MENTAL HEALTH SERVICES IN PUBLIC SCHOOLS: A PRELIMINARY STUDY OF SCHOOL COUNSELOR PERCEPTIONS

This descriptive survey research study (N = 120) examined the self-reported comfort level of school counselors in addressing the mental health needs of their students and school counselor perceptions regarding working relationships with school-based therapists. Survey results indicated that school counselors are generally confident in their counseling skills and comfortable addressing common issues brought to them by their students. However, these same school counselors indicated that they experience some discomfort in working with students living with DSM diagnoses and that specific courses within counselor training programs may have a mitigating effect on this discomfort. Results also revealed that school counselors are willing to lead and work with cross-disciplinary teams and school-based therapists to better meet the mental health needs of their students.

Schools serve as the primary access or entry point for mental health services for youth through prevention, assessment, intervention, and referral processes (Alegria et al., 2012; Lever, Andrews, & Weist, 2008). As the mental health needs of school-age children increase (Perfect & Morris, 2011), community mental health services for youth are decreasing and underfunded, putting increased pressure on schools to address the mental health needs of students (Lockhart & Keys, 1998; Teich, Robinson, & Weist, 2007). Youth needing mental health services are more likely to access those services in a school setting than in a community-based mental health setting (Burnett-Zeigler & Lyons, 2010; Lever et al., 2008; Mellin, 2009). This is particularly true for students living in poverty, urban and minority youth, and rural youth where access to and utilization of mental health services is more likely with school-based programs (Cummings & Druss, 2011; Cummings, Ponce, & Mays, 2010; Mills et al., 2006). School counselors are on the front lines in providing those mental health services to youth, both through prevention and short-term intervention services and by identifying students with mental health needs, coordinating mental health teams, making appropriate referrals to mental health professionals, and following up on those referrals to ensure appropriate services are provided (Teich et al., 2007; Walley, Grothaus, & Craigen, 2009).

Mental health functioning is increasingly acknowledged as a vital component of effective learning and academic success for all students in schools (Kury & Kury, 2006) and es-

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sential to a comprehensive and holistic school counseling program (American School Counseling Association [ASCA], 2012). The 2003 President's New Freedom Commission on Mental Health's final report called for schools to play a greater role in addressing the mental health needs of children (Mills et al., 2006). Developing school-based mental health centers was one of the 19 recommendations of the national survey report, *School Mental Health Services in the United States, 2002-2003* (Foster et al., 2005). Schools and communities are working toward addressing the mental health needs of students by creating school-based mental health centers (SBMHCs) and establishing collaborative mental health teams composed of school- and community-based mental health professionals (Kury & Kury, 2006; Mills et al., 2006). A 2004-2005 national study by the National Assembly on School-Based Health Care surveyed more than 1200 SBMHCs, with more than half of those in urban schools serving predominantly ethnic minority and low income students historically underserved for their mental health needs (Farahmand et al., 2011). One third of the SBMHCs surveyed in this study were in rural communities, again serving students and families with limited access to mental health services (National Assembly on School-Based Health Care, 2007).

The collaborative team approach of school-based mental health services includes, first and foremost, the student and the student's family, teachers, school counselors, social workers, nurses, and psychologists; and school-based and community-based mental health counselors, juvenile justice, and medical health professionals (Kury & Kury, 2006). School counselors make up the greatest number of school-based mental health providers (Foster et al., 2005) by providing brief counseling interventions with individuals, families, and groups and prevention activities through classroom guidance. They also serve as the primary contact person for referrals from teachers, parents, and other school personnel, and therefore are a vital link in the collaboration that is critical to the success of the mental health team (Flaherty et al., 1998).

YOUTH NEEDING MENTAL HEALTH SERVICES ARE MORE LIKELY TO ACCESS THOSE SERVICES IN A SCHOOL SETTING THAN IN A COMMUNITY-BASED MENTAL HEALTH SETTING.

Although school counselors possess a degree of knowledge and competence with child/adolescent mental health issues, the counseling profession has acknowledged the need for more training, supervision, and professional standards specifically focused on mental health services for children and adolescents for both professional school counselors and community-based counselors (Mellin & Sommers-Flanagan, 2008; Mellin, 2009; Repie, 2005; Walley et al., 2009). In a *Counseling Today* opinion piece, Mellin and Sommers-Flanagan (2008) referred to the invisibility of children and adolescents in the 2009 accreditation standards of the Council for the Accreditation of Counseling and Related Educational Programs (CACREP), saying that "the terms 'child' and 'adolescent' are not found within mental health or community counseling standards, and the term 'mental health' is not found within the school counseling standards" (p. 32). In their Delphi study concerning research priorities for counselors working with youth, Mellin and Pertuit (2009) polled 12 counselor educators and 15 practicing counselors and found that counselors working with youth want additional research and training in systems and family approaches and called on counseling programs to "infuse more youth-specific content into existing courses" (p. 151). Meeting the mental health needs of youth is a growing concern in our country and schools and preparing confident and capable school and mental health counselors to meet these needs is the counseling profession's challenge.

The literature is still mixed regarding who is in the best position to address the mental health needs of students in schools (Hall & Gushee, 2000; Kury & Kury, 2006). Certainly school counselors are in an ideal position in terms of access to, and identification of, students in need (Lemberger, Morris, Clemens, & Smith, 2010). However, job descriptions, responsibilities and duties, and large student-to-school-counselor ratios limit the amount of time school counselors can give to students with ongoing mental health needs (Brown, Dahlbeck, & Sparkman-Barnes, 2006; Walley et al., 2009). Although the use of collaborative teams to service the mental health needs of children and adolescents in schools is increasing (Brown et al., 2006), questions remain as to school counselors' attitudes toward working with mental health therapists in schools and school counselors' comfort levels with providing mental health services themselves.

Purpose of the Study

As a means of exploring this topic, the researchers used an online survey to examine school counselors' self-reported training in and comfort with mental health counseling interventions in the public school. The survey further examined school counselor-reported attitudes regarding the utilization of school-based mental health therapists in serving the mental health needs of students through collaborative teaming. The specific research questions addressed were:

- What is the school counselor-reported comfort level regarding issues typically brought to them by students?
- What is the school counselor-reported confidence level working with students living with various DSM diagnoses?

- What is the school counselor-reported confidence level in counseling skills?
- What degree and type of mental health/counseling training is reported by school counselors?
- What are the self-reported attitudes of school counselors regarding the use of school-based mental health therapists in their work environments?
- How do school counselors working with school-based therapists characterize their working relationships with those therapists?

METHOD

Participants

The target sample for this study consisted of the membership of the American School Counselor Association (ASCA). A distribution list consisting of emails for 1045 paid members of ASCA was obtained from the organization. Survey requests were sent to all 1045 school counselors in the distribution list. There were 120 surveys returned for an 11% return rate. Only 104 participants completed the entire survey, yet all surveys were utilized for analyses they informed. The sample included participants from every state with the exception of Alabama, Alaska, Arizona, Arkansas, District of Columbia, Kansas, Nebraska, New Mexico, and Rhode Island. Colorado and Virginia were the most heavily represented with 10 (8.3%) respondents each, followed by Missouri with 9 (7.5%), Georgia and Oregon with 6 (5.0%), and all other states with fewer than 6.

Participants were asked to respond to several items related to their professional lives including certification/licensure status, years of experience, and grade level at which they provide service. All participants indicated that they were working in the role of the school counselor. Of the 120 respondents, 112 (93.3%) indicated that they were licensed school counselors, 11 (9.2%) were licensed professional counselors, two (1.7%) were licensed school social workers, two (1.7%) licensed school psychologists, and one (.8%) was a licensed marriage and family therapist. These numbers reflect the fact that individuals were allowed to select more than one license category if it applied to them; nine respondents indicated holding both a school counseling license and being a licensed professional counselor, two indicated holding both a school counseling license and a school psychologist license, and one holding both a school counseling license and a school social work license. The most common other certification noted by participants was that of Nationally Certified Counselor/Nationally Certified School Counselor. Nine (8% of the sample) respondents indicated that they currently work with preschool children, 52 (44%) with elementary children, 47 (39%) with middle/junior high preadolescents, and 35 (29%) with high school adolescents. Total years of professional school counseling experience ranged from 2 to 37 years with an average of 12.5 years. Respondents working with preschoolers averaged 10.9 years of experience, elementary level 13.9 years, middle/junior high 13.6 years, and high school 11.4 years of experience.

> SCHOOL COUNSELORS MAKE UP THE GREATEST NUMBER OF SCHOOL-BASED MENTAL HEALTH PROVIDERS BY PROVIDING BRIEF COUNSELING INTERVENTIONS WITH INDIVIDUALS, FAMILIES, AND GROUPS AND PREVENTION ACTIVITIES THROUGH CLASSROOM GUIDANCE.

Instrument

This study utilized Web-based survey research to gather data. The School-Based Mental Health Services Survey was developed by the first author for use with the Qualtrics® online survey tool. Many items were revised with permission from a previously unpublished instrument by Angie Waliski and Audrey Barthel (A. D. Waliski, personal communication, December 5, 2011). Three counselor educators and one research faculty member reviewed the survey instrument for appropriateness and clarity prior to distribution. Comments and suggestions were considered and, if appropriate, integrated into the survey.

The survey instrument consisted of 17 questions with five of those questions composed of multiple items and constituting three subscales; the Skills Scale, the Student Issues Scale, and the Diagnoses Scale. Questions one through four presented demographic questions. The Skills Scale comprised 11 items within question five that examined self-reported confidence in specific counseling skills. Question six, the Student Issues Scale, explored self-reported confidence with 14 common issues. The Diagnoses Scale (question seven) explored confidence in working with students living with one or more of 15 *Diagnostic and Statistical Manual* (DSM; American Psychiatric Association [APA], 2000) diagnoses. Question eight examined education and training experiences related to 22 courses/topics, and question nine presented 13 items related to participant attitudes toward school-based therapists. Question 10 measured the percentage of participants who are currently working with a school-based therapist, and questions 11-17 explored issues related to the nature of the working relationships that existed between those participants and their school-based therapist/s.

Questions five, six, and seven utilized a 100-point graphical sliding scale in which participants used the computer

mouse to place the cursor on any point within the scale. Although Funke, Reips, and Thomas (2011) caution that such a scale interacts with educational attainment, Treiblemaier and Filzmoser (2011) indicate that continuous rating scales in online survey research protects against information loss due to a constrained response pattern and ultimately allows for more robust statistical analyses. A 100-point scale was used in this instrument because when one considers such qualities as confidence and comfort, framing the quality frame as a percentage is typical, e.g., "I am 100% confident." This scale, therefore, offered congruence for the participant and allowed for more meaningful variation in responses. Furthermore, educational attainment was not a confounding factor in the use of the graphical sliding scale in this research because all targeted participants were expected to have earned a master's degree or higher.

Reliability analyses yielded the following Cronbach's alphas – Skills Scale (.84), Student Issues Scale (.93), and Diagnoses Scale (.95).

For each of the 22 subjects presented in question eight, participants chose one of five possible education/training experiences: (a) stand-alone required course, (b) stand-alone elective course, (c) content presented as part of a course, (d) post-degree training/education, or (e) not taken/studied. Finally, question nine used a 4-point Likert scale to measure 13 different items related to participant attitudes concerning school-based therapists within their schools. Reliability analysis for this Attitudes Scale yielded a Cronbach's alpha of .80.

TABLE 1 NUMBER OF RESPONDENTS, MEANS, AND STANDARD DEVIATIONS FOR COMFORT LEVEL WITH ISSUES.

ISSUE	*N*	*M*	*SD*
Academic Concerns	111	91.40	9.59
Relationship Concerns	111	88.71	9.81
Stress Management	111	87.97	11.84
Grief/Loss	111	85.99	15.00
Divorce and Family Disruption	110	85.75	13.34
Abuse/Neglect	111	84.75	16.38
Suicidal Concerns	111	83.09	17.52
Transitions and Post-Secondary Planning	111	81.73	18.96
Concerns Related to Living in Poverty	111	77.29	21.81
Multicultural Concerns	110	76.33	17.47
Gender/Sexuality Concerns	110	73.55	19.12
Spirituality	107	68.01	27.02
Addiction and Substance Use	108	60.31	24.48
Immigration Concerns	105	56.07	29.83

RESULTS

The researchers analyzed the data using statistics including measures of central tendency and frequency, Pearson correlation, and chi-square test of independence. Descriptive analyses were utilized as opposed to inferential analyses due to the low response rate and possible response bias. Effect sizes, indicating practical significance, and narrative comments from participants add further clarity to the results.

Comfort Levels with Student Issues

Participants were instructed to "Please indicate your comfort level in helping students with the following issues. Please base your response on your training and experience apart from your employer's expectations." The contextual second sentence was included in all question stems regarding self-reporting of comfort and confidence as an attempt to control for differing workplace expectations of the participants. Typical student issues included academic concerns, transitions and post-secondary planning, relationship concerns, stress management, addiction and substance use, multicultural concerns, gender/sexuality concerns, abuse/neglect, suicidal concerns, grief/loss, concerns related to living in poverty (homelessness and hunger), immigration concerns, spirituality, and divorce and family disruption. A composite comfort level score for all issues was calculated utilizing an average score for all participants based on their scale scores across all 14 issues. This composite score ($N = 112$) yielded a mean of 77.3 with a standard deviation of 14.7. Means, standard deviations, and number of respondents are provided for all 14 separate issues in Table 1.

The three issues with the highest comfort level ratings (standard deviations reported in parentheses) included academic concerns ($n = 111$) with a mean of 91.4 (9.6), relationship

MEETING THE MENTAL HEALTH NEEDS OF YOUTH IS A GROWING CONCERN IN OUR COUNTRY AND SCHOOLS AND PREPARING CONFIDENT AND CAPABLE SCHOOL AND MENTAL HEALTH COUNSELORS TO MEET THESE NEEDS IS THE COUNSELING PROFESSION'S CHALLENGE.

concerns ($n = 111$) with a mean of 88.7 (9.8), and stress management ($n = 111$) with a mean of 87.9 (11.8). The three issues rated lowest by respondents included immigration concerns ($n = 105$) with a mean of 56.1 (29.8), addiction and substance use ($n = 108$) with a mean of 60.3 (24.5), and spirituality ($n = 107$) with a mean of 68 (27).

Confidence Working with Particular DSM Diagnoses

Participants were asked to rate their level of confidence in working with students living with particular Diagnostic and Statistical Manual (APA, 2000) diagnoses. Diagnoses included disorders primarily diagnosed in children, cognitive disorders, mental disorders due to a general medical condition, substance-related disorders, schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, somatoform disorders, factitious disorders, sexual/gender identity disorders, eating disorders, sleep disorders, impulse-control disorders, adjustment disorders, and personality disorders. The survey did not include explanations of the disorders, but disorders primarily diagnosed in children include learning disorders, motor skills disorders, communication disorders, pervasive developmental disorders, attention-deficit disorders, disruptive behavior disorders, feeding and eating disorders of infancy and early childhood, tic disorders and elimination disorders (APA, 2000). A composite comfort level score for all diagnoses was calculated utilizing an average score for all participants based upon their scale scores across all 15 diagnoses. This composite score ($N = 112$) yielded a mean of 53.5 with a standard deviation of 24.6. Means, standard deviations, and number of respondents are provided for all 15 disorders in Table 2.

Respondents indicated the most confidence working with anxiety disorders ($n = 109$) with a mean of 72.7 and a standard deviation of 23.3, disorders primarily diagnosed in children ($n = 109$) with a mean of 71.4 (23), and cognitive disorders ($n = 110$) with a mean of 69.7 (24.2).

TABLE 2 NUMBER OF RESPONDENTS, MEANS, AND STANDARD DEVIATIONS FOR COMFORT LEVEL WITH DSM DIAGNOSES.

DSM Diagnosis	*N*	*M*	*SD*
Anxiety Disorders	109	72.73	23.29
Disorders Primarily Diagnosedin Childhood	109	71.36	23.00
Cognitive Disorders	110	69.72	24.19
Impulse-Control Disorders	105	66.40	26.02
Mental Disorder Due to a General Medical Condition	111	64.99	26.82
Mood Disorders	108	63.04	26.28
Adjustment Disorders	103	62.60	27.94
Substance-Related Disorders	106	56.79	28.51
Eating Disorders	105	55.86	29.52
Sexual/Gender Identity Disorders	104	52.16	30.87
Personality Disorders	102	47.48	31.46
Somatoform Disorders	97	46.77	32.47
Sleep Disorders	99	42.77	31.19
Factitious Disorders	92	39.46	32.14

TABLE 3 NUMBER OF RESPONDENTS, MEANS, AND STANDARD DEVIATIONS FOR CONFIDENCE IN SKILLS.

SKILL	*N*	*M*	*SD*
Consultation with parents,teachers, and administrators	119	93.67	9.30
Collaboration/Teamwork	119	93.28	10.01
Ethical Practice	119	91.55	11.69
Individual Counseling	120	87.63	12.02
Group Counseling	120	78.96	18.16
Program Development & Evaluation	118	78.48	18.94
Testing and Assessment	119	71.08	25.56
Counseling Research	117	67.75	24.47
Treatment Planning (Goals & Objectives)	111	62.14	27.79
Family Counseling	115	57.27	28.58
Using the DSM to Diagnose Client Issues	103	41.57	29.25

The three diagnoses with the least degree of confidence included factitious disorders ($n = 92$) with a mean of 39.5 (32.1), sleep disorders ($n = 99$) with a mean of 42.8 (31.2), and schizophrenia and other psychotic disorders ($n = 105$) with a mean of 45 (29.7). These were among the group of diagnoses with the smallest number of valid responses.

Confidence in Counseling Skills

Participants were asked to rate their confidence regarding 11 professional

TABLE 4 NUMBER OF RESPONDENTS AND FREQUENCY OF RESPONDENTS ENDORSING EACH EDUCATION LEVEL BY COURSE.

Course	SAR	SAE	CWC	PDT	NT
Counseling Theories	96	01	11	09	00
Individual Counseling	77	01	29	08	01
Child/Adolescent	59	07	34	11	03
Group Counseling	90	02	13	08	00
Couples Counseling	04	04	31	05	62
Family Counseling	24	09	40	06	27
Advanced Skills Course	31	10	10	24	32
Abnormal Psychology	47	16	24	06	20
Appraisal and Assessment	68	04	22	10	07
Diagnostic (DSM) Course	18	06	50	08	25
Research and Evaluation	80	01	19	06	04
Ethics/Professional Practice	65	06	33	16	01
Multicultural Issues	65	07	27	10	00
Career Counseling	68	08	27	10	00
School Counseling	69	04	30	10	02
Consultation	20	07	63	15	07
Addictions/Substances	20	13	38	13	27
Pharmacology	03	04	31	05	63
Crisis/Trauma	12	11	53	27	07
Human Development	80	05	17	07	01
100 Hour Practicum	81	00	05	08	08
600 Hour Internship	79	01	07	04	11

Note. Respondents were allowed to indicate more than one level.
SAR = Stand alone required course; SAE = Stand alone elective course; CWC = Content presented within coursework; PDT = Post-degree training/education; NT = Not taken or studied

skills that included individual counseling, group counseling, family counseling, testing and assessment, using the DSM to diagnose client issues, treatment planning, ethical practice, consultation, collaboration, counseling research, and program development/evaluation. The authors calculated a composite confidence level score for all skills by utilizing an average score for all participants based on their scale scores across all 11 skills. This composite score ($N = 120$) yielded a mean of 73.1 with a standard deviation of 13.5. Means, standard deviations, and number of respondents are provided for all 11 skills in Table 3.

The three skills rated highest by respondents included consultation with parents, teachers, and administrators ($n = 119$) with a mean of 93.7 (9.3), collaboration/teamwork ($n = 119$) with a mean of 93.3 (10), and ethical practice ($n = 119$) with a mean of 91.6 (11.7). The three skills rated lowest by respondents included using the DSM to diagnose client issues ($n = 103$) with a mean of 41.6 (29.3), family counseling ($n = 115$) with a mean of 57.3 (28.6), and treatment planning ($n = 111$) with a mean of 62.1 (27.8). Again, the lowest scoring skills were among the group of skills with the smallest number of valid responses.

Education and Training

Survey respondents were asked to indicate the type of education/training they received on 22 course topics. Education and training experiences were classified using five categories as identified above. Respondents were allowed to check more than one box if the quality applied to them and also were allowed to skip individual training items. Raw frequency counts for all levels of education/training for each course topic is presented in Table 4.

To provide more meaningful interpretation of this variable, data was recoded to provide a composite education strength score for each

course topic. Each individual response was assigned a weighted value with both stand-alone required courses and stand-alone elective courses assigned a value of 3, content covered as part of a course assigned a value of 2, post-degree training or education assigned a value of 1, and not studied or taken assigned a value of 0. These values were assigned on the premise that a full stand-alone course would offer more training than content covered as part of a course, and so forth. The researchers then averaged these individual response scores to generate a composite education strength score for each course topic. The greatest composite strengths scores were for counseling theories (2.9), group counseling (2.8), career counseling (2.8), human development (2.7), and ethics (2.7). The lowest composite strengths scores were for pharmacology (1.4), couples counseling (1.4), advanced counseling skills (1.8), diagnosis (1.9), and crisis (1.9). All course topics with mean composite scores and standard deviations are offered in Table 5.

TABLE 5 MEAN COMPOSITE EDUCATIONAL STRENGTH SCORE AND STANDARD DEVIATIONS FOR ALL COURSES.

Course	*M*	*SD*
Counseling Theories	2.95	0.98
Group Counseling	2.84	0.77
Individual Counseling	2.76	1.06
Career Counseling	2.75	1.17
Human Development	2.72	1.00
Ethics/Professional Practice	2.72	1.12
Research and Evaluation	2.67	0.75
School Counseling	2.67	1.12
Multicultural Issues	2.62	0.97
Child/Adolescent	2.57	1.07
Appraisal and Assessment	2.54	0.91
100 Hour Practicum	2.47	1.05
600 Hour Internship	2.47	1.04
Abnormal Psychology	2.41	1.16
Consultation	2.10	0.82
Addictions/Substances	1.97	1.11
Family Counseling	1.95	0.89
Crisis/Trauma	1.92	0.86
Diagnostic (DSM) Course	1.88	0.86
Advanced Skills Course	1.83	1.04
Couples Counseling	1.40	0.75
Pharmacology	1.39	0.71

Note. $N = 109$

Attitudes Regarding School-Based Therapists

This study also sought to explore professional school counselors' attitudes towards the utilization of school-based therapists in their schools. Participants were asked to respond to 13 items on a 4-point Likert scale ranging from strongly disagree (1) to strongly agree (4). All 13 items with means and standard deviations are presented in Table 6. Results of these scale items generally indicate that school counselors feel they are qualified to provide mental health counseling to students but that the nature of their job precludes them from doing so on a large scale. Furthermore, responses to the survey indicate that school counselors see school-based therapists as a valuable asset in providing mental health services to students, they welcome them in the schools, and they feel that administration should further support such services in the schools through provision of office space.

THE THREE ISSUES WITH THE HIGHEST COMFORT LEVEL RATINGS INCLUDED ACADEMIC CONCERNS, RELATIONSHIP CONCERNS, AND STRESS MANAGEMENT.

Thirty-four percent of the sample reported that they had a current working relationship with a school-based therapist. A series of chi-square tests of independence examined the relationship between attitudes towards school-based therapists (13 items) and whether the participant had a current working relationship with a school-based therapist. Relationships between these variables were statistically significant for several of the items. Results indicated a strong relationship for the item, "schools should provide office space for school-based therapists", χ^2 (8, $N = 107$) = 30.035, $p = .000$. Effect size calculation for this analysis yielded a Cramér's V of .38, which constitutes a moderate association (Rea & Parker, 1992). These results indicate that those school counselors currently working with a school-based therapist are more supportive of providing office space for the therapist than are school counselors not currently working with

TABLE 4 MEANS AND STANDARD DEVIATIONS FOR ALL SCHOOL-BASED THERAPIST (SBT) ITEMS.

Survey Item	*M*	*SD*
I have enough time to work with all the students who need counseling in my school.	1.66	0.79
SBTs cause too much disruption to the daily schedule of students.	1.77	0.72
SBTs are a threat to the jobs of school counselors.	1.82	0.74
SBTs provide services that could be more appropriately provided by school counselors.	2.06	0.81
School counselors are as qualified by training to provide counseling as are SBTs	2.34	1.00
SBTs understand how to work well within the public school system.	2.36	1.04
I provide mental health counseling to students.	2.69	0.85
I feel competent to provide mental health counseling to students.	2.78	0.95
Seeing an SBT is a preferred option to leaving for outpatient therapy.	2.84	1.06
Schools should provide office space for SBTs.	2.85	0.85
SBTs provide a service that cannot be provided by school counselors due to the nature of school counselor duties.	2.98	1.04
SBTs provide a needed service to students in the schools	3.07	0.99
I welcome SBTs in the schools.	3.12	1.03

Note. $N = 107$

SCHOOL COUNSELORS FEEL THEY ARE QUALIFIED TO PROVIDE MENTAL HEALTH COUNSELING TO STUDENTS BUT THAT THE NATURE OF THEIR JOB PRECLUDES THEM FROM DOING SO ON A LARGE SCALE.

a school-based therapist. Results also indicated a significant relationship for the item, "school-based therapists cause too much disruption to the daily schedule of students", χ^2 (8, $N = 107$) = 20.203, $p = .010$, Cramér's $V = .31$, which again constitutes a moderate association (Rea & Parker, 1992). School counselors not currently working with a school-based therapist endorsed this item more fully than did those currently working with a school-based therapist. The last item indicating a statistically significant relationship was, "school-based therapists provide a needed service to students in the schools", χ^2 (8, $N = 107$) = 17.590, $p = .025$. This, too, represents a moderate effect size with a Cramér's $V = .29$ (Rea & Parker, 1992). In this instance, school counselors currently working with a school-based therapist more fully endorsed this item than did school counselors not currently working with a school-based therapist.

Several items on the survey offered opportunity for participants to comment narratively on the utilization of school-based therapists. Narrative comments were not formally analyzed through a particular qualitative approach; they were merely collated and are offered as more descriptive insight into the school counselor-mental health therapist relationship. The first question in this section asked, "does the school-based therapist provide services that you would prefer not to provide yourself and, if yes, which services?" Responses fell into four major areas of services provided by school-based therapists: (a) regular, on-going, intensive, and long-term therapy for individuals, (b) family therapy and home visits, (c) on-going therapy for difficult mental health diagnoses such as depression, severe anxiety, emotional and bipolar disorders, and substance abuse issues, and (d) consultation and coordination with psychiatrists on testing, diagnoses, medications, and threat assessment. In response to the second qualitative question, "does the school-based therapist enhance your ability to effectively do your job and, if yes, how?" school counselors replied that school-based therapists (a) provide another team member to collaborate and consult with to meet the needs of students, particularly the difficult mental health needs of students, (b) act as a referral source to provide ongoing individual, group, and family therapy, including home visits, for students with mental health needs, and (c) free up the school counselor's time to meet the needs of the larger student body through comprehensive school guidance counseling programs. This final point was emphasized by respondents as increasingly important as school counselor caseloads continue to be high and additional responsibilities are placed on them such as anti-bullying laws requiring them to serve as anti-bullying specialists and intervention and referral specialists.

DISCUSSION AND IMPLICATIONS

School counselors face increasingly complex expectations as they continue to address the needs of the students with whom they work. Research indicates that 75% of counselors and administrators agree that providing holistic services to students, including their mental health needs, is part of the school counselor's role (Brown et al., 2006). Results of the current online survey provide preliminary evidence that school counselors are mostly comfortable with issues typically brought to them by students and are generally confident in the skills essential to carrying out the expectations of their jobs. These same school counselors, however, indicate a greater degree of discomfort when working with students living with formal mental health diagnoses. Coursework specifically in individual counseling skills, child/adolescent counseling, couples counseling, family counseling, psychopathology/abnormal psychology, diagnostic (DSM) study, school counseling/educational systems, and addictions/substance abuse appear to have a significant relationship to this comfort level. Several of these courses are not commonly part of the core requirements for a school counseling master's degree. That raises the question of feasibility versus best practice regarding the inclusion of such courses within a required core curriculum. One implication might be that content contained within these courses be a focus of ongoing professional development opportunities for school counselors.

Eighty-eight percent of survey participants reported that they do not have enough time to provide needed services to the students they serve because of demands placed upon them by the needs of the setting. The American School Counselor Association has long advocated for the removal of non-counseling duties such as coordinating testing programs, teaching classes when teachers are absent, writing excuses for students who are absent or tardy, and providing long-term therapy for students with psychological disorders (ASCA, n.d.). A reallocation of school counselor time to appropriate activities related to responsive services, direct and indirect student services, core counseling curriculum, and individual student planning is one critical step to addressing this concern (ASCA, 2012).

SCHOOL COUNSELORS, HOWEVER, INDICATE A GREATER DEGREE OF DISCOMFORT WHEN WORKING WITH STUDENTS LIVING WITH FORMAL MENTAL HEALTH DIAGNOSES.

While school counselors provide the majority of mental health services in schools, they also function as team leaders, coordinating referrals to other mental health professionals to best meet the mental health needs of students in schools. Indeed, recent years have seen an increased presence of mental health counselors, social workers, and psychologists providing therapeutic services within the schools (Kury & Kury, 2006). Some authors indicate concern within the school counseling profession that such positions may compromise the integrity and security of the school counselor's role and lead to "turf wars," yet actual data indicates that school counselors generally support the use of school-based therapists (Mills, et al., 2006). The current study similarly found that school counselors welcome school-based therapists as colleagues as long as those therapists understand how to work within the school system and recognize the critical mental health role that school counselors play. Ninety one percent of the respondents on the current survey agreed or strongly agreed with the statement "I welcome school-based therapists in schools." Despite this acceptance, only 34% of the survey respondents reported that they work in a school with a school-based therapist.

LIMITATIONS

This study has several salient limitations. First, survey research that utilizes self-report can be problematic as there is no way to ensure the honesty of responses related to attitudes and beliefs as used in this study. Voluntary participation and non-threatening questions offered mitigating qualities regarding this limitation; however, researchers cannot guarantee respondents' honesty. Due to the low response rate, this study is considered descriptive only and the authors discourage any generalizations drawn from this study data to a larger. The response rate for this survey may have been affected in several ways. First, although results from research examining survey response rates are inconclusive, online surveys generally experience a lower response rate than mailed or phone surveys, with online surveys averaging a 6-15% response rate (Lozar Manfreda et al., 2008). The timing of this particular survey may have contributed to the relatively low response rate becausae some school counselors on the original e-mail distribution list were already off-contract for the summer when the invitation was originally sent. Although second and third reminders were utilized, some e-mail invitations were not delivered to the intended recipients due to automatic "out of office" reply settings. Second, completion data indicates that only 82% of individuals who began the online survey actually completed it. This is also consistent with past findings regarding online surveys (Jin, 2011), and introduces the possibility that the instrument itself may have been too long or complex for some targeted respondents. The authors attempted to mitigate these effects through presenting the survey in multiple screens and varying the presentation of items, but the effectiveness of those efforts is difficult to discern.

EIGHTY-EIGHT PERCENT OF SURVEY PARTICIPANTS REPORTED THAT THEY DO NOT HAVE ENOUGH TIME TO PROVIDE NEEDED SERVICES TO THE STUDENTS THEY SERVE BECAUSE OF DEMANDS PLACED UPON THEM BY THE NEEDS OF THE SETTING.

CONCLUSION

School counselors who responded to this survey indicated confidence regarding counseling skills and comfort with typical student issues, yet expressed a certain degree of discomfort in working extensively with students living with a mental health diagnosis. Survey results further indicate that revisions in education and training may contribute to a decrease in this discomfort, but would likely do little to address challenges regarding provision of mental health services within the current nature of job expectations. Innovative training and an expanded understanding by administrators regarding the critical role that school counselors play in providing mental health services to students seem to be needed to effect positive change. Thoughtful and robust school counselor training, professional development opportunities and resources such as this special issue dedicated to the mental health role of school counselors, professional advocacy driven by school counselors in the field, and meritorious cross-disciplinary partnerships will enhance the possibility of greater mental health outcomes for the youth in our schools.

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