2019

Accessing Mental Health Services For Students In Public Schools

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ACCESSING MENTAL HEALTH SERVICES FOR STUDENTS IN PUBLIC SCHOOLS

A Dissertation

Presented to

The College of Graduate and Professional Studies

Department of Educational Leadership

Indiana State University

Terre Haute, Indiana

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

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by

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May 2019

Keywords: Guidance counselor, mental health, school principal, school psychologist, school social worker, superintendents

VITA

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ABSTRACT

The purpose of this qualitative study was to learn what practicing educational leaders state are the competencies needed for school administrators to access school-based mental health services for students. Research questions included what competencies of elementary principals facilitate the provision of mental health services for students in elementary public schools and what administrative structures, policies, and procedures are needed in elementary schools for students to access mental health services. Standards for school administrators in pre-service programs were reviewed to determine if there are gaps in what administrators are taught in pre-service programs versus what knowledge they need to have in order to implement school-based mental health services. Elementary principals, guidance counselors, school-based mental health practitioners, and school social workers who have experience supervising or working with students who have a DSM-V diagnosis of eligibility for special education, such as an emotional disability, were interviewed for this study. One semi-structured interview with participants was conducted onsite to gain an understanding of the phenomenon of school-based mental health services for students. Emerging themes included the principals having the mindset that the academic needs of students cannot be met until mental health needs are met, providing ongoing professional development for all staff, intentionally using vocabulary for the social-emotional health provider position to avoid the stigma of the term, "mental health," having a defined structure of how students access services, having a relationship with the local community mental health center, having support from the central administration office, and the principal having

experience with mental health. A culture of care for all students was identified across participant responses. Barriers to providing school-based mental health services were physical space in the school building and ongoing funding sources. Participant responses did not reference the Professional Standards for Education Leaders. One of the top 10 graduate schools for educator leadership preparation referenced the Professional Standards for Education Leaders.

ACKNOWLEDGMENTS

Completing my dissertation is the most difficult thing I have done academically. Accomplishing this goal has been a lifelong dream. When people asked me why I was obtaining a Ph.D., I responded that I did not know exactly why, but I knew that God wanted me to pursue it. It has been a feeling I have had since I completed my master's degree in 2000. As I have completed the dissertation, I still do not have a definite reason, but I know that God has a plan and will reveal it to me in His time. I could not have done this without my husband, Kevin, and all of the support he has given me the past three years during this endeavor. This was a family decision, and we have accomplished this together. My mom and dad, Marilyn and Roger Bayak, were also my champions in this journey, and they instilled in me the value of service to others. I am sad they are not physically here to celebrate this accomplishment, but I know they are always with me and continue to motivate me to pursue this important work for children. I have been blessed with a rock star committee. Dr. Terry McDaniel was always there to answer any questions along the way and provided encouragement that I was on the right path. Dr. Boyd encouraged me to pursue this degree in 2005, and I will always be grateful for our book exchanges. Dr. Edington challenged my thinking in unique ways. I have always been in awe of Dr. Van Acker's extensive work across the country. Dr. Balch is a walking encyclopedia, and I am privileged to have all of these scholars in my life. My friends have been great supporters and have helped me to have fun during this strenuous journey. I appreciate Jamie and Angie Ross and Virginia Graham who opened their homes to me during my research. My work colleagues

have been incredibly supportive. My incredible administrative assistants, Diane Tietz, Michelle Graber, and Lee Wynn, supported me in ways they will never know. Dr. Angela Balsley, Dr. Steve Thalheimer, Lucy Witte, Jim Evans, Joy Goshert, Libby Christianson, and all of the mental health therapists I have worked with the last 19 years all played a key role in helping me attain this dream. I will forever be grateful to all of you. Finally, my pets who endured this journey with me, Odecca, Sarge, Max, Clare, Shelby, Bigfoot, and Francis, made me take breaks to play with them or stayed by my side at the desk, were most valuable players.

DEDICATION

This is dedicated to the children who experience incomprehensible trauma. You are my heroes. Finally, for Dochka, Cayden, Caleb, Savannah, Lindsey, Kenton, Hayden, Haleigh, Anya, Hannah, Audrey, Zak, and Andrew, it is my dream that you live in a world that is mentally healthy.

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CHAPTER 1

INTRODUCTION

In a typical school year, up to 20% of children in the United States are diagnosed with a mental health disorder (Perou et al., 2013). Katz et al. (2013) found that 13% of students had identified a suicidal plan. Merikangas et al. (2010) found that half of all children identified as needing mental health services actually received treatment for their needs. Given that the majority of children in the United States attend public schools, the role of an educational administrator extends beyond making sure that academic needs of students are met. Educational administrators need to have an understanding of how to provide for the mental health needs of their students.

Children have difficulty focusing on the learning process when their basic needs are unmet. Desrochers (2014) stated that performance improves substantially for students when schools provide comprehensive mental health services. The difficulty is that educational administrator preparation programs focus on teaching future school leaders about curriculum, assessment, supervision, policy, political contexts, leadership theories, and ethics, leaving little time to educate on how to access mental health services for students. Public schools provide nutritional, academic, medical, physical, and social programs for students. Providing mental health services for children in schools provide a natural foundation for the learning process. Providing school-based mental health services for students and their families removes

community-based barriers (Repie, 2005). When services are provided in school as opposed to community settings, transportation to community services is alleviated for families, stigma is lessened by students receiving services in a familiar location, and the effectiveness of services is improved by known, trusting providers who have established relationships with constituents (Repie, 2005).

School administrators face numerous barriers in expanding their role to provide mental health services for students. Mental health issues present significant challenges for children, families do not often access services for their child, and unmet mental health needs result in greater problems in school, ultimately impacting academics. Whitley (2010) highlighted the role that a school administrator plays in collaborating with community partners to improve students' well-being. Communities play a vital role in bringing together health and mental health services to schools as organizations join together to provide support for services (Capper, 1994; Dryfoos, 1993). Evidence-based programs focus on addressing mental health needs for students. Given that students spend the majority of their time in school, school-based programs are an efficient way to provide mental health services to those who need it (Burns et al., 1995; Farmer, Burns, Phillips, Angold, & Costello, 2003; Katz el al., 2013). Researchers of universal prevention strategies in school settings have revealed reductions in anxiety symptoms for all children (Barrett, Eber, & Weist, 2013; Lowry-Webster, Barrett, & Dadds, 2001).

Given high-stakes testing and accountability measures, students in schools experience a tremendous amount of stress. Poor academic performance correlates with negative mental health outcomes among students in high school (Harris & Plucker, 2014). Given the diversity that exists in schools across America, educational leaders must be knowledgeable of how to meet the wide variety of needs among the students in their school community. Stephan, Paternite, Grimm,

and Hurwitz (2014) stated that there is a lack of research on identifying the key factors of implementing school-based mental health services.

Problem Statement

A significant number of students have not capitalized on their learning potential because their basic psychological needs have not been met (Kataoka, Zhang, & Wells, 2002; R. C. Kessler et al., 2005; Mojtabai et al., 2015; Patel, Flisher, Hetrick, & McGorry, 2007). Administrators in public schools are in a unique position to facilitate meeting mental health needs by providing services or partnering with community mental health centers. Traditional principal preparation programs do not provide formalized training in school mental health practices (Caparelli, 2011). Traditional educational leadership preparation programs primarily focus on instructional leadership practices, such as curriculum, instruction, and assessment. Given the multitude of responsibilities of a school administrator, it can be difficult to know how to access resources for students. As a result, school administrators do not typically know how to access mental health services for their students. There are several evidence-based school mental health programs in existence, yet there is little research as to why school administrators predominantly across the United States have not placed an intentional focus on developing these programs within their school communities.

Purpose

The purpose of this study was to learn what practicing educational leaders state are the competencies needed for school administrators to access school-based mental health services for students. Researchers claim that the nation's public schools have become the de facto mental health system for children (Barrett et al., 2013; Burns et al., 1995). The research community knows that many mental health problems can be prevented (Hawkins et al., 2015; O'Connell,

Boat, & Warner, 2009). In a recent Phi Delta Kappa/Gallup Poll, results indicated that Americans believe that public schools should provide wraparound services, such as mental health services, particularly for those students who do not have access to these services elsewhere (*Phi Delta Kappan*, 2017). School principals are the key players in determining how mental health programs become part of the school community (Gottfredson & Gottfredson, 2002; Kam, Greenberg, & Walls, 2003). As a result of this study, education administrators will have knowledge of how community mental health centers can provide school-based mental health services to students. Education administrators will also have knowledge on the funding mechanisms utilized to provide school-based mental health services. Competencies for school administrators in pre-service programs were reviewed to determine if there are gaps in what administrators are taught in pre-service programs versus what knowledge they need to have in order to implement school-based mental health services.

Significance of the Study and Goals

The purpose of this study is multi-leveled. School administrators will be informed on how to access mental health services for students, resulting in an educational environment that is conducive to learning by meeting students' needs. Educational leaders will be able to create schools that promote positive mental health by understanding the resources available to them. Leaders will understand the funding mechanisms involved at the federal, state, and local level so services can be maximized. Faculty in educational leadership preparation programs will possess a better understanding of the competencies that graduates must possess and areas of skill development needed before obtaining administrative licensure. Students will be able to access comprehensive services that meet their mental health needs, allowing them to capitalize on the educational environment. My ultimate goals are for students to have their basic needs met and

be more engaged in the learning process; there will be less stigma on mental health and less violence in schools and communities. My hope is that families will be able to effectively partner with schools to provide comprehensive community programs.

Theoretical Base

One of the primary purposes of public education is to prepare students to live and productively participate in a democracy and in a global society. When the United States was in its infancy, the founding fathers knew the importance of education and its influence upon democracy (Michelli & Keiser, 2005). Public schools provide the portal for students to learn how to be productive citizens, contributing to democracy. Providing access to services that meet the physical and emotional needs of students helps stakeholders capitalize on the learning environments in schools. This study incorporated social justice theory, John Dewey's principles of democracy and education, and the scholar practitioner concept for educational administrators.

John Dewey's (1944) philosophy of democratic education, social justice theory, and educators as scholar practitioners are the foundation of the research. A society that encompasses democratic principles reflects respect for its members, collaboration, informed and engaged constituents, and active participation in achieving the principles of fairness and justice (Michelli & Keiser, 2005). Dewey (1944) articulated the relationship between education and democracy: "The devotion of democracy to education is a familiar fact. The superficial explanation is that a government resting upon popular suffrage cannot be successful unless those who elect and who obey their governors are educated" (p. 87). Public schools provide an integral role in preparing future generations to be participants in democracy. Dewey (1944) further explained,

> A democracy is more than a form of government; it is primarily a mode of associated living, of conjoint communicated experience. The extension in space of the number of

> individuals who participate in an interest so that each has to refer his own action to that of others, and to consider the action of others to give point and direction to his own, is equivalent to the breaking down of those barriers of class, race, and national territory which kept men from perceiving the full import of their activity. (p. 87)

There are numerous definitions of social justice in the literature. Novak (2000) defined social justice as the skills required for inspiring and harnessing people to work together for a common purpose, and valuing the contributions of underserved groups to advocate for equity in policies. For the purposes of this study, the theoretical underpinnings of social justice involve the responsibility of school administrators to preserve the basic human rights of individuals or groups, treating people with dignity and respect, and decision making based on principles that do no harm for constituents (Jost & Kay, 2010). The role of school administrators involves capitalizing on the learning potential of students and making sure that each student has the opportunity to be fully involved in the school community. Providing school-based mental health services for students contributes to the process. As a construct, social justice encompasses the values of democracy, care, and equity (Bourgeois, 2009; Foster, 1989; Horn, 2000; Jenlink & Embry-Jenlink, 2010; Lees, 1995). These values are germane to educational leaders when providing students with a quality education. Educational leaders must possess these values as a basis when exploring how to provide students an education that meets all of their needs, including mental health.

Sander et al. (2011) offered a definition of social justice for the educational setting as follows:

> Social justice is an advocacy-related construct that includes three specific, but not always distinct, ecological system qualities that promote educational success and psychological

> well-being: access to necessary and appropriate resources, experiences of being treated with respect, and the presence of fairness. (p. 311)

North (2006) affirmed the concepts of fairness and respect in educational settings as being ones where schools make resources accessible to all students. Regardless of what theoretical model educational leaders ascribe to, it is their obligation to the children and community to ensure that students are provided with an education that prepares them to become productive members and contributors to society. This obligation also involves treating all children with care, respect, and dignity.

In accordance with John Dewey's philosophy of education, effective educational leaders need to stay grounded in current research while determining its application to the school environment. The scholar-practitioner concept is defined as a "method of academically informing one's practice in a given field" (Lowery, 2016, p. 35). The model of scholar-practitioner is required in order to advance the causes of social justice, democracy, and equity in schools (Lowery, 2016). Capper (1998) identified a model that utilized the educational leader in developing "all-inclusive school communities" (p. 356). Capper described a leader who purposely engages individuals to identify issues and solutions so they may be empowered. Capper focused on the individual student using his or her unique abilities as the focus of the curriculum. Jenlink's (2010) model of scholar-practitioner involved an obligation of the educational leader to create opportunities for students that allow "the possibility of freedom through the organization of social space that is defined by democratic ideals and socially responsible curriculum and instruction" (p. 3).

Study Design and Methodology

This study focused on qualitative approaches utilizing a cross-case analysis

phenomenological methodology. Creswell (2013) defined qualitative research as "an inquiry process of understanding based on a distinct methodological approach to inquiry that explores a social or human problem" (p. 300). Creswell (2013) defined phenomenological study as one that "describes the common meaning of experiences of a phenomenon (or topic or concept) for several individuals" (p. 285). Interviewing school-based mental health practitioners, social workers, guidance counselors, psychologists, and elementary principals in learning institutions that have school-based mental health services in public schools in the state of Indiana provided baseline information for what skill sets are identified in school administrators as being conducive to accessing mental health services for students and then what areas need further development. Data analysis entailed comparing competencies necessary by current educational practitioners to provide school-based mental health services to students with comparing standards that are articulated in educational leadership standards in graduate programs for educational administrators. School structures that are conducive to providing mental health services for students were reviewed in the professional literature. The final product was recommendations for administrator preparation programs and for practicing school administrators.

Research Questions

1. What do school practitioners state are the necessary competencies of school administrators that help facilitate the acquisition of mental health services in schools to assure the provision of mental health services for students?
2. What administrative structures, policies, and procedures are needed for students to access mental health services in schools?

Participants and Recruitment

I obtained data from school-based mental health practitioners, guidance counselors, school social workers, and elementary principals who had experience with school-based mental health services in elementary public schools in the state of Indiana. Participants had to possess a master's degree as a minimum standard, and further certification such as national licensure, licensed clinical social worker, licensed marriage and family therapist, licensed mental health counselor, school administrator, or other similar credentials. Participants had to have experience working with K–6 public school students with a Diagnostic Statistical Manual of Mental Disorders (DSM-V) diagnosis, or eligibility for special education, such as an emotional disability. Other areas of disability were considered, such as specific learning disability or other health impairment, if the student had mental health needs as a result of these diagnoses. An email was sent to the following communities in the Learning Connection provided through the Indiana Department of Education (IDOE): elementary school counselors, school social workers, teachers who work with students with disabilities, special education administrators, school psychologists, Indiana resource center for autism, and elementary principals listed in the IDOE directory. Several members of these groups included school psychologists, school social workers, mental health therapists, and guidance counselors. It was my goal to have 10–12 participants to interview, although only 10 participants expressed interest in participating in the interviews. I selected participants based on geography throughout the state of Indiana. I had representation from a variety of areas around the state.

Assumptions

An assumption in this study was that students were more engaged in school once their mental health needs were met. An additional assumption in this study was that families felt

better connected to their school community when schools were providing assistance for their children. A final assumption was that once educational administrators are knowledgeable of how to access mental health therapy services for students, educational administrators would take advantage of this opportunity to capitalize on student learning.

Limitations of the Study

Participation in the study was voluntary. One limitation of this study was that I had worked in a school district that provided mental health services to students. In my previous role as special education administrator, I implemented school-based mental health services in the school district, so my bias was a factor. Ary, Jacobs, and Sorensen (2010) defined bracketing as "the researcher intentionally setting aside his or her own experiences, suspending his or her own beliefs in order to take a fresh perspective based on data collected from persons who have experienced the phenomenon" (p. 473). Creswell (2013) referenced a similar concept of bracketing and defined epoche as "the process of data analysis in which the researcher sets aside, as far as is humanly possible, all preconceived experiences to best understand the experiences of participants in the study" (p. 284). I adhered to these principles.

Criteria for selection of participants did not include the factors of gender, race, or socioeconomic status of the school. One participant indicated that there was a noticeable difference between administrator mindsets of men versus women. Ten participants is a limitation in being able to generalize findings across other settings. The participants all had involvement with mental health services in schools. Their responses reflected this statement. All participants interviewed were Caucasian. As the researcher, my Caucasian ethnicity could provide a limited view in the areas impacted by research on ethnicity. This study focused solely on public elementary schools in the state of Indiana. The study did not explore services provided

in charter schools, non-public schools, or secondary public schools.

Delimitations of the Study

This study was conducted with current mental health therapists, guidance counselors, social workers, and elementary principals from public schools in Indiana who had experience working with school-based mental health services. The participants had to possess a master's degree and an additional certification, such as National School Psychologist certification, a licensed clinical social worker, a licensed marriage and family therapist, or licensed mental health counselor that allows them to provide mental health therapy services to students. Limiting participants to those with these credentials provided a better representation of experiences of school staff as opposed to those with bachelor's degrees who could not provide mental health services according to professional and ethical standards. With these parameters, the applicability of results would be difficult for secondary schools, charter schools, and private schools. Throughout the study, there were statements referring to how research was being conducted at public schools in Indiana. Interviewing 10 participants provided me with a broader opportunity to hear a variety of experiences and identify themes across all interviews. The study did not include schools from every geographical region throughout the United States and provided a viewpoint from only elementary public-school practitioners in Indiana. The study did not account for race or gender, providing viewpoints unaffected by specific demographic of race or gender. Findings from the study may not be generalized to all schools in Indiana or across the United States. The intent of this study was to provide educational administrators with strategies and programs that can be utilized in their schools and school districts.

Definition of Terms

Definitions of terms referenced throughout the study are listed as follows:

Guidance counselor refers to master's level practitioners who help students by removing barriers to academic achievement, supporting social and emotional development, and guiding college and career readiness (University of North Carolina-Charlotte, 2018).

Mental health refers to "our emotional, psychological, and social well-being that affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices" (U.S. Department of Health and Human Services [HHS], 2017, para. 1).

School principal refers to "the highest ranking administrator in an elementary, middle or high school" ("Principal, School," 2002, para. 1).

School psychologist refers to "members of school teams that support students' ability to learn and teachers' ability to teach by applying expertise in metal health, learning, and behavior, to help children and youth succeed academically, socially, behaviorally, and emotionally" (National Association of School Psychologists, 2017, para. 1).

School social worker refers to a

> trained mental health professional with a degree in social work who provide services related to a person's social, emotional and life adjustment to school and/or society. School Social Workers are the link between the home, school and community in providing direct as well as indirect services to students, families and school personnel to promote and support students' academic and social success. (School Social Work Association of America, 2016, para. 3)

School superintendent is "an executive office having the rather clear-cut function of executing policies which are formulated and adopted by the board of education" (Story, 1952, p. 371).

Summary and Organization of the Study

The goal of this study was that educational leaders are informed on how to access mental health services for students, resulting in an educational environment that is conducive to learning by meeting students' needs. The study is divided into five chapters. Chapter 1 included the introduction, statement of the problem, purpose statement, research questions, significance of the study, methodological brief, assumptions, limitations and delimitations of the study, personal statement, definition of terms, and summary. Chapter 2 includes the literature review relating to the study. Chapter 3 provides the methodology, method of inquiry, research questions, selection process and participants, data collection, data analysis, and validity and reliability. Chapter 4 presents the findings of the themes that developed from each interview. Chapter 5 provides a discussion of results and findings, summary of findings, implications for future research, and conclusion and closing thoughts. Throughout Chapters 4 and 5, guidance counselor, mental health practitioner, and school social worker are referred to as "social-emotional health providers" since they represent the same role in the school providing or accessing mental health services for students.

CHAPTER 2

LITERATURE REVIEW

History

Today's American public schools consist of students who come from diverse educational, cultural, socioeconomic, linguistic, and religious backgrounds. Children enter kindergarten with a variety of experiences; some attended preschool for years and others have little experience in an educational setting. Children come from homes that have diverse child-rearing arrangements consisting of two parents, single parents, same-sex parents, grandparents, and extended family members. According to the Federal Interagency Forum on Child and Family Statistics (2012), there were 73.9 million children in the United States in 2011. In 2010, the rate of substantiated cases of child abuse was 10 per 1,000 children, and 22% of children lived in poverty. During the 2013–14 school year, 6.5 million children ages 3–21 received special education services (National Center for Education Statistics, 2016). For students identified as having an emotional disability and receiving special education services, fewer than 40% received mental health services in their special education programming (Wagner et al., 2006). Accessing mental health services is difficult for many children, but for children from poverty and are minorities, it is even more difficult with only 20% to 30% receiving appropriate services (Richardson, Keller, Shelby-Harrington, & Parrish, 1996; Tuma, 1989). An estimated 40–70% of the one million youth who were incarcerated were suspected of meeting the criteria for a co-morbid mental illness (C.

Kessler, 2002). In looking at the data on a surface level, it appears the potential for students having unmet mental health needs is significant. Given that the majority of children attend public schools, children with unmet physical and psychological needs can present significant issues in the classroom environment. Rosenblatt and Rosenblatt (1999) stated that schools are viewed as the de facto mental health delivery system for children where up to 10% of students can qualify as meeting the criteria for a psychiatric disorder.

During a study conducted in 2015 in Indiana, 19.8% of high school students reported that they seriously considered suicide (Centers for Disease Control and Prevention [CDC], 2016). Students (29.3%) in the state reported feelings of sadness and hopelessness (Indiana State Department of Health, 2016). Indiana high school students (15.7%) reported being electronically bullied (CDC, 2016). Children (20.9%) in Indiana live in poverty (U. S. Census Bureau, 2017). Data taken from the Indiana Department of Child Services in 2015 indicated that there were 29,359 substantiated cases of child abuse and neglect (Annie E. Casey Foundation, 2019). The number of Child in Need of Services cases increased by 56.1% from 2012 to 2017 (Indiana Department of Child Services, 2012, 2017).

Bullying of students, especially those with disabilities, has been a significant concern in recent years. Researchers found that students who received special education services were twice as likely to be bullied as their non-disabled peers (Carter & Spencer, 2006; Van Cleave & Davis, 2006). The effects of children who have been bullied are immeasurable with the potential to last a lifetime. Children who have been bullied on a regular basis are at risk for developing depression, anxiety, peer rejection, and low self-esteem (Hawker & Boulton, 2000). Hartley, Bauman, Nixon, and Davis (2015) found that school staff, including teachers, bullied students with disabilities verbally, relationally, and physically, indicating that school environments are

not free from harmful practices. It is the role of the educational leader and classroom teacher to ensure that all students are provided a safe, nurturing educational environment.

The increasing incidence of mental health disorders in youth is not confined to the United States. Internationally almost 20% of adolescents experience symptoms that are indicative of a mental health issue (Belfer, 2008). Polanczyck, Salum, Sugaya, Caye, and Rohde (2015) identified a worldwide problem as 13.5% of youth having a mental health disorder. Given the increase of social media and instant access to worldwide events, economic disparities within countries, and the increase in terrorism and refugees, one could assert that an inordinate number of children around the world have mental health concerns.

Meeting the needs of all students in the classroom can be difficult for school staff, particularly when students have unmet mental health needs (Lean & Colucci, 2010; Weist & Evans, 2005). Given accountability measures, the focus on high stakes testing, reductions in school budgets, and increasingly difficult state standards, educators are under a great deal of stress to provide a quality education for their students. Students are increasingly faced with pressures at school due to similar circumstances as teachers with high-stakes testing, larger class sizes, and rigorous curriculum with the additional pressure of acceptance to post-secondary education, peer influences, and social media. Hurtwitz and Weston (2010) found that students with mental health difficulties are less likely to graduate from high school than students without mental health issues.

The prevalence of school-based mental health services is not a new concept. In the late 1800s, mental health resources were targeted to the increasing population of children who were being placed in adult jails. Counseling services were directed at children who demonstrated school problems (Kutash, Duchnowski, & Lynn, 2006). Bardon (1963) discussed the primary

purpose of school-based mental health programs as assisting the school in fulfilling its intention to meet student needs in the 1960s. Bardon viewed educational and mental health goals as congruent as long as educators and specialists coordinated on the intended goals. Morse, Finger, and Gilmore (1968) stated that comprehensive school mental health programs would be provided in the educational process on an ongoing basis rather than being provided in a supplemental manner. Hunt (1968) stated that the school environment was the natural environment to provide mental health services because all children attend school. In the 1970s and 1980s, the focus on providing mental health services to students was with students identified as having a disability, specifically an emotional or behavioral disorder, as identified in the Education of All Handicapped Children Act, P.L. 94-142 (Pumariega & Vance, 1999).

Given federal regulations and the increase in inclusive practices, the majority of students who receive special education services are now educated in general education settings. The majority of these students are identified as having emotional disabilities, learning disabilities, speech and language impairments, and mild intellectual disabilities (U.S. Department of Education, 2011). School-based personnel, such as school psychologists, school social workers, special education teachers, school nurses, paraprofessionals, and guidance counselors, play a significant role in providing for the needs of all students, not just those identified as having special needs. Flaherty et al. (1998) stressed the importance of coordinating services, redefining roles, and collaborating among staff to capitalize on each discipline's area of expertise in order to meet students' diverse needs. When determining whose responsibility it is to provide services for students with mental health issues, numerous staff members play a role so it does not rest solely on one person's responsibility. Flaherty et al. further explained that effective collaboration among the various disciplines has been difficult to achieve in the school environment.

The term mental health can have multiple meanings for people. According to the World Health Organization (2016), mental health is defined as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (para. 2). There are differing views among professionals in the community of what constitutes mental health. The HHS (2017) defined mental health as "our emotional, psychological and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices" (para. 1). In order for schools to focus on promising practices that address students' mental health needs, everyone needs to have a common understanding of the definition of mental health.

President George W. Bush established the New Freedom Commission which recommended that all "Federal, State, and local child-serving agencies fully recognize and address the mental health needs of youth in the educational system" (President's New Freedom Commission on Mental Health, 2003, p. 62). Tashman, Waxman, Nabors, and Weist (1998) demonstrated the need for addressing children's mental health needs by stating that 70% of children with a diagnosable mental illness do not receive adequate treatment. Ringel and Sturm (2001) affirmed that only 15–30% of students with mental health issues receive treatment for their problems. Burns et al. (1995), Leaf et al. (1996), and Weisz (2004) identified that only one-sixth of children with an identified mental health diagnosis receive treatment, and half of them receive services that appropriately meet their needs. Lean and Colucci (2010) found that 80% of students who receive mental health services obtain them at school. Rones and Hoagwood (2000) affirmed the claim that the majority of students receive services to address their mental needs at school. Boger (1990) and Peeks (1993) stressed that children can capitalize on their learning

opportunities when their psychological needs are addressed. When evaluating the level of needs among students in the school setting, it is instrumental to involve the family system in ensuring a comprehensive approach to service delivery.

Family

Families who have a child with a mental health condition experience a great deal of stress. Researchers have found that at any moment 20% of children under the age of 18 have a mental health condition that interferes with their daily lives (Angold et al., 1998, Ezpeleta, Keeler, Erkanli, Costello, & Angold, 2001). Bell and Jenkins (1993) found that 30% of elementary and middle school children living in an inner city had witnessed a stabbing, and 26% had witnessed a shooting. Giaconia et al. (1995) found that 14.5% of older adolescents developed post-traumatic stress disorder (PTSD) as a result of experiencing a serious trauma.

The family system is stressful for the siblings that do not have a disability as the focus is placed on helping the child with special needs (Fox, Vaughn, Wyatte, & Dunlap, 2002). Lessenberry and Rehfeldt (2004) asserted that stress levels of parents affect the frequency and interactions with their child which can affect the psychological health of the child and family system. The Parenting Stress Index and the Parental Stress Scale are assessments that evaluate a parent's stress level (Lessenberry & Rehfeldt, 2004). The Parenting Stress Index has been shown to predict parent risk factors for abuse (LaFreniere & Dumas, 1995). Lessenberry and Rehfeldt suggested that evaluating parental stress should be an integral component of assessing the child and should be ongoing throughout the treatment plan. Evaluating the parents' stress level can assist in defining the components and support for the treatment plan.

Due to the difficulty in obtaining mental health treatment for their child, families have sought the juvenile justice system as a final opportunity to obtain mental health treatment for

their child. Koppelman (2005) indicated that a 2003 study by the Government Accountability Office identified more than 12,000 families terminated their parental rights to the juvenile justice system so their children could obtain mental health services. Of particular concern is that the incidence rate of children with mental health disorders is in alignment of those placed in residential psychiatric facilities (Rosenblatt, Rosenblatt, & Biggs, 2000).

The role of a parent presents itself with many challenges. Stress levels are higher among parents who have a child with a mental health challenge or disability than parents who have a child without a disability (Lessenberry & Rehfeldt, 2004; McKinney & Peterson, 1987). Parents who have a child with severe behavioral or mental health challenges indicated that it can be an isolating experience. Baker, Blacher, Crnic, and Edelbrock (2002) found that parents of children with disabilities reported the highest stressors when their child displayed challenging behaviors in public.

Fox et al. (2002) found that families of children with problematic behaviors found themselves socially isolated, limiting their activities outside of the home due to their child's behaviors. The researchers found that the same families felt as if they were separated from their friends and extended family because of their experiences with their child with special needs (Fox et al., 2002). One study identified that the more a family organizes their routines around the child's anxiety and accommodates for the child's needs, treatment outcomes were not as effective (Norman, Silverman, & Lebowitz, 2015). Given the significant need for parents to get help for their child, the majority of parents have little knowledge on how to access mental health services for their children (Evans & Weist, 2004).

Parent training and involvement in their child's treatment plan has been shown to improve the effectiveness of treatment outcomes (Mahoney, Boyce, Fewell, Spiker, & Wheeden,

1998). Despite the importance of involving parents in their child's treatment plan, it is noted that families who have children with challenging behaviors have limited support systems (Fox et al., 2002). Paul and Frea (2002) found that typical services, such as parent training, may be inadequate to meet the comprehensive needs of the family. Poverty, single-parent households, and the daily stresses of family life are all factors that inhibit a parent's ability to access assistance for their child's mental health issues (N. Haynes, 2002).

R. C. Kessler et al. (2005) found that the most common mental health issue in children and adults is anxiety disorders, with typical onset being in childhood or early adolescence. Beidel (1991) indicated that the most common reason for children being referred to mental health services is for an anxiety disorder. According to the Anxiety and Depression Society of America (2016), "People with generalized anxiety disorder (GAD) experience excessive anxiety and worry, often about health, family, money, or work" (para. 1). The worrying is persistent, occurring every day and for a great deal of the day. The excessive worrying interferes with daily activities with school and family. Only one symptom needs to be present in children to require a diagnosis: restlessness or feeling on edge, becoming easily fatigued, difficulty concentrating, irritability, muscle tension, and sleep disturbances. When children are in a continual anxious state, they have difficulty engaging in the learning process.

Despite the fact that children are being referred for anxiety disorders more than any other mental health condition, Fukushima-Flores and Miller (2011) found that treatment is lacking and not comprehensive. Due to the genetic predisposition for mental health disorders, children with mental health disorders often have one or both parents with mental health concerns. For example, researchers have found that up to 80% of parents who have a child with a diagnosed anxiety disorder also have been diagnosed with an anxiety disorder (Cobham, Dadds, & Spence,

1998; Turner, Beidel, Roberson-Nay, & Tervo, 2003). Given that many parents also have an anxiety disorder, treatment efforts focusing on the family system and reducing parent anxiety is imperative (Fukushima-Flores & Miller, 2011). Children of anxious parents are five times more likely to have an anxiety disorder than those with parents who are not anxious. Parenting a child with a disability involves having to attend multiple medical appointments, navigating specialists, understanding treatment plans, managing medications, and coordinating care for one's child. For children in single-parent families, the task can be daunting. Schools play a significant role in helping provide family support for meeting the mental health needs of children.

Recent Practices

There are established school-based practices that have been found to address students' mental health needs. In order for these practices to be effective, they must be led by district and school-based leaders. Whitley (2010) contended that mental health supports for students will become integrated into the culture of the school when teachers collaborate and focus on continued learning. Whitley stated that one of the easiest ways to provide support to students with mental health needs is for school administrators to provide information to them. Pamphlets, websites, informational items, and telephone hotlines are easy ways that students can become aware of services. Levesque and Manion (2006) reinforced the idea that knowing what resources are available and how they can be accessed increases the chances that students will receive the help they need. Catron and Weiss (1994) found that when schools provide a referral for mental health services in the community, only 17% of families followed through. When mental health services were provided at school, 98% of families follow through. Students have reported that they are more willing to access mental health services at school than in other settings (Burns et al., 1995; Farmer et al., 2003).

Partnering with the community is one avenue for meeting students' mental health needs (Meldrum, Venn, & Kutcher, 2009). Brown, Dahlbeck, and Sparkman-Barnes (2006) indicated there is a growing movement in the United States to provide mental health programs by partnering with community mental health centers. By working with school-based mental health therapists, school psychologists, and licensed clinical social workers, more comprehensive services can be provided to students. When entering into community-based partnerships, Brown et al. found that refining contract obligations, roles and responsibilities, service options, and legal requirements are necessary among school and mental health leaders. Walsh and Galassi (2002) reinforced the concept of implementing partnerships between schools and mental health agencies to help build skill sets among school staff. Minahan and Baker (2015) indicated there is a "disconnect between the needs of students with mental health issues and teachers' skills" (p. 68). Mental health therapists can assist teachers in helping them understand their students' needs. Professionals who serve as *frontline gate-keepers*, such as educators, school psychologists, and pediatricians, are predominantly providing access to treatment for a small percentage of students (Briggs-Gowan, Horwitz, Schwab-Stone, Leventhal, & Leaf, 2000).

When teachers have a set of practices that address positive mental health, their students will benefit, making the classroom a more conducive environment for learning. Mindfulness is a recent practice that has gained attention among educators and is easy to implement in the classroom setting. Students who practice mindfulness have decreased levels of stress and anxiety and increased impulse control (Shonert-Reichl et al., 2015). When student behavior is difficult to manage in the classroom, school staff can have the perception that the child needs better discipline and that the child is choosing to misbehave. Greene (2014) stated that if children had the skills to behave, they would. The child's misbehavior is due to an undeveloped

skill. Often students with mental health issues are viewed as being discipline problems, rather than having an emotional problem that is causing the problematic behavior (Santor, Short, & Ferguson, 2009). Students who have unmet mental health needs which result in problematic behavior in classrooms affect other students in the classrooms (Lean & Colucci, 2010).

Utilizing school counselors, school social workers, and school psychologists is one mechanism for delivering mental health services to students. The American School Counselor Association (ASCA, 2015) stated that the primary responsibility of the school counselor is to provide direct services to students at least 80% of the time. ASCAs position statement on mental health states that counselors "respond to the need for mental health and behavioral prevention, early intervention and crisis services that promote psychosocial wellness and development for all students" (ASCA, 2015, p. 1). School counselors encounter barriers to adequately meet students' mental health needs, such as high caseloads, additional roles within the school, lack of training, and lack of knowledge on how to access community mental health centers. Kaffenberger and O'Rorke-Trigiani (2013) asserted that school counselors can collaborate with special education staff to learn additional strategies for providing direct mental health services to students.

Educational leaders can build upon the existing Response to Intervention (RtI), general education intervention (GEI) teams, or child study team in schools to provide mental health supports for students. Shepherd (2006) found that shared responsibilities among district and building level administrators resulted in better decision making and sustained practices focused on student needs. Although schools may have evidence-based practices available, it is imperative that the interventions are implemented with fidelity. Odom (2009) indicated that practices must be implemented in the classroom in the way they are intended because they are

research based. If teachers adapt practices to fit their needs in the classroom, the efficacy of the intervention becomes compromised. Coffey and Horner (2012) stated that using evidenced-based interventions with fidelity is critical in attempting to close achievement gaps between students with disabilities and their non-disabled peers. The authors stated that initiatives are more likely to be sustained if they have administrative support that promotes communication about the initiative and utilizes data to implement and adjust accordingly.

Many schools and districts have value statements that are intended to communicate expectations for student behavior. Petersen, Strawhun, and Hoff (2015) stated that school value statements are typically positive attributes that function as broad goals for staff and student behavior. Positive behavior interventions and supports (PBIS) is an evidence-based program that focuses on identifying school expectations and values and intentionally teaching students the values, expectations, and appropriate behaviors. The PBIS model began in the mental health field and focuses on preventing problem behaviors from occurring. Bradshaw, Koth, Thornton, and Leaf (2009) found that schools that implement PBIS with fidelity improve academics and behavior in students. Bradshaw, Koth, Bevans, Ialongo, and Leaf (2008) found that administrators can increase their schools' overall organizational health among all school staff by adopting a school-wide PBIS program.

Given the complexities of schools and the increasing societal and political demands placed upon administrators, administrators need to be thoughtful about the change process when making a determination to add a new program or service. Adelman and Taylor (2007) identified critical factors that must be incorporated when administrators are determining a school's readiness for implementing systemic changes. Those factors are:

- A high level of policy commitment that is translated into appropriate resources, including leadership, space, budget, and time,
- Incentives for change, such as intrinsically valued outcomes, expectations for success, recognition, and rewards,
- Procedural options from which those expected to implement change can select those they see as workable,
- A willingness to establish mechanisms and processes that facilitate change efforts
- Accomplishing change in stages and with realistic time lines,
- Providing progress feedback,
- Institutionalizing support mechanisms to maintain and evolve changes and to generate periodic renewal. (Adelman & Taylor, 2007, p. 63)

Adelman and Taylor indicated that traditional leadership preparation programs for administrators have not placed emphasis on systemic change processes. The National Policy Board for Educational Administration published Professional Standards for Educational Leaders in 2015 (National Policy Board for Educational Administration, 2015). The standards reflected input from the American Association of Colleges of Teacher Education, the American Association of School Administrators, the Council for the Accreditation of Educator Preparation, the Council of Chief State School Officers, the National Association of Elementary School Principals, the National Association of Secondary School Principals, the National Council of Professors of Educational Administration, the National School Boards Association, and the University Council for Educational Administration. The responsibility of a school administrator to provide access to mental health services to students is identified in Standard 5, Community of Care and Support for Students. The elements within the standard identify effective leaders as those who

- Build and maintain a safe, caring, and health school environment that meets the academic, social, emotional and physical needs of each student.
- Create and sustain a school environment in which each student is known, accepted and valued, trusted and respected, care for, and encouraged to be an active and responsible member of the school community.
- Provide coherent systems of academic and social supports, services, extracurricular activities, and accommodations to meet the range of learning needs of each student.
- Promote adult-student, student-peer, and school-community relationships that value and support academic learning and positive social and emotional development.
- Cultivate and reinforce student engagement in school and positive student conduct. (National Policy Board for Educational Administration, 2015, p. 13)

Standards for any profession need to be identified, articulated, and infiltrated in college preparation programs.

Educational Leadership Preparation Programs

Whitley (2010) stated that educational leaders need to be committed to providing mental health services in schools. Given that many students' mental health issues are dealt with on a regular basis in the form of discipline referrals, absences, and failing grades, it makes sense that school administrators seek ways to offer mental health services for their students (Adelman & Taylor, 2000; Epstein et al., 1993). Stevenson-Jacobson, Jacobson, and Hilton (2006) surveyed school principals and found that 58% of certified principals spent more than 11 hours a week on special education issues. Iachini, Pitner, Morgan, and Rhodes (2016) found that principals identified mental health as one of the greatest student, teacher, and staff needs. In a study conducted by Shoho and Barnett (2010), new principals were less prepared for working with the

budget and special education. Fullan (2008) stressed the importance of district level leaders focusing on culture in schools and having a common understanding of what mental health means. Whitley extended Fullan's concepts by stating that school staff members need to be involved in developing the mission and vision statements that encompass mental health to foster responsibility and commitment among all school personnel.

When it comes to mental health problems in students, teachers and administrators indicated they do not have the necessary knowledge or resources and desire more training in this area (Rothi, Leavey, & Best, 2008; Santor et al., 2009; Walter, Gouze, & Lim, 2006). Koller and Bertel (2006) stressed the importance of a change in preservice training for school-based personnel to address the mental health needs of students. They asserted that traditional models of training programs do not focus on proactive mental health strategies. Lack of preservice training to address mental health issues was also articulated by Rones and Hoagwood (2000) and Frabutt and Speach (2012). Lechtenberger, Mullins, and Greenwood (2008) stated, "University preservice teacher education programs provide little, if any, training for preservice teachers and administrators in the area of children's mental health" (p. 57). Fleming and Bay (2004) purported that classroom teachers bear the primary responsibility of teaching social and emotional skills to students, despite having formal training beyond basic child development coursework to do so. Researchers have found that the highest-rated factors in providing effective school-based mental health services are the desire to provide mental health services, the attitudes and willingness to provide evidence-based practices, and training (Beidas et al., 2012; Langley, Nadeem, Kataoka, Stein, & Jaycox, 2010).

Addressing mental health, social, and emotional needs of students provides a powerful influence on academic performance in the classroom (Collaborative for Academic, Social, and

Emotional Learning [CASEL], 2003). School mental health services are linked to increases in academic performance, better relationships, and improved school climate (Hurwitz & Weston, 2010; Ysseldyke, 2004). It has been well documented that the primary determinant of student achievement is the classroom teacher. Holzbauer (2008) and Mastropieri and Scruggs (2010) found that the success of inclusive practices for students with disabilities is the attitude of the classroom teacher. Many teachers indicated that they do not feel prepared to accommodate students with disabilities into the general education environment, especially with students who have problematic behaviors (Rose, Espelage, Aragon, & Elliott, 2011). Salend and Garrick Duhaney (1999) found that some teachers felt threatened and frustrated by having students with disabilities in their classrooms. McDuffie, Landrum, and Gelman (2008) stated, "In the absence of sound academic instruction, the most effective behavior management systems in the world will do little to prepare students for school or later-life success" (p. 11). The principal plays a significant role in providing support for classroom teachers in implementing evidence-based practices.

A primary role of the building principal is to promote the mission and vision of the school. It is the principal's responsibility to ensure that teachers are supported with best practices and programs that promote inclusionary practices for the school community (Döş & Cezmi Savaş, 2015). The success of program implementation is dependent on the principal (Gingiss, 1992; Gottfredson & Gottfredson, 2002; Kramer, Laumann, & Brunson, 2000; McMahon, Ward, Pruett, Davidson, & Griffith, 2000). Despite the importance of the role of the principal in implementing programs, Iachini et al. (2016) identified that principals' perspectives on the contributions to teaching and learning and school improvement models are underrepresented. In their study, health and mental health was the greatest need identified by elementary and high

school principals. The principals also indicated that providing training and professional development to school staff would better assist them in addressing mental health needs in the classroom. Having more counselors and social workers to identify and address the mental and behavioral health needs of students was also identified as a priority.

Given increasing fiscal constraints and competing demands for programs, a concern for administrators for adding services is where the funding is going to come from. Educational leaders need to have knowledge on how existing mental health services can be provided, both programmatically and financially. Mental health services can be funded in numerous ways. Medicaid, private insurance, community mental health centers, and private grants are ways in which services for students can be funded and not paid for through school funding mechanisms. "In 2010, 90% of children had health insurance coverage at least some time during the year" (Federal Interagency Forum on Child and Family Statistics, 2012, p. 8). Funding sources can be blended to capitalize on the dollars available. Part B and Part C of the Individuals with Disabilities Education Act (IDEA, 2004) provide funding for services for students with special needs. Bruder (2010) stressed the importance of policy makers and administrators integrating programs by blending funding mechanisms. Whitley (2010) stressed the fact that all resources, whether financial or human, may need reconfigured to ensure the goals of meeting student needs are met.

As educational leaders attempt to provide mental health services for students, they need to understand the cultural composition among the students in their classrooms (President's New Freedom Commission on Mental Health, 2003). Mental health service delivery in schools is particularly important in removing barriers to access for children from low-income households and those who are non-Caucasian (Alegria, Green, McLaughlin, & Loder, 2015). Given that the

majority of educators are Caucasian and raised in middle class environments, a conscientious effort needs to be made by educators to understand the various dynamics their students bring to the classroom. Delpit (1995) discussed that it is imperative to realize that many students possess different worldviews and experiences than the educators leading the educational process. Delpit (1995) identified "the culture of power" (p. 24) that manifests in classrooms with those having the majority of power being the least likely to acknowledge its presence and those having the least amount of power being strongly aware of its existence. Children who do not comprise the majority of the students in the classroom can manifest their uncertainty or discontent in myriad ways. Embracing the diversity in the classroom and meeting the unique needs that children possess is paramount to providing a quality education and helping children feel safe.

Model Programs

There are several programs that are effective in providing mental health services to students in schools. Evidence-based practices is a term that has been utilized to make sure educators are utilizing strategies and programs that have proven to be effective. Dunst and Trivette (2009) defined evidence-based practices as those that "are informed by research, demonstrate a relationship between the characteristics and consequences of a planned, or naturally occurring, experience or opportunity; where the nature of the relationship directly informs what a practitioner can do to produce a desired outcome" (p. 41). The No Child Left Behind Act of 2001 (2002) does not use the term evidence-based practice but defines scientifically research-based instruction as being research that

> applies rigorous, systematic, and objective procedures to obtain valid knowledge relevant to reading development, reading instruction, and reading difficulties; and employs systematic, empirical methods that draw on observation or experiment; involves rigorous

> data analyses that are adequate to test the stated hypotheses and justify the general conclusions drawn; relies on measurements or observational methods that provide valid data across evaluators and observers and across multiple measurements and observations; and has been accepted by a peer-reviewed journal or approved by a panel of independent experts through a comparably rigorous, objective, and scientific review. (Sec. 9101, para. 37)

The reauthorization of the No Child Left Behind Act of 2001, entitled Every Student Succeeds Act of 2015 (2015–2016), defined evidence-based practice as

> an activity, strategy, or intervention that demonstrates a statistically significant effect on improving student outcomes or other relevant outcomes based on strong evidence from at least 1 well-designed and well-implemented experimental study; moderate evidence from at least 1 well-designed and well-implemented quasi-experimental study; or promising evidence from at least 1 well-designed and well-implemented correlational study with statistical controls for selection bias; or demonstrates a rationale based on high-quality research findings or positive evaluation that such activity, strategy, or intervention is likely to improve student outcomes or other relevant outcomes; and includes ongoing efforts to examine the effects of such activity, strategy, or intervention. (Sec. 8101(21)(A))

The Every Student Succeeds Act (2015–2016) also requires schools to provide training for students who have been affected by trauma, including those who may be at risk of mental illness, by

> carrying out in-service training for school personnel in the techniques and supports needed to help educators understand when and how to refer students affected by trauma,

> and children with, or at risk of, mental illness; the use of referral mechanisms that effectively link such children to appropriate treatment and intervention services in the school and in the community, where appropriate; forming partnerships between school-based mental health programs and public or private mental health organizations. (8101(21)(A)

Although federal regulations and statues dictate what must be done, little guidance is provided as to how to provide the required services.

Providing mental health interventions in an educational setting is referred to as school-based mental health or school mental health (Capp, 2015). There are a myriad of ways in which mental health services can be integrated into the school setting. Promoting positive mental health and intervention programs are centered on partnerships between schools and community agencies (Paternite, 2005; Weist, 2005; Weist & Evans, 2005). It can be difficult for families to access traditional mental health services when they may have more than one place of employment, have minimal access to transportation, and have other children in the family. Providing school-based mental health services benefits families in that it removes barriers, such as lack of transportation, insurance coverage, and stigma (Weist, Paternite, Wheatley-Rowe, & Gall, 2009). In addition to partnering with mental health agencies, schools can employ mental health therapists to provide services for students.

Educational leaders in large inner city school systems have brought multiple stakeholders together and implemented creative utilization of resources to provide mental health services to students. Vaillancourt and Amador (2014/2015) described six components of partnerships among schools and communities, whether they are initiated at the district or school level, as “a team that consists of school and community leaders, continual needs assessments and identified

strengths, a defined coordinator, clear expectations and shared accountability systems, ongoing professional development, and regular evaluation" (p. 58). Boston Public Schools, Cincinnati Public Schools, and Fairfax Community Public Schools utilized this framework to implement school-based mental health services in their school communities (Vaillancourt & Amador, 2014/2015).

Multi-tiered system of support (MTSS) is a framework that provides a continuum of academic and behavioral services for all students at three levels (Desrochers, 2014). Tier 1 provides universal interventions for all students, while Tiers 2 and 3 provide targeted interventions for students who have more intensive needs. In an MTSS model, all students are screened for emotional and behavioral problems. The purpose of screeners is not to provide students with a label but to identify students who need more intensive supports (Desrochers, 2014). Desrochers (2014) stated that the use of MTSS as a school delivery model is inexpensive and easily available for school personnel to use. Implementing MTSS with fidelity can prevent mental health issues and bolster school climate and academic performance of students. Figure 1 depicts the MTSS model that includes a three-tier system for interventions that include academics and behavior.

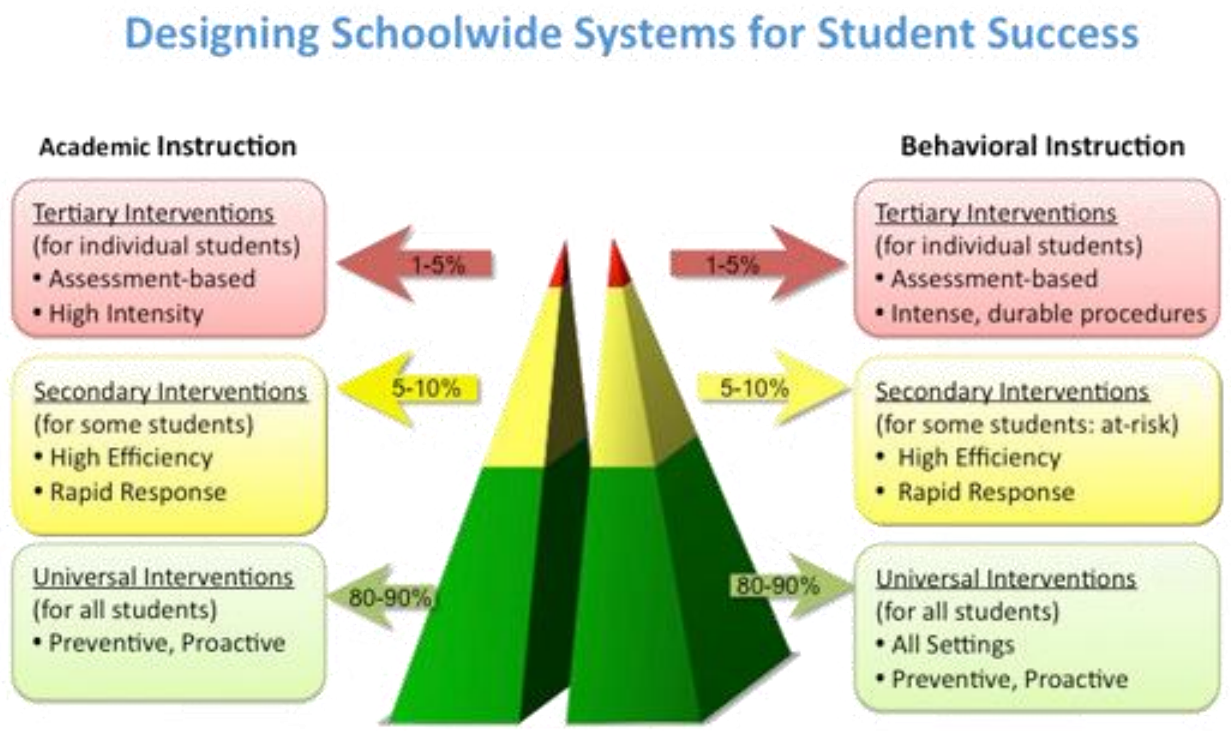

Figure 1. Multi-tiered system of support model. From "Multi-tiered system of support (MTSS) & PBIS," by Office of Special Education Programs, Technical Assistance Center, 2017 (www.pbis.org/school/mtss). Copyright 2019 by Positive Behavioral Interventions & Supports

Our Community, Our Schools (OCOS) was a pilot program that was implemented in the 2012–2013 school year in two schools in Southern California (Capp, 2015). The goals of the program included serving the entire school community; being integrated into the school community, providing access for families who did not have health insurance; and providing support to students, families, and school staff to promote positive mental health. The initial results of the study found that the school-based mental health therapists were involved in pre-

expulsion meetings, parenting workshops, staff training, crisis interventions, classroom incidents, classroom observations, and teacher consultations in addition to individual student counseling sessions. At the end of the first year of implementation, therapists were spending 10 to 20% of their week consulting with school staff on approximately 25% of the student population (Capp, 2015).

The Excellence in School Mental Health Initiative was implemented in the Baltimore City Public Schools beginning with the 2006–2007 school year (Weist, Stiegler, Stephan, Cox, & Vaughan, 2010). This partnership encompassed collaboration among foundations, universities, the schools, and the community with the focus on meeting the unmet mental health needs of students. Universal screening of students, staff surveys, and environmental assessments were conducted to identify needs of the school community. Whole class and small group interventions led by clinicians, outreach to parents and caregivers, and teacher training was provided throughout program implementation. Porter, Epp, and Bryant (2000) described the partnership that Johns Hopkins University developed with the Baltimore City Public Schools to provide weekly consultation services with psychiatrists in 19 schools. Mental health clinicians provided individual, group, and family counseling services in addition to medication management. This program included partnerships with juvenile justice, law enforcement, and social services and operated on a year around basis. The program utilized an interdisciplinary approach among professionals to ensure that student needs were met in a comprehensive manner. The program's structure allowed for responsibilities among all professionals to be distributed equitably so one person did not assume primary responsibility for implementation. Services are provided during the school day, after school, and during the summer. The partnership with the Baltimore City Public Schools has resulted in recommendations for implementation of evidence-

based programs in schools. Using real-world examples from practitioners in the field is crucial in developing preventive models and increasing the probability of implementation in schools.

The School Success for All Coalition (2010) encourages schools to adopt school-wide PBIS. PBIS is an approach for assisting schools in organizing evidence-based behavioral interventions in a continuum that improves academic and behavior outcomes for students (Office of Special Education Programs, 2017). PBIS focuses on preventative efforts that schools can utilize to improve the learning environment by applying behavior, social, and organizational behavioral principles (Lewis & Sugai, 1999; Lindsley, 1992). PBIS encompasses a three-tiered model based on public health approaches with universal, targeted, and individual components (Bradshaw et al., 2008).

The Collaborative for Academic, Social, and Emotional Learning (CASEL) is an organization that provides researchers and educators with information to improve school-based social and emotional learning practices (Zins, Weissberg, Wang, & Walberg, 2004). CASEL provides research-based programs that can be practically implemented in the school environment to focus on developing the social and emotional learning principles for students. Programs that have produced promising results are Promoting Alternative Thinking Strategies, the Seattle Social Development Project, and Resolving Conflicts Creatively. Proponents of social and emotional learning believe that an essential goal of education is to provide students with the social and emotional skills needed to live a productive life. Although this work is extremely important, more research needs to be done to demonstrate the link between academic achievement and social and emotional skills (Zins et al., 2004).

The Three Cs Program has been implemented in schools throughout Asia, Europe, Africa, the Middle East, and North and South America. The program incorporates social

interdependence and conflict theories as a basis for its principles of cooperative community, constructive conflict resolution, and civic values (Johnson & Johnson, 1989). The program has been successfully implemented with students from all socioeconomic backgrounds, as well as students who live in urban, suburban, and rural settings. Johnson and Johnson (1989) identified that people who are unable to build and maintain interdependent relationships with others become depressed, anxious, and isolated, resulting in poor psychological health. With an intentional focus on building social skills, teachers and school leaders are developing interdependence among students.

Check and Connect is an intervention based on social and emotional learning principles (Sinclair, Christenson, Evelo, & Hurley, 1998). Check and Connect is "designed to promote student engagement" (Sinclair et al., 1998, p. 68) and uses mentors who continuously monitor student attendance, academic performance, and behavioral referrals. The role of mentors is to work with families and other significant adults in the student's life to support student success (Sinclair et al., 1998). Mentors work with parents to empower them with the supports and skills necessary to communicate with teachers, to identify and connect parents with resources, and to increase overall participation in their children's education. The ultimate goal of the Check and Connect program is to promote resilience and perseverance in the face of everyday challenges among students. Results from a study conducted by Sinclair et al. (1998) indicated that middle school students that participated in Check and Connect were significantly more engaged in school and earned more credits during their first year of high school than the control group.

Regardless of the program that is implemented to provide school-based mental health services, consistent, intentional collaboration is required between schools and community agencies. For schools that provide school-based mental health services to students,

implementation efforts primarily focus on individual treatment rather than preventative measures (Adelman & Taylor, 2012). Blank (2015) indicated the importance of health-education partnerships as healthy students are more apt to capitalize on learning opportunities in the classroom. In reviewing what program is needed, schools and community agencies must review data to identify needs. Shared ownership, shared vision, collaborative decision making, accountability, sustainability, and ongoing progress monitoring are vital components for school and community partnerships (Blank, 2015).

Summary

The practice of providing school-based mental health services has existed since the late 1800s. Public schools are in a unique position to provide mental health services to students since the majority of school-age children attend public schools in the United States. Providing school-based mental health services alleviates barriers for families in obtaining treatment for their child. There are several evidence-based programs being utilized by schools across the United States to address the mental health needs of students. The ingredient needed to improve the mental well-being of students and enable them to capitalize on their learning potential requires commitment among the school administrator from the onset. There is a gap between the knowledge base of evidence-based practices and the training and infrastructure needed to implement these practices in schools (Ringeisen, Henderson, & Hoagwood, 2003; Weist et al., 2009). The competencies needed among school administrators to provide access to mental health services is the question that requires further development.

CHAPTER 3

RESEARCH METHODOLOGY

The purpose of this qualitative study was to learn what school practitioners feel the competencies that are needed in order for school administrators to access school-based mental health services for students. Ary et al. (2010) stated that a phenomenological study is "designed to describe and interpret an experience by determining the meaning of the experience as perceived by the people who have participated in it" (p. 471). Researching questions about the common experiences of school personnel who engage in school-based mental health services enabled me to understand better the relationship between school administrators' competencies and quality implementation of school-based mental health services.

Method of Inquiry

This research study utilized a cross-case analysis phenomenological approach in that participants were interviewed about their experiences with school-based mental health services. Ary et al. (2010) indicated that personal interviews are the primary data collection method for a phenomenological study. I interviewed participants onsite in their schools and conducted walk throughs and observations in 10 schools to compare respondent's answers and evidence of school-based mental health services. It was important to interview the participants in the natural environment where the phenomenon occurred. Comparisons were made between administrator and counselor responses to determine similarities and differences among statements regarding

school-based mental health services. The top 10 graduate schools of education for educational administration programs as identified in the U.S. News and World (2017) report were reviewed for their standards as they related to accessing community resources for students. Professional educational organization websites were reviewed to obtain competencies required for school administrators to access community resources for students.

Research Questions

Using Dewey's (1944) philosophy of education and democracy, social justice theory, and the scholar practitioner concept, this study was designed to answer the following research questions:

1. What do school practitioners state are the necessary competencies of school administrators that help facilitate the acquisition of mental health services in schools to assure provision of mental health services for students?
2. What administrative structures, policies, and procedures are needed in schools for students to access mental health services?

Selection of Participants

Data were obtained from school-based mental health practitioners, guidance counselors, school social workers, and elementary principals who had experience with school-based mental health services in elementary public schools in the state of Indiana. To be included in the pool of respondents, participants had to possess a master's degree as a minimum standard and further certification such as National School Psychologist licensure, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Mental Health Counselor, School Administrator, or other similar credentials. Participants had to have experience working directly with or supervising K–6 public school students who had a DSM-V diagnosis or eligibility for

special education, such as an emotional disability. Other areas of disability were considered, such as specific learning disability or other health impairment, if the student had mental health needs as a result of these diagnoses. It was my goal to have 10–12 participants to interview. Polkinghorne (1989) recommended that five to 25 individuals who had experienced the phenomenon be selected by researchers to interview. Ten participated in the study. The participants that responded represented rural, suburban, and urban school districts across the state of Indiana. No participants withdrew from this study.

Recruitment

An email was sent to the following communities in the Learning Connection provided through the IDOE: elementary school counselors, secondary school counselors, school social work, teachers who work with students with disabilities, special education administrators, school psychologists, and Indiana resource center for autism (Appendix A**)**. Membership in these groups is voluntary for educators in the state of Indiana, and several members of these groups include school psychologists, school social workers, mental health therapists, and guidance counselors. An email was sent to 957 elementary principals as identified in the IDOE 2018–19 Directory (www.doe.in.gov/idoe/idoe-data). Table 1 identifies the number of participants in each Learning Connection Community.

Table 1

Total Number Breakdown of Available Participants in Indiana

Position	Number in Field
Elementary school counselors	715
Secondary school counselors	1,612
School social work	223
Teachers who work with students with disabilities	1,862
Special education administrators	3,745
School psychologists	690
Teachers who work to improve student behavior and discipline	1,581
Indiana Resource Center for Autism	194

Instrumentation

This study utilized a semi-structured interview for data collection. Data included information gathered from interviews. I reviewed the related literature on the school administrator's role in providing school-based mental health services to students. After the review I created a structured interview protocol and guiding questions. I sought review of the protocol questions from administrators who had experience providing school-based mental health services to students either in their previous or current position. After obtaining their input, I finalized the interview protocol. I conducted one-on-one interviews with 10 school-based mental health practitioners, guidance counselors, school social workers, and elementary principals to gain insight into each personal experience with school-based mental health services. The interviews consisted of semi-structured questions to provide for uniformity between

interviews but also allowed opportunity for individual responses as well as for probing and clarification. Each participant was interviewed for approximately 60 minutes. Interview questions are included in the interview protocols (Appendices B, C, and D). The questions were developed based on my review of the related literature and to inform my research. Data were collected through audio recordings and researcher notes guided through the use of an interview protocol. After each interview, I engaged in a reflection of the experience which was recorded in the form of researcher field notes. The notes captured my opinions about what the interviewee stated in relation to my research questions as well as offered an indication of his or her nonverbal communications throughout the interview.

All participants were given pseudonyms to protect their anonymity. The recording device, computer, and notes were coded so I was the only one who knew the identities of the participants, schools, and school districts for the purposes of confidentiality. A Sony stereo digital voice recorder (ICD-UX533) was used to record interviews. After interviews were conducted, I transcribed the interviews on my personal home computer using Microsoft Word and Trint software. I listened to each recording a minimum of three times to ensure the data were recorded accurately. All digital and non-digital data storage locations were protected by a computer digital password or locked file located at my personal home address to protect confidentiality.

Merriam and Tisdell (2016) stated, "Reliability is problematic in the social sciences simply because human behavior is never static" (p. 250). Merriam and Tisdell (2016) discussed reliability in qualitative research as being "whether the results are consistent with the data collected" (p. 251). Triangulation of data can be used to ensure reliability in qualitative research (Merriam & Tisdell, 2016). Patton (2015) stated, "Triangulation . . . increases credibility and

quality by countering the concern that a study's findings are simply an artifact of a single method, a single source, or a single investigator's blinders" (p. 674). I utilized triangulation of data collection through review of educational leadership standards, interviews, onsite visits, and the literature review.

Content Validity

S. N. Haynes, Richard, and Kubany (1995) defined content validity as "the extent to which the elements within a measurement procedure are relevant and representative of the construct that they will be used to measure" (p. 238). I shared potential interview questions for elementary principals with school administrators who had been elementary principals in my Ph.D. cohort and with elementary principals from the Wawasee Community School Corporation where I was previously employed. These individuals had administrative experience with school-based mental health services either in their current position or previous position. Eight elementary principals provided feedback on the potential interview questions that I asked of elementary principals in the study. Obtaining their input and expertise with school-based mental health services enabled me to refine what questions were asked of the participants during the study. I compared the responses from the participants and identified common terminology to use in the questions. Initial questions that I thought were relevant were changed to provide more detail and clarity from the school administrator's perspectives and experiences on school-based mental health services.

Data Analysis

Creswell (2013) stated,

> Phenomenological data analysis are similar for all psychological phenomenologists . . . building on the data from the first and second research questions . . . go through the data,

> and highlight ‘significant statements’ sentences, or quotes that provide an understanding of how the participants experienced the phenomenon. (p. 82)

Utilizing this process of horizonalization, clusters of meaning are developed into themes (Moustakas, 1994). When analyzing the data, notes were made throughout the documents to identify themes. Coding of transcriptions and artifacts was done via Microsoft Word using the highlighting feature to identify frequently used terms and phrases that were given during the responses to the questions.

Personal Statement

This research project is more than a process of collecting data and disseminating results for me. The genesis for this research began during my professional and personal experiences with mental health issues. It is my belief that the root causes of the majority of dysfunctions in this world is centered on untreated mental health problems. During my 25-year tenure as special education teacher and special education administrator, I witnessed too often the inability of students and adults to know how to access and navigate the mental health system. This lack of knowledge resulted in suicides, family dysfunction, students dropping out of school, addiction, and students and families unable to fulfill their goals for their lives. Even when families know how to access services, living with an individual with mental illness can be taxing on the family unit.

Public schools are where the majority of children in the United States receive mental health services. Students already receive nutritious meals, vision and hearing screenings, social work services, and dental services at schools. Providing mental health services to students is an additional opportunity that schools can better meet the needs of the school community. School

administrators are the impetus to providing school-based mental health services, capitalizing on the learning potential of their students by making sure their needs are met.

Summary

The purpose of this study was to examine what practicing educational administrators feel are the competencies needed to provide school-based mental health services. A review of the literature revealed a critical gap between the number of students who need mental health services and the number who receive these services. Kaffenberger and Seligman (2007) stated that 20% of students need mental health services, but only 20% of these students receive them. Repie (2005) found that students who had access to school-based mental health services were "more likely to have their mental health care needs met" (p. 296). Repie asserted that school systems and administrators need to assess the problems prevalent in their communities and determine what services should be provided, requiring a paradigm shift within schools. Forman and Barakat (2011) found that supportive administrators, particularly the principal, are influential in the implementation of successful evidence-based interventions.

CHAPTER 4

FINDINGS OF THE STUDY

The purpose of this phenomenological qualitative study was to learn what competencies practicing school personnel feel are needed in order for school administrators to access school-based mental health services for students. Results included having a mindset that academic learning cannot occur until mental health needs are met, providing professional development for staff, having support from the central administration office, and utilizing terminology that does not use the term "mental health" to avoid the stigma attached to the term. Administrative structures, policies, and procedures needed for students include having adequate physical space in the building to provide services and protect confidentiality of the student and family; having adequate, sustainable funding sources; having a partnership with the local community mental health center; having a tiered system that defines what support students are to receive; and clearly defining the role of the social-emotional health provider.

Research Questions

1. What do school practitioners state are the necessary competencies of school administrators that help facilitate the acquisition of mental health services in schools to assure the provision for students to access mental services for students?
2. What administrative structures, policies, and procedures are needed for students to access mental health services in schools?

Presentation of Study Sample

Principals, guidance counselors, school-based mental health therapists, and school social workers in rural, suburban, and urban elementary public schools in Indiana were selected for this research study. Table 2 depicts the number of years of experience in the principalship of the elementary principals interviewed, the total number of years in education, and the number of degrees held. Table 3 depicts the number of years of experience of the social-emotional health providers, the number of principals with whom they worked, the total number of years worked in education, and the number of degrees held. One participant had a predominantly administrative role yet also provided some mental health services to students, so this participant was placed in the principal's group.

Table 1

Years of Experience of Elementary Principals

Principal	Years of experience as a principal	Total years experience	Degrees held
P1	10	35	BS, MS, PhD
P2	6	22	BS, MS, EdS
P3	7	24	BS, MA
P4	14	20	BS, MA
P5*		14	BS, MA
P6	11	23	BS, MA

Note. P5* was not a principal but was in an administrative role.

Table 2

Years of Experience as Social-Emotional Health Provider and Number of Principals With Whom They Worked

Social-Emotional Health Provider	Years of experience in role	Principals with whom they worked	Total years of school experience	Degrees held
GM1	8	8	7	BS, MA
GM2	18	9	20	BS, MS, MA
GM3	10	9	12	BA, MS
GM4	22	12	22	BS, MS

Prior to the interviews, receipt of informed consent was obtained. One semi-structured interview was conducted with each participant. Interviews were conducted in person and lasted 45–60 minutes. Specific names or identifiable descriptions of school corporations and schools were substituted with a generic acronym to protect confidentiality. After interviews were transcribed, I emailed the transcription to the participant to proofread and verify content. No corrections were made to the transcription after participants reviewed the content.

Summary of the Interviews and Field Observations

Why/Mindset That Mental Health was a Priority

For Research Question 1, several themes emerged regarding the competencies needed in school administrators to facilitate student acquisition of mental health services in schools. All of the principals displayed the mindset of the importance of providing mental health services to students. They conveyed to all staff, parents, and the school community the attitude that learning

cannot happen until the student's emotional and mental health needs are met. P4 stated, "Mental health affects everything we do. It's not misbehavior. It's mental health." P5 stated that educators need to view the child that is having difficulty from the lens of, "What happened to this child?" as opposed to, "What's wrong with this child?" Each principal stated that the trauma with students must be addressed before the academics can be addressed, and they wanted to make sure students had the ideal learning environment. P6 stated, "We understand that whatever is happening with children affects both their home life and their school life." When staff expressed frustration with why some students that exhibited challenging behaviors remained in the school setting, P6 affirmed that it was important that every day the staff members were going to see successes among their students and those successes were celebrated.

The commitment to finding ways that the students could be successful in the school environment was conveyed by all participants. P4 stated that getting to the root cause of the student's issue was key in addressing students' mental health needs. This realization evolved after noting the number of students in the nurse's office and those being sent to the principal's office for discipline issues. In talking with these students, P4 started by putting together programs in the school to make sure students had food to take home on the weekends and had shoes and clothing, and said, "It's a community effort." Once the programs were in place, the number of visits to the nurse's office and discipline issues went down significantly. Meeting the basic needs of food and clothing allowed the school to then look at how to help the students' mental health issues because the relationship building among the student and families had occurred. One social-emotional health provider stated that the principal had a partnership with the community mental health center because he knew the needs of the students were larger than what a school could provide.

Professional Development Was Provided

All of the principals placed an importance on providing professional development for their staff on trauma informed practices. Building the knowledge base among their staff that behavior is driven by something was a priority. All participants referenced the Adverse Childhood Experiences study (Felitti et. al., 1999), trauma informed practices, and the effects of secondary trauma among their staff. The National Child Traumatic Stress Network (2018) defined secondary trauma as "the emotional duress that results when an individual hears about the firsthand trauma experiences of another" (para. 1). The principals indicated that meeting the mental health needs of their students was a priority, but meeting the needs of their staff and equipping them to better care of themselves was also important. There was a focus on training for all staff members, including custodians, bus drivers, cafeteria staff, paraprofessionals, and secretaries. As P1 stated, "All the children in this building are everybody's children." P1 further described that each staff member had a responsibility in helping to educate all of the children in the school and that role was clearly articulated to all staff. P6 indicated that teachers and principals are not prepared for meeting the mental health needs of students in college preparation programs, and stated, "There is so much you don't know." Participants indicated that secondary trauma among students is also prevalent. P4 stated, "I also worry about the kids in the classroom who have secondary trauma from what's going on, and we have to address it because it's affecting other kids' learning in the room."

Professional development for staff was provided in a variety of formats. Principals and their student-support personnel conducted book studies, read articles, led discussion groups, brought in experts, and partnered with professors to train their staff. Graduate students at local colleges and universities provided training to school staff members. A variety of topics were

discussed, including trauma informed practices, social-emotional wellness, bullying prevention, the effects of poverty on learning, restorative practices, autism training, and mental health first aid. Teachers held morning circles in their classrooms and implemented social and emotional curriculum in their lessons.

In addition to professional development being provided to staff, participants provided information to parents in a variety of formats. Two participants stated that pamphlets on programs were provided in the front office, information on services was provided in parent newsletters and at school programs, and the school website contained information as to what services could be provided. One district was in the process of developing an asset map that identified all community resources. This finding was supported by previously cited research in this study (Whitley, 2010).

Central Office Support Was Provided

All participants had support for providing mental health services from either the prior central office administration or the current central office administration. They indicated that it was important to their superintendent to provide mental health services. P2 stated that the superintendent understood trauma driven behavior. P3 stated that the superintendent was one of the driving forces behind the social emotional support provided to students. This superintendent also worked with the IDOE and state legislators on social emotional initiatives. Each school's central administration office had an agreement or memorandum of understanding with the local community mental health center. The central administration office had initiated the agreement with the local community mental health center. The local community mental health center provided direct therapy, case management, intake appointments, and social skills training to students within the schools. Having access to services within the schools reduced the barrier of

transportation for their children to obtain services at school. Intake appointments were also provided at some schools which helped to decrease the number of locations that families had to go to for appointments. All participants indicated positive relationships among the schools and the community mental health center. When asked if there were any concerns about the community mental health therapists coming into the schools and the perception that they may be attempting to take over the role of the social-emotional health provider, P3 stated, "We will take all the supports we can get." Each school valued the relationship with the staff at the community mental health center. One frustration articulated by all participants was the turnover rate of providers in the community mental health center, which is supported in the literature review.

Superintendents committed financial resources either through hiring additional staff, protecting positions during budget shortfalls, or applying for grants to provide services for their students. All participants indicated that support from the central administration office was vital to making sure principals and staff had the mindset to make services available for students. P5 stated that there was a cultural or paradigm shift for the school community and that the support from the school board and the superintendent was instrumental in making sure the importance of providing services was conveyed to all stakeholders. P3 stated, "My assistant superintendent knows my heart. My passion is in social emotional learning."

Terminology Used Was Selective

All of the participants identified vocabulary, or terminology, as being an important consideration in providing services and potentially removing barriers that develop through stigma attached to the term mental health. The title of the position of the social-emotional health provider was instrumental in making sure families do not confront an initial barrier by making a judgment based on the connotation of the job title. The term social worker was not utilized as

some parents viewed that position as related to child protection services or department of family services and a person who is going to take away their children. Mental health was not used since that can imply antiquated thoughts and judgments about the student's needs. "Student assistant specialist" was the title of one position in addition to "student services coordinator," "student services advisor," and "school and family liaison." In one school, the special education room where students could access supports when needed was referred to as the "student support center" instead of the traditional "special education room."

Another finding related to terminology was that participants knew what language to utilize when talking with the community mental health centers. Having an understanding of the vocabulary used in the mental health community assisted everyone in having common ground regarding the services that could be provided. Having this knowledge also reduced the amount of time it took to access services for students as everyone knew what was needed for the student. When a student needed a risk assessment or crisis assessment, there was a clear understanding of the process, assessments used, and follow up regarding the outcome. One district in a rural area of the state provided tele-therapy assessments via iPads to minimize the amount of time it takes to access services when a student is in crisis.

Relationships Among All Stakeholders Was A Priority

All participants identified relationships among the staff, students, parents, central administration office, and the community mental health center as being a priority in providing services to the students. Relationships among the central administration office included not only the superintendent but also the assistant superintendent and special education director. GM1 stated that it was important to have a great relationship with the special education teachers in the building. P3 stated that how she communicated with parents and families was one strategy used

to establish a positive relationship. “I try to be very gentle and easy to talk to,” P3 stated. P3 further explained that talking to parents about their child being in crisis is a very sensitive topic and it is important to be mindful of how information is conveyed. Many parents also have mental health needs and/or negative experiences of school, so approaching the topic with the utmost respect was a priority. All participants were intentional about their relationships with stakeholders. Finding ways to connect with parents and families and understanding their perspectives was important. P6 stated that one component of success for two students was the fact that the teacher was willing to see that the students did not have to do everything all of the other students were doing in the exact same way. The teacher was willing to make some concessions for the students based on their needs at the time. Speaking about the teacher, P6 said, “She saw the value of valuing those students. She made them important in her classroom. She had something every day they had to be there for and articulated that to the students.” P6 stated that when parents complained about having a self-contained classroom for students with emotional disabilities in the school, she shifted the focus to student safety and affirmed her values by stating, “Every child is welcome here.” P4 stated, “You have to be a relationship and trust builder to make it work.” This principal formed relationships with churches, the YMCA, and the Boys and Girls Club because, “We’re all dealing with the same kids. We’re going to share what we’re doing and our resources, and hopefully, we can all support one another to help the kids.”

Background of Principal Included Mental Health Experience

Five of the principals had a background in counseling or mental health via being married to a counselor or therapist, obtaining his or her counseling degree, or having a family member or

friend with mental health issues. Participants were not directly questioned regarding their backgrounds or family experiences, but these details emerged in the interviews. P3 stated,

> My own experiences and having hard situations, I know how important it is to have a support system to help you get through and to not give up hope. I want to give them (the students) the tools to help them be resilient and make it.

There was not sufficient data to determine if the background experiences of the principals was one of the key factors as to why providing mental health services to students was important. It can be assumed that this background played an important piece in developing the principal's mindset throughout his or her personal and professional life.

Structures Were in Place

All of the principals had a clearly defined structure, such as RtI or MTSS, for how and what services students were to receive. Staff knew what the structure and process was for accessing services for students who needed them. All of the participants indicated they had a tiered model that delineated the amount of support students could receive based on their needs. The tiered models mentioned were RtI, MTSS, and PBIS. Tier 1 support, or universal, included the teachers having daily morning circles, counselors coming into the classrooms to provide social emotional lessons, teachers trained in social emotional curriculum to provide lessons, and teachers that provide brain-based strategies involving trauma informed practices. Each school had the social-emotional health provider conduct push in lessons into the classrooms on a regular basis. Tier 2 services included the social-emotional provider conducting group lessons for particular students on anxiety, divorce, grief, bullying, and other identified needs. Functional behavioral assessments and behavior intervention plans were also provided in Tier 2 services. Tier 3 services were for students that presented significantly more behaviors and needed more

intensive services, such as functional behavioral assessments, behavior intervention plans, individual therapy sessions, home visits, family therapy sessions, medication management, behavior or social skills coaches, and case management. Teachers in the schools knew the referral process and how to make referrals for students when necessary.

Role of the Social-Emotional Health Provider Was Clearly Defined

The role of the social-emotional health provider was clearly defined in the building. In four of the schools, the role of the social-emotional health provider did not involve managing assessment, data, or punitive discipline. Their role was solely focused on student services. Instead of administering traditional discipline practices, such as loss of recess and in-school suspension, the social-emotional health provider worked with students on restorative practices. GM1, who had worked in four urban and rural schools, stated that her role in her current building was unique by focusing solely on the social-emotional needs of the students. GM1 said, "We are not the norm, and I know that." Each social-emotional health provider felt that the principal valued their expertise by consulting with them, having them provide professional development to staff, and communicating with them on a regular basis, particularly when problematic situations occurred. A subtheme under the role of the social-emotional health provider was being highly visible in the school community. They were involved in recess duty, cafeteria supervision, car duty, school assemblies, and family nights. The visibility of this position helped the students and parents to understand this person's role and see them as another teacher in the building, reducing the stigma that comes with the term "mental health." All of the social-emotional health providers were on district and community-wide committees to develop relationships outside of the immediate school building. One school created a list of mental health providers in the area to share with parents and families.

Educational Administration Programs

The standards for the top 10 graduate schools of education for educational administration and supervision programs as identified in *U.S. News and World Report* (2017) were reviewed to determine if they related to accessing community resources for students. The top 10 colleges and universities listed were University of Wisconsin at Madison, Vanderbilt University, Harvard University, Teachers College, Columbia University, University of Texas at Austin, Stanford University, University of Virginia, Michigan State University, Pennsylvania State University, and University of Washington. Member organizations of the National Policy Board for Educational Administration, such as the Council of Chief State School Officers, and the American Association of Colleges of Teacher Education, worked together to create the standards based on research and experiences of educational administrators. The *Professional Standards for Educational Leaders 2015* included 10 standards (National Policy Board for Educational Administration, 2015). After review of the standards, only one of the 10 graduate schools of education, the University of Washington, referenced the standards.

Upon review of the 10 standards, each standard conveyed a reference or objective to the educational administrator as making decisions based on the well-being of the student, possessing social-emotional insight, utilizing principles of social justice and equity, ensuring access to necessary resources, providing a healthy environment for students, providing staff with professional knowledge, and engaging families and the community. For example, Standard 8: "Meaningful, Engagement of Families and Community" identifies effective educational leaders as "approachable, accessible . . . [and they] develop and provide the school as a resource for families and the community . . . [and] advocate publicly for the needs and priorities of students, families, and the community" (National Policy Board for Educational Administration, 2015, p.

16). These standards are consistent with the findings stated earlier. The standards also reinforce the theoretical base of social justice and equitable access to resources for students.

Barriers

Physical Space Was Needed

For Research Question 2, several themes emerged regarding the administrative structures, policies, and procedures needed for students to access mental health services in school. All of the participants identified the lack of physical space in their buildings as being a barrier to providing mental health services for their students. Having adequate space for students to receive counseling services or a calming place for students to go when they needed to take a break was challenging. Some schools had former closets being utilized when students needed a quiet place for a while and every space in the building was utilized. Spaces in the building for students to go voluntarily when they needed a break in the schools were referred to as calming rooms, regulation rooms, reset rooms, and amygdala rooms. It was difficult to provide quality, confidential counseling services if the space was being shared by other students who needed the same services. Confidentially must continually be adhered to, and the lack of space makes it difficult to provide services to more families. P3 stated that more counselors are needed in the building, but "I have no space for them." Many of the schools have the classroom teachers provide a space in the classroom if students need a place to reset, calm down, or take a break. In the classrooms there are flexible seating options, yoga balls, standing desks, scoop chairs, and items that students can use to address their sensory needs. P1 was the first participant to state that meeting the needs of students starts with class size: "Everybody knows that that relationship is key to learning. And so it's extremely difficult when you have that many students in a room to

actually reach them and be able to develop relationships. It's a true equity issue." This concern was articulated by other participants.

Funding Sources Were a Concern

All of the participants identified funding of services as being a barrier to provide mental health services to students. Many of the students that received mental health services through the partnership with the community mental health center were eligible for Medicaid. Schools and districts were creative at looking at their existing resources but also sought additional resources. All but two of the participant's school districts received the Lilly Counseling grant. The Lilly Counseling grant provides professional development opportunities and curriculum development for staff. One district utilized the grant funds to hire a social emotional wellness coach and another district used the grant funds to hire a student success advocate. Concern was stated by all participants as to the continuity of services once the grant cycle was completed. Existing school financial resources included blended funding among general funds, Title 1, and special education. GM4 discussed the frustration of decreasing financial resources given the presence of student needs. GM4 said, "We have more knowledge now, and it would be nice to have the resources we had 20 years ago."

CHAPTER 5

SUMMARY, DISCUSSION, IMPLICATIONS, CONCLUSIONS

The purpose of this study was to learn what school practitioners state are the competencies needed in order for school administrators to access school-based mental health services for students. Through this qualitative study, the school structures needed to provide mental health services for students were explored. This study sought to obtain understanding of the phenomenon as to why and how elementary principals provide access to mental health services to students.

Summary and Discussion of Findings

The interviews consisted of semi-structured questions to provide for uniformity between interviews but also allowed opportunities for individual responses as well as for probing and clarification. Conducting the interviews in person and on the school campus allowed a better understanding of the school demographics and needs of the students and community. The participants had experience providing school-based mental health services and were committed to ensuring that students' mental health need were met regardless of the barriers. The participants represented schools throughout the state of Indiana from various regions geographically. The average number of years of experience as a principal among participants was 9.6. The average number of principals that the social-emotional behavioral health provider worked with was 9.5. The average number of years of experience in the role of social-emotional

health provider was 14.5. The themes, sub-themes, and supporting data provided a detailed synopsis of the interviews conducted with principals, guidance counselors, mental health practitioners, and school social workers. Themes that emerged were consistent among the two groups. The following provides an overview of the findings from this research study.

Why/Mindset That Mental Health Was a Priority

The theme of school principals being the key player in determining how mental health programs become implemented in schools was supported by research previously cited in this study (Beidas et al., 2012; Gottfredson & Gottfredson, 2002; Kam et al., 2003, Langley et al., 2010). The passion and desire to see students with significant needs succeed was prevalent in all participants, and this message was consistently conveyed across stakeholders in the school community. The message that the academic needs of students cannot be met until the mental health needs are met was consistent across participants. These comments made by participants did not reflect the tie among academic and behavioral instruction. Program implementation being dependent on the building principal was supported by research previously cited in this study (Gingiss, 1992; Gottfredson & Gottfredson, 2002; Kramer et al., 2000; McMahon et al., 2000).

Professional Development Was Provided to Staff

All participants indicated that providing professional development to all school staff, not solely teachers, was instrumental in providing mental health services to students (Iachini et al., 2016). Professional development was provided in a variety of formats, including providing in-service opportunities, providing book studies, reading articles, having discussion groups, and having professors and experts in the field work with staff in the building. Ongoing professional development was mentioned as necessary. All participants identified the adverse childhood

experience (ACE) study as part of their rationale for providing mental health services to students. School staff members were trained on the ACE study and its implications that provided a better understanding as to the reasoning for meeting the social emotional needs of students in schools. Figure 2 provides a model of the potential influences throughout the lifespan of adverse childhood experiences.

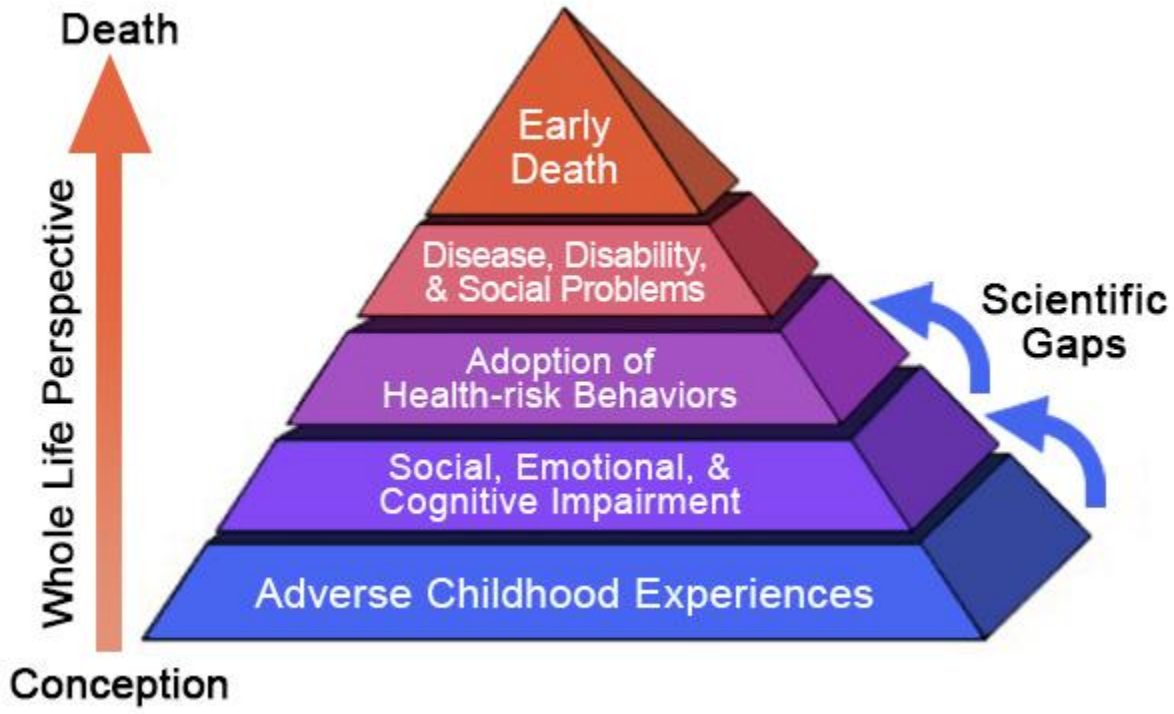

Figure 2. The mechanism by which adverse childhood experiences influence health and well-being throughout the lifespan (ACE) study. From the Ace Pyramid by Centers for Disease Control and Prevention (n.d.). From "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults" by V. Felitti, et al., 1998 (https://www.cdc.gov/)

Central Administration Office Support Was Provided

All participants identified having support from the central administration office, specifically the superintendent, was vital in making sure students have access to mental health services. GM1's statement reflected the direction and commitment from the superintendent when he said, "We have to make this work." For respondents who had a change in principals or superintendents in buildings where mental health services were already being provided, the social-emotional health provider informed the new principal and/or superintendent as to the importance of the services being provided for students and families. Support from central administration was primarily financial in terms of committing resources, providing resources, or finding community resources to provide services. The theme of central office support was supported by research previously cited in this study.

Terminology Used for Social-Emotional Health Providers Was Selective

All participants identified avoiding vocabulary that had a negative connotation toward mental health services. The terms used for the space for students to go to were focused on reducing stigma attached to the word. The term "time out" was not referred to by participants. The title of the social-emotional health provider was also important to alleviate a barrier for students and families to access services. Terminology was not an area that was identified in the literature review cited in this study.

Relationships Among All Stakeholders Was A Priority

All participants had a partnership with the local community mental health center. Having this partnership was instrumental in accessing services for students and their families. The theme of having partnerships with community agencies to meet students' mental health needs was supported by research previously cited in this study (Meldrum et al., 2009; Paternite, 2005;

Walsh & Galassi, 2002; Weist, 2005; Weist & Evans, 2005). Participants cited that relationships with the community was a key factor in making sure everyone was working together to meet the needs of the students. Community relationships included those with churches, businesses, social service agencies, and service clubs.

Background of Principal Included Mental Health Experience

The majority of the principals in this study indicated that they had backgrounds in mental health, whether it was through personal or professional experiences. It was not known if this background directly contributed to the reasons why the principals provided access to mental health services to students. Questions were not asked specifically of participants regarding personal background in mental health yet responses were shared during the interviews. There was not previously cited research in this study to support this finding.

Structure of Services Were in Place

Each school had a defined tiered-intervention process that articulated what services students would receive. Several models of tiered services, such as RtI, MTSS, and PBIS, were identified. Teachers were educated on how to refer a child for services. The theme of having a clearly defined structure for providing services in meeting the needs of students was supported by previously cited research in this study (Desrochers, 2014, 2015; Vaillancourt & Amador, 2014/2015).

Role of Social Emotional Health Provider Was Clearly Defined

Each school clearly defined the role of the social-emotional health provider and did not assign responsibilities for discipline, assessment, or other administrative duties to the position. The person in the position was responsible for coordinating services with the community mental health center. Visibility throughout the school and at school events was an important role of the

position. Students and parents viewed the social-emotional health provider as another school resource like a teacher, not someone who is providing mental health or social work services to their child. The theme of the role of the social emotional health provider was not supported by research previously cited in this study.

Educational Administration Programs

The theme of lack of training for teachers and principals in knowing how to meet the mental health needs of students was supported by previously cited research in this study (Caparelli, 2011, Rothi et al., 2008; Santor et al., 2009, Walter et al., 2006). None of the principals in the study cited the standards in their educator preparation programs as being a component in addressing the mental health needs of students. Only one of the top 10 graduate schools for educator leadership preparation referenced the Professional Standards for Educational Leaders. The Professional Standards for Educational Leaders identify principles building leaders are required to know in order to access resources that meet the needs of students.

Barriers

Lack of adequate physical space was a concern. All participants identified the lack of space as being a barrier in providing adequate mental health services for students. Helping students and families feel comfortable in a private space and respecting confidentiality was a priority. Teachers had spaces in their classrooms so students could access a quiet area when needed. These spaces included calming objects and sensory items that were utilized by the students. The theme of adequate space was not supported by research previously cited in this study.

Funding of services was a concern. Funding of services was identified as a barrier for families. Funding provided through Medicaid was the primary way that schools were able to provide individual mental health services to students. Eight of the schools in the study received the Lilly Counseling grant. Concern regarding the continuity of programs once the grant cycle was completed was expressed. The theme of lack of funding was supported by previously cited research (Bruder, 2010; IDEA, 2004; Whitley, 2010).

Implications and Suggestions for Further Research

This study provided a foundation to explore further avenues related to accessing mental health services for students. The results of this study prompted additional areas of exploration for the provision of mental health services in public schools.

Implications for Policy

Throughout the interviews, every participant identified funding as being a barrier to providing access to mental health services in schools. All of the schools relied on the use of Medicaid funds and a partnership with the community mental health center to provide services to students. Further research needs to be conducted to look at alternative methods for funding services. If Medicaid funds are no longer available, many students and families will no longer have access to mental health services at school. What are the policy implications of relying on state and federal funds if the program is altered or eliminated? The concept of blending and braiding funding streams should be explored as a way to capitalize on all revenue sources for schools. Many school districts utilize grants to provide services to students yet human capital is needed to further explore available grant opportunities. As with any grant program, once the grant cycle is completed, the question of sustainability presents itself.

Implications for Higher Education Programs

Colleges that have school administrator preparation programs should have clearly articulated standards that identify principals as having knowledge of how to access resources for their students. Professional preservice education and certification programs require further research in capitalizing on the knowledge base of the mental health field. There are a great deal of free resources available to inform school administrators on evidence-based practices, yet effort needs to be made to make this a priority. Given that a significant amount of administrator's time is spent on community resources, soliciting the assistance of community leaders from non-profit organizations, community mental health centers, the juvenile justice system, and others would be beneficial in building the knowledge base of available resources and knowing how to navigate the system. The emphasis that college preparation programs place on accessing mental health services for students should be studied. The reason why more colleges and universities that prepare educational administrators are not utilizing the Professional Standards for Educational Leaders needs to be explored. This study focused on why building principals provide access to mental health services to students. Further research of principals who do not provide access to these services and the reasons for such should be explored.

Implications for Buildings and District Level Leadership

Each school district in the study had a partnership with a community mental health center. Further research exploring the components of a successful relationship among school districts and community mental health centers would allow others to emulate those practices. Successful relationships require time and effort among participants. When there is staff turnover in schools and community mental health centers, having established protocols and channels of

communication enable services to continue without interruption. Onboard processes for hiring new staff should include identification of all community partnerships.

The support from the central administration office was crucial in providing support to the principal and schools. Many programs for providing mental health services to students were identified by participants and were identified in the research literature. Further research regarding the most effective programs or structures for various types of schools would provide guidance for administrators. Are there more effective programs for students in rural, suburban, and urban areas? Are there significant differences in evidence-based programs among elementary and secondary schools? Are there noticeable differences in programs provided at private, parochial, and charter schools? Are there differences in programs for students from different socioeconomic, cultural, and ethnic backgrounds?

The why/mindset of the principal is key in providing mental health services to students. The relationship between providing access to mental health services and student achievement data should be an area of further research. What are the specific outcomes in relationship to school-based mental health services? Do mental health services significantly affect graduation rates and employment outcomes? Do students who receive school-based mental health services report a better quality of life in adulthood than those who did not receive those services? Does providing school based mental health services results in fewer students needing to access more intensive mental health services?

Principals in the study identified a clearly articulated system that addressed student needs at different levels. Does the MTSS process actually delay students at the neediest level from getting services? Is the identified system person dependent or does it operate seamlessly in the absence of key members? What kinds of services are most effective and align with the school's

vision and mission? What have been the arguments for using universal screeners for behavioral health with all students? What are the ethical and legal implications for schools that have knowledge a student has a mental health need and does not receive services to address that need? All schools in the study had an existing relationship with a community mental health center. Further research delving into the genesis of that relationship and the specific actions involved in that process is warranted.

Summary

This research study provides insight into an area that has not received a great deal of attention. The education and mental health community understand the importance of providing access to mental health services to students and knows there are evidence-based programs that exist, yet there is little known as to why more educational administrators do not provide or promote these services to their students. I was initially surprised by the discovery that all of the schools had an agreement with a community mental health center. There are still a great deal of schools and school districts that do not have a relationship with a mental health center, so it was a nice discovery to realize there were more agreements than I initially anticipated. I was also disappointed that only one of the top 10 graduate schools of education referenced the Professional Standards for Educational Leaders. More college and university preparation programs need to make sure that what they are teaching their students is in concert with research from the field. Further ongoing professional development and support for administrators need to focus on this area.

I was continually impressed by the passion and desire each participant possessed to make sure their students were receiving services that met their needs. Each participant displayed a “do whatever it takes” attitude and understood the importance of meeting the mental health and

emotional needs of the students before they could meet their academic needs. Each participant also conveyed the importance of working closely with families in order to help their child. The positions of school administrator are difficult and become increasingly challenging given the complexity of student needs. P1 summarized the unwavering commitment to meeting the mental health needs of students: “This is my mission in life.”

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APPENDIX A: INTRODUCTORY EMAIL

Greetings Colleagues,

I am writing you today both as a colleague and a researcher engaged in the dissertation process through Indiana State University. The purpose of my qualitative case study is to investigate the competencies needed for school administrators to access school-based mental health services for K-6 students in public schools in the state of Indiana. The goal of the research is to inform practice and policy.

A majority of the previous research related to my study indicates that 20% of children have had a mental health condition at some point in their lives. Of the 20% of this population, only 20% have received services that meet their mental health needs. The problem, from a practitioner's perspective, is that we know there is a significant need for students to have mental health services, but we don't know why more schools aren't facilitating these services for their students.

I am looking for 10-12 school psychologists, school social workers, mental health practitioners, guidance counselors, and elementary principals who have experience providing or supervising school-based mental health services to be participants in my study. Participants should have at least a Master's degree and licensure that allows them to provide school-based mental health services, such as national certification as a school psychologist, a licensed clinical social worker, a licensed marriage and family therapist, a licensed mental health counselor, or a principal's license. Participants should have worked with students in an elementary school

setting who have an identified emotional disability per Indiana's special education law, Article 7, or a DSM-V diagnosis of a mental health disorder. I will collect data by creating an audio recording of one-on-one interviews with the participants. The recording will be transcribed and coded for analysis. Participation is voluntary and confidential. No personal or district identity will be revealed in this study. I hope to conduct interviews this winter. I anticipate that the interviews will last sixty minutes. The interviews will be scheduled at the preferred time and location of the participant. I will provide each participant with a copy of the transcription of the interview to ensure that I've accurately captured the information relayed during the exchange. It is possible that I may follow-up with participants via phone or email during the data analysis process to ask clarifying questions.

This is an important topic in our field. I am optimistic that I will receive a strong response of interested and potential subjects to assist me with this research. If you are interested in participating in this study, please contact me at my personal email address: wendybayak@gmail.com Thank you for your assistance in this process.

Your time and consideration is appreciated,

Wendy L. Hite

APPENDIX B: INTERVIEW PROTOCOL

Interview Protocol
Date:
Time:
Location:
Interview Number:

Thank you for your agreement to meet for this interview. The purpose of this interview is to gather information about the competencies needed for school administrators to access school-based mental health services for their students. The information collected will be recorded, transcribed, and stored in a secure database. This interview will be confidential and will not be shared with anyone. At any time you may decide to withdraw participation from this interview.

APPENDIX C: INTERVIEW QUESTIONS FOR GUIDANCE COUNSELORS, SCHOOL SOCIAL WORKERS, SCHOOL PSYCHOLOGISTS, AND MENTAL HEALTH PRACTITIONERS

1. Do you believe it is important to your building principal to provide school-based mental health services to students? What does that look like?
2. Do you believe it is important to your superintendent to provide school-based mental health services to students? What does that look like?
3. How do you promote the use of school-based mental health services?
4. In your experience with school-based mental health services, what characteristics did you possess that promoted the use of school-based mental health services?
5. In your role, do you provide school-based mental health services to students? If yes, what kinds?
6. Does your school have a partnership with a community mental health center or a private mental health center?
7. If yes, what kinds of services do they provide to the school?
8. What do you perceive are the administrative barriers to providing school-based mental health services?
9. Were there any major obstacles for your school that made implementing and sustaining school-based mental health services difficult?