychologists and experienced school psychologists. However, it is necessary to replicate these findings before broader generalizations can be made about the role years of experience may play in perceived barriers to mental health service provision and the mental health training needs of school psychologists. Although it was outside the scope of the present study, future research should examine the relationship between the provision of mental health services and other demographic variables. For example, differences may exist when examining the relationship between research findings and the grade level that practitioners serve (i.e., elementary, middle, or high school). Similarly, future investigations should examine the relationship between the provision of mental health service and the type of school district (i.e., rural, urban, or suburban).

Conclusions

This study has provided the first known qualitative study of the barriers to school psychologists' provision of psychotherapeutic services in the schools, the mental health training needs of school psychologists, and the unique differences between new and experienced practitioners. The study indicated that school psychologists are currently receiving school-based referrals for a diverse set of student problems. Similarly, school

psychologists indicated providing a broad array of school-based mental health services, from individual counseling to crisis intervention.

Changes in government policy and societal initiatives have underscored the need for school psychologists to provide school-based mental health services. In spite of the rising call for a more concerted effort in mental health, however, changes within the field have been minimal (e.g., Curtis et al., 1999; Fagan & Wise, 2000; Hosp & Reschly, 2002). This study provided current information with respect to the mental health practices of school psychologists and elaborated upon the factors that school psychologists perceive inhibit them from providing more services and training that would allow school psychologists to feel sufficiently prepared to provide mental health services in the schools. If school psychologists are to fully realize their roles as mental health service providers, the factors affecting their ability to provide such services must be addressed. Similarly, the training needs of modern psychologists working in schools must be recognized by graduate training programs and professional development services must be provided for practicing school psychologists to enhance the knowledge and skills necessary for mental health service provision in schools.

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Appendices

Appendix A: School Psychologist Consent Form

Dear School Psychologist:

Thank you for allowing us to meet with you to discuss school psychologists' provision of mental health assessment and intervention services. Our goal in conducting the study is to identify the types of students referred for mental health help, factors that facilitate and prohibit school psychologists from providing mental health assessment and intervention, and the specific knowledge and skill areas in which additional training would be helpful in order to enable school psychologists to provide mental health interventions.

- ✓ Who We Are: The research team consists of Shannon Suldo, Ph.D., a professor in the College of Education at the University of South Florida (USF), and several doctoral students in the USF School Psychology Program.
- ✓ Why We are Requesting Your Participation: This study is being conducted as part of a project entitled, "School Psychologists Provision of Mental Health Assessment and Interventions." You are being asked to participate because you are a practicing school psychologist either within a district that expressed interest in participating in the study, or you are attending a professional conference.
- ✓ Why You Should Participate: The information that we collect from school psychologists will help us understand factors associated with school psychologists' provision of mental health assessment and interventions. Findings from this study may ultimately aide in the design and implementation of effective mental health training in school psychology programs. Please note that you will receive a \$25.00 gift certificate for participating in the study.
- ✓ What Participation Requires: Participation will entail attending one 45-60 minute meeting in which we will conduct a focus group with small groups of practitioners. Focus groups will be conducted on a school campus in your county or at a professional conference. Participation will also require completion of a short demographic questionnaire.
- ✓ Please Note: Your decision to participate in this research study must be completely voluntary. You are free to participate in this research study or to withdraw from participation at any time. If you choose not to participate, or if you withdraw at any point during the study, this will in no way affect your relationship with your school district, USF, your professional organization, or any other party.
- ✓ Confidentiality of Your Responses: There is minimal risk for participating in this research. Your privacy and research records will be kept confidential (private, secret) to the extent of the law. People approved to do research at USF, people who work for the Department of Health and Human Services, and the USF Institutional Review Board may look at the records from this research project, but your individual responses will not be shared with people in the school system or anyone other than the research team. After the focus group session has been transcribed, the

Appendix A: (Continued)

- ✓ information that you provide during the focus groups and your completed demographic questionnaire will be assigned a code number after the transcription to protect the confidentiality of your responses. Only the principal investigator (Dr. Suldo) has access to the locked file cabinet stored at USF that will contain all records linking code numbers to participants' names.
- ✓ What We'll Do With Your Responses: We plan to use the information from this study to aid in the design and implementation of effective mental health training in school psychology programs and school districts. The results of this study may be published. However, the data obtained from you will be combined with data from other people in the publication. The published results will not include your name or any other information that would in any way personally identify you.
- ✓ Questions? If you have any questions about this research study, please contact Dr. Suldo at (813) 974-2223. If you have questions about your rights as a person who is taking part in a research study, you may contact a member of the Division of Research Integrity and Compliance of the University of South Florida at 813-974-5638 or the Florida Department of Health, Review Council for Human Subjects at 1-850-245-4585 or toll free at 1-866-433-2775.
- ✓ Want to Participate? To participate in this study, sign the attached consent form.

Sincerely,

Shannon Suldo, Ph.D.
Assistant Professor of School Psychology
Department of Psychological and Social Foundations

Consent to Take Part in this Research Study

I freely give my permission to take part in this study. I understand that this is research. I have received a copy of this letter and consent form for my records.

Signature of psychologist

Printed name of psychologist

Date

Statement of Person Obtaining Informed Consent

I certify that participants have been provided with an informed consent form that has been approved by the University of South Florida's Institutional Review Board and that explains the nature, demands, risks, and benefits involved in participating in this study. I further certify that a phone number has been provided in the event of additional questions.

Signature of person
obtaining consent

Printed name of person
obtaining consent

Date

Appendix B: E-Mail Invitation

Dear School Psychologist Colleague:

We are conducting a study of school psychologists' provision of mental health assessment and interventions. We define mental health assessment and intervention as any activity in which school psychologists purposefully engage in an effort to ameliorate the mental health problem(s) within an identified child. Such activities include the following: counseling/ psychotherapy; clinical or behavioral assessment with intent to intervene; and consultation with adults including educational personnel and family members. Our research group is conducting this research to identify systems-level and within-person factors associated with school psychologists' provision of mental health assessment and intervention.

We would like you to be a participant in this study, regardless of the amount of time you currently spend providing mental health services. Participation will entail attending one 45-60 minute meeting in which we will conduct a focus group with a small group of practicing school psychologists. Focus groups will be conducted on a school campus in your school district. All participant responses will be confidential. In part to compensate you for your time, participants will receive a \$25 gift card at the focus group session. Beverages and snacks will also be provided throughout the activity.

The study will take place within the next few months. Dates and times for focus groups will be determined based on participants' availability. If you are interested in participating in this study, please contact us at (e-mail address) and let us know days of the week and periods of time during those days in which you would be able to participate in a 45 - 60 minute meeting. We will respond shortly with an e-mail containing several options for meeting dates and times. Thank you in advance for your time and cooperation.

Sincerely,

Shannon Suldo, Ph.D.

Principal Investigator, School-Based Mental Health Research Group
Assistant Professor, University of South Florida School Psychology Program
suldo@coedu.usf.edu; (813) 849 - 8213

Appendix C: Demographic Form

Information about Training

1. Did your graduate training include specific coursework in the following areas: (please check all that apply)

- Developmental psychology/child development
- Behavioral disorders/psychopathology
- Psychopharmacology
- Behavioral interventions
- Counseling children/psychotherapeutic interventions
- Group counseling
- Family counseling
- Multicultural counseling
- Advanced counseling/psychotherapy
- Personality/social-emotional-behavioral assessment
- Mental health consultation
- Practicum in mental health assessment
- Practicum in mental health intervention
- Other (please list any other courses that were available specific to mental health assessment and intervention)

2. How many graduate level courses that covered the topics listed above (i.e., mental health assessment and intervention) did you take?

- 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 >15

3. Did your practicum training include the opportunity to observe and/or sit in on the provision of mental assessment and intervention conducted by a school psychologist?

YES NO

4. Did your practicum training include the opportunity to provide any mental health assessment and intervention?

YES NO

5. Did your internship training include the opportunity to provide any mental health assessment and intervention?

YES NO

6. Were there any other opportunities available (e.g., assistantship) through your training that involved mental health assessment and intervention (please list)?

Appendix C: (Continued)

8. Do you think that your formal academic training provided sufficient emphasis on mental health assessment and intervention?

___ YES ___ NO

9. Have you attended any continuing education programs during the past 5 years that were specifically focused on mental health assessment and intervention?

___ YES ___ NO

10. Please list any continuing education courses related to mental health assessment and intervention that you took within the last 5 years.

Information about You

1. Where did you attend graduate school?

2. What was the highest degree that you have earned?

___ MA/MS ___ PhD/PsyD/EdD
___ Specialist/EdS ___ Other (Please specify) _____

3. Was your graduate program accredited by (check all that apply)?

___ NASP ___ APA ___ NCATE
___ State ___ Not accredited

4. How many years have you been practicing in the school setting?

5. In your current position, how many different schools do you work in?

6. In what type of school do you primarily work?

___ rural ___ inner city
___ suburban ___ other (please specify) _____

7. What are the grade levels of the students that you serve (please circle all that apply)?

Preschool K 1 2 3 4 5 6 7 8 9 10 11 12

8. In your current position, what is the school psychologist: student ratio?

___ 1: <500 ___ 1: 500-999 ___ 1: 1000-1499
___ 1: 1500-2000 ___ 1: >2000

Appendix D: Focus Group Protocol

Date of Group: _____
Time of Group: _____
Facilitator: _____
Note-Taker: _____

Focus Group Protocol

Procedures and Questions for Focus Groups

School Psychologists' Provision of Mental Health Assessment and Intervention
Shannon Suldo, Ph.D. & Allison Friedrich, M.A.

Instructions

- Welcome participants to session individually as they arrive- immediately make small talk. *Hi! (introduce self) Thank you so much for coming- would you like a snack while you make a nametag for yourself? [make name tag][comment on outfit, plans for evening/weekend, etc.]*
 - Give each participant 2 copies of consent forms- ask to read then sign (collect the signed the; they keep extra copy for own records)
 - Give demographics sheet and marker
 - After they've completed the demographics questionnaire, ask them to draw something about themselves/interests on their name tag
- Introduction to moderator and note-taker. *Thank you for attending.*
- Purpose of today's discussion: *We're interested in learning about what factors you perceive enable and limit your provision of mental health assessment and intervention in the schools- we refer to the limiting factors as "barriers." We define mental health assessment and intervention as, following the identification of a given child at-risk for, suspected of, or diagnosed as having a mental health problem, any activity in which school psychologists purposefully engage in an effort to ameliorate the mental health problem(s) within the identified child. Such activities include the following: clinical or behavioral assessment with intent to intervene; individual, group, or family counseling/psychotherapy; case management; consultation with adults including educational personnel and family members; crisis intervention; and medication management/coordination of care with physicians. The following activities are excluded: assessment for special educational eligibility (with no intent to personally provide interventions after placement); academic assessment/intervention for children without mental health problems; school-wide or classroom counseling; and school-level research and evaluation.*
- Broad overview: *For the rest of this period, we are going to ask you a series of questions regarding a number of issues related to providing mental health services in the school. There are no right or wrong answers, but probably some differing points of view. We are interested in hearing what each of you has to say, so please speak up and share your point of view no matter if it is the same or different from what others have said. However, if one or more of the questions does not apply to you, do not feel compelled to answer it. Keep in mind that we're here to gather information only, not to reach agreement to a question; we're also NOT here to tell you what to do or even to provide advice, just to listen.*

Appendix D: (Continued)

- Confidentiality: *Everything discussed today will be kept confidential (private, secret) to the extent of the law. Your specific responses will not be shared with administration or school staff. We are tape recording this session only as a tool to capture all information. After we have finished transcribing today's session, you will not be identified by name in our work.*
 - Turn on recorder
- Icebreaker. *This session will last 45 minutes, and we'll ask 7 – 10 questions during that time. Let's begin. Everyone has a name tag on- let's find out some more about each other by hearing about the pictures everyone drew on their nametags*

Questions

1. For which type of problems are students referred for mental health assessment and intervention to either you or other school personnel? *(possible examples if no one responds: anxiety, depression)*
2. Which mental health assessment and interventions services have you provided during your past few years of practice in the schools?
3. School psychologists spend varying amounts of time in their work week providing mental health assessment and intervention. What enables you to provide these services?
 - PROBE: Which specific systems-level/external factors enable you to provide these services? *(examples if no one responds: district-wide professional development, supervision)*
 - PROBE: Which specific individual or personal factors enable you to provide these services? *(examples if no one responds: graduate school training, knowledge of mental health interventions)*
4. Which factors prevent you from providing mental health assessment and intervention?
 - PROBE: Which specific systems-level/external barriers prevent you from providing these services? *(examples if no one responds: time constraints, lack of space)*
 - PROBE: Which specific individual or personal barriers prevent you from providing these services? *(examples if no one responds: knowledge of mental health interventions, comfort level with counseling)*
5. Which specific content areas that were taught in your graduate school or continuing education training most enable you to provide mental health assessment and intervention? *(in other words, class work... we'll talk about practical experiences next) (examples if no one responds: theories of counseling, case documentation, how to select EBIs)*

Appendix D: (Continued)

- FOLLOW-UP: In which content areas would additional information increase the likelihood you would provide mental health services?
6. What types of training experiences (beyond class work) that were included in your graduate school or continuing education training most enable you to provide mental health assessment and intervention? (*examples if no one responds: role-plays, supervised practica, continuing supervision/case consultation*)
- FOLLOW-UP: Which additional training experiences would help you to feel adequately prepared to provide mental health services?
7. [Summarize responses] is that correct? Would you like to add anything?

Appendix E: Sample Form for Field Notes

Focus Group # _____

Date:

Time:

Names

Question 1- For which type of problems (e.g., anxiety, depression) are students referred for mental health services to either you or other school personnel?

1)

2)

3)

4)

5)

6)

7)

8)