PROFESSIONAL AND CLINICAL SUPPORTS FOR SCHOOL PSYCHOLOGISTS AS MENTAL HEALTH PROVIDERS IN SCHOOLS

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Abstract

Many students with mental health problems are only receiving mental health services in schools. Yet, the role of the school psychologist continues to be narrowly defined as an evaluator. This study surveyed 93 school psychologists working in schools in Central New Jersey to investigate areas of professional development and clinical supports for the delivery of mental health services such as supports needed, frequency and usefulness of in-service professional development, preferences for formats for training, opinions about clinical supervision, and preferences for clinical supports. Additionally, this study surveyed 41 school administrators working within central New Jersey to ascertain their willingness and opinions about feasibility for implementing professional development and clinical supports for school psychologists. Participants' type of degree was examined in relation to the above-mentioned components. Results revealed that school psychologists indicate professional development, resources and administrative support as needed to provide mental health services. Unfortunately, school psychologists do not have access to in-service professional development. Professional development that addresses areas of interest are perceived as useful along with preferred styles of trainings, which are discussion and case study. Similarly, school psychologists are not receiving clinical supervision, but are willing to engage in alternative forms of clinical supports such as case conferencing, topic-specific meeting, mentoring with a small group of peers with an experienced peer and mentoring with an experienced peer. However, most school psychologists are only willing to participate in these activities annually or on an as-needed basis. Fewer school psychologists are willing to participate monthly and even less

weekly. School psychologists with doctoral degrees reported greater levels of competency than masters level school psychologists in individual counseling, group counseling, mental health screening, provision of mental health services, and consultation. School administrators perceive single session training as feasible to implement along with other clinical supports that occur monthly. Other supports that occur more frequently are perceived as not as feasible with less likelihood of being implemented. Future research should survey school psychologists and administrators from other areas in New Jersey and other states. Additionally, further research should clarify the role of the administrator as one that supervises school psychologists.

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A final comment is to acknowledge the importance of setting goals. We can imagine where we want to be, but we need to adhere to the nonlinear path to get there.

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Statement of the Problem

The role of the school psychologist is evolving to better meet the needs of children and adolescents with mental health issues. Mental health services in the schools are often the only treatment these students receive (Farmer, Bruns, Philip, Angold, & Costello, 2003; National Association of School Psychologists, 2008). Even though the shift in the school psychologist's role is supported by the National Association of School Psychologists (NASP), the evolution of the school psychologist's role is a slow process, with much resistance from systemic factors within organizations (Hanchon & Fernald, 2013; National Association of School Psychologists, 2008). The revised Blueprint III in 2006, a document outlining domains for school psychology practice and training, acknowledges the paradigm shift in school-based psychological services from assessment practices toward broader services that meet the instructional, social and emotional, and mental health needs of students (Ysseldyke et al., 2006; Ysseldyke, Burns, Rosenfield, 2009). NASP's policy statements outline the expectations of the role of a school psychologist, and specifically emphasize the provision of mental health services to schools, children, and families (NASP, 2010).

There remains a discrepancy between aspirations in the field of school psychology and school psychologists' practices (Ysseldyke et al., 2009). Multiple studies show that school psychologists still spend a majority of their time involved in isolated activities related to special education eligibility such as assessment, report writing, and case-conferencing (Bramlet, Murphy, Johnson, Wallingsford, & Hall, 2002; Curtis et al., 2008; Curtis, Castillo, & Gelley, 2012; Suldo, Friedrich, & Michalowski, 2010, Hanchon & Fernald, 2013). Limited time for mental health services such as counseling, crisis

intervention, and consultation does not allow school psychologists to practice these aspects of their training. Often times administrators, school personnel, and school staff are unaware of the breadth of the school psychologist's role.

Current research has examined systemic factors that inhibit the role of the school psychologist in a mental health capacity (Splett, Fowler, Weist, McDaniel, & Dvorsky, 2013; Suldo et al., 2010). Many of the systemic factors are related to the traditional notion of the position, which include, but are not limited to, large caseloads for which school psychologists are required to manage and conduct psychological assessments as well as write psycho-educational reports, manage cases, and facilitate meetings. Important systemic factors that impede the school psychologist's ability to embrace the expansion of the role are the need for administrative support for professional development (Suldo et al., 2010), clinical support and supervision related to the provision of mental health services (Curtis et al., 2008; Splett et al., 2013), and inadequate training and limited professional development (Splett et al., 2013). School psychologists report needing more professional development in the areas of consultation (Ysseldyke et al., 2009), individual and group counseling and crisis intervention (Adamson & Peacock, 2007; Hanchon & Fernald, 2013: Nickerson & Zhe, 2004; Suldo et al., 2010).

The expectations from NASP are that school psychologists will receive quality training in graduate schools to provide mental health services and that quality training will be available in work environments (NASP, 2010). Included in the revised Blueprint III document is the importance of developing skills as a lifelong process, which requires continuous professional development to maintain competence (Splett et al., 2013; Ysseldyke et al., 2009). Yet, in numerous studies school psychologists report a need for

additional professional development to provide mental health services (e.g., Leffler, West, Jackson, McCarty, & Atkins, 2013; Perfect & Morris, 2011; Ringeisen et al., 2003; Splett et al., 2013; Suldo et al., 2010).

Purpose of the Study

Several factors have been identified in the research that help explain the slowly changing role of the traditional school psychologist to a broader role with an emphasis on mental health: (a) lack of administrator knowledge about school psychologists' roles and expertise; (b) too many competing special education eligibility responsibilities; (c) large caseloads; (d) limited time; (e) need for more professional development, and (f) need for clinical supports and supervision (e.g., Leffler et al., 2013; Perfect & Morris, 2011; Ringeisen et al., 2003; Splett et al., 2013; Suldo et al., 2010). Aspects of professional development and clinical supports have not been included in the current literature (Armistead, Castillo, Curtis, Chappel, and Cunningham, 2013: Splett et al., 2013). For this reason, the purpose of this study is to explore, through surveys, these two inhibiting factors that contribute to the slowly changing role of the school psychologist: the need for more (1) professional development at one's place of employment (i.e., in-service trainings) and (2) clinical supports.

There is a paucity of research addressing the usefulness and perceived quality of professional development offered at one's place of employment, also referred to as in-service trainings (Splett et al., 2013). Further, confusion regarding the role of the school psychologist often leads to limited or irrelevant professional training offerings at places of employment. School psychologists often are required to attend trainings unrelated to their role. There is limited research investigating how often school psychologists receive

in-service training related to their roles (Armistead et al., 2013; Bramlet et al., 2002). Only one study asked school psychologists to describe in-service trainings (Armistead et al., 2013). Some of their responses were "generic" and "ineffective" (Armistead et al., 2013). The Bramlet et al. (2002) and the Armistead et al. (2013) studies do not specify whether trainings were useful to the provision of mental health services. None of the studies considered school psychologists' opinions about formats of in-service trainings (Splett et al., 2013). Much of the professional development in the field of school psychology utilizes a didactic model with a lecture format that does not consider best practices in adult learning (Neimeyer, Taylor, & Rozensky, 2012; Splett et al., 2013).

Another area insufficiently addressed in the current literature is the need for clinical supports for school psychologists when addressing the mental health needs of students. Two types of supervision noted in the literature are administrative supervision and clinical supervision (Bramlet et al., 2002; Curtis et al., 2008; Curtis et al., 2012). Clinical supervision differs from administrative supervision, which typically involves a superior in an employment setting (e.g., school) addressing organizational and personnel issues (Graves, Proctor, & Aston, 2014), and ensuring school psychologists are compliant with state laws and completing job assignments within an expected period of time (Curtis et al., 2008). Definitions for clinical supervision vary. This study will define clinical supervision as an interpersonal interaction with a clinical supervisor with the same discipline-specific training and knowledge who models and teaches skills through case conceptualization, sharing of knowledge, objective feedback and discussion of practice, and provides support during and after challenging situations (Harvey & Pearrow, 2010; McIntosh & Phelps, 2000).

Current findings show that school psychologists receive mostly administrative supervision, not clinical supervision (Bramlet et al., 2002; Curtis et al., 2008; Curtis et al., 2012). An exploration of alternative approaches to clinical supervision, such as peer supervision and mentoring, has the potential to be applied to various work settings to help broaden the role of a school psychologist to a mental health provider (Fischetti & Lines, 2004; Splett et al., 2013).

School psychologists receiving clinical support and who are engaged in meaningful and useful professional development trainings often provide more mental health services (e.g., Meyers & Swerdlik, 2003; Suldo et al., 2010). To address these gaps in the current literature, the following research questions will be explored:

Research Questions

1. What types of supports do school psychologists need to feel competent providing mental health services?
2. How often do school psychologists attend in-service professional development related to their role as mental health providers?
3. To what extent are in-service professional development activities addressing mental health services useful in practice?
4. What styles of in-service professional development addressing mental health services foster the most learning for school psychologists?
5. How often do school psychologists receive clinical supervision at their schools?
6. What clinical supports do school psychologists deem useful for the provision of mental health services?

7. Are these differences in the above responses based on school psychologists' educational level?
8. To what extent are administrators willing to implement in-service professional development related to the provision of mental health services and clinical supports for school psychologists?
9. Do school psychologist administrators' attitudes differ from other types of administrators towards these activities?

CHAPTER II: Review of the literature

Students in Need of Mental Health Services

There is a growing population of children and adolescents with mental health issues in this country. It is estimated that 20% of children and adolescents have a diagnosis of an emotional, psychological, or behavioral disorder (National Advisory Mental Health Council's Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001). The Centers for Disease Prevention (CDC) reports that between 2005-2006 around 8.3 million children, aged 4 to 17, approximately 14.5% of the population, have parents that contacted school professionals or mental healthcare providers to address mental health issues (Simpson, Cohen, Pastor, & Reuben, 2008). Further, the majority of children and adolescents with mental health issues only receive treatment within their schools (Farmer, Bruns, Philip, Angold, & Costello, 2003; National Association of School Psychologists, 2008).

One study reported that in any one year between 11% and 12% of children with mental health issues receive mental health support from the schools while only 4% and 7% report receiving mental health support from clinics and hospitals (Farmer et al., 2003). Accessing mental health services out of school can be costly and oftentimes the demand for services is greater than the availability (Hanchon & Fernald, 2013). In addition, there is a stigma surrounding mental health services (Hanchon & Fernald, 2013). All of these barriers affect the availability of mental health services to low-income population, who often need it the most (Hanchon & Fernald, 2013; Masi & Cooper, 2006). Providing mental health services in schools is cost-effective and services are available (National Association of School Psychologists, 2008).

Research findings report that students with emotional and behavioral disorders have poorer educational outcomes than students with other disabilities (Chafouleas, Volpe, Gresham, & Cook, 2010; National Center for Special Education Research [NCSER], 2013). These students have higher drop-out rates, are more likely to report higher use of alcohol and illegal drugs, and have greater chances of involvement in the criminal justice system or mental health facilities (e.g., Chafouleas et al., 2010; Heathfield & Clark, 2004; NCSER, 2013; Perfect & Morris, 2011). It is known that attending to students' mental health needs has the potential to increase academic performance (Reddy, Thomas, Newman, & Chun, 2009). Still, students with severe mental health needs do not always receive adequate services (e.g., Heathfield & Clark, 2004; NCSER, 2013; Perfect & Morris, 2011). This is surprising since this population of students consumes a large portion of many schools' resources when they are not provided with mental health services outside of the school setting. The cost for servicing these students within a school district is very expensive (e.g., Heathfield & Clark, 2004). When students' behaviors and problems exceed the support services available at a school they are often placed in an alternative setting outside of the district, which results in higher costs to school districts over time. Improving schools' mental health services has the potential to lower future financial expenses (e.g., Heathfield & Clark, 2004).

Students with emotional and behavioral disorders are not the only students in need of mental health services within the schools. Children and adolescents with mental health issues, like those children with learning disabilities, physical disabilities, developmental disabilities, or chronic health issues in general, also need to qualify for intensive mental health services in schools. If evidence from comprehensive evaluations supports the need

for service, many students might receive special education and related services under a variety of special education classifications (e.g., Learning disability, Autism, Other Health Impaired). However, currently, only about one percent of the student population has a classification of emotional disturbance (ED). Under this classification, schools are required by law to provide these students with consistent mental health services (e.g., counseling, behavior intervention plans). Students that do not qualify for special education with mental health services are still in need of these services in the school. Heathfield and Clark (2004) report that approximately 70% of children in the general education population with mental health issues do not receive any services in or out of school.

Children and adolescents with mental health issues in the schools can have an array of diagnoses, with some symptoms more obvious than others. Expressions of mental health issues range from severe (e.g., Clinical Depression, Bipolar, ADHD, psychosis) to mild (social difficulties, mild attentional issues). Some students exhibit severe symptoms that are easily identifiable, while some symptoms are nuanced and difficult to identify. Additionally, typical development has many social and emotional developmental challenges. Along with typical development, many students experience family crises (e.g., illness, divorce, unemployment) that impact their mental health and ability to adjust to school. Addressing these mental health challenges through the delivery of mental health support in schools can provide students with opportunities to succeed academically. Without help, psychological and emotional distress severely compromises a child's ability to learn as well as limiting future success and well-being.

History of Mental Health Services in School

Mental health services in the schools are not a new concept. Early documentation starts in the late 1800s when an individual, who is now referred to as a school social worker, visited schools to prevent further deaths of students from low socioeconomic backgrounds exhibiting psychological difficulties (Sedlak, 1997 as cited in Perfect & Morris, 2011). The first university school mental health clinic was established in 1896 to address the learning needs of students with intellectual or sensory impairments (Sedlak, 1997 as cited in Perfect & Morris, 2011). Meyers and Swerdlik (2003) describe school-based mental health centers as various services located within a school that exceed traditional notions of education:

These may include: (a) health services such as screenings, school physicals, immunizations; (b) mental health services such as group or individual counseling and a variety of psychoeducational services; (c) social services designed to link students and their families with needed resources such as housing, food stamps, and parenting support or assistance; and (d) health promotion and primary prevention services addressing such issues as drug abuse, bullying, nutrition, smoking, and sexual risk-taking. (Bucy, Meyers, & Swerdlik, 2002; Dryfoos, 1994 as cited in Meyers & Swerdlik, 2003, p.253)

A small number of school-based mental health clinics are in existence today. However, insufficient resources hinder the expansion of these programs (Perfect & Morris, 2011). An additional barrier to the implementation of school-based mental health clinics is the perceived narrow role of the school psychologist (Meyers & Swerdlik, 2003). If utilized according to their training, school psychologists could potentially be involved in multiple components of mental health services, with or without the school-

based mental health clinics. Examples of multiple components of mental health activities include (a) collaboration and consultation with school staff, parents, students, and community; (b) provision of indirect and direct mental health services, and (c) communication of evidence-based prevention and intervention knowledge (Meyers & Swerdlik, 2003). Without school-based mental health clinics, schools can still provide mental health services through alternative approaches.

Provision of Mental Health Services

Addressing the mental health needs of students without comprehensive school-based mental health clinics is possible. One approach is expanding the role of the school psychologist within a school. The school psychologist differs from other mental health providers, such as social workers and school counselors, as the graduate training of the school psychologist focuses on learning, in addition to mental health (Suldo et al., 2010). This dual training model fosters school psychologists' knowledge of mental health needs as well as educational needs. However, it most likely contributes to the confusion regarding the role of the school psychologist and how best to utilize the school psychologist. School psychology graduate education requires students to take coursework to address mental health issues in schools, rendering them able to provide mental health services (Hanchon & Fernald, 2013; Splett et al., 2013; Suldo et al., 2010). However, addressing mental health issues in schools effectively requires ongoing professional development.

School psychologists taking a greater role in mental health services often are involved in various indirect and direct related services. Examples of such services include individual and group counseling, prevention and mental health screening, crisis

intervention, consultation and behavioral assessment (Perfect & Morris, 2011). Each mental health service will be explained in the subsequent paragraphs to illustrate what the school psychologist's role as a mental health provider can entail within a school. Each mental health service provides its own challenges for school psychologists that can potentially be supported through in-service professional development and clinical supports. Once implemented, in-service professional development and clinical supports are likely to increase school psychologists' involvement in these mental health services (e.g., Splett et al., 2013).

Individual and Group Counseling

One of the primary mental health services that school psychologists provide in schools is individual and group counseling. The generic term "counseling" is generally used in research literature and commonly in schools to describe therapy, educational training, psychotherapy, and psychoeducational counseling (Hughes & Theodore, 2009). Counseling services, by law, include ongoing development, implementation, and management of psychological services for a student (Jacob & Hartshorne, 2007). Counseling is a direct service in which a trained school professional works with a student to develop a relationship that becomes the pathway to changing a student's maladaptive behaviors (Hughes & Theodore, 2009).

The rationale for counseling in schools typically varies according to the individual student. There are different types of counseling in the schools. Some students receive counseling, with parental permission, during a crisis situation, or if it is found that behavioral, emotional, and/or social problems are negatively affecting a student's ability to academically perform at grade level (Hughes & Theodore, 2009). While important,

these types of counseling are generally informal and short-term (Hughes & Theodore, 2009). Other students receive counseling as a service as part of their Individualized Educational Program (IEP). In the IEP, counseling services are described in terms of how often the student receives the services; if the student receives it in a group of a certain number of students or individually; the duration of the session; and where the session will take place.

Recommendations for counseling in the schools are determined by the degree to which emotional, social, and/or behavioral problems and interpersonal functioning adversely affect a student's academic performance. Children with the following difficulties often receive counseling services: (a) externalizing problems, (b) internalizing problems, (c) learning and mental disabilities, and (d) severe and pervasive pathology (Nicholas, Foots, & Grigerick, 2009). However, proximal environmental factors (e.g., external to the child that can affect behavior) within the school must not create and maintain the problem, otherwise counseling services would be deemed unnecessary (Hughes & Theodore, 2009).

Part of the role of the school psychologist in providing counseling is the careful selection of appropriate interventions that align with students' needs. Positive outcomes such as emotional, social, and cognitive behavioral changes can result from counseling in schools that match appropriate intervention strategies with presenting problems (Hughes & Theodore, 2009). The school psychologist selects an intervention that targets the student's social and emotional needs. Appropriate intervention strategies need to be evidence-based as national laws such as the Individuals with Disabilities Education Improvement Act (2004) and No Child Left Behind mandate the use of evidence-based

practices in the schools (Forman, Olin, Hoagwood, Crowe, & Saka, 2009). Examples of commonly used evidence-based practices in counseling include cognitive behavioral strategies, modeling, and reinforced practice; all of which have been shown to be effective in treating specific problems such as anxiety and depression (Nicholas et al., 2009).

Prevention and Mental Health Screening

Multi-tiered system of supports (MTSS) is a framework schools use to identify and address mental health problems (Desrochers & Houck, 2013). The MTSS, similar to other frameworks, includes multiple levels of support to address student needs (Desrochers & Houck, 2013). Supports within the first level promote a positive school climate (Desrochers & Houck, 2013) and use preventive and screening strategies to identify students in need of mental health services or exhibiting at-risk behaviors (Suldo et al., 2010). Preventive practices within the first level of support aim to address many aspects of a student's psychological, emotional, and social development. Preventive programs can range from violence prevention to substance abuse prevention (Brown & Bolen, 2008) to suicide prevention education (Joe & Bryant, 2007). School psychologists play an active role in all levels of mental health supports within this framework. However, their participation as a facilitator of preventive programs, consultant to other staff members, and an assessor within the screening process, is essential within the first level of support.

Mental health screening encompasses indirect and direct mental health services and is typically a responsibility of the school psychologist. Accurately identifying students of all ages with mental health problems can prevent symptoms from evolving

into mental and emotional disorders that impede learning and social development (Feeney-Kettler, Kratochwill, Kaiser, Hemmeter, & Kettler, 2010). For example, depression is a mental health problem that can go unnoticed. Oftentimes, students with internalizing disorders (e.g., anxiety, depression) are not identified as "at-risk" since much of the attention from staff focuses on students with externalizing disorders (e.g., ADHD, Conduct Disorder). Part of suicide prevention is assisting with the implementation of curricula designed to teach suicide prevention (Joe & Bryant, 2007). School psychologists can also teach school staff members through in-service trainings how to identify depressive symptoms and follow procedures such as notifying a school psychologist in these situations (Joe & Bryant, 2007). Once notified that a student exhibits depressive symptoms school psychologists screen for suicidality, which helps decrease suicides and injuries from suicide attempts (Peebles-Wilkins, 2006 as cited in Joe & Bryant, 2007).

Crisis Intervention

Another responsibility of a school psychologist as a mental health provider is to intervene during a crisis situation, regardless of whether it is an individual student crisis or school-wide. Individual student crises require urgent temporary assistance to help a student address a troubling event or situation that causes behavioral, psychological, emotional, or physical distress (Suldo et al., 2010). Examples of individual crisis services include using de-escalation techniques when a student is unable to self regulate, assessing suicidality and homicidality and taking appropriate action, (Suldo et al., 2010), and peer mediation (Nickerson & Zhe, 2004). School-wide crises are broader in scope and impact most or all members of the school. Examples of school-wide crises are the

expected or unexpected death of a student or school member, violence in or outside of the school, community crisis (e.g., natural disaster), war, and man-made disaster (Nickerson & Zhe, 2004).

School psychologists play a significant role during crisis situations as the call for immediate action often takes precedence over other responsibilities. Nickerson and Zhe (2004) surveyed 197 school psychologists from NASP to learn more about school psychologists' crisis intervention experiences and practices. The most prevalent crisis situations reported by respondents were suicide attempts, physical aggression and assaults between students, illnesses and deaths, and students bringing weapons and guns to schools. The most frequently employed strategy was a crisis response team. To navigate crisis situations the recommended procedures are for schools to develop crisis management plans and crisis response teams (Adamson & Peacok, 2007; Nickerson & Zhe, 2004). The school psychologist can function as the counseling and intervention expert on the crisis response team (Adamson & Peacock, 2007). Other preventative methods are crisis plans, violence prevention programs, anger management programs, and coping and problem solving skills programs; all of which can be lead by a school psychologist operating as a mental health provider.

Adamson and Peacock's (2007) survey of 500 school psychologists highlighted mental health services provided by school psychologists during crisis situations. An important finding was that seventy-eight percent of the respondents in the study reported using strategies for individual students that include referring out of the school for mental health services, providing psychological first-aid and individual counseling, and making time for groups of students to talk about a crisis situation. Another important mental

health role for school psychologists is sharing information with teachers about community services and outreach for students experiencing crises (Adamson & Peacock, 2007). This is evidence that school psychologists are providing mental health services during crisis situations.

Consultation

Consultation is a type of indirect mental health service where a school psychologist meets with at least one or more staff members or a parent to address a specific problem and work collaboratively to solve a problem (Fagan & Wise, 2007; Suldo et al., 2010). The school psychologist is the consultant (i.e., the expert) and the other school professional is the consultee. Both come together by choice to address a consultee's work-related problem (Fagan & Wise, 2007). The outcomes of the consultation may or may not be used by the consultee due to the voluntary nature of the collaboration and the lack of power differential between the professionals. Most of the time this is considered an indirect service since the school psychologist is working directly with a school professional to address a student issue (Erchul, 2011; Fagan & Wise, 2007). Consultation is often perceived as a prevention-based service (Erchul, 2011), as a school psychologist works with a teacher or the team to develop strategies to address challenging behaviors. The goal of this type of consultation is to solve the problem behavior so the student is not referred for an evaluation as a result.

Multiple forms of consultation exist. A few examples of consultation include mental health consultation, crisis consultation, behavioral consultation, problem-solving consultation, collaborative consultation and organizational consultation (Fagen & Wise, 2007). Regardless of the form chosen by the school psychologist, consulting with other

school professionals effectively requires many abilities such as a vast knowledge base of learning, behavioral and psychological theory, and interpersonal and communication skills (Fagan & Wise, 2007). Fagan and Wise (2007) summarize the stages of consultative relations:

> (a) Enter into the consultation relationship; (b) Diagnose the nature of the work-related problem; (c) Collect data; (d) Create and maintain a workable relationship; (e) Define boundaries of the consultation relationship; (f) Identify and develop possible resources; (g) Make decisions; and (h) Terminate the consultation relationship (pp. 136-137).

Utilizing productive methods for consulting with staff in schools is imperative to address students' mental health needs.

Behavioral Assessment

Another aspect of the school psychologist's role as a mental health provider is behavioral assessment, which is generally embedded in the consultative process. Similar to some forms of consultation, behavioral assessment follows a problem-solving model. Chafouleas et al. (2010) illustrates the evolution of behavioral assessment beginning with systematic direct observation by trained observers to including rating scales as the current trends in behavioral assessment, which include utilizing school-wide data collection tools (e.g., office discipline referrals) as part of the three tier problem-solving prevention model. School psychologists have an active role in this process by observing behavior and consulting with other members of the school working with individual students to develop intervention plans to address problematic behaviors.

Problems identified within the School Psychologist's Role as a Mental Health Provider

Support from the current research as well as national and state organizations (e.g., NASP) advocate for the expansion of the school psychologist's role to include the aforementioned mental health services (e.g., Hanchon & Fernald, 2013; National Association of School Psychologists, 2008). According to the Blueprint III for Training and Practice, the contemporary role of the school psychologist is no longer the isolated school psychologist involved in assessment practices, rather it includes broader services that meet instructional, social and emotional and mental health needs of students (Ysseldyke et al., 2009). This is contrary to recent research outcomes. Many challenges exist that inhibit the school psychologist's role as a mental health provider in the schools. The following studies have investigated roles and responsibilities of school psychologists and factors impeding the shift in the school psychologist's role.

School Psychologists and Mental Health Services

Studies that survey schools' psychologists' responsibilities throughout the years show that the majority of time centers around activities related to special education eligibility (e.g., assessment, report writing, case conferencing) instead of involvement in mental health services (Bramlet, Murphy, Johnson, Wallingsford, & Hall, 2002; Curtis et al., 2008; Curtis et al., 2012; Hanchon & Fernald, 2013; Suldo et al., 2010). For example, Bramlet et al. (2002) survey of 370 members from the National Association of School Psychologists (NASP) found that school psychologists spend almost half their time completing assessments (46%). Other mental health activities were reported less frequently such as 26% consulting with school staff, 13% providing some type of

intervention for students, 8% counseling students, 7% conferencing, 3% supervision, 2% receiving in-service training, 1% providing parent training, and 3% doing other activities. A more recent survey to NASP members asked respondents to reflect on their practices during the 2009-2010 school year (Curtis et al., 2012). Even though the number of initial evaluations and re-evaluations decreased from the Bramlet et al. (2002) survey, respondents reported spending more than half of the their time engaged in activities related to special education.

Consultation, although a very important part of being a mental health provider, is another service that is often excluded from typical school psychology day-to-day activities. Survey research approximates that school psychologists engage in consultation only between 16-20% of the time (Bramlet et al., 2002; Conoley, Conoley, & Reese, 2009; Curtis et al., 2012). One survey indicated that 47.9% of the participants (out of 1,748) had between 1 and 25 consultation cases annually while 28.5% engaged in 50 or more cases (Curtis et al., 2008).

Another qualitative research study by Suldo et al. (2010) asked 39 school psychologists from two large southeastern school districts to participate in focus groups. One purpose of the qualitative study was to explore the types of mental health services being provided by school psychologists. Results indicated that the most common types of mental health services provided mentioned by school psychologists in the focus groups included group counseling, individual counseling, and crisis intervention. Other mental health services identified in the study such as consultation, case management, and behavioral and clinical assessment were less frequently discussed. The Suldo et al. (2010) study proposes that even though various mental health services exist, school

psychologists' mental health services are limited to individual and group counseling and crisis intervention.

Hanchon and Fernald (2013) investigated school psychologists' involvement in counseling services (i.e., training and practices) by surveying 771 school psychologists across the United States, with most concentrated in only 12 states. Results indicated that 58% of the sample reported providing individual or group counseling or responding to a crisis. However, 42% of the respondents were not involved in any counseling-related service. This is troubling given mental health statistics of children and adolescents and the suggested school psychologist to student ratio of 1,200 to 1 (Hanchon & Fernald, 2013). This implies that many students are not receiving intensive mental health services in schools by school psychologists.

Urban districts characteristically work with more students at-risk for academic and behavioral challenges (Stoiber & Vanderwood, 2008). To investigate the shift of the urban school psychologist's role and function, Stoiber and Vanderwood (2008) surveyed 86 school psychologists working in a large urban school district consisting of 220 schools with over 100,000 students. Similar to other studies, the majority of school psychologists' time involved traditional assessment with less time for consultation and prevention and intervention activities.

Barriers to the Delivery of Mental Health Services

Researchers have been investigating the factors that perpetuate the slow change moving from the primary role in special education identification to a comprehensive mental health service provider. Suldo et al., (2010) investigated barriers to the delivery of these services. The majority of the barriers to the delivery of mental health services,

specifically individual and group counseling, by school psychologists, were systems-level. The focus group identified challenges delivering these types of services within a school environment such as limited space, time, students, lack of clearly defined responsibilities among other school staff able to provide mental health services, and too many responsibilities in the role. Other systems-level barriers were limited support from school personnel and district and departmental administration, and frustrations collaborating with school personnel. Most relevant to this study is that even though a large percentage of the sample reported receiving training in graduate school, almost half of the participants identified insufficient professional preparation to provide mental health services. This is consistent with the Splett et al., (2013) study that reported inadequate and limited training, professional development and supervision as barriers to the delivery of mental health services by school psychologists. These studies support the need for adequate professional development and clinical supports to increase involvement in the delivery of mental health services.

Competency and Mental Health Services

An important finding of the Suldo et al. (2010) study was that aside from the large percentage of the sample reporting receiving training to provide counseling services in graduate school and practicum experiences (i.e., internship and externship), almost 40% reported feeling unprepared to provide individual counseling and 43% reported feeling not fully prepared to provide group counseling. Additionally, one third of the sample reported prior training as poor in crisis response and intervention. Similarly, in the Nickerson and Zhe (2004) study less than 36% of school psychologists reported learning about crisis intervention in graduate school, and from national and state trainings. School

psychologists surveyed in the Adamson and Peacock (2007) study suggested the need for more training and practice in crisis intervention at the school and district level.

The respondents in the Stoiber and Vanderwood (2008) study reported traditional assessment as their most competent area, yet rated consultation and prevention and intervention as more important than traditional assessment. Even though school psychologists value prevention and intervention activities, they reported being less likely to implement any and to do so competently. When surveyed about professional development interests, the most frequently endorsed area was classroom-based behavioral interventions (69%), followed by therapeutic interventions (46%) and functional behavioral assessment (45%). Information regarding the usefulness and quality of trainings has not been addressed in these studies and remains an area in need of study (Armistead, 2013; Splett et al., 2013). Insufficient training in these areas will deter school psychologists from seeking out active engagement in these activities and perpetuate the limitations of a traditional school psychologist role.

Professional Development and Clinical Supports

Opportunities for professional development and clinical supports can help to facilitate the broadening role of the school psychologist and foster confidence and efficacy when providing mental health services. "Supervision and professional development have been identified as crucial to the ongoing provision of quality mental health services to schools and communities" (Fischette & Lines, 2004, p.76). Failure to provide adequate supports to school psychologists can lead to burnout (e.g., Fischette & Lines, 2004). The need for ongoing professional development is essential in the field of school psychology, but attending professional development does not guarantee an

improvement in practice (Wnek, Klein, & Bracken, 2008). For this reason, this study will investigate other aspects of professional development, such as types of formats of training (e.g. lecture, discussion, modeling and practice) and clinical supports available to school psychologists.

One way to make professional development meaningful is for school psychologists to identify their own training needs. Multiple studies surveyed school psychologists to find out areas of need and interest for future professional development (e.g., Armistead et al., 2013; Fowler & Harrison, 2001; Wnek et al., 2008). Most of the areas identified for future professional development fell under the umbrella of mental health services such as consultation, direct services, crisis intervention and behavioral, social, and emotional interventions (Armistead et al., 2013; Fowler & Harrison, 2001; Wnek et al., 2008), indicating the need for more trainings in this area. There still remains a need for research to identify types of professional development activities that would improve practice (Perfect & Morris, 2011).

Throughout the literature few studies address in-service professional development (i.e., training available at one's place of employment) for school psychologists (Armistead et al., 2013; Splett et al., 2013; Suldo et al., 2010). This is surprising since the quality and quantity of in-service training greatly impacts the delivery of mental health services by school psychologists (Splett et al., 2013). The Armistead et al., (2013) study reports on the quality of general in-service trainings, not specific to the provision of mental health services. For example, respondents in the study reported attending "generic" in-service professional development within their school districts. In-service trainings are often perceived as ineffective (Wnek et al., 2008), but can be beneficial if the material is

relevant and skill-based, and support is provided to implement new skills (Armistead, 2008 as cited in Armistead et al., 2013). The Armistead et al., (2013) study highlights the need for future studies to provide school psychologists with opportunities to evaluate continuing in-service professional development and judge how well these professional development activities are increasing their ability to provide adequate mental health services to students.

Professional Development Formats

Many studies identify professional development areas of interest and need for school psychologists as mental health providers (e.g., Armistead et al., 2013; Suldo et al., 2010). Identifying areas of interest and need is one component to addressing the problem. Another component is to investigate useful training formats when providing professional development activities to school psychologists. Considering school psychologists' learning styles is important for meaningful professional development (Splett et al., 2013).

Many of the continuing professional development activities follow a didactic model similar to the medical profession, whereas someone speaks about a certain topic to a large audience (Neimeyer et al., 2012). These methods for professional development do not often take into consideration adult education practices. Six adult learning principles that are often excluded from professional development activities include: (a) creating a climate of respect; (b) encouraging active participation; (c) building on experience; (d) employing collaborative inquiry; (e) learning for action; and (f) empowering participants (Lawler, 2003). Feist (2003) found that professionals are most likely to utilize information and new skills learned in professional development settings if they relate to current practices and can be implemented immediately following training.

Professional development experiences for adults are most beneficial when there are opportunities to connect prior experiences with new information and integrate information into daily lives (Lawler, 2003).

The infusion of these adult learning principles and practices with in-service professional development activities for school psychologists has not yet been addressed in the literature (Splett et al., 2013). Information gleaned from surveying school psychologists about useful professional development formats, such as lectures, small group seminars, and participation in experiential activities, at their place of employment can lead to meaningful training related to the delivery of mental health services.

Clinical Supports

One of the organizational principles included in NASP's Model for Comprehensive and Integrated School Psychological Services is Principle 5: Supervision and Mentoring (NASP, 2010). According to Principle 5, "The school system ensures that all personnel have levels and types of supervision/or mentoring adequate to ensure the provision of effective and accountable services" (NASP, 2010, p.332). Three examples of what should be part of supervision in schools include: (a) supervisors should have adequate credentials and experience; (b) methods of supervision should be consistent with needs and level of the school psychologist; and (c) schools should allocate time for supervision (NASP, 2010). Unfortunately, these examples are not consistent with what is reported in the literature about practices in school psychology (Crespi & Dupe, 2005; Fischetti & Crespi, 1999; Harvey & Pearrow, 2010). Additionally, recommendations for supervision do not clarify how it should be provided (Fischetti &

Lines, 2004). Also, the vast definitions for the term supervision do not mitigate the discrepancies between research and practice.

There are various types of supervision found in the literature as it relates to school psychology. Sometimes supervision is defined "…as key to facilitating effective delivery of school psychological services and promoting professional development in practitioners" (Strein, 1996, as cited Crespi & Dube, 2005, p. 118). Clinical supervision, more narrow than the definition for supervision by itself, has many definitions. One proposed definition for clinical supervision is by McIntosh and Phelps (2000):

> Supervision is an interpersonal interaction between two or more individuals for the purpose of sharing knowledge, assessing professional competencies, and providing objective feedback with the terminal goals of developing new competencies, facilitating effective delivery of psychological services, and maintaining professional competencies. (pp. 33 – 34)

Another definition by Harvey and Pearrow (2010) considers the role of the clinical supervisor:

> Clinical supervisors oversee professional practice and thus must have discipline specific training and knowledge. Clinical supervisors model and teach professional skills by helping supervisees conceptualize cases, examine work products, and assist in the disaggregation and interpretation of data. They ensure that supervisees practice only within areas of professional competence and support supervisees by debriefing during and after difficult situation. (p. 568)

This study will define clinical supervision using elements of Harvey and Pearrow's (2010) definition of a clinical supervisor and McIntosh and Phelps (2000) definition of

clinical supervision. Clinical supervision is an interpersonal interaction with a clinical supervisor with the same discipline-specific training and knowledge who models and teaches skills through case conceptualization, sharing of knowledge, objective feedback and discussion of practice, and provides support during and after challenging situations (Harvey & Pearrow, 2010; McIntosh & Phelps, 2000).

Another type of supervision is administrative supervision, which is usually a superior in an employment setting (e.g., school) addressing organizational and personnel issues (Graves, Proctor, & Aston, 2014), and ensuring school psychologists are compliant with state laws and are completing job assignments within an expected period of time (Curtis et al., 2008). Typically, administrative supervisors are not school psychologists (Harvey & Pearrow, 2010). Therefore, administrative supervisors cannot always meet the needs of school psychologists and address skills, knowledge, and research about the profession (Harvey & Pearrow, 2010).

School psychologists report in multiple studies participating in limited clinical supervision (e.g., Crespi & Dupe, 2005; Curtis et al., 2012; Fischetti & Crespi, 1999; Harvey & Pearrow, 2010). For example, Fischette and Crespi (1999) surveyed 337 school psychologists from the NASP membership list and found that 70% viewed clinical supervision as necessary, but only 10% reported receiving clinical supervision. One reason cited in the study was the difficulties accessing clinical supervision (Fischette & Crespi, 1999). Supervision typically consists of meeting with a supervisor individually on a weekly basis. This remains a problem today and continues to limit school psychologists access to this resource even when clinical supervision is perceived as an

activity that strengthens school psychologists' competencies in delivering mental health services (Fischetti & Lines, 2004).

Administrative supervision, which differs greatly from clinical supervision, is accessible to school psychologists (Curtis et al., 2008; Curtis et al., 2012), but is often limited to the overseeing and evaluation of one's job performance. Curtis et al., (2008) surveyed 1748 school psychologists to gather information about characteristics, employment conditions, professional practices, and continuing professional development for NASP's national database. Forty-nine percent of the school psychologists employed full-time in schools reported receiving administrative supervision. Similarly, Curtis et al., (2012) found four years later that 56.2% of the school psychologists surveyed reported receiving administrative supervision, which is only a slight increase from the earlier study. Only 12.3% reported receiving clinical supervision (Curtis et al., 2008). To emphasize the lack of appropriate supervision, Curtis et al, (2008) highlighted a finding: "…Only 7 out of 100 school psychologists reported receiving clinical supervision by an individual with a degree in school psychology." (p.28) This is consistent with the Fischette and Crespi (1999) study. It is an indication that most school psychologists still do not receive clinical supervision even with greater expectations for providing mental health services (NASP, 2010). In the later study, Curtis et al., (2012) did not inquire about clinical supervision. Instead, school psychologists were asked if they received systematic professional support, mentoring, and/or peer supervision through their district. A small percentage (28.5%) of participants reported receiving these clinical supports.

Fischette and Lines (2004) presented alternatives for implementing clinical supervision and supports in different schools to circumvent the difficulties accessing this

resource (i.e., individual weekly meetings with a supervisor) reported by many school psychologists (Fischette & Crespi, 1999). Examples of alternatives to traditional clinical supervision include: (a) small supervision groups; (b) peer supervision/consultation during monthly meetings with other school psychologists; (c) case conferences to review challenging diagnostic or intervention issues with peers; (d) assignment of an experienced mentor to meet with bi-weekly to review cases and daily challenges; (e) peer consultation groups with an assigned leader who then meets with a supervisor to discuss issues and receive support; and (f) topic-specific meetings to address areas of concern (Fischetti & Lines, 2004).

Gaps in the Current Research

The enormity of the role of school psychologists to function as the mental health experts in schools has highlighted the need for more training and support (Leffler, West, Jackson, McCarty, & Atkins, 2013; Perfect & Morris, 2011; Ringeisen et al., 2003; Splett et al., 2013; Suldo et al., 2010). The research shows that many school psychologists do participate and/or actively seek out professional development to maintain continuing education credits as part of the NASP requirements (Armistead et al., 2013). Yet, school psychologists still indicate the need for more training covering mental health services (e.g., counseling, crisis intervention) (e.g., Armistead et al., 2013). Furthermore, limited research thus far has inquired about the quality or the usefulness of the trainings addressing mental health services at the in-service level (i.e., at professionals place of employment). Unfortunately, current research suggests that school psychologists do not feel prepared and supported in regard to providing mental health services (e.g., Hanchon & Fernald, 2013).

Current research has not explored types of continuing education activities that improve mental health practice for school psychologists (Perfect & Morris, 2011) and have not differentiated the types of support or quality of support received (Suldo et al., 2010). Most of the studies about professional development do not consider the importance of how professionals learn, acquire, and use new skills in practice (Fixsen, Naoom, Blasé, Friedman, & Wallance, 2005; Perfect & Morris, 2011; Splett et al., 2013; Weist, Stephan, et al., 2007). Only one article briefly mentions how most professional psychology trainings follow the same didactic learning model used in the medical profession (Neimeyer, Taylor, & Cox, 2012). This type of training is antithetical to what is known about adult education.

Furthermore, there have been limited studies focusing on the need for school psychologists to receive clinical supervision especially at the place of employment. As the field of school psychology shifts to a more comprehensive role and school psychologists will be addressing severe mental health challenges from students, clinical supervision is essential. However, majority of practicing school psychologists receive only administrative supervision in school (Curtis et al., 2008; Curtis et al., 2012). Alternative forms of clinical supervision exist that have potential to be used within schools during the workday (Curtis et al., 2012; Fischetti & Lines, 2004).

Important aspects of professional development and clinical supports have not been addressed in the current literature (Armistead, Castillo, Curtis, Chappel, and Cunningham, 2013: Splett et al., 2013). Numerous authors acknowledge that there is a need to improve in-service professional development; provide trainings that include principles of adult learning; utilize experiential learning activities (Fixsen et al., 2005;

Perfect & Morris, 2011; Splett et al., 2013); and provide consistent scheduled supervision to school psychologists (Splett et al., 2013). All of these activities are designed to support school psychologists in the delivery of mental health services. More information regarding preferences for professional development addressing mental health services and formats for learning, quality of in-service professional development, and supervision within the schools is needed to implement these in-service professional development and clinical supports. School psychologists receiving clinical support and useful professional development trainings often provide more mental health services (e.g., Meyers & Swerdlik, 2003; Suldo et al., 2010).

Purpose of the Study

For this study, school psychologists working within districts in central New Jersey were surveyed, with the goal to investigate the following areas related to professional development and clinical supports for the delivery of mental health services: (a) types of supports needed to enhance competency to provide mental health services; (b) the frequency and usefulness of formats of in-service professional development related to mental health services; (c) opinions about the usefulness of clinical supports for the provision of mental health services; and (d) preferences for alternatives to traditional clinical supervision. School psychologists' responses were used to develop practical cost effective suggestions for addressing the need for training in mental health services and clinical support. Additionally, supervisors of school psychologists working within districts in central New Jersey were surveyed to ascertain their: (a) perception of feasibility and (b) willingness to implement professional development and clinical supports for school psychologists.

Chapter 3:Method

Participants

Participants in this study included school psychologists and administrators of school psychologists. All participants worked in schools located in Central New Jersey in the following counties: Middlesex, Mercer, Somerset, and Monmouth. School districts per county vary such that Middlesex has 25 districts, Mercer has 11 districts, Somerset has 18 districts, and Monmouth has 51 districts. School psychologists received an email with an invitation to voluntarily complete an online survey (see appendix A). Inclusionary criteria included active employment in a school setting in Central New Jersey as a school psychologist. Exclusionary criteria included school psychology interns. School Administrators such as Assistant Principals, Principals, and Special Education Supervisors received an email with an invitation to voluntarily complete an online survey (see appendix B). Inclusionary criteria included actively employed in a school setting as an administrator.

A total of 289 school psychologists were invited to participate in the study. Ninety-three school psychologists completed some or all of the survey. The total response rate was 32.1%. As shown in Table 1, more school psychologists had master's degrees (69.9%) than doctoral degrees (30.1%). Almost half of the participants worked less than five years (48.4%) as school psychologists compared with the participants who worked between 5 and 10 (20.4%) or more than 10 years (31.2%). However, almost half of the participants had more than 10 years (49.5%) of professional experience. Majority of the participants (88.2%) reported being responsible for a large number of students in their schools from 30 to 60 or more than 60 students. Similarly, participants reported

having student populations of more than a 1000 students (72%). Additionally, many of the participants work in Urban Districts (66%) compared with the participants in Suburban (23%) or Rural Districts (4%). More than half of the participants work in Elementary Schools (57%) and Middle Schools (50.5%) while the others work in Preschools (32%) and High Schools (37.6%).

A total of 464 administrators were invited to participate in the study. Forty-one administrators completed some or all of the survey. Therefore, the total response rate was 8%. As can be seen in Table 2, the majority of the participants had master's degrees (80.5%) compared with doctoral degrees (19.5%). Participants were actively employed in an administrative position such as Assistant Principal (31.7%), Principal (39%), or Supervisor (26.8%). Majority of the participants (83%) had 10 or less years working in an administrator role while a small number of participants (17.1%) had more than 10 years at that position. More than half of the administrators work in Suburban Districts (68.3%) and the majority work with students in General and Special Education (85.4%).

Instrumentation

School psychologists completed the Professional Development and Clinical Supports Survey (see appendix A). This survey was developed by the author to gather specific information about the provision of mental health services; perceived competency in relation to these services; supports needed to improve services; quantity and quality of in-service trainings and clinical supports; and interests in alternatives to traditional clinical supervision. A current measure does not exist that addresses the aforementioned areas. The survey consisted of 29 items with three parts: (a) demographic information, (b) provision of mental health services, and (c) in-service training and clinical supports. The

questions on this survey varied in presentation: (a) six items were open-ended; (b) 17 items were multiple choice and (c) six items used a 5-point Likert scale. Demographic information included educational level, years of experience, years working at participant's school, student population, school setting, size of student population, number of students the participants are responsible for in their school and socioeconomic status of students. The final item in the survey was for additional thoughts.

School Psychology Administrators completed the Professional Development and Clinical Supports Feasibility Survey for Administrators (see appendix B). This survey was developed by the author to gather information from administrators of school psychologists regarding the feasibility of implementing professional development and clinical supports for school psychologists. A current measure does not exist that addresses the aforementioned areas. This survey consisted of 16 items with two parts, demographic information and feasibility of supports. Items one to ten were multiple choice and addressed educational level, current title, degree, professional experience in this supervisory role, student population, school setting, size of student population, number of students participants are responsible for in their school and socioeconomic status of students. Items 12 and 13 provided examples of professional development and clinical supports and used a 5-point Likert scale. Administrators indicated the feasibility of implementing professional development and clinical supports in most schools for school psychologists and the likelihood of implementing these supports in their schools. Items 14 through 17 were open-ended to identify barriers and supports needed to implement professional development and clinical supports.

Procedures

To obtain feedback about the clarity and readability of the surveys, the investigator asked five colleagues and three administrators to complete the surveys. Five school psychologists completed the Professional Development and Clinical Supports Survey and three administrators of school psychologists completed the Professional Development and Clinical Supports Feasibility Survey for Administrators.

Data collection took place from March to September, a period of six months. The investigator utilized two strategies to procure participants to complete surveys. Both surveys were posted online utilizing Survey Monkey, which is an online research tool that allows researchers to develop surveys and collect responses. The first strategy included contacting the New Jersey Association of School Psychologists to inquire about utilizing the organizational membership email list. The coordinator emailed the survey for this investigator to the members of the organization with a clause stating that in order to qualify participants must currently work in a school in Central New Jersey. The investigator emailed the coordinator to ascertain how many members are in the organization, but never received a response. Therefore, it is unknown how many school psychologists who are members of the organization received the invitation to participate in the survey. The first strategy also included contacting the New Jersey Association of School Administrators to utilize the organizational membership email list. The New Jersey Association of School Administrators would not provide the membership email list.

The second strategy included searching on the internet for public school websites for schools located in Middlesex, Mercer, Somerset, and Monmouth counties in Central

New Jersey. In addition, the investigator used the New Jersey School Directory found on the State of New Jersey Department of Education website. The investigator developed a grid for each county. Schools on the grid were organized according to district. Each grid included 7 columns per school in each district: (a) name of school; (b) name of principal with an email address; (c) names of assistant principals along with email addresses; (d) names of school psychologists along with email addresses; (e) a space to indicate if the survey was emailed to the school psychologists and administrators; and (f) two additional spaces to indicate if reminder emails to complete the survey were emailed two times. The investigator logged information about each school into the grid according to the information available on the websites.

The investigator sent an invitation to participate in the study via an email to the school psychologists (see appendix C) and administrators (see appendix D). The email provided a brief description of the study and how to access the consent form and the survey through a web browser. This ensured confidentiality since participants' identifying information would not be linked to participants' responses. Two reminder emails were sent to participants in July and August to increase the rate of response.

Participants (i.e., school psychologists and administrators) gained access to the consent form (see appendix E and F) and survey after typing in the link in a web browser. The consent form included the following: (a) a description of the study; (b) the purpose of the study; (c) benefits and risks; and (d) an option to agree or disagree to participate. Respondents indicated consent by continuing to the survey and selecting the agree tab. All surveys are stored in Survey Monkey. Responses on both surveys are confidential. Participants cut and pasted the link of the survey into a web browser. Therefore,

participants' responses were anonymous and responses cannot be linked to the participants' identifying information. Both surveys took approximately 20 minutes to complete. Participants had an opportunity to win one out of three $30 gift cards through a raffle at the completion of the study as compensation for completing the survey.

Data Analysis Procedures

The purpose of this study was to explore the need for more in-service professional development and clinical supports. Quantitative data and qualitative analyses procedures were used to gain a better understanding of these two areas.

Data analysis was performed in SPSS 22. All tests were performed at the 95% confidence (α =.05) level. Quantitative analysis was performed in several steps. Before statistical tests were performed to analyze the quantitative research questions, descriptive statistics were calculated. The demographic characteristics of both the sample of psychologists and the sample administrators were analyzed. Means and standard deviations of all continuous measures were computed. Frequency counts and percentages of all categorical measurements were calculated.

Quantitative analysis was used to analyze Research Question #6. The relationship between demographic characteristics and questionnaire responses was examined. Specifically, the effect of dependent variables such as the type of a respondent's degree on select questionnaire responses was analyzed. The independent variables used in this analysis were categorical. *T*-tests were used to analyze the relationships between these categorical independent variables and continuous questionnaire responses. An independent samples *t*-test was used to assess the difference in mean perceived level of mental health problems amongst students at the respondent's school between school

psychologists with a master's degree and school psychologists with a doctoral degree. An independent samples *t*-test was used to assess the difference in self-perceived mean levels of competency in addressing mental health problems between school psychologists with a master's degree and psychologists with a doctoral degree. In order to analyze the relationship between a respondent's degree type and willingness to participate in clinical support, a *t*-test was used.

Quantitative analysis was used to analyze Research Question #9. Independent sample *t*-tests were used to determine whether a statistically significant difference in perception of feasibility and likelihood of implementation of professional and clinical supports existed between school administrators with a degree in School Psychology and those with other degrees. A *t*-test was performed to analyze differences in the feasibility and likelihood of implementation in each of the following: (a) a single session of training addressing the provision of mental health services; (b) multi-session ongoing training addressing the provision of mental health services; (c) weekly clinical supervision; (d) monthly clinical supervision; (e) mentoring; (f) small (4 peers of less) monthly mentoring groups facilitated by an experienced peer; (g) peer monthly supervision groups without a supervisor; (h) case conferences; (h) topic-specific bi-weekly meetings with peers.

Power analysis was performed to ensure sufficient sample size to achieve 80% power (as standard in psychology research) for all statistical tests (Cohen, 1992). For an effect size of Cohen's $d = .5$, a sample size of 36 school administrators was required. For an effect size of $f = .4$, a sample size of 66 school psychologists was required.

Qualitative content analysis was the method to analyze open-ended responses from the Professional Development and Clinical Supports Survey and the Professional

Development and Clinical Supports Feasibility Survey for Administrators. Procedures for qualitative content analysis followed Creswell's (2009) six step approach: (a) organizing and preparing the data; (b) reading through the open-ended responses to obtain a general understanding of the responses; (c) coding the responses, which entailed segmenting and organizing responses into emerging and predetermined codes; (d) emerging and predetermined codes were used to develop categories and themes related to the research questions; (e) highlighting examples from the responses to illustrate categories; and (f) interpreting the information, answering the research questions, and making comparisons to the literature.

Chapter 4: Results

School Psychologists' Perspectives of Mental Health Problems in Schools

School psychologists were asked to rate using a scale of 1 (not a problem) to 5 (a big problem) their opinion about the extent of mental health problems amongst students in their schools. As shown in Table 3, not one of the participants indicated that there was not a mental health problem in their school, 2.9% of the participants reported a slight problem, 35.29% participants reported a somewhat of a problem, 47.1% of the participants reported a problem, and 14.7% of the participants reported a big problem. The overall mean was 3.74 (somewhat of a problem), meaning that school psychologists perceive that mental health problems exist amongst students in their schools.

Participants were also asked to list the five most common types of mental health problems amongst students in their schools. As can be seen in Table 4, the five highest categories of mental health problems identified by participants were Mood Disorders (89.5%), Anxiety (86.6%), Behavioral Disorders (73.1%), ADHD (47.8%), and Substance Abuse (16.4%). The mental health problems were grouped into categories. Responses related to a student's mood such as Depression were categorized as Mood Disorders. All responses such as Anxiety or disorders deriving from anxiety (e.g., Obsessive Compulsive Disorders) were categorized as Anxiety. Behavioral Disorders were another category for disorders primarily related to disruptive behaviors such as Impulse Control Disorder, Oppositional Defiant Disorder, Conduct Disorder, and Intermittent Explosive Disorder. Difficulties with Executive Functioning were included with Attention Deficit Hyperactivity Disorder (ADHD) since one of the main features of ADHD is Executive Dysfunction.

School Psychologists' Provision of Mental Health Services in a Typical Week and Barriers to the Provision of Mental Health Services

Participants were asked to provide a percentage indicating how much time during a typical week they spend providing mental health services. As can be seen in Table 5, percentage of time providing mental health services in a typical week varied among participants. The four highest response percentages were mostly at the low-end of time spent on the percentage continuum with only one at the higher-end of time spent. For example, 23.9% of the participants reported spending 10% of the time, 19.7% of the participants reported spending 20% of the time, 12.7% of the participants reported spending 30% of the time, while 15.5% of the participants reported 70% of the time.

Consistent with a higher number of responses indicating less time spent providing mental health services in a week are the multitude of barriers to delivering mental health services identified by the participants. Participants were asked through an open-ended response mode to list the barriers that impede their ability to deliver mental health services. As can be seen in Table 7, the six most indicated barriers were Time (98.15%), Limited Resources (41.8%), Staff Indifference (40.3%), School Administration (29.85%), Lack of Parental Involvement (22.4%) and Limited Training of Staff (19.4%). Many of the participants' responses reflected an issue with aspects related to Time such as other job responsibilities, case management, large case loads, too much assessment, and not enough time to address mental health problems. Limited resources encapsulated the external resources needed to provide mental health services like funding, space, and training. Responses that described other staff members' apathy towards mental health services and mental health in general were categorized as Staff Indifference. Examples

included “Teachers with limited understanding of mental health issues”, “Academics are more important”, “Less emphasis on mental health”, and “Stigma”. School Administration was featured in many of the participants’ descriptions of barriers such as lack of administrative support, mental health services not deemed a priority from the school administration, and lack of recognition of mental health problems from administration. One participant responded, “The decision-makers are not knowledgeable of the topic.” Another said, “Being advised that we can only address school problems.” Responses identifying limited communication between home and school and parent resistant to addressing mental health problems were categorized as Limited Parental Involvement. For example one participant said, “Parental denial of their child’s mental health issues.” Responses that addressed the limited amounts of training amongst other staff excluding the school psychologist were categorized as Limited Training of Staff.

Given the various responsibilities and roles of a mental health provider, it was important to ascertain what types of mental health services are provided in a typical week. As shown in Table 6, 80.6% of the participants reported providing Individual Counseling, 47.8% of the participants reported providing Group Counseling, 64.2% of the participants reported providing Crisis Intervention, 91% of the participants reported providing Consultation, 59.7% of the participants reported providing Behavioral Assessment, 22.4% of the participants reported providing Provision of Prevention Programs, and 23.9% of the participants reported providing Mental Health Screening.

School psychologists' Reported Competency Levels of Mental Health Services and Supports Indicated to Improve Competency

Using the scale of 1 (not competent) to 5 (very competent), participants were asked to indicate their perceived level of competency delivering mental health services. As shown in Table 8, the highest percentage of participants reported being either Competent or Very Competent in Consultation (78.6%), Individual Counseling (69%), Crisis Intervention (68.6%), and Behavioral Assessment (62%). Participants reported being either Competent or Somewhat Competent in Group Counseling (66.2%) and Mental Health Screening (55%). Participants reported being Not Competent, Slightly Competent, or Somewhat Competent in the Provision of Prevention Programs (65.7%). Provision of Prevention Programs had the lowest levels of competency amongst participants.

Table 9 shows the types of supports participants listed to improve their delivery of mental health services. The highest percentage of participants indicated Professional Development (64.4%) as the support most needed to make their mental health services more effective. The second most indicated supports by participants include Resources (46.4%) such as time, space, funding, and technology. Administrative Support (33.9%) was the third indicated support followed by Home School Collaboration (23.3%). Surprisingly, the lowest percentage of participants indicated Clinical Supervision (1.8%) as a necessary support to improve their provision of mental health services.

More than half of the responses described the need for more Professional Development supports. Some of the responses were general such as "Professional Development Opportunities", "Access to more training", and others were specific to

mental health services. Examples include “Focused professional development instead of standard school Professional Development”, “More time to provide mental health Professional Development”, and “More consistent training on approaches rather than theory.” Any response that referenced administration was categorized as Administrative Support. Some of these responses described the need for administration training so administrators could be more supportive and knowledgeable on mental health issues while other responses focused on the need for administration involvement in mental health issues in the schools. Responses that indicated parental involvement and communication with families were categorized as Home-School Collaboration.

Additionally, participants were asked to list what topics they would like to receive training on to assist in the provision of mental health services. As can be seen on Table 10, the highest percentage of participants indicated needing trainings on Mental Health Disorders (43.4%), Evidence-Based Counseling Interventions (43.4%), Mental Health Screening (30.1%), Crisis Intervention (25%), Behavior Assessment (16.7%), Prevention Programs (15%), and Group Counseling (15%). Mental Health Disorders included responses that identified a Mental Health Disorder; some examples include Anxiety, Depression, ADHD, and Schizophrenia. All responses that described and named an empirically-supported counseling approach (e.g., Cognitive-Behavioral Therapy, Dialectical- Behavioral Therapy, Social Skills Training) were categorized as Evidence-Based Counseling Interventions. The category of Mental Health Screening encapsulated topics related to identification and prevention such as suicide assessment and prevention, threat assessment, and mental health screening. Responses categorized with the Crisis Intervention category included de-escalation methods, addressing violent situations and

addressing individual and school-wide crises. Behavior Assessment was the category for responses related to functional behavioral assessment and behavioral assessment in general. Prevention Programs included any response that included a general prevention program or a targeted one such as "Prevention programs for suicide and self-harming".

Frequency in which School Psychologists Attend In-service Professional Development and the Helpfulness of these Activities Addressing Mental Health Services

Participants were asked to report how many in-service (i.e. trainings available at your place of employment) professional development events they attended this year. As seen in Table 11, participants attended varying numbers of in-service trainings this past year. The majority of the participants attended five or less in-service trainings this past year. The highest percentage of participants reported attending two (14.0%) or three (14.0%) in-service trainings this past year. Additionally, using the scale of 1 (not helpful) to 5 (most helpful), participants were asked to list a maximum of 5 training topics they attended and the helpfulness of those trainings. As shown in Table 12, participants reported Crisis Intervention and Prevention (62.50%), Evidence-based Counseling Interventions (66.16%), and Mental Health Disorders (52.38%) as helpful and the most helpful in-service trainings attended this past year. Crisis Intervention and Prevention was the category for training topics related to individual or school-wide crisis such as crisis response, crisis intervention, trauma response, suicide prevention, child abuse, specific methods for crisis intervention, and proper strategies for restraint. Evidence-Based Counseling Interventions was the category for trainings teaching research supported counseling practices such as Cognitive Behavioral Therapy, Applied

Behavioral Analysis, Dialectical Behavioral Therapy, and stress management techniques. Mental Health Disorders encompassed trainings related to any Mental Health Disorder (e.g. Depression, Anxiety, ADHD).

In contrast, trainings reported as not helpful to slightly helpful were Academic Interventions (80.00%), Assessment (74.19%), Educational Classifications (72.73%), Special Education (56.66%), Administrative Responsibilities (100.00%) and Technology (100.00%). Responses describing aspects related to academic learning such as reading interventions, Common Core, differentiated instruction, and response to intervention were grouped under Academic Interventions. The category of Assessment included trainings about particular instruments such as WISC-V or WJ5 and broader workshops on personality or intellectual assessment. Many of the participants attended trainings addressing educational classifications such as Learning Disabilities, Emotional and Behavioral Disturbances, Dyslexia. Special Education was a category for trainings related to aspects of special education law. The category of Administrative Responsibilities included responses related to managing or supervising other staff. All trainings about software were grouped under Technology.

Preferences for Styles of In-service Professional Development and Helpfulness of Styles at Professional Development Attended

Participants were asked to report which in-service training formats they found most effective. As shown in Table 13, the highest percentage of participants indicated that they found discussion (77.5%), Observation/Modeling (76.1%), Lecture (57.8%), and Case Study (53.5%) most effective.

To obtain more information about the preferences for styles of in-service professional development formats, using a scale of 1 (not helpful) to 5 (most helpful) participants rated the helpfulness of the training formats by topic of training attended. Each training topic was matched with each training style such as Lecture, Discussion, Observation/Modeling, Role Play/Practice, Case Study, and Webinar. As can be seen in Table 14, Discussion had the most favorable ratings. In six out of the 13 training topics, Discussion was rated helpful to the most helpful training style. Case Study had the second highest ratings. In five out of 13 training topics, Case Study was rated helpful to most helpful. Observation/ Modeling was another preferable style of training with three helpful to most helpful ratings out of 13 topics. Lecture, a common training format, only received two ratings of helpful to most helpful out of 13 training topics, which was consistent with Role Play/Practice. Lecture had consistent ratings between Slightly Helpful to Helpful. Webinar was the least favorable training format.

Frequency of School Psychologists Receiving Clinical Supervision at their Schools and Perceptions of Usefulness of Clinical Supervision and Supports

Using a scale of 1 (not useful) to 5 (very useful), participants rated how useful it would be to participate in clinical supervision at their schools. As can be see in Table 15, a greater number of participants perceive participating in clinical supervision at their schools to be Useful (39.4%) or Very Useful (33.3%), while few of the participants consider clinical supervision at their schools to be only Somewhat Useful (7.6%) or Not Useful (7.6%). As shown in Table 16, even though participants believe that it would be Useful, a majority of participants (74.6%) responded that they never receive any type of clinical supervision at their school.

Participants were asked to report the type of clinical supports in which they were willing to participate. As can be seen in Table 17, participants are willing to engage in various types of clinical supports. The majority of participants reported that they are most willing to participate in Case Conferences (84.9%) and Topic-Specific Meeting with Peers (75.8%). The least endorsed clinical support was Peer Supervision Groups Without a Clinical Supervisor (56.1%), however, more than half the participants reported being willing to participate in Peer Supervision. Two participants included responses in the Other category; one participant (1.6%) was not willing to participate in clinical supports, and one participant (1.6%) was willing to only participate in clinical behavior analysis.

Additionally, participants were asked how often they were willing to reserve time in their schedules to participate in training related to mental health service and clinical supports. As shown in Table 18, the highest percentage of responses was for participation Annually (37.3%) and on an As Needed basis (28.4%). A small percentage of participants endorsed meeting Weekly (6.0%) or Monthly (20.9%).

Differences in the Above Responses Based on School Psychologists Type of Degree

The relationship between demographic characteristics and questionnaire responses was examined. More specifically, the effect of dependent variables, such as the type of a respondent's degree, on select questionnaire responses was analyzed. The independent variables used in this analysis were categorical, and *t*-tests were used to analyze the relationships between these categorical independent variables and continuous questionnaire responses.

First, as shown in Table 19, an independent samples *t*-test was used to assess the difference in rating perceived level of mental health problems among students at the

respondent's school between school psychologists with a master's degree and school psychologists with a doctoral degree. Before, a *t*-test was performed, Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, the two groups demonstrated did not demonstrate adequate homogeneity of variance, so an independent *t*-test with equal variances not assumed was performed, $F(1, 66) = .02$, $p = .89$. As can be seen in Table 20, there was no statistically significant difference in rating perceived level of mental health problems among students at the respondent's school between school psychologists with a master's degree and school psychologists with a doctoral degree, $t(36.77) = .25$, $p = .80$.

Secondly, as shown in Tables 21 and 22, an independent samples *t*-test was also used to assess the difference in self-perceived rating levels of competency in addressing mental health problems between school psychologists with a master's degree and psychologists with a doctoral degree. Analysis was performed for each competency area. First, competency in individual counseling was analyzed. Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, the two groups demonstrated adequate homogeneity of variance, so a *t*-test was performed, $F(2, 69) = 2.40$, $p = .12$. Those psychologists with a doctoral degree reported greater rating levels of competency in individual counseling than psychologists with Master's degrees, $t(69) = 3.78$, $p < .001$. Second, competency in group counseling was analyzed. Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, the two groups demonstrated adequate homogeneity of variance, so a *t*-test was performed, $F(2, 69) = .57$ $p = .45$. Those psychologists with a doctoral degree reported greater rating levels of competency in group counseling than psychologists with master's degrees, $t(69)$

= 3.83, $p < .001$. Third, competency in crisis intervention was analyzed. Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, the two groups did not demonstrate adequate homogeneity of variance, so a *t*-test for equal variances not assumed was performed, $F(2, 69) = .57$ $p = .45$. Those psychologists with a doctoral degree reported greater rating levels of competency than psychologists with master's degrees in crisis intervention, $t(37.43) = 2.71$, $p = .01$. Fourth, competency in consultation was analyzed. Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, the two groups demonstrated adequate homogeneity of variance, so a *t*-test was performed, $F(2, 68) = .10$ $p = .75$. Those psychologists with a doctoral degree reported greater rating levels of competency in consultation than psychologists with master's degrees, $t(68) = 3.00$, $p = .004$. Fifth, competency in behavioral assessment was analyzed. Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, the two groups demonstrated adequate homogeneity of variance, so a *t*-test was performed, $F(2, 60) = .29$ $p = .59$. There was no statistically significant difference in rating self-report levels of competency in behavioral assessment between psychologists with a doctoral degree and a master's degree, $t(69) = 1.30$, $p = .20$. Sixth, competency in provision of prevention programs was analyzed. Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, the two groups demonstrated adequate homogeneity of variance, so a *t*-test was performed, $F(2, 60) = .29$ $p = .59$. Those psychologists with a doctoral degree reported greater rating levels of competency in provision of prevention programs than psychologists with master's degrees, $t(68) = 3.69$, $p < .001$. Seventh, competency in mental health screening was analyzed. Levine's test

was conducted to assess homogeneity between the two groups. According to Levine's test, the two groups demonstrated adequate homogeneity of variance, so a *t*-test was performed, $F(2, 67) = .93$ $p = .34$. Those psychologists with a doctoral degree reported greater rating levels of competency in mental health screening than psychologists with master's degrees, $t(67) = 2.89$, $p = .005$.

Finally, the relationship between a respondent's degree type and willingness to participate in clinical support was analyzed. Before, a *t*-test was performed, Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, the two groups demonstrated did not show adequate homogeneity of variance, so an independent *t*-test with equal variances not assumed was performed, $F(1, 65) = 5.27$, $p = .03$. As shown in Tables 23 and 24, those psychologists with doctoral degrees were more willing to receive clinical support than those with master's degrees, $t(60.25) = 2.09$, $p = .04$.

Administrators Willingness to Implement In-service Professional Development

School Administrators were asked to report feasibility of implementation of the following types of professional development and clinical supports for school psychologists: (a) a single session of training addressing the provision of mental health services; (b) multi-session ongoing training addressing the provision of mental health services; (c) weekly clinical supervision; (d) monthly clinical supervision; (e) mentoring; (f) small (4 peers or less) monthly mentoring groups facilitated by an experienced peer; (g) peer monthly supervision groups without a supervisor; (h) case conferences; (h) topic-specific bi-weekly meetings with peers.

As shown in Table 25, Single Session Training had the highest percentage of feasibility ratings among administrators compared with the other professional development and clinical supports. For example, the majority of administrators (56.1%) reported that Single Session Training is Feasible or Very Feasible, unlike Weekly Clinical Supervision (9.8%) and Topic-Specific Every Other Week Meetings with Peers (19.6%). Similarly, the second highest percentage of responses for Feasible and Very Feasible was for Peer Monthly Supervision Groups Without a Supervisor (39.0%), Small Monthly Mentoring Groups (39%), Case Conferences (36.6%) and Mentoring (35.8%). Weekly Clinical Supervision (24.4%) was perceived as the least feasible support. However, some administrators did perceive Weekly Clinical Supervision (36.6%) as Somewhat Feasible. Comparable with Weekly Clinical Supervision was Multi-Session Ongoing Training (41.5%), which was perceived as Somewhat Feasible.

School Administrators were asked to report the likelihood of implementation of the following types of professional development and clinical supports for school psychologists: (a) a single session of training addressing the provision of mental health services; (b) multi-session ongoing training addressing the provision of mental health services; (c) weekly clinical supervision; (d) monthly clinical supervision; (e) mentoring; (f) small (4 peers of less) monthly mentoring groups facilitated by an experienced peer; (g) peer monthly supervision groups without a supervisor; (h) case conferences; (h) topic-specific bi-weekly meetings with peers.

As can be seen in Table 26, administrators' opinions about the likelihood of implementation varied among the supports. Analogous to the feasibility ratings was administrators' opinions about Single Session Training. The likelihood of Will

Implement and Will Definitely Implement for Single Session Training (61%) surpassed the other supports. Weekly Clinical Supervision (24.4%) and Topic-specific Every Other Week Meetings with Peers (14.6%) had the least likelihood of No Implementation. Multi-Session Ongoing Training (37.4%), Small Monthly Mentoring Groups (39.1%) and Mentoring (36.6%) had the second highest percentages for Will Definitely Implement. Overall, as can be seen in Tables 25 and 26, administrators' responses among feasibility ratings and implementation ratings were consistent.

Indicated Barriers and Supports Needed to Provide Training

Administrators were asked what they believe are the barriers to providing training on the provision of mental health services through an open-ended response mode. As shown in Table 27, Time had the highest percentage of responses (93.10%) followed by Limited Interest (48.28%). Limited Interest was any response that described apathy or no interest from staff to participate in trainings. The third highest percentage of responses was Cost (27.59%), which describes responses indicating money, finances, and funding as barriers. Four other categories were used to describe administrators' responses of barriers: Limited Staff, Large Caseload, Scheduling, and Lack of Facilities. Limited Staff categorized responses such as "Need staff to facilitate the trainings."

In addition to barriers, administrators were asked through an open-ended response mode to describe what supports they believe are needed to provide training on the provision of mental health services. As can be seen in Table 28, the three supports that had the highest percentage of responses were Cost (46.15%), More Time (42.31%) and Additional staff (38.47%).

Indicated Barriers and Supports to Providing Clinical Supports

Administrators were asked what they believe are the barriers to providing clinical supports for school psychologists through an open-ended response mode. As shown in Table 29, the most endorsed barriers were Time (78.5%), followed by Staff (35.71%). The next highest percentage of responses was Large Caseload (21.43%), which describes a large number of students school psychologists are responsible for managing. Four other categories were used to describe administrators' responses of barriers: Cost, Limited Interest, Scheduling, and Limited Space.

In addition to supports to provide training, school psychologist administrators were also asked what supports they needed to provide clinical supports for school psychologists through an open-ended response mode. As can be seen in Table 30, the supports with the highest percentage of responses were Time (44%), Cost (28%), and Staff (36%). These supports were identical to the supports needed to provide professional development. Four other categories were used to describe administrators' responses: Consultants, More Space, Smaller Caseloads, and Superintendent Support.

Differences in Perception of Feasibility Between Administrators with Different Backgrounds

Independent sample *t*-tests were used to determine whether a statistically significant difference in perception of feasibility of professional and clinical supports exists between school administrators with a degree in Psychology and those with other degrees. A *t*-test was performed to analyze differences in the feasibility of implementation in each of the following: (a) a single session of training addressing the provision of mental health services; (b) multi-session ongoing training addressing the

provision of mental health services; (c) weekly clinical supervision; (d) monthly clinical supervision; (e) mentoring; (f) small (4 peers or less) monthly mentoring groups facilitated by an experienced peer; (g) peer monthly supervision groups without a supervisor; (h) case conferences; (h) topic-specific bi-weekly meetings with peers.

As can be seen in Table 31 and Table 32, an independent samples *t*-test was used to assess the difference in rating perception of feasibility of implementation of single session training between school administrators with a psychology degree and those with an education degree. Before, a *t*-test was performed, Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, the two groups demonstrated adequate homogeneity of variance, so an independent *t*-test was performed, $F(1, 28) = .25$, $p = .62$. There was no statistically significant difference in rating perception of feasibility of implementation of single session training between school administrators with a psychology degree and those with an education degree, $t(28) = .76$, $p = .45$.

As can be seen in Table 31 and Table 32, an independent samples *t*-test was used to assess the difference in rating perception of feasibility of implementation of multi-session training between school administrators with a psychology degree and those with an education degree. Before, a *t*-test was performed, Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, the two groups demonstrated adequate homogeneity of variance, so an independent *t*-test was performed, $F(1, 28) = .22$, $p = .65$. There was no statistically significant difference in rating perception of feasibility of implementation of multi-session training between school

administrators with a psychology degree and those with an education degree, $t(28) = .09$, $p = .93$.

As can be seen in Table 31 and Table 32, an independent samples *t*-test was used to assess the difference in rating perception of feasibility of implementation of monthly clinical supervision between school administrators with a psychology degree and those with an education degree. Before, a *t*-test was performed, Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, the two groups demonstrated adequate homogeneity of variance, so an independent *t*-test was performed, $F(1, 28) = .69$, $p = .41$. There was no statistically significant difference in rating perception of feasibility of implementation of weekly clinical supervision between school administrators with a psychology degree and those with an education degree, $t(28) = 1.03$, $p = .31$.

As can be seen in Table 31 and Table 32, an independent samples *t*-test was used to assess the difference in rating perception of feasibility of implementation of weekly clinical supervision between school administrators with a psychology degree and those with an education degree. Before, a *t*-test was performed, Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, the two groups demonstrated adequate homogeneity of variance, so an independent *t*-test was performed, $F(1, 28) = 1.41$, $p = .41$. There was no statistically significant difference in rating perception of feasibility of implementation of weekly clinical supervision between school administrators with a psychology degree and those with an education degree, $t(28) = .55$, $p = .59$.

An independent samples *t*-test was used to assess the difference in rating perception of feasibility of implementation of mentoring between school administrators with a psychology degree and those with an education degree. Before, a *t*-test was performed, Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, as can be seen in Table 31 and Table 32 the two groups demonstrated adequate homogeneity of variance, so an independent *t*-test was performed, $F(1, 28) = .16$, $p = .69$. There was no statistically significant difference in rating perception of feasibility of implementation of mentoring between school administrators with a psychology degree and those with an education degree, $t(28) = 1.32$, $p = .20$.

An independent samples *t*-test was used to assess the difference in rating perception of feasibility of implementation of small mentoring groups between school administrators with a psychology degree and those with an education degree. Before, a *t*-test was performed, Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, as is shown in Table 31 and Table 32 the two groups demonstrated adequate homogeneity of variance, so an independent *t*-test was performed, $F(1, 27) = .36$, $p = .56$. School administrators with a psychology degree were more likely to believe that it was feasible to implement small mentoring groups than school administrators with an education degree, $t(27) = 2.42$, $p = .02$.

An independent samples *t*-test was used to assess the difference in rating perception of feasibility of implementation of small monthly supervision groups between school administrators with a psychology degree and those with an education degree. Before, a *t*-test was performed, Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, as can be seen in Table 31 and Table

32 the two groups demonstrated adequate homogeneity of variance, so an independent *t*-test was performed, $F(1, 27) = .18$, $p = .19$. There was no statistically significant difference in rating perception of feasibility of implementation of small monthly supervision groups between school administrators with a psychology degree and those with an education degree, $t(27) = 1.44$, $p = .16$.

An independent samples *t*-test was used to assess the difference in rating perception of feasibility of implementation of case conferences between school administrators with a psychology degree and those with an education degree. Before, a *t*-test was performed, Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, as can be seen in Table 31 and Table 32 the two groups demonstrated adequate homogeneity of variance, so an independent *t*-test was performed, $F(1, 27) = 1.04$, $p = .32$. There was no statistically significant difference in rating perception of feasibility of implementation of case conferences between school administrators with a psychology degree and those with an education degree, $t(28) = 2.07$, $p = .05$.

Finally, an independent samples *t*-test was used to assess the difference in rating perception of feasibility of implementation of topic specific meetings between school administrators with a psychology degree and those with an education degree. Before, a *t*-test was performed, Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, as can be seen in Table 31 and 32 the two groups demonstrated adequate homogeneity of variance, so an independent *t*-test was performed, $F(1, 27) = .87$, $p = .36$. There was no statistically significant difference in rating perception of feasibility of implementation of topic specific meetings between school

administrators with a psychology degree and those with an education degree, $t(27) = 1.32$, $p = .20$.

Differences in Likelihood of Implementation Between Administrators with Different Backgrounds

Independent sample *t*-tests were used to determine whether a statistically significant difference in perception of likelihood of implementation of professional and clinical supports exists between school administrators with a degree in psychology and those with other degrees. A *t*-test was performed to analyze differences in the likelihood of implementation in each of the following: (a) a single session of training addressing the provision of mental health services; (b) multi-session ongoing training addressing the provision of mental health services; (c) weekly clinical supervision; (d) monthly clinical supervision; (e) mentoring; (f) small (4 peers or less) monthly mentoring groups facilitated by an experienced peer; (g) peer monthly supervision groups without a supervisor; (h) case conferences; (h) topic-specific bi-weekly meetings with peers.

First, an independent samples *t*-test was used to assess the difference in mean perception of likelihood of implementation of single session training between school administrators with a psychology degree and those with an education degree. Before, a *t*-test was performed, Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, as can be seen in Table 33 and Table 34 the two groups demonstrated adequate homogeneity of variance, so an independent *t*-test was performed, $F(1, 28) = 1.61$, $p = .22$. There was no statistically significant difference in mean perception of likelihood of implementation of single session training between

school administrators with a psychology degree and those with an education degree, $t(28) = 1.06$, $p = .30$.

Second, an independent samples *t*-test was used to assess the difference in mean perception of likelihood of implementation of multi-session training between school administrators with a psychology degree and those with an education degree. Before, a *t*-test was performed, Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, as can be seen in Table 33 and Table 34 the two groups demonstrated adequate homogeneity of variance, so an independent *t*-test was performed, $F(1, 28) = .63$, $p = .34$. There was no statistically significant difference in mean perception of likelihood of implementation of multi-session training between school administrators with a psychology degree and those with an education degree, $t(28) = .30$, $p = .77$.

Third, an independent samples *t*-test was used to assess the difference in mean perception of likelihood of implementation of monthly clinical supervision between school administrators with a psychology degree and those with an education degree. Before, a *t*-test was performed, Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, as can be seen in Table 33 and Table 34 the two groups demonstrated adequate homogeneity of variance, so an independent *t*-test was performed, $F(1, 28) = .05$, $p = .83$. There was no statistically significant difference in mean perception of likelihood of implementation of weekly clinical supervision between school administrators with a psychology degree and those with an education degree, $t(28) = .06$, $p = .95$.

Fourth, an independent samples *t*-test was used to assess the difference in mean perception of likelihood of implementation of weekly clinical supervision between school administrators with a psychology degree and those with an education degree. Before, a *t*-test was performed, Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, as can be seen in Table 33 and Table 34 the two groups demonstrated adequate homogeneity of variance, so an independent *t*-test was performed, $F(1, 28) = .04$, $p = .85$. There was no statistically significant difference in mean perception of feasibility of likelihood of weekly clinical supervision between school administrators with a psychology degree and those with an education degree, $t(28) = .22$, $p = .12$.

Fifth, an independent samples *t*-test was used to assess the difference in mean perception of likelihood of implementation of mentoring between school administrators with a psychology degree and those with an education degree. Before, a *t*-test was performed, Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, as can be seen in Table 33 and Table 34 the two groups demonstrated adequate homogeneity of variance, so an independent *t*-test was performed, $F(1, 28) = .35$, $p = .56$. There was no statistically significant difference in mean perception of likelihood of implementation of mentoring between school administrators with a psychology degree and those with an education degree, $t(28) = .50$, $p = .28$.

Sixth, an independent samples *t*-test was used to assess the difference in mean perception of likelihood of implementation of small mentoring groups between school administrators with a psychology degree and those with an education degree. Before, a *t*-test was performed, Levine's test was conducted to assess homogeneity between the two

groups. According to Levine's test, as can be seen in Table 33 and Table 34 the two groups demonstrated adequate homogeneity of variance, so an independent *t*-test was performed, $F(1, 27) = .64$, $p = .43$. There was no statistically significant difference in mean perception of likelihood of implementation of small mentoring groups between school administrators with a psychology degree and those with an education degree, $t(27) = .27$, $p = .79$.

Seventh, an independent samples *t*-test was used to assess the difference in mean perception of likelihood of implementation of small monthly supervision groups between school administrators with a psychology degree and those with an education degree. Before, a *t*-test was performed, Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, as can be seen in Table 33 and Table 34 the two groups demonstrated adequate homogeneity of variance, so an independent *t*-test, $F(1, 28) = .51$, $p = .48$ was given. There was no statistically significant difference in mean perception of likelihood of implementation of small monthly supervision groups between school administrators with a psychology degree and those with an education degree, $t(28) = 1.04$, $p = .31$.

Eighth, an independent samples *t*-test was used to assess the difference in mean perception of likelihood of implementation of case conferences between school administrators with a psychology degree and those with an education degree. Before, a *t*-test was performed, Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, as can be seen in Table 33 and Table 34 the two groups demonstrated adequate homogeneity of variance, so an independent *t*-test was performed, $F(1, 28) = 1.39$, $p = .25$. There was no statistically significant difference in

mean perception of likelihood of implementation of case conferences between school administrators with a psychology degree and those with an education degree, $t(28) = .93$, $p = .36$.

Finally, an independent samples *t*-test was used to assess the difference in mean perception of likelihood of implementation of topic specific meetings between school administrators with a psychology degree and those with an education degree. Before, a *t*-test was performed, Levine's test was conducted to assess homogeneity between the two groups. According to Levine's test, as can be seen in Table 33 and Table 34 the two groups demonstrated adequate homogeneity of variance, so an independent *t*-test was performed, $F(1, 27) = .39$, $p = .54$. There was no statistically significant difference in mean perception of likelihood of implementation of topic specific meetings between school administrators with a psychology degree and those with an education degree, $t(27) = 1.35$, $p = .19$ (see Table 3 and Table 4).

Chapter V: Discussion

Supports Needed to Provide Mental Health Services

The first question this study was designed to answer was: What types of supports do school psychologists need to feel competent providing mental health services? Prior research suggests that school psychologists need administrative support, professional development (Suldo et al., 2010), and clinical support and supervision (Curtis et al., 2008; Splett et al., 2013) to feel competent providing mental health services. Also, research shows that school psychologists need specific professional development addressing aspects of mental health services such as counseling, consultation, and crisis intervention (e.g., Adamson & Peacock, 2007; Hanchon & Fernald, 2013; Nickerson & Zhe, 2004; Suldo et al., 2010;Ysseldyke et al., 2009).

Similar to the literature, this study found that school psychologists indicated professional development as the support most needed to make their mental health services more effective. Many of the responses highlight the need for trainings with a focus on mental health services. When asked to list preferences for trainings in this area, Mental Health Disorders, Evidence-based Counseling Interventions, Mental Health Screening, and Crisis Intervention were the most endorsed topics. Other studies support this finding as school psychologists have reported feeling less competent providing mental health intervention/prevention activities (Splett et al., 2013) and desire to participate in mental health professional development trainings (Suldo et al., 2010). In contrast, participants reported in this study feeling competent in many mental health activities (e.g., individual counseling, consultation, crisis intervention). Based on these results, it appears that school psychologists want to participate in professional

development that furthers their knowledge of mental health and increases their skills to provide targeted interventions in counseling, crisis intervention, and mental health screening.

The second most indicated supports in this study were resources such as time, space, funding, and technology. Similarly, time and limited space have been identified in the literature as barriers to delivering mental health services (e.g., Suldo et al., 2010), which is consistent with barriers identified in this study. Time was identified as a considerable barrier to providing mental health services.

School psychologists identified administrative support, another support consistent with previous literature (e.g., Splett et al., 2013), as needed to provide mental health services. Lack of administrator support was also identified as a barrier to providing mental health services. Responses indicated that school psychologists believe that administrators need training on mental health issues to be supportive. Increasing administrator's knowledge about mental health problems has potential to cultivate greater involvement from administrators and more competency to be supportive to school psychologists.

In contrast to the literature, in this study clinical supervision was not identified as a support needed. Perhaps this study's results differ from previous literature because practicing school psychologists are concerned with the practical day-to-day aspects of their positions and may regard clinical supervision as unrealistic. Resources (e.g., time, space, funding) were the second most indicated support. If time is a support needed to provide mental health services and is considered the greatest barrier then participating in clinical supervision might be perceived as untenable given other time-consuming

responsibilities. Another possible explanation is school psychologists may perceive clinical supervision as unattainable in comparison to the other identified supports.

Participation and Helpfulness of In-service Professional Development

The second question of this study was: How often do school psychologists attend in-service professional development related to their role as mental health providers? Providing in-service mental health targeted professional development opportunities fosters competency and participation in these activities (e.g., Perfect & Morris, 2011; Splett et al., 2013; Suldo et al., 2010). Yet according to previous literature, most school psychologists report attending in-service professional development unrelated to their roles (Armistead et al., 2013). However, one study found that 52.2% of the participants reported attending staff development for school psychologists, but were in agreement that districts need to provide more training specific to the role of the school psychologist (Armistead et al., 2013). Similarly, the majority of the participants in this study attended only five or less in-service trainings this past year; many of which did not address mental health services or mental health topics.

This problem is most likely contributing to the slowly shifting role of the school psychologist to the mental health provider. By not providing adequate trainings addressing mental health services in schools, school psychologists may not feel prepared to engage in these activities or supported by the administrators. The further removed school psychologists are from engaging in mental health activities, the less likely they will be perceived as competent in these areas by administrators and other staff. Also, the less likely they will feel competent engaging in mental health services. Therefore, school

psychologists will continue to fulfill the expected role of an evaluator determining special education eligibility, which perpetuates the narrow role of the school psychologist.

Additionally, district supported professional development conference days often target academic instruction, curricula, and academic interventions for teachers, which makes financial sense given that teachers constitute a large portion of the educational staff. With a suggested ratio of 1200 to 1, the number of school psychologists in any one school is quite small, making targeted professional development for school psychologists impractical. However, developing competency within the area of mental health and providing support through in-service professional development for school psychologists will increase the likelihood of engaging in these activities (Splett et al., 2013; Suldo et al., 2010), and can potentially save resources (e.g., money, time) in the future. School psychologists competent in mental health services can manage school-wide and individual crises, and prevent future crisis through prevention services to limit the need for intensive services, which are expensive and time-consuming.

The third question of this study was: To what extent are in-service professional development activities addressing mental health services useful in practice? To date, there is little literature exploring the usefulness of in-service professional development activities. One study found that in-service staff development for school psychologists was generic and ineffective (Armistead et al., 2013). In this study, the perceived usefulness of the professional development activities was contingent on the content of the trainings. Most of the trainings addressing mental health services such as Crisis Intervention and Prevention, Evidence-Based Counseling Interventions, Mental Health Disorders were rated as helpful to very helpful. This is consistent with the literature as school

psychologists report a desire to learn more about mental health topics (e.g., Armistead et al., 2013; Splett et al., 2013l Suldo et al., 2010). Perhaps, school psychologists will perceive in-service professional development activities addressing mental health services useful if trainings are based on their identified needs and interests.

In contrast, trainings addressing Assessment were indicated as not helpful. According to the literature, school psychologists feel competent with Assessment-related activities and it is not a preferred professional development topic (Splett et al., 2013; Stoiber & Vanderwood, 2008). Another topic that was deemed not helpful was Education Classifications, which can be considered an addendum to Assessment activities as special education classifications align with Assessment-related activities. Additionally, the least helpful trainings were ones focusing on Administrative Responsibilities and Technology, which are unrelated to their role as mental health providers.

Preferences for Styles and Formats of in-service Professional Development

The fourth question of this study was: What styles of in-service professional development addressing mental health services foster the most learning for school psychologists? To date, literature has not examined school psychologists' opinions about formats of in-service trainings (Splett et al., 2013).

In this study, Discussion had the highest favorability ratings followed by Case Study. These findings are consistent with principles of adult education (Feist, 2003; Lawler, 2003). Discussion and Case Study allow time for school psychologists to share experiences and relate new information to prior experiences. Both formats require a level of participation that might not be perceived as intimidating and uncomfortable like Observation/Modeling and Role Play/ Practice. Opinions about Observation/Modeling

and Role Play/Practice formats ranged from Not Helpful to Helpful as more is required of the participants. Depending on the level of comfort, participants may enjoy these activities or not feel comfortable. Opinions about the Lecture format ranged from Slightly Helpful to Helpful. Lecture is a common format for professional development. Perhaps, school psychologists see Lecture as helpful to a degree, but with limitations. Lecture does not allow for contributing experiences and engaging in in-depth discussion about topics. The least preferred training style format was Webinar. Multiple reasons could explain the unpopularity of webinars such as learning in isolation and the format not allowing for opportunities to share experiences and work alongside peers.

Clinical Supports and Supervision in the Schools

The fifth question of this study was: How often do school psychologists receive clinical supervision at their schools? In the literature reviewed, school psychologists report receiving limited clinical supervision (e.g., Crespi & Dupe, 2005; Curtis et al., 2008; Curtis et al., 2012; Harey & Pearrow, 2010). The most recent survey of the field found that slightly more than half of school psychologists' surveyed report receiving administrative supervision, not clinical supervision (Curtis et al., 2012).

Like prior literature, majority of school psychologists in this study reported not participating in clinical supervision at their schools. Yet, participants report that it would be useful to receive clinical supervision. Unfortunately, school psychologists are not receiving clinical supervision. Even though this type of support could potentially address the problem of limited participation in mental health services and low levels of competency.

Since the expectation of receiving clinical supervision is low, alternatives to clinical supervision have become more predominant in the literature (e.g., Curtis et al., 2012). Therefore, the sixth question of this study was: What clinical supports do school psychologists deem useful for the provision of mental health services? According to the literature, 28.5% reported receiving some form of clinical support such as systematic professional support, mentoring, and/or peer supervision (Curtis et al., 2012). However, the literature has no yet addressed the perceptions of usefulness of clinical supports in practice. It is interesting to note that the most recent survey of practices of school psychologists did not even acknowledge clinical supervision. Instead the question of clinical supervision was reframed as clinical supports (Curtis et al., 2012).

In this study, the majority of the school psychologists were willing to participate in all of the clinical supports with varying degrees of willingness. Case Conferences and Topic-Specific Meetings with Peers were the most preferred clinical supports followed by Small Mentoring Groups and Mentoring. The least favorable clinical support was Peer Supervision without a Clinical Supervisor. A possible explanation for these results is that school psychologists prefer meeting in structured (i.e., case conferences, topic-specific meetings) groups with peers. This could be another example of school psychologists feeling the constraints of time. Instead of an open-ended processing group like Peer Supervision without a Clinical Supervisor, participants in this study prefer learning about a topic or reviewing a case, and possibly want to avoid the common practice of professional peers congregating at work and discussing topics unrelated to work. This might also explain why Mentoring with an Experienced Peers was also preferred. The experienced peer can facilitate the discussion and ensure that the experience is based on

improving skills and knowledge. These results reveal that school psychologists do want to learn from other school psychologists with more experience. This is an important finding and should be examined more closely in regards to clinical supports.

Even though participants expressed a willingness to participate in clinical supports, when asked about reserving time in their schedules for these activities, responses were divided with Annually having the highest percentage. Engaging in clinical supports once a year is not sufficient time to improve practice and increase competency in the delivery of mental health services. On an As Needed Basis had the second highest percentage, but this too would make changes to practice questionable. Some participants are willing to participate Monthly, which can be an adequate time for making changes to practices.

School Psychologists' Level of Degree and Effect on Responses

The seventh question of this study was: Are these differences in the above responses based on school psychologists level of degree, master's degree or doctoral degree? This study examined how a school psychologist's level of degree, master's degree or doctoral degree, would affect how they responded on questions related to mental health problems in their schools, levels of competency in various mental health services, and willingness to participate in clinical supports. Based on the results, doctoral level school psychologists report greater levels of competence in individual counseling, group counseling, crisis intervention, consultation, the provision of prevention programs, and mental health screening. A reasonable explanation for doctoral level school psychologists reporting greater levels of competency in these mental health services is the extended graduate training and more supervised experienced compared with master's

level school psychologists. Depending on the doctoral graduate program, school psychologists have to engage in a specific number of clinical hours, which involves providing mental health services and being supervised by a clinical doctoral level supervisor. These types of supports can lead to greater overall competency in these areas. This finding supports the importance of continuous training and clinical supports for the delivery of mental health services for increasing competency for school psychologists.

This study did not find a significant difference between competency level and level of degree in the area of Behavioral Assessment. A possible explanation to this finding is that master's level graduate programs and doctoral level graduate programs may have similar training in regards to behavioral assessment. Also, not as much attention may be given to behavioral assessment in doctoral programs compared with other mental health services (e.g., counseling, consultation). Some school psychologists have more exposure to behavioral assessment activities regardless of degree depending on their position within a school. Overall, participants reported lower levels of competency in Behavioral Assessment compared with Consultation, Crisis Intervention, and Individual Counseling.

Another area that was examined was if level of degree affected an individual's willingness to participate in clinical supports. School psychologists with a doctoral degree were more willing to receive clinical support than school psychologists with master's degree. A possible explanation is that school psychologists with a doctoral degree may be more dedicated to expanding their practice and learning. Committing to a doctoral program shows dedication to ongoing learning.

Willingness and Feasibility of Professional Development and Clinical Supports

Administrative support has been emphasized in the literature (e.g., Splett et al., 2013; Suldo et al., 2010) and in this study as a needed support to providing mental health services. Therefore, it was important to ascertain a description of administrative support relating to professional development and clinical supports for school psychologists. The eighth question of this study was: To what extent are administrators willing to implement in-service professional development related to the provision of mental health services and clinical supports for school psychologists? Current literature has not yet examined administrators' willingness to implement in-service professional development and clinical supports related to mental health services for school psychologists.

Not surprisingly, administrators endorsed Single Session Training over other clinical supports. Single Session Training is most likely the support currently used if in-service professional development exists at a district. It takes less planning and coordination to implement Single Session Training and consumes less resources (e.g., time, space, personnel) to sustain compared with other types of supports. Another finding was that administrators are more likely to implement a clinical support that occurs monthly rather than weekly or every other week. The supports least likely to be implemented were Weekly Clinical Supervision and Topic-Specific Every Other Week Meetings with Peers. These types of support are continuous and take time out of school psychologists' and supervisors' schedules.

Most of the findings in this study focus on a need for more time, which is consistent with previous literature (e.g., Suldo et al., 2010). Time is a significant barrier to supporting the provision of mental health services. In addition to time, funding and

staff were also identified as barriers and needed supports for implementing professional development and clinical supports. These barriers and necessary supports describe educational systems in need of resources.

School Administrators' Backgrounds and Attitudes towards Professional Development and Clinical Supports

School administrators who supervise school psychologists can have various backgrounds (i.e., psychology, education). Therefore, the ninth question of this study was: Do school psychologist administrators' attitudes differ from other types of administrators towards these activities? Findings in this study did not reveal much difference in attitudes towards feasibility and likelihood of implementation of professional development and clinical support based on school administrators' backgrounds. Only in one area, school administrators with a psychology degree rather than an education degree, were they more likely to perceive Small Mentoring Groups as more feasible to implement. There are possible explanations for these findings. Firstly, administrators regardless of degree type or background have similar functions and responsibilities. These responsibilities mostly revolve around compliance issues, ensuring that professionals are fulfilling their roles and expectations, managing schedules, and addressing crises that arise within the school. Most of the literature reports that school psychologists receive administrative supervision (e.g., Curtis et al., 2012), which focuses on the aforementioned responsibilities. Secondly, perhaps professional development and clinical supports for school psychologists are not perceived as valuable enough which to devote time. Also, administrators may not believe that school psychologists need

additional training in mental health services. Most of the literature supports this notion that school administrators are not abreast of the mental health needs of students.

Limitations and Future Research

A limitation of this study is the small number of participants, both school psychologists and school administrators. Results derived from both groups cannot be generalized to other areas. An even smaller percentage of school administrators completed the surveys than school psychologists. Thus, findings from the school administrators cannot be viewed as a representative of school administrators' opinions within Central New Jersey, the location designated within the study. Further research could expand this study to include other parts of New Jersey and other states.

Additionally, the administrator survey was emailed to principals, supervisors, and assistant principals in Central New Jersey. The nature and extent of supervision the respondents provided to school psychologists was unclear. When examining school administrators' perceptions about professional development and clinical supports for school psychologists, further research should specify if school administrators supervise school psychologists directly. This study attempted to examine if a school administrator's background might affect their willingness to implement professional development and clinical supports for school psychologists. However, within the sample of administrators only a small percentage had a degree in psychology. This discrepancy affected the answer to Research Question 9.

The need for administrative support was highlighted in this study and previous literature (e.g., Splett et al., 2013). Future research should explore the extent that school administrators are knowledgeable of mental health issues and ways they believe mental

health can be addressed in schools. Information can then be used to develop trainings for school administrators so they can better meet the needs of school psychologists in this area.

Suggestions for Practical Professional Development and Clinical Supports

Findings from this study reinforce the need for professional development to support the delivery of mental health services by school psychologists. Time has been identified in the literature and this study as the main barrier to delivering mental health services. Therefore, it needs to be considered when developing and implementing professional development and clinical supports for school psychologists. It is suggested that these supports occur once a month or every other month. Additionally, providing time at the start of the school year for professional development and clinical supports to be scheduled on the school calendar throughout the school year will allow school psychologists to plan ahead and manage time more efficiently to make space for these activities.

At the start of the school year or in the summer months, school psychologist supervisors or administrators should survey the school psychologists in their districts to identify training preferences for mental health topics. A list can then be compiled with the top ten most frequently indicated topics, which will be returned to the school psychologists at the start of the school year for review. Each school psychologist in the district should have opportunities to guide monthly discussions with peers through a format (e.g., discussion, case study, case conference) of their choosing as long as they address one of the preferred topics. Since school psychologists prefer a more experienced peer to facilitate the group, a supervisor or administrator could select a school

psychologist with the most experience to facilitate the trainings. The school psychologists could develop the training schedule in September that organizes the professional development throughout the school year. Additionally, if there is a topic unfamiliar to the school psychologists, the supervisor or administrator should be notified to look for a guest speaker, if possible, if a school psychologist does not volunteer to learn about the topic and share the knowledge with his or her peers. Case conferencing or case presentation can be integrated with each topic to illustrate how to use a particular strategy or to provide an example based on the content. These professional development suggestions can be modified for schools with a fewer number of school psychologists. A supervisor or administrator can contact a local district so school psychologists from a different district can have an opportunity to work in small groups addressing preferred topics.

Mentoring programs are also an inexpensive method for providing professional development and clinical supports. Experienced school psychologists in a district could be paired with a less experienced school psychologist at the start of the school year. The mentor and mentee could meet to develop a schedule for the year that includes monthly times and dates to meet. It is also suggested that the mentee and the mentor each develop a list of problems related to mental health services that need addressing along with a list of skills that are important to learn or enhance. Additionally, time could be allotted for case conferencing in the mentoring program.

Conclusion

Overall, the slowly shifting role of the school psychologist from an evaluator to a mental health provider affects many students in need of mental health services. Graduate training is not enough to ensure that school psychologists are competent in providing mental health services. Professional development and clinical supports need to be available for school psychologists at their place of employment like other professionals in schools who receive in-service professional development. This should not be different for school psychologists. However, multiple barriers identified in this study and in previous research exist that impede school districts ability to provided these supports. The information gleaned from this study can be used by school districts to provide cost effective and practical solutions for professional development and clinical supports so school psychologists can fully encompass their training as mental health providers.

Appendix A: **Professional Development and Clinical Supports Survey**

Part I: Demographic Information

2. Please select your current degree(s).

- [ ] Master's
- [ ] Doctorate
- [ ] Other (please specify)

3. Please select the school level(s) in which you currently work.

- [ ] Preschool
- [ ] Elementary School
- [ ] Middle School
- [ ] High School

4. Please select the population with which you currently work.

- [ ] General Education
- [ ] Special Education
- [ ] Both

5. Please select the setting of your school.

- [ ] Urban
- [ ] Suburban
- [ ] Rural

6. Please select the number of students in your district.

- [ ] less than 500
- [ ] 500 to 1000
- [ ] 1000 to 5000
- [ ] greater than 5000

7. Please select the number of students you are responsible for in your school.

- [ ] less than 30
- [ ] 30 to 60
- [ ] more than 60

8. Please select the general socioeconomic status of students in your school.

- [ ] low
- [ ] medium
- [ ] high

9. How many years have you been working as a school psychologist for your district?

- [ ] less than 5
- [ ] between 5 and 10
- [ ] more than 10

10. How many years of professional experience do you have?

- [ ] less than 5
- [ ] between 5 and 10
- [ ] more than 10

Part II: Provision of Mental Health Services

11. Using the scale of 1 (not a problem) to 5 (a big problem), what is your opinion about the extent of mental health problems amongst students in your school?

1	2	3	4	5
○	○	○	○	○

12. Please list 5 of the most common mental health problems amongst students in your school.

1.
2.
3.
4.
5.

13. What percentage of your time during a typical week is spent providing mental health services?

- ☐ 0
- ☐ 10
- ☐ 20
- ☐ 30
- ☐ 40
- ☐ 50
- ☐ 60
- ☐ 70
- ☐ 80
- ☐ 90
- ☐ 100

☐

14. Indicate which mental health services you provide in a typical week. Check all that apply.

- [ ] Individual Counseling
- [ ] Group Counseling
- [ ] Crisis intervention
- [ ] Consultation
- [ ] Behavioral Assessment
- [ ] Provision of Prevention Programs
- [ ] Mental Health Screening

Other (please specify)

15. Using the scale of 1 (not competent) to 5 (very competent), indicate your perceived level of competency delivering mental health services.

	1	2	3	4	5
Individual Counseling	○	○	○	○	○
Group Counseling	○	○	○	○	○
Crisis intervention	○	○	○	○	○
Consultation	○	○	○	○	○
Behavioral Assessment	○	○	○	○	○
Provision of Prevention Programs	○	○	○	○	○
Mental Health Screening	○	○	○	○	○
Other Category	○	○	○	○	○

Please specify other category

16. Indicate what topics you would like to receive training on to assist in the provision of mental health services.

1.
2.
3.
4.
5.

17. Indicate which training formats you find most effective. Check all that apply.

- [ ] Lecture
- [ ] Discussion
- [ ] Observation/ Modeling
- [ ] Role-Play/ Practice
- [ ] Case Study
- [ ] Webinar
- [ ] Other Category

18. What do you believe are the barriers to providing mental health services in your school(s)?

1.
2.
3.
4.
5.

19. What types of support do you feel you need to improve your mental health services to make them more effective?

1.
2.
3.
4.
5.

Part III: In-Service Training and Clinical Supports

20. How many in-service trainings (i.e., trainings available at your place of employment) did you attend this year?

21. Indicate up to 5 in-service training topics you attended this year.

Training Topic 1
Training Topic 2
Training Topic 3
Training Topic 4
Training Topic 5

22. Rate 1 (not helpful) to 5 (most helpful) the extent the training helped you deliver mental health services.

	1	2	3	4	5
Training Topic 1	○	○	○	○	○
Training Topic 2	○	○	○	○	○
Training Topic 3	○	○	○	○	○
Training Topic 4	○	○	○	○	○
Training Topic 5	○	○	○	○	○

23. Rate 1 (not helpful) to 5 (most helpful) the extent methods used in each training were helpful in delivering the content of the training. It is not necessary to rate methods that were not used in a training.

	Lecture	Discussion	Observation/ Modeling	Role-Play/ Practice	Case Study	Webinar	Other
Training Topic 1	☐	☐	☐	☐	☐	☐	☐
Training Topic 2	☐	☐	☐	☐	☐	☐	☐
Training Topic 3	☐	☐	☐	☐	☐	☐	☐
Training Topic 4	☐	☐	☐	☐	☐	☐	☐
Training Topic 5	☐	☐	☐	☐	☐	☐	☐

Other (please specify)

Clinical supervision is a regularly scheduled meeting with a clinical supervisor with the same discipline-specific training and knowle who models and teaches skills through case conceptualization, sharing of knowledge, objective feedback and discussion of practic and provides support during and after challenging situations.

24. Using the scale of 1 (not useful) to 5 (very useful), how useful would it be to participate in clinical supervision at your school?

1	2	3	4	5
○	○	○	○	○

25. How often do you receive some type of clinical supervision at your school?

- ○ Never
- ○ Weekly
- ○ Monthly
- ○ Annually
- ○ As Needed

26. What types of clinical supports are you willing to participate in? Check all that apply.

- ☐ Mentoring (i.e., individual meetings with an experienced peer)
- ☐ Small (4 peers or less) mentoring groups facilitated by an experienced peer
- ☐ Peer supervision groups without a clinical supervisor
- ☐ Case conferences (i.e., meetings with peers to review challenging cases)
- ☐ Topic-specific meetings with peers
- ☐ Other (please specify)

27. Finding time for clinical supervision is difficult. Using the scale of 1 (not at all) to 5 (very willing), how willing are you to participate in clinical supports at your school?

1	2	3	4	5
○	○	○	○	○

28. How often are you willing to reserve time in your work schedule to participate in trainings related to mental health services and clinical supports?

- [ ] Weekly
- [ ] Monthly
- [ ] Every Other Month

29. Do you think you would be more willing to expand your role as a mental health provider if you received useful mental health trainings and ongoing clinical supports?

- ( ) Yes
- ( ) No

30. Please provide any additional thoughts regarding training and clinical supervision as a school psychologist.

1.
2.
3.
4.

Please send an email to dana.freed@gmail.com and include your name and email address if you would like to enter to win one of three $30.00 gift cards. Thank you for your participation.

Appendix B: **Professional Development and Clinical Supports Feasibility Survey for Administrators**

Part I: Demographic Information

2. Please select your current degree(s).

- [ ] Master's
- [ ] Doctorate
- [ ] Other (please specify)

3. Please select your current title.

- [ ] Supervisor
- [ ] Principal
- [ ] Assistant Principal

4. What is your degree in (name of graduate program)?

Degree:

Name of Graduate Program:

5. How many years have you been working in this position?

- ○ less than 5
- ○ between 5 and 10
- ○ more than 10

6. Please select the setting of your school.

- [ ] Urban
- [ ] Suburban
- [ ] Rural

7. Please select the number of students in your district.

- ◯ less than 500
- ◯ 500 to 1000
- ◯ 1000 to 5000
- ◯ greater than 5000

8. Please select the number of students you are responsible for in your school.

- ◯ less than 50
- ◯ 50 to 100
- ◯ more than 100

9. Please select the general socioeconomic status of students in your school.

- ☐ low
- ☐ medium
- ☐ high

10. Please select the school level(s) in which you currently work.

- ◯ Preschool
- ◯ Elementary School
- ◯ Middle School
- ◯ High School

11. Please select the population with which you currently work.

- ◯ General Education
- ◯ Special Education
- ◯ Both

Part II: Feasibility of Supports

Providing professional development and other supports to school psychologists can facilitate school psychologists to take a greater role in addressing the mental health needs of students.

12. Below is a list of types of professional development and clinical supports for school psychologists providing mental health services. Using the scale of 1 (not feasible) to 5 (very feasible), in your opinion how feasible are these supports in most schools for school psychologists?

	1	2	3	4	5
Single session training addressing the provision of mental health services (e.g., individual and group counseling, crisis intervention, consultation, topics related to mental health)	○	○	○	○	○
Multi-session ongoing training addressing the provision of mental health services (e.g., individual and group counseling, crisis intervention, consultation, topics related to mental health)	○	○	○	○	○
Weekly clinical supervision (i.e., with a clinical supervisor with the same discipline-specific training and knowledge who models and teaches skills through case conceptualization, sharing of knowledge, objective feedback and discussion of practice)	○	○	○	○	○

	1	2	3	4	5
Monthly clinical supervision (i.e., with a clinical supervisor with the same discipline-specific training and knowledge who models and teaches skills through case conceptualization, sharing of knowledge, objective feedback and discussion of practice)	○	○	○	○	○
Mentoring (i.e., individual every other week meetings with an experienced peer)	○	○	○	○	○
Small (4 peer of less) monthly mentoring groups facilitated by an experienced peer	○	○	○	○	○
Peer monthly supervision groups without a supervisor	○	○	○	○	○
Case Conferences (i.e., monthly meetings with peers to review challenging cases)	○	○	○	○	○
Topic-specific every other week meetings with peers	○	○	○	○	○

13. Using the scale of 1 (will not implement) to 5 (will definitely implement), indicate the likelihood you are willing to work to implement these supports in your district.

	1	2	3	4	5
Single session training addressing the provision of mental health services (e.g., individual and group counseling, crisis intervention, consultation, topics related to mental health)	○	○	○	○	○

	1	2	3	4	5
Multi-session ongoing training addressing the provision of mental health services (e.g., individual and group counseling, crisis intervention, consultation, topics related to mental health)	○	○	○	○	○
Weekly clinical supervision (i.e., with a clinical supervisor with the same discipline-specific training and knowledge who models and teaches skills through case conceptualization, sharing of knowledge, objective feedback and discussion of practice).	○	○	○	○	○
Monthly clinical supervision (i.e., with a clinical supervisor with the same discipline-specific training and knowledge who models and teaches skills through case conceptualization, sharing of knowledge, objective feedback and discussion of practice)	○	○	○	○	○
Mentoring (i.e., individual every other week meetings with an experienced peer)	○	○	○	○	○
Small (4 peer of less) monthly mentoring groups facilitated by an experienced peer	○	○	○	○	○
Peer monthly supervision groups without a supervisor	○	○	○	○	○
Case Conferences (i.e., monthly meetings with peers to review challenging cases)	○	○	○	○	○

	1	2	3	4	5
Topic-specific every other week meetings with peers	○	○	○	○	○

14. What do you believe are the barriers to providing training on the provision of mental health services?

1.
2.
3.
4.
5.

15. What additional supports do you need to provide training on the provision of mental health services?

1.
2.
3.
4.
5.

16. What do you believe are the barriers to providing clinical supervision supports for school psychologist?

1.
2.
3.
4.
5.

17. What additional supports do you need to provide clinical supervision supports for school psychologists?

1.
2.
3.
4.
5.

Please send an email to dana.freed@gmail.com and include your name and email address if you would like to enter to win one of three $30.00 gift cards. Thank you for your participation.

Appendix C: **Email Invitation for School Psychologists**

Dear School Psychologist,

You are being invited to participate in a study being conducted by Dana Freed, a doctoral student in School Psychology. The purpose of this study is to develop practical cost effective suggestions for addressing the need for training in mental health services and clinical support for school psychologists. If you choose to participate, you will be asked to complete an online survey by responding to questions about your experiences and preferences for professional development and clinical supports related to the provision of mental health services at your place of employment. It should take approximately 20 minutes to complete the survey.

Your participation is anonymous and voluntary. If you choose to participate, you will type the link into a web browser. Therefore, your responses will not be linked to you in anyway. The first page of the survey is a consent form, which will include details about the study and provide an option to consent to participate. There are no foreseeable risks to participation in this study.

By choosing to participate in this study, you can choose to enter into a raffle drawing to win one of three $30.00 gift cards. Instructions for entering the raffle will be included at the end of the survey. Your request will not be attached to your survey responses.

To begin the survey, please open an internet web browser and type in the following link:

https://www.surveymonkey.com/r/5ZX8LPD

Thank you for your time.

Dana Freed, MS.Ed, Psy.M
Doctoral Student in School Psychology
Graduate School of Applied and Professional Psychology
Rutgers University
152 Frelinghuysen Rd
Piscataway, NJ 008854
Tel: 347-249-0121

Appendix D: **Email Invitation for Administrators**

Dear Administrator,

You are being invited to participate in a study being conducted by Dana Freed, a doctoral student in School Psychology. The purpose of this study is to develop practical cost effective suggestions for addressing the need for training in mental health services and clinical support for school psychologists. If you choose to participate, you will be asked to complete an online survey by responding to questions about your preferences for implementing professional development and clinical supports related to the provision of mental health services for school psychologists. It should take approximately 20 minutes to complete the survey.

Your participation is anonymous and voluntary. If you choose to participate, you will type the link into a web browser. Therefore, your responses will not be linked to you in anyway. The first page of the survey is a consent form, which will include details about the study and provide an option to consent to participate. There are no foreseeable risks to participation in this study.

By choosing to participate in this study, you can choose to enter into a raffle drawing to win one of three $30.00 gift cards. Instructions for entering the raffle will be included at the end of the survey. Your request will not be attached to your survey responses.

To begin the survey, please open an internet web browser and type in the following link:

https://www.surveymonkey.com/r/55WRTQ5

Thank you for your time.

Dana Freed, MS.Ed, PsyM
Doctoral Student in School Psychology
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Piscataway, NJ 008854
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Appendix E: **Consent Form for School Psychologists**

Rutgers, The State University of New Jersey
Consent Form
Professional Development and Clinical Supports Survey

Dear School Psychologist,

You are being invited to participate in a study being conducted by Dana Freed, a doctoral student in School Psychology. The purpose of this study is to develop practical cost effective suggestions for addressing the need for training in mental health services and clinical support for school psychologists. If you choose to participate, you will be asked complete an online survey by responding to questions about your experiences and preferences for professional development and clinical supports related to the provision of mental health services at your place of employment. It should take approximately 20 minutes to complete the survey.

This research is anonymous. Anonymous ratings that I will record no information about you that could identify you. This ratings that I will not record your name, address, phone number, date of birth, etc. If you choose to participate, you will type the link into a web browser. Therefore, your responses will not be linked to you in anyway. There are no foreseeable risks to participation in this study. The research team and the Institutional Review Board at Rutgers University are the only parties that will be allowed to see the data, except as may be required by law. All study data will be kept for three years.

Your participation in this study is voluntary. You may choose not to participate. If you choose to participate, you may stop working on the survey at any time without any penalty to you. In addition, you may choose not to answer any questions with which you are not comfortable.

By choosing to participate in this study, you can choose to enter into a raffle drawing to win one of three $30.00 gift cards. Instructions for entering the raffle will be included at the end of the survey. Your request will not be attached to your survey responses.

If you have any questions about the study procedures, you may contact the primary investigator, Dana Freed or the study faculty advisor, Susan Forman at:

Dana Freed, MS.Ed, Psy.M.
Doctoral Student in School Psychology
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Rutgers University
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Susan Forman, Ph.D
University Professor
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Graduate School of Applied and Professional Psychology, Rutgers University
152 Frelinghuysen Rd.
Piscataway, NJ 008854
Tel: 848-445-3975
Email: sgforman@rci.rutgers.edu

If you have any questions about your rights as a research subject, please contact an IRB Administrator at the Rutgers University, Arts and Sciences IRB:

Institutional Review Board
Rutgers University, the State University of New Jersey
Liberty Plaza / Suite 3200
335 George Street, 3rd Floor
New Brunswick, NJ 08901
Phone: 732-235-9806
Email: humansubjects@orsp.rutgers.edu

If you are 18 years of age or older, understand the statements above, and will consent to participate in the study, click on the "I Agree" button to begin the survey/experiment. If not, please click on the "I Do Not Agree" button which you will exit this program.

I Agree | I Do Not Agree

Appendix F: **Consent Form for Administrators**

Rutgers, The State University of New Jersey
Consent Form
Professional Development and Clinical Supports Feasibility Survey for Administrators

Dear Administrator,

You are being invited to participate in a study being conducted by Dana Freed, a doctoral student in School Psychology. The purpose of this study is to develop practical cost effective suggestions for addressing the need for training in mental health services and clinical support for school psychologists. If you choose to participate, you will be asked to complete an online survey by responding to questions about your preferences for implementing professional development and clinical supports related to the provision of mental health services for school psychologists. It should take approximately 20 minutes to complete the survey.

This research is anonymous. Anonymous ratings that I will record no information about you that could identify you. This ratings that I will not record your name, address, phone number, date of birth, etc. If you choose to participate, you will type the link into a web browser. Therefore, your responses will not be linked to you in anyway. There are no foreseeable risks to participation in this study. The research team and the Institutional Review Board at Rutgers University are the only parties that will be allowed to see the data, except as may be required by law. All study data will be kept for three years.

Your participation in this study is voluntary. You may choose not to participate. If you choose to participate, you may stop working on the survey at any time without any penalty to you. In addition, you may choose not to answer any questions with which you are not comfortable.

By choosing to participate in this study, you can choose to enter into a raffle drawing to win one of three $30.00 gift cards. Instructions for entering the raffle will be included at the end of the survey. Your request will not be attached to your survey responses.

If you have any questions about the study procedures, you may contact the primary investigator, Dana Freed or the study faculty advisor, Susan Forman at:

Dana Freed, MS.Ed, Psy.M.
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Graduate School of Applied and Professional Psychology, Rutgers University
152 Frelinghuysen Rd.
Piscataway, NJ 008854
Tel: 848-445-3975
Email: sgforman@rci.rutgers.edu

If you have any questions about your rights as a research subject, please contact an IRB Administrator at the Rutgers University, Arts and Sciences IRB:

Institutional Review Board
Rutgers University, the State University of New Jersey
Liberty Plaza / Suite 3200
335 George Street, 3rd Floor
New Brunswick, NJ 08901
Phone: 732-235-9806
Email: humansubjects@orsp.rutgers.edu

If you are 18 years of age or older, understand the statements above, and will consent to participate in the study, click on the "I Agree" button to begin the survey/experiment. If not, please click on the "I Do Not Agree" button which you will exit this program.

I Agree | I Do Not Agree

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Tables

Table 1

Frequencies and Percentages of Demographic Characteristics within the Sample of Psychologists

Variable	Value	*N*	*%*
Education	Doctorate	28	30.1
	Master's	65	69.9
Years as School Psychologist	Less than 5	45	48.4
	Between 5 and 10	19	20.4
	More than 10	29	31.2
Years of Professional Experience	Less than 5	30	32.3
	Between 5 and 10	17	18.3
	More than 10	46	49.5
Number of Students Responsible For	Less than 30	9	9.7
	30 to 60	48	51.6
	More than 60	34	36.6
	Not Reported	2	2.2
Levels With Which You Currently Work	Pre-School	32	34.4
	Elementary School	53	57.0
	Middle School	47	50.5
	High School	35	37.6
Population With Which You Work	General Education	1	1.1
	Special Education	47	50.5
	Both	45	48.4
Urbanicity	Suburban	23	24.7
	Urban	66	71.0
	Rural	4	4.3
Number of Students in District	1000 to 5000	42	45.2
	500 to 1000	14	15.1
	Greater than 5000	30	32.3
	Less than 500	7	7.5
Median Socio-Economic Status	Low	31	33.3
	Medium	46	49.5
	High	15	16.1

Table 2

Frequencies and Percentages of Demographic Characteristics within the Sample of Administrators

Variable	Value	*N*	*%*
Education	Doctorate	8	19.5
	Master's	33	80.5
Administrative Role	Assistant Principal	13	31.7
	Principal	16	39.0
	Supervisor	11	26.8
	Missing	1	2.4
Degree Type	Doctorate	8	19.5
	Master's	33	80.5
Years at Position	Between 5 and 10	17	41.5
	Less than 5	17	41.5
	More than 10	7	17.1
Number of Students Under Responsibility	More than 100	40	97.6
	Missing	1	2.4
School Type	Elementary School	19	46.3
	High School	10	24.4
	Middle School	11	26.8
	Missing	1	2.4
Urbanicity	Suburban	28	68.3
	Urban	10	24.4
	Missing	3	7.3
Number of Students in District	1000 to 5000	17	41.5
	500 to 1000	10	24.4
	Greater than 5000	12	29.3
	Less than 500	2	4.9
Median Socio-Economic Status	Low	13	31.7
	Medium	22	53.7
	High	6	14.6
Population Type	General Education	2	4.9
	Special Education	4	9.8
	General Education and Special Education	35	85.4

Table 3

Percentages of Ratings of Mental Health Problems in Schools

		Percentage who scored						
	n	Not at all a problem	Slight problem	Somewhat a problem	Problem	Big Problem	*M*	*SD*
Using the scale of 1 (not a problem) to 5 (a big problem), what is your opinion about the extent of mental health problems amongst students in your school?	68	0.0	2.9	35.29	47.1	14.7	3.74	.75

Table 4

Percentages of Responses Indicating Most Common Mental Health Problems in Schools

Please list 5 of the most common mental health problems amongst students in your school.	*N*	*%*
Mood Disorder	60	89.5
Anxiety	58	86.6
Behavioral Disorders	49	73.1
ADHD	36	53.8
Substance Abuse	11	16.4
Social Deficits	10	15
Autism	10	14.9
Undiagnosed Disorder	10	14.9
Self Injury	6	9.0
School Phobia	6	9.0
PTSD	2	3.0
Adjustment Disorder	1	1.5
Attachment Disorder	1	1.5
Eating Disorder	1	1.5
Medication Mismanagement	1	1.5
Schizophrenia	1	1.5
Sensory Integration Disorder	1	1.5

Table 5

Response Means of Percentages of Time in a Typical Week Providing Mental Health Services

		Percentage of time indicated										
	n	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
What percentage of your time during a typical week is spent providing mental health services?	71	8.5	23.9	19.7	12.7	7.0	5.6	2.8	15.5	1.4	2.8	0.0

Table 6

Percentages of Responses Indicating Mental Health Services Provided in a Typical Week

Indicate which mental health services you provide in a typical week. Check all that apply.	*N*	*%*
Individual Counseling	54	80.6
Group Counseling	32	47.8
Crisis Intervention	43	64.2
Consultation	61	91.0
Behavioral Assessment	40	59.7
Provision of Prevention Programs	15	22.4
Mental Health Screening	16	23.9

Table 7

Percentages of Responses Indicating Barriers to Mental Health Services

Indicate what are the barriers in the provision of mental health services.	*N*	*%*
Time	66	98.51
Limited Resources	28	41.8
Staff Indifference	27	40.3
School Administration	20	29.85
Lack of Parental Involvement	15	22.4
Limited Training for Staff	13	19.4
Student Resistance	5	7.47
Limited Community Resources	3	4.48
School Policies	1	1.49
Limited Prevention Practices	1	1.49
Limited Clinical Supervision	1	1.49

Table 8

Percentages of Ratings of Competency Delivering Mental Health Services

Using the scale of 1 (not competent) to 5 (very competent), indicate your perceived level of competency delivering mental health services.		Percentage who scored						
	n	Not Competent	Slightly Competent	Somewhat Competent	Competent	Very Competent	*M*	*SD*
Individual Counseling	71	1.4	5.6	23.9	38.0	31.0	3.92	.95
Group Counseling	71	1.4	11.3	38.0	28.2	21.1	3.56	1.00
Crisis Intervention	71	2.9	5.7	22.9	44.3	24.3	3.81	.97
Consultation	71	1.4	2.9	17.1	44.3	34.3	4.07	.87
Behavioral Assessment	71	1.4	12.7	23.9	36.6	25.4	3.72	1.03
Provision of Prevention Programs	71	5.7	30.0	30.0	24.3	10.0	3.03	1.09
Mental Health Screening	71	4.4	21.7	24.6	30.4	18.9	3.38	1.15

Table 9

Percentages of Types of Supports Identified to Improve Mental Health Services

What types of support do you feel you need to improve your mental health services to make them more effective?	*N*	*%*
Professional Development	36	64.4
Resources (e.g., time, space, funding, technology)	29	46.4
Administrative Support	19	33.9
Home School Collaboration	13	23.3
Smaller Caseload	10	17.9
Wraparound	7	12.6
Prioritization of Mental Health Services	6	10.7
Peer Supervision	5	8.9
Teacher Training	4	7.1
Behavior Supports in School	3	5.4
Staff Collaboration	3	5.4
Clinical Supervision	1	1.8

Table 10

Percentages of Identified Training Topics by Participants

Indicate what topics you would like to receive training on to assist in the provision of mental health services.	*N*	*%*
Mental Health Disorders (e.g., anxiety, depression, OCD, ODD, ADHD, self-injury, Schizophrenia)	26	43.4
Evidence-Based Counseling Interventions (e.g., CBT, DBT)	26	43.4
Mental Health Screening	18	30.1
Crisis Intervention	15	25
Behavior Assessment	10	16.7
Prevention Programs	9	15.0
Group Counseling	9	15.0
School Phobia	5	8.4
Systems Change	4	6.7
Positive Psychology	4	6.7
LBGT Issues	3	5.0
Family Interventions	3	5.0
Consultation	3	5.0
Behavioral Intervention	3	5.0
Psychopharmacology	2	3.3
Community Services	2	3.3
Classroom Interventions	2	3.3
Trauma	1	1.7
RTI	1	1.7
Resource Allocation	1	1.7
Positive Behavior Supports	1	1.7
Neuropsychology	1	1.7
Legal Issues	1	1.7
Grant Writing	1	1.7
Cultural Competency	1	1.7
Case Management	1	1.7

Table 11

Percentage of In-Service Trainings Attended in the Past Year

Number of In-service Trainings Attended	*N*	*%*
0	5	5.4
1	3	3.2
2	13	14.0
3	13	14.0
4	6	6.5
5	9	9.7
6	3	3.2
7	2	2.2
8	1	1.1
10	6	6.5
15	3	3.2
20	1	1.1
50	1	1.1

Table 12

Percentage of Helpfulness of Topic of Trainings Attended

	N	Not Helpful	Slightly Helpful	Somewhat Helpful	Helpful	Most Helpful	Mean	SD
Academic Interventions/ Instruction	15	73.33%	6.67%	13.33%	6.67%	0.00%	1.53	0.99
Administrative/Management Responsibilities	8	100.00%	0.00%	0.00%	0.00%	0.00%	1.00	0.00
Assessment	31	67.74%	6.45%	6.45%	12.90%	6.45%	1.84	1.37
Behavioral Assessment and Intervention	20	20.00%	15.00%	30.00%	30.00%	5.00%	2.85	1.23
Case Management	3	33.33%	0.00%	33.33%	0.00%	33.33%	3.00	2.00
Crisis intervention & Prevention	32	12.50%	6.25%	18.75%	31.25%	31.25%	3.63	1.34
Developmental Disabilities	6	0.00%	33.33%	33.33%	16.67%	16.67%	3.17	1.17
Educational Classifications	22	59.09%	13.64%	4.55%	13.64%	9.09%	2.00	1.45
Evidence-Based Counseling Interventions	18	5.56%	16.67%	11.11%	27.78%	38.89%	3.78	1.31
Health-Related Concerns	4	50.00%	0.00%	0.00%	25.00%	25.00%	2.75	2.06
Mental Health Disorders	21	4.76%	14.29%	28.57%	28.57%	23.81%	3.52	1.17
Special Education	30	33.33%	23.33%	23.33%	3.33%	16.67%	2.47	1.43
Technology	6	83.33%	16.67%	0.00%	0.00%	0.00%	1.17	0.41

Table 13

Percentage of Training Formats Found Most Effective Amongst Participants

(N = 71)

Indicate which training formats you find most effective. Check all that apply.	*N*	*%*
Discussion	55	77.5
Observation/Modeling	54	76.1
Lecture	41	57.8
Case Study	38	53.5
Role-Play / Practice	33	46.5
Webinar	27	30.8
Other	4	5.6

Table 14

Response Means of Helpfulness of Training Format Per Training Topic Attended Using a Likert Scale

	N	Overall Rating	Lecture	Discussion	Observation Modeling	Role Play Practice	Case Study	Webinar	Other
Academic Interventions/ Instruction	15	1.71	2.77	4.00		3.00	4.00		
Administrative/ Management Responsibilities	8	1.00	2.50	3.00	3.00			3.00	
Assessment	31	1.97	2.86	3.21	2.00	3.83	3.60	2.60	
Behavioral Assessment and Intervention	20	3.00	2.75	4.00	3.00		3.86	3.00	
Case Management	3	3.00	4.50	4.00			3.00		
Crisis intervention & Prevention	32	3.56	3.46	3.88	4.00	3.50	3.89	2.25	
Developmental Disabilities	6	3.17	4.00	4.00			4.00		
Educational Classifications	22	2.00	2.56	3.56	1.00	2.00	2.00	2.50	
Evidence-Based Counseling Interventions	18	3.88	3.88	4.20	4.25	4.50	3.33		4.00
Health-Related Concerns	4	2.75	3.50	4.50	2.00	3.00	5.00	2.33	
Mental Health Disorders	21	3.63	3.63	3.89	4.33		4.67	2.50	
Special Education	30	2.36	3.14	3.45	3.00	2.75	4.00	1.00	
Technology	6	1.20	2.20	3.33		5.00			

Note. Mean Likert Scale ratings include 1 (not helpful), 2 (slightly helpful), 3 (somewhat helpful), 4 (helpful), and 5 (most helpful).

Table 15

Response Means of Percentages of Usefulness of Participating in Clinical Supervision

		Percentage who scored						
	n	Not Useful	Slightly Useful	Somewhat Useful	Useful	Very Useful	*M*	*SD*
Using the scale of 1 (not useful) to 5 (very useful), how useful would it be to participate in clinical supervision at your school?	66	7.6	7.6	12.1	39.4	33.3	3.83	1.20

Table 16

Response Means of Percentages of Frequency of Clinical Supervision

		Percentage who scored				
	n	Never	Weekly	Monthly	Annually	As Needed
How often do you receive some type of clinical supervision at your school?	67	74.6	10.5	6.0	1.5	7.5

Table 17

Response Means of Willingness to Participate in Clinical Supports

What types of clinical supports are you willing to participate in? Check all that apply.	*N*	*%*
Mentoring	43	66.2
Small mentoring groups facilitated by an experienced peer	44	66.7
Peer supervisions groups without a clinical supervisor	37	56.1
Case conferences	56	84.9
Topic-specific meetings with peers	50	75.8
Other	2	3.0

Table 18

Response Means of Willingness to Reserve Time to Participate in Trainings

		Percentage who reported				
	n	Never	Weekly	Monthly	Annually	As Needed
How often are you willing to reserve time in your work schedule to participate in trainings related to mental health services and clinical supports?	67	7.46	6.0	20.9	37.3	28.4

Table 19

Levels of Mental Health Problems Among Students at Respondents School by Degree

Graduate Degree Type	*N*	Rating	*SD*
Master's	48	3.75	.76
Doctorate	20	3.70	.73

Table 20

T-test for Levels of Mental Health Problems Among Students at Respondents School by Degree

Levine's Test		*t*-test				
F	*p* - value	*t*	*df*	Rating Difference	Std. Error Difference	*p* - value
.02	.89	.25	36.77	.05	.20	.80

Table 21

Self-report Competency by Degree Type

	Graduate Degree Type	N	Rating	SD
Individual Counseling	Master's	49	3.65	.948
	Doctorate	22	4.50	.673
Group Counseling	Master's	49	3.29	.957
	Doctorate	22	4.18	.795
Crisis Intervention	Master's	48	3.60	.893
	Doctorate	22	4.27	.985
Consultation	Master's	49	3.88	.832
	Doctorate	21	4.52	.814
Behavioral Assessment	Master's	49	3.61	1.037
	Doctorate	22	3.95	.999
Provision of Prevention Programs	Master's	48	2.73	1.047
	Doctorate	22	3.68	.894
Mental Health Screening	Master's	48	3.13	1.123
	Doctorate	21	3.95	1.024

Table 22

T-test for Self-report Competency by Degree Type

	Levene's Test for Equality of Variances		t-test for Equality of Ratings				
	F	*p* - value	t	df	Rating Difference	Std. Error Difference	*p* - value
Individual Counseling	2.40	.12	-3.78	69	-.85	.22	<.001
Group Counseling	.57	.45	-3.83	69	-.90	.23	<.001
Crisis Intervention	<.001	.99	-2.71	37.43	-.67	.24	.01
Consultation	.10	.75	-3.00	68	-.65	.22	.004
Behavioral Assessment	.29	.59	-1.30	69	-.34	.26	.20
Provision of Prevention Programs	.80	.37	-3.69	68	-.95	.26	<.001
Mental Health Screening	.93	.34	-2.89	67	-.83	.29	.005

Table 23

Levels of Willingness to Receive Clinical Support by Degree Type

Graduate Degree Type	*N*	Rating	*SD*
Master's	45	3.56	1.271
Doctorate	22	4.09	.811

Table 24

T-test for Levels of Willingness to Receive Clinical Support by Degree Type

Levine's Test for Equality of Variances		t-test for Equality of Ratings				
F	Sig.	t	df	Rating Difference	Std. Error Difference	*p*-value
5.27	.03	2.09	60.25	-.54	.26	.04

Table 25

Response Means of Percentages of Feasibility of Providing Professional Development and Supports

Below is a list of types of professional development and clinical supports for school psychologists providing mental health services. Using the scale of 1 (not feasible) to 5 (very feasible), in your opinion how feasible are these supports in most schools for school psychologists?	Percentage who scored							
	n	Not Feasible	Slightly Feasible	Somewhat Feasible	Feasible	Very Feasible	*M*	*SD*
Single session training addressing the provision of mental health services	33	0	7.3	17.1	31.7	24.4	3.91	0.95
Multi-session ongoing training addressing the provision of mental health services	33	0	12.2	41.5	17.1	9.8	3.3	0.88
Weekly clinical supervision	33	24.4	9.8	36.6	4.9	4.9	2.45	1.18
Monthly clinical supervision	33	0	14.6	39	12.2	14.6	3.33	0.99
Mentoring	33	2.4	9.8	31.7	26.8	9.8	3.39	0.97
Small (4 peer of less) monthly mentoring groups facilitated by an experienced peer	33	0	2.4	39	26.8	12.2	3.61	0.79
Peer monthly supervision groups without a supervisor	33	0	4.9	34.1	24.4	14.6	3.63	0.87
Case Conferences	33	0	7.3	34.1	12.2	24.4	3.69	1.03
Topic-specific every other week meetings with peers	33	7.3	22.0	29.3	9.8	9.8	2.91	1.15

Table 26

Response Means of Percentages of Likelihood of Implementation

Using the scale of 1 (will not implement) to 5 (will definitely implement), indicate the likelihood you are willing to work to implement these supports in your district.	Percentage who scored							
	n	Will Not Implement	Slight Possibility	Possibility of Implementing	Will Implement	Will Definitely Implement	*M*	*SD*
Single session training addressing the provision of mental health services	33	4.9	7.3	7.3	36.6	24.4	3.85	1.15
Multi-session ongoing training addressing the provision of mental health services	33	4.9	14.6	26.8	19.5	18.2	3.30	1.16
Weekly clinical supervision	33	24.4	17.1	22.0	12.2	4.9	2.45	1.25
Monthly clinical supervision	33	4.9	19.5	22.0	24.4	9.8	3.18	1.13
Mentoring	33	7.3	12.2	24.4	26.8	9.8	3.24	1.15
Small (4 peer of less) monthly mentoring groups facilitated by an experienced peer	33	4.9	9.8	24.4	29.3	9.8	3.38	1.07
Peer monthly supervision groups without a supervisor	33	4.9	19.5	22.0	22.0	12.2	3.21	1.17
Case Conferences	33	4.9	4.9	36.6	14.6	19.5	3.48	1.12
Topic-specific every other week meetings with peers	33	14.6	19.5	22.0	19.5	2.4	2.69	1.15

Table 27

Percentages of Responses Indicating Barriers to Providing Training

What do you believe are the barriers to providing training on the provision of mental health services?	*N*	*%*
Time	27	93.10
Limited Interest	14	48.28
Cost	8	27.59
Limited Staff	7	24.14
Large Caseload	3	10.34
Scheduling	3	10.34
Lack of Facilities	3	10.34

Table 28

Percentages of Responses Indicating Additional Supports to Providing Training

What additional supports do you need to provide training on the provision of mental health services?	*N*	*%*
Cost	12	46.15
More Time	11	42.31
Additional Staff	10	38.47
Better Scheduling	3	11.54
Consultants	1	3.85
More Interest	1	3.85
Additional Space	1	3.85

Table 29

Percentages of Responses Indicating Barriers to Providing Clinical Supervision

What do you believe are the barriers to providing clinical supervision supports for school psychologist?	*N*	*%*
Time	22	78.57
Staff	10	35.71
Large Caseload	6	21.43
Cost	5	17.86
Limited Interest	5	17.86
Scheduling	3	10.71
Limited Space	1	3.57

Table 30

Percentages of Responses Indicating Additional Supports to Providing Clinical Supervision

What additional supports do you need to provide clinical supervision supports for school psychologists?	*N*	*%*
Time	11	44.00
Cost	7	28.00
Staff	9	36.00
Consultants	2	8.00
More Space	1	4.00
Smaller Caseload	1	4.00
Superintendent Support	1	4.00

Table 31

Perception of Feasibility of Support Implementation by Degree Type

	Degree Type	*N*	Rating	*SD*
Single Session Training	Psychology	5	4.20	.84
	Education	25	3.84	.99
Implement Multi-session Training	Psychology	5	3.40	.89
	Education	25	3.36	.91
Weekly Clinical Supervision	Psychology	5	3.00	1.58
	Education	25	2.40	1.12
Monthly Clinical Supervision	Psychology	5	3.60	1.34
	Education	25	3.32	.99
Mentoring	Psychology	5	4.00	1.23
	Education	25	3.40	.87
Small Mentoring Groups	Psychology	5	4.40	.89
	Education	24	3.52	.71
Small Monthly Supervision Groups	Psychology	5	4.20	1.10
	Education	25	3.58	.83
Case Conferences	Psychology	5	4.60	.89
	Education	25	3.58	1.02
Topic Specific Meetings	Psychology	5	3.60	1.34
	Education	24	2.88	1.08

Table 32

T-test for Perception of Feasibility of Support Implementation by Degree Type

	Levine's Test		t-test				
	F	*p*-value	*t*	*df*	Rating Difference	Std. Error Difference	*p*-value
Single Session Training	.25	.62	.76	28	.36	.47	.45
Multi-session Training	.22	.65	.09	28	.04	.44	.93
Weekly Clinical Supervision	.69	.41	1.03	28	.60	.59	.31
Monthly Clinical Supervision	1.41	.25	.55	28	.28	.51	.59
Mentoring	.16	.69	1.32	28	.60	.45	.20
Small Mentoring Groups	.36	.56	2.42	28	.88	.36	.02
Small Monthly Supervision Groups	.18	.19	1.44	27	.62	.43	.16
Case Conferences	1.04	.32	2.07	27	1.02	.49	.05
Topic Specific Meetings	.87	.36	1.32	27	.73	.55	.20

Table 33

Perception of Likelihood of Support Implementation by Degree Type

	Degree Type	*N*	Rating	*SD*
Single Session Training	Psychology	5	4.40	.548
	Education	25	3.80	1.225
Implement Multi-session Training	Psychology	5	3.60	.894
	Education	25	3.44	1.121
Weekly Clinical Supervision	Psychology	5	2.60	1.517
	Education	25	2.56	1.227
Monthly Clinical Supervision	Psychology	5	3.40	1.140
	Education	25	3.28	1.100
Mentoring	Psychology	5	3.60	1.517
	Education	25	3.32	1.069
Small Mentoring Groups	Psychology	5	3.60	1.517
	Education	24	3.46	.977
Small Monthly Supervision Groups	Psychology	5	3.80	1.643
	Education	25	3.20	1.080
Case Conferences	Psychology	5	4.00	1.732
	Education	25	3.48	1.005
Topic Specific Meetings	Psychology	5	3.40	1.517
	Education	24	2.63	1.096

Table 34

T-test for Perception of Likelihood of Support Implementation by Degree Type

	Levine's Test		t-test				
	F	*p*-value	*t*	*df*	Rating Difference	Std. Error Difference	*p*-value
Single Session Training	1.61	.22	1.06	28	.60	.57	.30
Multi-session Training	.63	.44	.30	28	.16	.54	.77
Weekly Clinical Supervision	.05	.83	.06	28	.04	.62	.95
Monthly Clinical Supervision	.04	.85	.22	28	.12	.54	.83
Mentoring	.35	.56	.50	28	.28	.56	.62
Small Mentoring Groups	.64	.43	.27	27	.14	.53	.79
Small Monthly Supervision Groups	.51	.48	1.04	28	.60	.58	.31
Case Conferences	1.39	.25	.93	28	.52	.56	.36
Topic Specific Meetings	.39	.54	1.35	27	.8	.57	.19