Adolescent Mental Health: Exploring the School Counselor Experience

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Alison W. Furey

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Abstract

The purpose of this qualitative study was to identify how high school counselors are currently addressing the increasing mental health issues of their students so that they can be academically successful. To accomplish this goal, three research questions were formulated to guide this study: 1) What are the experiences of school counselors who provide support to learners who struggle with mental health issues?; 2) In what ways do school counselors perceive their role as shifting as they work with these students?; and 3) How do guidance and counseling services and programs support the academic achievement of students struggling with mental health issues?

Participants were chosen from suburban high schools north of Boston, Massachusetts, and currently serve as the chair or director of the school’s Guidance Department. Data was collected from three participants through a series of semi-structured, in-depth interviews. Data was analyzed using general inductive analysis, and was coded using multiple strategies, including open and axial coding. From the findings of this research, three noteworthy conclusions were drawn. First, in order to support all students academically, schools must support all students emotionally, providing further support for the relationship between academic achievement and mental health. Second, the model of school counseling services has not progressed as our knowledge of how to support students has evolved. And finally, programmatic intervention can work for general education students when they are systematically need-based and focus on relationship building.

Keywords: school counselors, adolescent mental health, school-based mental health, Response to Intervention
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Chapter 1

Topic

Adolescence is a critical period of mental, emotional and physical development, and the still-developing brain and hormonal changes make adolescents more at risk for depression and more likely to pursue risky behaviors (Knopf, Park, & Mulye, 2008). Experts indicate that approximately one in five adolescents have a diagnosable mental health disorder, with depression being the most common (Knopf et al., 2008; Schwarz, 2009). Unfortunately, only a small percentage of these adolescents actually receive care through mental health systems (Knopf et al., 2008; National Association of School Psychologists, 2002). While some schools question if they should be held accountable for the mental health needs of students (Gresham, 2007), all schools have a responsibility to educate all students. And, individuals with untreated mental illness are likely to experience difficulties finding success or even staying in school (Schwarz, 2009).

The Individuals with Disabilities Education Act (1990) guarantees a free, appropriate public education for all children. Schools must offer appropriate services or pay for a student to attend another school. To determine if a student qualified for special education, a “discrepancy model” was used, measuring the difference between a student’s potential and actual achievement. A discrepancy meant the student has a disability, and was in need of additional time or specialized instruction through special education services (Buffum, Mattos & Weber, 2009). Unfortunately, this model needed the discrepancy to be significantly measurable, therefore allowing students to fail before implementing support (Gresham, 2005). In 2004, the United States government passed the Individuals with Disabilities Improvement Act to address the criticisms of the discrepancy model and the growing number of students needing special
Response to Intervention (RTI) became the new model.

Response to Intervention is defined as a formal process to provide instruction and intervention for any student experiencing academic and/or behavioral difficulties within the general education classroom (Gerzel-Short & Wilkins, 2009). Special education services are only considered after a student has not responded to a “series of timely, systematic, increasingly focused and intensive research-based interventions” (Buffum, Mattos, & Weber, 2001). In addition to addressing the learning needs of students, some researchers have posited that RTI be used as a potential means of addressing students’ mental health needs within the limitations of a school (Gresham, 2007; Saeki,Jimerson,Earhart,Hart,Renshaw,Singh & Stewart, 2011).

**Research Problem**

Secondary school counselors are responsible for assisting students’ development of academic, workplace readiness and social/emotional skills that they will need to be successful after high school. The American School Counselor Association (2003) specifies that school counselors provide programs, classroom-based interventions, and counseling in order to improve achievement and promote the positive social and personal development of all students. Programs and interventions can be delivered by the school counselor individually, or in collaboration with other staff, such as social workers and teachers. Typically, school counselors must monitor student progress, identifying areas of continued need, and use data to design and deliver services.

Traditionally, counselors in public schools have offered a range of services to promote the healthy development of its students, including health classes, a guidance curriculum, and other student support. In addition, counselors provide individual counseling and crisis intervention on an as needed basis. However, with adolescents’ increasing mental health needs
(Collishaw, Maughan, Goodman & Pickles, 2004), it is unlikely that students are receiving the support they need.

In addition, the majority of programs aimed at addressing barriers to learning are viewed as supplemental and are planned, implemented, and evaluated in a fragmented and piecemeal manner making them redundant and costly (Adelman & Taylor, 2008). Instead, support services need to be part of a comprehensive, multifaceted, and cohesive framework. Adelman and Taylor (2008) argue that “we must rethink how schools, families, and communities can meet the challenge of addressing persistent barriers to student learning, and, at the same time, enhance how all stakeholders work together to promote healthy development” (p. 302). This framework will shift the paradigm from a focus on the needs of a single child to a focus on the needs of all children (Doll & Cummings, 2008).

**Justification of Research Problem**

School-based mental health is not a new idea, however within the last few decades, the model has gained more traction (Weist, Lever, Bradshaw & Owens, 2013). Currently, the mental health system for children and adolescents is inadequate (Horowitz & Reinhardt, 2009) and families encounter many obstacles that they must learn to navigate, such as insurance problems and poor knowledge of mental health. Therefore, schools have become the de facto mental health provider for these individuals. Unfortunately, schools do not have enough resources to address the emotional and behavioral challenges that students present (Weist, Paternite, Wheatley-Rowe & Gall, 2010). Support staff work with a large number of students, and, even though they are trained in effective prevention and intervention techniques, they tend to be constrained by their roles. For example, school counselors are seen as academic advisers and school psychologists are relegated to the role of evaluator.
One of the dominant themes in recent literature is the utilization of a tiered system of support, which draws upon the theory of prevention science. Much of the research in the area of school-based mental health interventions has primarily been focused on the effectiveness of particular interventions and programs, such as Eber, Sugai, Smith and Scott’s (2002) research on the implementation of the Positive Behavioral Interventions and Support (PBIS) curriculum in an elementary school. More recently, some researchers have begun to study the implementation of curriculum at each level of intervention to identify what helped and hindered successful execution (Weist, Stiegler, Stephan, Cox & Vaughan, 2010). Finally, others have focused specifically on how utilizing an RTI framework can impact individual student outcomes (Hawken, Vincent, & Schumann, 2008; Froiland, 2011).

Deficiencies in Research

Most of the current discussion about school improvement and educational reform has been focused on curriculum and instruction, standards-based assessment and other innovative ideas to improve student outcomes (Ravitch, 2010). While there are some researchers (Gresham, 2004; Repie, 2005; Weist et al., 2010; Froiland, 2011) that continue to talk about the need to address social and emotional health due to its inextricable link to learning, these voices are few and cannot break through the other rhetoric about educational reform. Research must continue in the area of school-based mental health services and the importance of supporting the social and emotional health of children and adolescents in order to promote learning of all students. Related, discussions about teachers and working conditions seem to be discussed frequently, but this researcher has not come across any studies about school counselors and their experience with the growing mental health needs of students.
Until recently, most of the research and discussion about Response to Intervention has been academically focused; however researchers are beginning to explore its use in addressing mental health and behavioral issues. Despite its potential usefulness, existing articles regarding the use of Response to Intervention to address and promote mental health in schools are mostly theoretical (Gresham, 2004; Saeki et al., 2011), although some have begun to explore its application (Froiland, 2011). By further examining Response to Intervention, school personnel can begin to implement new strategies to address adolescent social and emotional issues. Much of the previous research discusses Response to Intervention in elementary schools, but little research details or recounts its implementation in high school. In addition, while student outcomes have been measured, few studies have discussed the experience of school staff using these interventions.

**Significance of Research Problem**

Educational leaders have struggled to identify ways to address the growing mental health needs of the American adolescent population (Saeki et al., 2011), and many schools address the ensuing behavioral issues with detention, suspension or expulsion (Skiba & Rausch, 2006). However, disciplinary strategies do not address underlying mental health issues. In many schools, school counselors, social workers and psychologists provide individual support for students with mental health and behavioral issues. With their large caseloads, though, it is unlikely that students receive the attention and services they need (McCarthy, Kerne, Clafa, Lambert, & Guzman, 2010). Moreover, “a disproportionate amount of time is spent on serving a small number of students with social-emotional and behavioral problems” (Saeki et al., 2011, p. 43). Since the majority of adolescents with mental health issues receive care in school (U.S. Department of Human Health & Services, 1999), school-based intervention and prevention
strategies are integral to addressing mental health issues in adolescents (Gerrity & DeLucia-Waack, 2007).

The Individuals with Disabilities Education Act (IDEA, 1990) guarantees a free, appropriate public education for all children. According to the National Center for Education Statistics (2012), students in special education for emotional disturbances, including mood disorders and other mental illness, make up six percent of the total number of students receiving services. Although this number seems minimal, most symptoms of mental illness do not appear until adolescence, putting the burden on high schools to address them. Without a comprehensive and systematic way of addressing mental illness, high schools typically rely on special education services and/or resources outside of the school to address the students’ needs.

Unfortunately, schools are not adequately funded to provide the services of the growing population needing special education services (Waxman, Weist, & Benson, 1999). The number of students needing special education is rising, and therefore so is the cost of educating them. Public schools spend two to three times more on students in special education than on those in general education (Learning Rx, 2012), and special education costs consist of about twenty percent of a school’s annual budget (Carroll, 2010). While these costs are growing, state aid is being reduced, leading to budget cuts and staff layoffs. Since IDEA mandates services, school leadership must cut services in other areas. In wealthy districts, these budget concerns may not be felt as deeply as they are in districts that already have tighter budgets. Therefore, the challenge is to find a way to address the mental health needs of students in general education, thereby reducing the burden on special education.

Positionality Statement
When people find out that I work in a school, questions about testing and school choice, and a discussion about the “failure” of public education tend to dominate the conversation. In my school, located in a wealthy suburb of Boston, these conversations are not relevant. Last year, 100% of our graduating class reached proficiency on the state test and 95% immediately attended a post-secondary institution. As a counselor at the school, it is my opinion that the most pressing issue in education is the mental health and wellness of our students. The small number of students who struggle academically tend to also have some significant mental health, familial or other issue that significantly impacts their learning.

My department deals with student mental health on a daily basis. While many of these issues can be addressed individually, we have also endured intense tragedy that has impacted the entire community. It was my first day in my new position as the chair of the Guidance and Counseling Department. I was thoroughly excited to embark on this new professional opportunity, a new set of responsibilities and challenges. While the first day of school is always chaotic, I was totally unprepared for the message my principal passed along to me in my office. One of our seniors had killed herself before she even left for school. Unfortunately, suicides among adolescents tend to be contagious, so our work was just beginning. Two other times during the school year, our community had to endure the loss of young life due to suicide. I think we were able to remain strong and hold ourselves together until the third suicide. That was the straw that broke the camel’s back.

I spent the day just trying to keep students safe and supported; it was not until I got home that I finally broke down crying, my stress level at an all-time high. The remaining two months of school were the most exhausting I have ever experienced. I spent every day with the best friends of the student who died; most days were tearful, some were filled with anger and denial.
As I experienced the extreme and overwhelming grief with my students, it took every ounce of energy I had to get out of bed every morning. It took me half the summer to decompress and feel like myself again. I vowed that I would do anything to help our community avoid this kind of tragedy again. That was four years ago.

Could these suicides have been prevented? What demons were these students struggling with that we could have helped with? Why didn’t we know that they were having trouble? And at what point is the school not responsible? Since that tragic year, I have encountered mental health issues on a daily basis. In my ten years in the profession, I have witnessed the growing needs of our students. While the community has mostly emotionally recovered from the losses, it is clear that addressing mental health is still urgently needed. Adolescent depression and anxiety are worsening, although there is no research pointing to why it is worsening. In my opinion, much of this growing need stems from a lack of coping skills and a need for immediate gratification due to a mixture of “helicopter parenting” and unlimited access to technology like cell phones and the internet. While my school has utilized some preventative measures, we have relied heavily on reactive services to respond to students in crisis. We now tend to hold crisis meetings several times per week. This practice is becoming unmanageable. I feel helpless and frustrated at times. We need to do something to make sure that every student, not just those in crisis, gets the help they need and deserve. I do not know if I could have prevented the suicides that occurred, but I must try to make a difference moving forward.

**Research Questions**

Much of the focus of education reform is on the academic progress of students, however little attention has been paid to student mental health needs, except in reactive and individualized ways. And, the demands placed on school counselors’ time regarding student mental health is
increasing and overwhelming. How can counselors support the increasing number of students who have mental health needs that impact their learning? The Response to Intervention (RTI) model, a process of early identification and intervention for any student experiencing academic and/or behavioral issues within the general education context, has been adopted nationally to address the growing number of students needing special education services (Berkeley, Bender, Peaster & Saunders, 2009). This study will explore how RTI can be used to address students’ social and emotional needs as well.

School counselors must find a way to support these students so that they can do their work without being overwhelmed or overworked. I am interested in determining how school counselors are addressing mental health issues in order to help inform federal and state policy makers, school leaders, school counseling graduate programs, and counselors themselves, so that we may be able to address these students’ needs and promote academic success. With this in mind, my research will seek to answer the following questions: What are the experiences of school counselors who provide support to learners who struggle with mental health issues? In what ways do school counselors perceive their roles as shifting as they work with these students? Finally, how do guidance and counseling services and programs support the academic achievement of students struggling with mental health issues?

Theoretical Framework

Gresham (2004) argues for the use of interventions to prevent behavior problems as opposed to those procedures that punish or try to avert the behavior. In other words, instead of addressing issues that have already surfaced, the goal of preventive interventions is to counteract risk factors and reinforce protective factors to disrupt an individual’s trajectory towards mental health dysfunction. Gresham discusses the school’s role in prevention and intervention
specifically through his theory of school-based behavioral interventions. Schools are an important setting for child and adolescent behavioral interventions, since so many students do not seek help outside of school. In addition, due to the amount of time students spend in school, it becomes the ideal place for powerful adolescent mental health intervention.

Gresham (2004) suggests that interventions must be conceptualized based on intensity level and purpose, and that the goal is to match the intensity of the intervention with the intensity of the presenting problem behavior. Gresham outlines three levels of prevention. Primary (or universal) prevention seeks to prevent harm and is designed to affect all students. These interventions can be delivered at a class-wide, school-wide or district-wide level, and seek to assist in the academic and social development of students by teaching academic and prosocial skills. Secondary (or selected) intervention is designed for students at risk of developing severe problems and therefore seeks to reverse harm. This level of intervention targets the 5-10% of students who do not respond to the universal intervention, and therefore require more targeted interventions. The goal of selected interventions is to “provide students with effective academic and social-behavioral repertoires that will make them more responsive to universal interventions” (Gresham, 2004, p. 330). Tertiary (or intensive) interventions are reserved for the small percentage of students who exhibit chronic difficulties and are responsible for most of the behavioral disruptions in school. These interventions attempt to reduce harm and decrease the frequency and intensity of the problem behaviors through intense, individualized, and comprehensive services.

In addition to these levels of intervention, Gresham also suggests the use of a Response to Intervention framework as a means of determining the level of intervention needed. “An RTI model uses a student’s lack of response to an evidence-based intervention that is implemented
with integrity as *the* basis for intensifying, modifying, or changing the intervention” (Gresham, 2004, p. 330). He argues that this approach allows for students who are having difficulties to receive immediate assistance, as opposed to waiting for the issue to become more severe before interventions are implemented. Gresham believes that early intervention is critical. Early proactive involvement for all students may reduce the need for more expensive and intensive treatment later in their development.

The incidence of mental health issues among adolescents is growing (Collishaw, Maughan, Goodman & Pickles, 2004), and it is widely known that untreated or undertreated mental health issues only get worse as time goes on (Repie, 2005). In a survey of educational professionals and families, Repie (2005) found that the cost of care, the quality of care and access to services were cited as the main complications. Therefore, individuals who do not receive care present very challenging and difficult problems for secondary schools to service. RTI is a useful theory for understanding how school counselors support students with mental health issues in their schools. This theory provides the guidance that schools need in order to be proactive, provide immediate assistance to those students in need, and maximize general education’s overall effectiveness.
Chapter 2

“School systems are not responsible for meeting every need of their students. But when the need directly affects learning, the school must meet the challenge.”
Carnegie Council on Education Task Force; quoted by Center for Mental Health in Schools at UCLA (2005)

Schools are responsible for educating all students, and typically their effectiveness is judged by their students’ math and reading scores, as well as drop-out and graduation rates. Student success, though, is more than academic success, and a school’s mission must be more than an instructional one. As Doll and Cummings (2008) assert, “life success is a product of social and emotional competence and personal ambition as much as academic achievement and literacy” (p. 15). Therefore, just as schools are rethinking the way they traditionally offer academic curricula and services, so too should they reframe the way they implement student supports. Individual responsive services are not effective enough to address the rising number of mental health issues, nor can they adequately curtail the increase in the number of students receiving special education services and its related costs (Martinez & Ellis, 2008). Instead, support services need to be part of a comprehensive, multifaceted, and cohesive framework.

School administrators must ensure that every student has an equal opportunity to succeed in school. In order to do so, they must put as much emphasis on social and emotional learning as they do on academic learning. This literature review will discuss current trends in adolescent mental health, the historical and current perspective of school mental health, prevention science’s tiers of intervention, and explain the theory and model of Response to Intervention. In addition, this review will discuss how the Response to Intervention model can be implemented to address students’ social and emotional needs, consider the benefits and challenges of implementing the Response to Intervention framework, and examine how it fits into a comprehensive framework.
for addressing mental health issues. Finally, a review of the research regarding school mental health and school counselors will be included.

Adolescent Mental Health

Current state. For decades, psychologists have proposed theories of development to explain the changes that humans undergo. In each theory, adolescence, the period that marks the transition from childhood to adulthood, is given its own significance. Sigmund Freud (1965), in his psychosexual theory of development, used the “genital” stage to characterize adolescence. Successful resolution at this stage of development would include settling down in a monogamous relationship. Jean Piaget (1936) focused on the cognitive development of humans, and identified adolescence as the “formal operational” stage, in which individuals develop the capacity for abstract and higher order reasoning. Erik Erikson (1950) focused on the development of the ego as it successfully resolves social crises. Adolescence is characterized as the crucial stage of developing identity, and failure to do so leads to role confusion.

No matter if the focus is psychosexual, cognitive or psychosocial, it is clear that adolescence is a critical time of development and change that leads to adulthood. Along with the obvious physical changes that result from puberty, there are also significant changes in hormones, brain development, emotions, cognitions, behavior and interpersonal relationships. Adolescence is also the time when the first signs of mental disorders often appear (Evans, Foa, Gur, Hendin, O’Brien, Seligman, & Walsh, 2005). Some current research suggests that one in five adolescents suffers from some sort of mental health issue (Evans et al., 2005). Other research indicates that about 20-38% of adolescents need intervention, with 9-13% experiencing serious disturbances (Weist, Steigler, Stephan, Cox & Vaughan, 2010). In addition, many more youth are at risk of developing disorders or suffering from non-significant symptoms, and
therefore would not be clinically diagnosed. The most common mental disorders among adolescents are depression, anxiety disorders, eating disorders, substance abuse, suicide, and attention deficit-hyperactivity disorder (ADHD) (Evans et al., 2005).

Evans et al. (2005) state some very alarming statistics about mental illness during adolescence. First, the lifetime prevalence of Major Depressive Disorder (American Psychiatric Association, 2013) in adolescence is about 15%, however about 20-30% of adolescents experience clinically significant levels of depressive symptoms. Depression in adolescents is chronic, recurring and serious, and there is strong continuity to adulthood. Decades ago, it was thought that adolescents were incapable of experiencing depression. At that time, the mean age of the disorder’s onset was thirty. The medical world changed its perception, acknowledging that adolescents can experience depression. Now, the mean age of the onset of depression is fifteen. Second, over half of youth have used an illicit drug by the time they graduate from high school. In addition, as time has gone on, youth continually have access to new drugs, such as ecstasy and prescription drugs. Third, the prevalence of anxiety experienced within a twelve-month period ranges from 9-21%, with 3-5% of the population suffering from the disorder on any given day. Some data indicates that between 50% and 75% of youth with anxiety disorders develop these during adolescence (Schwarz, 2009). Finally, suicide is the third leading cause of death among adolescents, with those between the ages of fifteen and nineteen at an increased risk of suicide. Each year, between 500,000 and 1,000,000 youth between the ages of 15 and 24 attempt suicide (Schwarz, 2009).

**Historical changes.** As the research shows, mental disorders in adolescents are fairly common. In addition, the prevalence of disorders in adolescents is on the rise with each successive generation (Evans et al., 2005). It is unclear exactly why this is occurring, but Evans
et al. have speculated about a few influencing factors. First, the onset of puberty is happening earlier in developed countries and marriage is occurring later, thereby extending the timeframe of adolescence. Another factor is increasing access to potentially harmful environments and substances, such as drugs that can be ordered and content that can be viewed online. Evans et al. also purport that adolescence is increasingly becoming a time of behavioral independence with less adult influence and supervision. Finally, it is possible that some of the increased incidence is due to the fact that it may be more acceptable to diagnose adolescents with mental illness than it was in the past.

Challenges. Unfortunately, treating and preventing mental health issues in adolescence is a neglected area compared to the work done with adult populations (Kazdin, 1993). While increasing attention has been given to child psychopathology recently, Kazdin (1993) argues that adolescence has received much less for several reasons. First, for a long time, adolescence has been viewed as a transitional period, rather than a life period in its own right. Therefore, research has focused on adulthood, when development has plateaued, or childhood, when development is just beginning. Second, many think that the emotional turmoil of adolescence will pass with time, and therefore, emotional and behavioral problems are just part of being an adolescent. As Kazdin (1993) argues, “the assumption that youth will simply ‘grow out of their problems’ has diverted attention from the debilitating and chronic conditions that adolescents are now known to experience” (p.127). Finally, there are many methodological challenges that are associated with studying adolescents due to the biological, cognitive and social changes that make adolescence so active and vibrant.

A second major challenge is that most adolescents who suffer from mental health issues do not seek treatment (Schwarz, 2009). One reason for the lack of utilization is the stigma that
continues to be associated with mental illness and receiving care. Penn, Judge, Jamieson, Garczynski, Hennessy and Romer (2005) define stigma as a person or group that is “labeled in a perjoratively categorized way that sets them apart from the majority and, as a result, is treated in ways that mark the person as socially unacceptable” (p. 532). While it is more common for adolescents to be diagnosed with mental illness, a fear of stigma still prevents many more people from seeking help in order to avoid the negative stereotypes associated with people with mental illness. Second, adolescents represent about one quarter of the uninsured youth in the country (Schwarz, 2009). A lack of insurance, or insurance that does not cover mental health services, makes getting treatment extremely expensive, and therefore, not a financial option for most families. In addition, many insurance programs place limits on both inpatient and outpatient mental health care (Schwarz, 2009). Finally, some youth lack stable living conditions, and therefore do not access any medical services. Schwarz (2009) states that serious mental health disorders among homeless youth range from 19% to 50%, yet rarely do they receive treatment.

As time has progressed, so too has psychology’s understanding of the significance of this period of development. It is clear now that treating and preventing adolescent mental health issues must be a priority. Adolescence is an ideal time for interventions because it is a “period of development that is foundational but also noticeably malleable and plastic” (Evans et al., 2005, p. xxv). In addition, existing mental health problems become increasingly complex with time, and untreated mental health issues often result in negative outcomes, such as poor school performance, and school dropout (Schwarz, 2009). Researchers are also clear that focusing on getting rid of disorders is not comprehensive enough; the focus must also be on instilling positive values and behaviors, and resiliency.
Kazdin (1993) argues that mental health includes two domains: 1) the absence of dysfunction in the psychological, emotional, behavioral and social spheres, and 2) optimal functioning and well-being. He states, “well-being is not merely the absence of impairment; rather it refers to the presence of personal and interpersonal strengths that promote optimal functioning” (p. 128). Therefore, a comprehensive model of adolescent mental health focuses on both prevention and treatment of dysfunction, as well as on the promotion of positive adaptive functioning (Kazdin, 1993). Since youth spend a large amount of time in school, it is an ideal place to provide assessments and interventions for adolescents. Students are monitored regularly in school, and therefore, interventions may be implemented earlier in the individual’s life. Statistics show that between 70% and 80% of adolescents who receive any form of mental health service, receive it in schools (Evans et al., 2005). Therefore, schools are a critical component in addressing adolescent mental health needs.

School Mental Health

**Historical perspective.** The history of school-based mental health services is fairly short, with its value first emphasized at the turn of the 20th century in Chicago (Hoagwood & Erwin, 1997). Beginning as part of the child study movement, the school district opened a laboratory for psychologists to study and identify the “normal” child. The focus of psychological services began to shift during the reform movements of the 1920s to the identification of intellectually sub-average children (Fagan, 1992; as cited in Hoagwood & Erwin, 1997). With the introduction of Alfred Binet’s intelligence tests, psychological services in schools became linked with testing and special education. Compounded with this shift in focus was the confluence of several other factors. First, people were arriving in America from all over Europe, and one of the first things they did was enroll the children in school (Mondale &
Additionally, with the collapse of the child labor market and the introduction of the compulsory education law, even more children enrolled in schools (Reese, 2005). All of the factors increased the pressure on schools to provide psychological services and, through the next few decades, the focus of school-based services was largely on assessments for special services.

In the 1970s, there was growing federal support of research to identify ways to promote academic success among poor children, however, many of the support services implemented did not produce significant achievement (Waxman, Weist & Benson, 1999). At the same time that effectiveness of mental health programs was being questioned, the United States Congress passed the Education for All Handicapped Children Act (1975), which guarantees a free and appropriate education for all students and entitled them to services, such as counseling, consultations, and placements. School mental health services were now being viewed more broadly as a range of interventions, rather than merely assessment for services (Hoagwood & Erwin, 1997). Unfortunately, while districts were mandated to meet the social, emotional, physical and learning needs of all students, they were not compensated adequately to provide all the necessary services. In addition, criticism was mounting that the services that were available, were only for a few students, which left the majority of general education students unable to access services. Waxman, Weist and Benson (1999) argue that these reasons “combined to create an ‘emerging passivity’ to approaching mental health and social welfare issues of students” (p. 241).

This emerging passivity led to a decrease in the number of mental health programs offered. At the same time, researchers were beginning to discuss the significant disparity between the mental health needs of youth and the services available. While community mental health centers are significant places for youth to get support, the complex process required of
families to get help through these centers is not negotiable for most (Waxman et al., 1999). Recognizing the need, districts developed school-based health centers (SBHC), which were staffed by multidisciplinary teams of nurses, health educators, mental health providers, and, in some cases, even dentists (Weist, Lever, Bradshaw & Owens, 2013). These centers offered services such as primary care for acute and chronic health conditions, nutrition education, health promotion and mental health services, with mental health services being the leading cause of student referrals (Weist et al., 2013). This led many schools to include more mental health services, as well as create “stand alone” expanded school mental health programs.

With the passage of the Individuals with Disabilities Education Improvement Act (1997), increasing support for early prevention and intervention, and collaboration among various child-serving agencies were promoted. While this was encouraging, many believed that it led to more confusion about who is responsible for providing mental health services to youth. In fact, some “viewed this new legislation as a mandate for schools to pay for mental health services – services that were under-funded within the community mental health centers” (Kutash, Duchnowski & Lynn, 2006, p. 3). In the past decade, additions to school-based mental health services include the presence of individualized and specialized programs for students at risk, both academically and emotionally, and promotes a comprehensive and coordinated spectrum of services.

Most schools have someone, if not a group of people, who is responsible for the mental health programming. Most schools also have mental health professionals on site, although previous research has shown a wide range of availability of services across states, and in urban versus rural environments (Romer & McIntosh, 2005). School counselors are present in most schools and have a wide range of responsibilities, including assisting those students who are having difficulty in school. Many schools also have psychologists whose main focus is testing
and assessment. Some schools have a social worker to assist with student and crisis interventions. In some cases, both the psychologist and social worker work part time or work in several schools within the district. Unfortunately, most of these professionals spend less than half of the work week counseling students, with most professionals indicating this time to be less than ten hours per week. Since most schools have school or guidance counselors present, this role is a natural fit for assisting in addressing mental health issues.

**School counseling profession.** While the counseling profession has a long history, beginning with vocational guidance in the early seventeenth century and the birth of psychology at the end of the nineteenth century, counseling professionals did not become part of schools until more recently (Schmidt, 2003). As the role of school-based mental health services changed through the twentieth century, so have the roles and responsibilities of school counselors. In the early twentieth century, vocational guidance emerged as a way to instruct students “about their moral development, interpersonal relationships, and the world of work” (Schmidt, 2003, p. 7). This model gained traction through the first few decades of the 1900s as Frank Parsons proposed his model of self-understanding and knowledge for successful career development and the necessity of training counselors to help students with this development. However, some questioned the profession’s narrow focus (Schmidt, 2003).

The introduction of progressive education by John Dewey (1990) changed the focus of counseling to include personal, social and moral, as well as vocational development. Critics of the progressive movement, along with the difficulties of the Great Depression, led to the abandonment of guidance and counseling services in schools. Between the 1940s and 1960s, several significant influences encouraged the resurgence of the profession. First was the emergence of Carl Rogers’ client-centered counseling (1951), an approach that emphasized a
growth-oriented relationship between counselor and client as opposed to a problem-solving or informational relationship. Second, the George-Barden Act (1946) provided funds to schools to develop and support guidance and counseling activities, and established the Guidance and Personnel Services Section of the U.S. Department of Education, which continued to push the profession toward a broader perspective of student services. Finally, the launch of the Russian satellite Sputnik in 1957 and the United States’ subsequent response with the National Defense Education Act (1958) were critical to the expansion of guidance and counseling services and personnel in schools across the country.

After the 1960s, the expansion of the counseling profession coincided with the need for people to solve personal and social difficulties in a changing world, such as the shift to the technological age and the professions available, the changing role of women, and the accelerated pace of change in society (Schmidt, 2003). School counselors were given two functions: programmatic, which included assessing student need, student placement, and aligning services with curriculum, and process, which included individual and group counseling, parent assistance, and consultation. This era corresponded with the Education for All Handicapped Children Act (1975). The demand for consultations increased dramatically, and therefore the number of school counselors needed in schools rose to meet the need (Hoagwood & Erwin, 1997). The role of a professional school counselor has changed dramatically since its inception, and counselors can be found in elementary, middle and secondary schools. Unfortunately, as the role of counselors has shifted, a lack of clarity regarding its purpose has proliferated and created a huge disparity among schools in the roles and responsibilities of counselors (Schmidt, 2003).

**American School Counselor Association comprehensive guidance model.** In the mid-1990s, the American School Counselor Association (ASCA) heeded the call for more certainty
and the need for a clear identity by creating a model framework for a comprehensive counseling program. This framework provides a common language regarding the role and tasks of the school counselor across school districts and the country. ASCA states that counselors are vital to student success because they “promote equity and access to rigorous educational experiences…support a safe learning environment…and address the needs of all students through culturally relevant prevention and intervention programs” (ASCA, 2013). Implementing a comprehensive counseling program puts school counselors at the center of education, allowing them to make a significant contribution towards achieving school and district goals (ASCA, 2003).

Not only does ASCA formalize an identity for counselors in schools, it also specifies how counselors should spend their time. Comprehensive counseling programs are preventive in design, developmental in nature, and driven by data with consistent monitoring of student progress (ASCA, 2003). ASCA states that counselors should spend the majority of their time in direct service to and contact with their students through the guidance curriculum, individual student planning and responsive services. Only a small percentage of time should be spent on indirect service support. While most counselors historically spent a majority of their time responding to high achievers or high risk youth, the new framework was designed to ensure that every student receives the benefits of a school counselor (ASCA, 2003). At this time, it is unclear how many schools have adopted and implemented the framework, and research regarding the program’s impact on student success is still in its infancy. What is clear, though, is that the framework is being embraced by state education departments, with 44 states developing their own models based on the national framework and school counseling graduate programs (ASCA, 2013).
**Challenges.** With schools providing assistance for the majority of adolescents with mental health issues, they have become a sort of de facto mental health care system. There are several obstacles that schools and counselors face. First, there continues to be more and more pressure placed on schools to provide services to a student population with diverse needs (Hoagwood & Erwin, 1997). In addition, the needs of students are constantly changing and increasing in number and scale (Evans et al., 2005). Schools must not only support those students who are in crisis, but also the students at risk of developing a mental illness as well as the large majority of students who need to learn resilience and other interpersonal strengths. Moreover, the supports that are offered must address a wide range of mental illness. Second, generally schools are under-resourced to effectively address the social and emotional challenges students present (Romer & McIntosh, 2005). Between excessive counselor caseloads and part-time schedules of psychologists and social workers, there are not enough resources in most schools for social and emotional learning to be a priority. In addition, despite the documented benefits of school-based mental health services and awareness of barriers to learning, research and reform continue to focus on instruction and curriculum (Repie, 2005). Finally, while the American School Counselor Association standards have helped to make significant inroads in the professional school counseling field, there remains a significant amount of role ambiguity for both counselors and administrators (DeKruyf, Auger & Trice-Black, 2013). In most cases, administrators are unaware of the full range of counselors’ competencies and therefore counselors are left to handle many administrative tasks, as well as scheduling, testing, and even substitute teaching (Brown, Dahlbeck & Sparkman-Barnes, 2010). Focusing on other tasks can lead to an erosion of a counselor’s self-efficacy in the counseling realm and contribute to diminished clinical skills over time (DeKruyf et al., 2013). It also has created an environment in
which counselors react to individual student needs, as opposed to being proactive to address the needs of all students.

While reactive interventions are a necessary component to effective school counseling programs, they do not sufficiently address the needs of the high number of students whom counselors work with. Consequently, counselors must also focus on preventive interventions, which are targeted at all students and may even prevent some problems from arising. At this time, a brief description of prevention science, tiers of intervention, and Response to Intervention is warranted as these models will assist in addressing the challenges that school counselors currently face.

**Prevention Science**

**Theory.** Prevention science has long been accepted as the model for promoting public health (Caplan, 1964). The focus is on preventing health problems in the entire population, as opposed to treating individuals as they become sick. One example is the use of immunizations in babies to prevent the more costly treatment of specific illnesses, such as tuberculosis. The use of prevention science in the realm of mental health gained traction in the 1960s (Caplan, 1964), and has continued to be proposed, implemented and researched. For mental health, Coie, Watt, West, Hawkins, Asarnow, Markman, Ramey, Shure and Long (1993) state that “the goal of prevention science is to prevent or moderate major human dysfunction…[and] to eliminate or mitigate the causes of disorder” (p. 1013). Instead of addressing issues that have already surfaced, the goal of preventive interventions is to counteract risk factors and reinforce protective factors to disrupt an individual’s trajectory towards mental health dysfunction. Risk factors are those variables connected with a greater probability of onset, severity and duration of mental health issues. Just as an individual risk factor is not always predictive of a specific disorder, a
specific disorder is not related to a singular risk factor. In fact, specific dysfunctions are related to myriad risk factors. Moreover, multiple risk factors have a cumulative effect, having “additive effects on vulnerability” (Coie et al., 1993, p. 1014).

Protective factors, on the other hand, may decrease dysfunction and potentially prevent the prevalence of the risk factor altogether (Coie et al., 1993). Coie et al. identify two types of protective factors: individual characteristics and environmental attributes. Individual characteristics, such as temperament, disposition, and skills, help one to cope with stress or adversity. Attributes of one’s environment, such as social support, parental warmth, discipline, adult supervision, and bonding to family, can also serve as protective factors. When risk factors are difficult to identify ahead of time, enhancing protective factors is the preferred choice of strategy (Coie et al., 1993).

Finally, Coie et al. (1993) indicate that it is optimal for prevention strategies to be implemented before the onset of dysfunction. To postpone intervention until later might allow for dysfunctional behavior to become established. The earlier an intervention can be implemented, the greater the chance is of preventing or postponing the first occurrence of the disorder. In addition, the most effective interventions address risk factors across domains with multiple components (Coie et al., 1993). The individual, the family, the school and the community are interdependent, and therefore successful efforts include these elements for comprehensive implementation.

**Tiers of intervention.** The model of prevention science includes three levels of prevention and intervention (Caplan, 1964). The first level, called primary prevention, “seeks to reduce the risk for the whole population” (Caplan, 1964, p. 26). Caplan argues that the focus of primary prevention must be on identifying current harmful influences, what factors assist
individuals in resisting them, and those factors that influence the population in resisting
influences in the future. With this focus, it is hoped “that the incidence of mental disorder will
be lowered, that harmful pressures will be reduced in intensity, that people will be helped to find
healthy ways of dealing with them, and that their capacity to deal with future difficulties will be
increased” (Caplan, 1964, p. 28). Caplan’s approach makes the assumption that many mental
illnesses are a result of maladaptation and/or maladjustment, but that altering the influence of
surrounding forces will lead to healthy adaptation and adjustment.

While primary prevention should have an effect on the majority of the population, there
will still be a population that is at risk of developing a mental disorder. Secondary prevention
seeks to reduce the prevalence of disorders by “shortening the duration of existing cases through
early diagnosis and effective treatment” (Caplan, 1964, p. 89). In other words, the earlier the
intervention is implemented, the less likely the disorder has become imbedded in the individual’s
psychological self and therefore is more easily transformed. However, in order to have a
significant impact on reducing the prevalence of the disorder, treatment should focus on the
group rather than individuals (Caplan, 1964). The intention of this level of intervention is to give
short-term assistance in order to help people deal with their current difficulties better than if they
had faced them alone.

Finally, tertiary prevention aims to reduce the rate of defective functioning due to mental
illness (Caplan, 1964). In other words, this level of intervention is a form of rehabilitation for
those who have an established disorder in order to reduce the “residual defect, the lowered
capacity to contribute to the occupational and social life of the community” (Caplan, 1964, p.
113). In total, the three levels of prevention represent a comprehensive model of care that
supports both mental health and mental disorders. Caplan (1964) argues that in order for a
preventive program to be effective, all three levels of care must be present. It is this framework that Response to Intervention has been modeled after to address academic and behavioral difficulties in schools.

**The Response to Intervention model.** The Individuals with Disabilities Education Act, passed in 1990, guarantees a free, appropriate public education for all children, putting the burden on schools to offer appropriate services or pay for the student to attend another school. In the first decades of implementation, a “discrepancy model” was used, which looked at the difference between a student’s potential and actual achievement. If a discrepancy was found, the student was determined to have a disability, and be in need of additional time or specialized instruction through special education services (Buffum, Mattos & Weber, 2009). Unfortunately, this model meant the school waited for the discrepancy to be significantly measurable; in other words, the model unwittingly encouraged counselors to wait for students to fail before implementing support (Gresham, 2005).

In 2004, the United States government passed the Individuals with Disabilities Improvement Act to address the criticisms of the discrepancy model and the growing number of students needing special education services (Hazelkorn, Bucholz, Goodman, Duffy & Brady, 2011). Response to Intervention became the new model. Response to Intervention is defined as a formal process to provide instruction and intervention for any student experiencing academic and/or behavioral difficulties within the general education classroom (Gerzel-Short & Wilkins, 2009). It can also be described as the change in behavior as a result of an intervention.

In order to provide all students with an opportunity to succeed, the Response to Intervention model describes a simple four-step process: identify students at risk of poor performance, provide evidence-based interventions, monitor student progress, and adjust the
interventions depending upon the student’s responsiveness (Center for Mental Health in Schools at UCLA, 2011, p. 1). One of the advantages of this system is that it “provides immediate assistance to students who are having difficulties with behavioral or academic challenges” (Gresham, 2004, p. 331). Therefore, there is no need to wait for a student’s presenting issue to become severe in order to implement intervention services.

One of the fundamental principles of Response to Intervention is the matching of student problems with the appropriate intensity of intervention (Saeki, Jimerson, Earhart, Hart, Renshaw, Singh, & Stewart, 2011). Buffum et al. (2009) describe the three tiers of intervention intensity in any Response to Intervention system. Tier 1 utilizes differentiated instruction in the general education classroom requiring ongoing monitoring of progress by teachers. Tier 2 includes supplementary interventions, which are “immediate and powerful targeted interventions systematically applied and monitored for any student not achieving” (Buffum et al., 2009, p. 88). Finally, Tier 3 includes intensive interventions for those students who did not respond to the supplementary interventions.

Interventions in classrooms, both formal and informal, have been common for a long period of time (Martinez & Young, 2011). While Response to Intervention has been primarily used to address issues in the academic domain, it can also serve as an effective means of addressing social, emotional and behavioral problems of students (Saeki et al., 2011).

**Implementing Response to Intervention to Address Mental Health Issues**

Historically, school mental health has focused on the individual student and interventions have been targeted to that need specifically. School administrators have typically viewed mental health issues as outside the realm of the school’s duty to address because they stem from outside factors (Gresham, 2004). If a mental health issue became severe enough, it was addressed
through special education. Administrators did not view schools “as proactive agents in the process of prevention and/or behavioral change” (Gresham, 2004, p. 326). However, since psychological well-being is considered a foundation for student success, school mental health models should be designed to meet the needs of all students in the school.

While Response to Intervention has been primarily used to address issues in the academic domain, school counselors can also use it as an effective means of addressing the social, emotional and behavioral problems of students (Saeki et al., 2011). Just as with academic issues, using Response to Intervention to address mental health issues involves three tiered steps (Buffum, Mattos & Weber, 2009). Put simply, tier one interventions are provided to all students to prevent harm (Saeki et al., 2011). Tier two interventions seek to reverse harm for students experiencing mental health issues and are at risk for school problems (Gresham, 2004). Finally, intense and highly individualized tier three interventions are utilized for students with the most severe issues (Saeki et al., 2011). Data are collected at each stage to determine the effectiveness of the intervention.

Mental health is not only about the absence of mental illness; it also consists of building skills to help youth adapt to and experience success in life. Therefore, tier one, also called primary prevention or universal intervention service, seeks to promote academic achievement, mental health and a positive school climate for all students (Usaj, Shine & Mandlawitz, 2006). These interventions are designed to prevent harm by targeting and affecting all students, and typically are implemented by teachers or student support personnel in the classroom. Because of the positive correlation between mental health and academic achievement, effective universal interventions influence both academic and social development (Hoagwood, Olin, Kerker, Kratochwill, Crowe, & Saka, 2007). Along with everyday strategies, such as seating
arrangements, positive reinforcement and classroom behavior rules, school counselors also may identify a specific need to address through universal prevention strategies. Many of these strategies deal with the social-emotional development of each student due to its influence on current and later success. One’s inability to acquire these skills is correlated with higher rates of mental illness and unemployment (Merrell, Gueldner, & Tran, 2008).

For those students for whom the universal prevention strategies prove to be insufficient, school counselors should implement tier-two or selected intervention services. These students are at risk for more severe problem behaviors and need these interventions to reverse harm. Buffum et al. (2009) indicate that only about 15 to 20 percent of the student population need this more targeted intervention, which is provided through group counseling, mentoring programs, or a behavioral plan. For issues surrounding mental health, psychoeducational and psychotherapeutic group formats are effective at facilitating skill mastery, including increasing prosocial behaviors and improving student achievement (Campbell & Brigman, 2005).

Additionally, the National Institute of Mental Health (2006) asserts that self-regulation of emotion is a powerful social mediator, and can be an important factor in an adolescent’s ability to utilize prosocial behaviors (Augustyniak, Brooks, Rinaldo, Bogner & Hodges, 2009). Counselor-led group work focused on social skills training can facilitate coping skills and social interaction skills in a safe and risk-free environment.

While some students respond to tier-two interventions, there may be individuals who require more intense and highly individualized support that focuses on their specific behavior (Buffum et al., 2009). Students needing tier-three interventions make up about 1% to 5% of the student population, however, as Gresham (2005) argues, “they are responsible for 40-50% of behavioral disruptions in schools, and drain 50-60% of school building and classroom resources”
These interventions can involve intensive individual counseling, such as cognitive-behavioral or dialectical-behavioral counseling, in order to understand and address the underlying motivation for a student’s behavior. For example, Froiland (2011) found a tier-three intervention helpful in identifying one student’s underlying reason for school refusal. While an administrator would traditionally categorize this kind of behavior as defiance, individual counseling uncovered severe depressive symptoms. If tier-three supports and interventions are ineffective, however, a referral to special education or an outside therapeutic agency may follow (VanDerHeyden, Witt & Gilbertson, 2007).

Implications of Response to Intervention. Gresham (2005) identifies several implications for those school counselors who implement a Response to Intervention framework to address mental health needs. First, and most importantly, Response to Intervention provides immediate assistance to students who experience difficulties. As mentioned before, in the previous “discrepancy” model, schools waited for the difficulties to become severe before implementing interventions. Those students who did not qualify for more intensive interventions or special education services were left to quietly suffer on their own. Instead, Saeki et al. (2011) argue that a three-tiered Response to Intervention framework for social, emotional, and behavioral issues provides meaningful supports for students who are at risk but may not qualify for special education services. In effect, Response to Intervention ensures that all students can receive the assistance they need to be successful.

A second related advantage is that Response to Intervention affords schools an opportunity to proactively identify students who need assistance. Therefore, instead of the deficit model, Response to Intervention operates under a risk model (Gresham, 2007). Gresham (2005) highlights the impact of early intervention in its ability to reduce the need for more
intensive and expensive intervention later in life, as Caplan (1964) argued previously. Early identification and intervention can even help in avoiding more serious mental health issues entirely. According to Cheney, Flower and Templeton (2008), early identification of and intervention with children who are at risk for emotional and behavioral disorders “appear to be the most powerful course of action for ameliorating life-long problems associated for children at risk for EBD [emotional or behavioral disorder]” (p. 109).

Response to Intervention can also improve decision-making regarding eligibility for and services in special education. Over the past twenty-five years, the number of students identified as having a learning disability and receiving special education services has increased by 283% (Martinez & Ellis, 2008). Experts attribute this increase to an overidentification and misidentification of students with disabilities, including those recognized as having an emotional, social, or behavioral disability. In general, determining whether a student’s emotional or behavioral difficulty represents a true disability is unclear and involves subjective judgment. As Gresham (2007) asks “When does social withdrawal and shyness become an anxiety disorder? When does sadness and loneliness become a major depressive disorder?” (p. 215). Relatedly, Response to Intervention decreases the need to rely solely on the teacher in order to gauge the severity of the problem and the effectiveness of an intervention in changing behavior (Gresham, 2004). In a Response to Intervention model, only those students who do not respond to a series of targeted interventions are considered for special education services, thereby substantially reducing the number of false positive identifications.

A final implication of the Response to Intervention model relates to outcomes. In an era of increasing accountability, school counselors must provide evidence of the effectiveness of their practice in schools. Response to Intervention requires school counselors to make decisions
based on data collected over a period of time (Gresham, 2004). In addition, Response to Intervention is “based on the notion that measures and domains assessed should be determined by their relationships to…positive child outcomes, not just predictions of failure” (Gresham, 2007, p. 217). Therefore, those implementing the intervention can use both quantitative and qualitative data to report student responsiveness and outcomes, as well as demonstrate their own effectiveness.

While there are certainly many benefits to utilizing a Response to Intervention model for emotional, behavioral, and social difficulties, there are also some challenges and limitations that are noted by theorists. In the academic domain, quantitative data, such as before and after scores on a reading fluency test, are a sufficient determinant of responsiveness. However, in the emotional and behavioral domain, pre- and post-test data have not been able to fully explain a student’s social, emotional and behavioral functioning (Saeki et al., 2011). While some researchers have proposed metrics for measuring the progress of at-risk students (Gresham, 2005), these models are still in their infancy. Therefore, Saeki et al. (2011) argue for the importance of utilizing a multifaceted evaluation process of both quantitative and qualitative data. However, they also make note of two potential challenges with qualitative data. First, qualitative information must be incorporated systematically or else objectivity may be compromised in the decision-making process. Second, the systematic collection and analysis of data is beyond the scope of time and resources for most student support personnel.

**Comprehensive mental health framework.** Put simply, Response to Intervention is a promising strategy to address barriers to learning and re-engage disengaged learners through a three-tier framework. However, Response to Intervention strategies by themselves cannot entirely address barriers to learning and when only conceptualized as a continuum of fragmented
services, is entirely ineffective (Center for Mental Health in Schools at UCLA, 2011, April). The Center for Mental Health in School at UCLA (2011, February) highlights four main concerns about the pyramid formulation: “it mainly stresses levels of intensity, does not address the problem of systematically connecting interventions that fall into and across each level, and does not address the need to connect school and community interventions” (p. 3). In addition, while the stated percentages are given as guidelines, they tend to be taken as factual data, although the reality is that some schools will have a higher percentage of students needing intensive interventions.

In response to these concerns, there has been a push to move from a three-tier pyramid with a continuum of interventions to a comprehensive intervention framework that emphasizes the importance of utilizing school, home and community resources. As the Center for Mental Health in Schools at UCLA (April, 2011) argues, “the complex set of factors causing poor student performance calls for a comprehensive and systemic set of interventions” (p. 19). This does not imply, though, that the continuum of interventions is ignored; instead, it becomes a piece of a much larger framework to address barriers to learning.

Partnering with families is a key element of enhancing mental health outcomes for adolescents because it is based on the belief that a child’s education and socialization are shared responsibilities (Christenson, Whitehouse & VanGetson, 2008). Evidence exists pointing to the positive effects of family influences on children’s academic, social and behavioral competence. Christenson, Whitehouse, and VanGetson (2008) completed a comprehensive review of the literature and found that family involvement is a positive and significant correlate of desired outcomes, such as avoidance of high-risk behavior and problem solving, and the involvement of
parents in early/intervention programs is beneficial. In addition, continuity across home and school is an important protective factor (Christenson, Whitehouse, & VanGetson, 2008).

Christenson, Whitehouse & VanGetson (2008) report that many parents felt that special education did not meet their child’s emotional and social needs, and what parents desired the most was information. Just as a three-tier intervention strategy works with students to address different levels of needs in a Response to Intervention model, so does a three-tier service delivery for parents (Christenson et al., 2008), which also includes a universal, selected, and indicated delivery system. At the universal level, school personnel utilize educational activities to identify critical mental health issues and disseminate information about protective factors and indicators of risk. School-wide parent meetings and monthly newsletters would fit into this category. Selected service delivery narrows the focus to a smaller percentage of the population, and can include workshops for parents on specific topics, such as anxiety or depression, or parent-teacher consultation about risk behaviors and brainstorm appropriate interventions. Finally, indicated service delivery is the most rigorous of interventions and can include family counseling or a home visit.

Involving families in a comprehensive framework for adolescent mental health is critical. Even though there is a plethora of research touting the positive effects, many schools often ignore or underutilize this component (Christenson et al., 2008). Mental health is not only about the absence of mental illness; it also consists of building skills to help youth adapt to and experience success in life. Therefore, “intentional and ongoing relationships” (Christenson et al., 2008, p. 71) create stronger partnerships with families, thereby enhancing trust and promoting a more effective service delivery.
Summary. Public schools must meet the challenge of addressing the growing mental health needs of their students, even in the face of decreasing budgets and staff reductions. School age youth “deserve an opportunity to thrive in the least restrictive environment” (Froiland, 2011, p. 41) and Response to Intervention grants this opportunity by providing deliberate, early intervention. Response to Intervention is being implemented across the country to address academic issues; however, it is underutilized by school systems in addressing social and emotional challenges (Froiland, 2011). Unfortunately, school leadership has been very slow to recognize and address the needs of students at risk for behavioral and mental health issues (Gresham, 2005), and counselors continue to struggle with how to meet the needs of this growing population (U.S. Department of Education, 2009).

Currently, due to ineffective strategies, school counselors spend a disproportionate amount of time working with a small number of students with emotional and behavioral problems (Saeki et al, 2011). School counselors, though, are an important piece of the mental health intervention puzzle because they can reach a large number of at-risk adolescents through a variety of formal and informal opportunities (Gresham, 2004). When used appropriately, school counselors have the potential to not only help far more children thrive socially and emotionally, they also can “develop potent interventions that foster students’ mental health, social success, and resilience” (Froiland, 2011, p. 41).

Review of Research: Mental Health and School Counselors

Four main categories emerged in the review of the research regarding school-based mental health and school counselors. The categories are a) availability of services within schools, b) meta-analyses of previous research of school-based mental health programs, c) effectiveness
of specific programming at the primary, secondary and tertiary intervention level, and d) school counselor perceptions of self-efficacy and effectiveness of implemented interventions.

**Availability of services in school.** Slade (2003) surveyed 80 middle and high schools across the United States to identify the availability of mental health services in schools. The schools were categorized by size, type (public, parochial, and private), urbanicity, geographic region, and percentage of non-white students. Overall, almost half of the schools offered on-site mental health counseling and about 40% offered substance abuse counseling. Slade found that the percentage of minority students, urbanicity of the school’s location and larger schools had a positive relationship with the availability of on-site mental health counseling. There was also a significant relationship between region and availability; more than two-thirds of schools in the Northeast and West offer on-site counseling, while less than half of the South and less than a third of the Midwest offer mental health counseling. Slade proposed several possible explanations for the discrepancy, including the number of mental health care providers in the area and finances.

**Meta-analysis of previous research.** While Slade (2003) looked at the availability of services in schools, Hoagwood and Erwin (1997) conducted a meta-analytic review of the literature to examine the effectiveness of school-based mental health services. Only 16 studies met all of the criteria for inclusion in the review: it needed to incorporate a program evaluation, have random assignment to the intervention, include a control group and use standardized outcome measures. Hoagwood and Erwin found that three types of interventions had empirical support for their effectiveness, including cognitive-behavioral therapy (CBT), social skills training, and teacher consultation. Studies utilizing CBT focused on the prevention of depression, substance use and school adjustment; social skill training targeted at school
adjustment and substance use problems; and teacher consultation studies focused on the effects of behavioral consultation on pre-referral practices and teacher stress. Hoagwood and Erwin suggested that future research investigate the effectiveness of these techniques on other emotional and behavioral problems.

In their review of school-based mental health services in schools, Wells, Barlow and Stewart-Brown (2003) focused on universal approaches to mental health promotion. Seventeen studies met all of the criteria to be included in the review, with the majority of the studied schools from low socio-economic areas and with a high percentage of minority students. The majority of the studies measured negative aspects of mental health, such as suicide, aggression and conduct disorders, while others measured aspects that strengthen positive mental health, like self-esteem. Wells et al. categorized the studies by interventions taking a whole-school approach, a classroom approach, and those outside of the classroom, but were not whole-school approaches. Overall, those interventions that focused on mental health promotion, instead of mental illness prevention, that used a whole-school approach, and those that were implemented for a longer period of time were found to be the most effective.

Hoagwood, Olin, Kerker, Kratochwill, Crowe and Saka (2007) also focused on school-wide programs in their research review, but chose studies that examined both mental health and academic outcomes. Twenty-four studies met all of the criteria, including having a longitudinal design and a focus on both outcomes, with the majority of the studies focused on elementary school students. Hoagwood et al. found that fifteen of the studies demonstrated a statistically significant effect on both academic and mental health outcomes, however most of the interventions only had modest effects. The most effective interventions were intensive, targeting students, parents and teachers, as well as focused multiple contexts.
Durlak and Wells (1998) examined secondary, or indicated, prevention programs for mental health to study their effectiveness and identify the variables that influence outcomes. Durlak and Wells identified 121 studies to be included in the review that met all of the criteria, including those involving children and adolescents and involving a control group. The results showed that secondary prevention programs produced positive effects, with participants experiencing significantly reduced problems and increased competencies. Durlak and Wells also found a longitudinal effect of participation in the programs. Those programs that utilized a behavioral or cognitive-behavioral model showed the most significant impact on behavior.

All of these studies utilized meta-analysis to review the general effectiveness of universal interventions in schools (Hoagwood & Erwin, 1997; Wells et al., 2003; Hoagwood et al., 2007). Each meta-analytic review found that the majority of the interventions implemented have a positive effect on participants, with a few having no effect or a negative effect. The most effective interventions utilized a cognitive-behavioral or behavioral program, a whole-school approach, focused on the promotion of mental health, and were implemented for longer periods of time. Durlak and Wells (1998) also found that behavioral treatments were superior to non-behavioral treatments at the secondary level, and that these indicated interventions produced positive effects on behavior and personality.

**Research on specific interventions.** One area of research regarding school mental health examines the effectiveness of particular programs at the universal (tier 1), secondary (tier 2) and/or tertiary (tier 3) level of intervention, as outlined by prevention science theory. Eber, Sugai, Smith and Scott (2002) state that the need for a comprehensive system of service is evident in previous literature, and that previous implementation has produced some promising outcomes; unfortunately, collaboration across disciplines is complex and difficult. Eber et al.
argue that the implementation of the Positive Behavioral Interventions and Supports (PBIS), an evidenced-based, three-tiered prevention program, leads to improved behavioral functioning, along with systematic wraparound services, a community-based approach to providing comprehensive and integrated services. In addition, the authors describe the environmental factors within a school that support implementation, including using trained facilitators, keeping a focus on strengths and needs, and adhering to the value base during plan implementation. Eber et al. state that more research is needed to confirm the effectiveness of PBIS and wraparound services. In addition, there is a need to understand why schools do not adopt a systems approach to support, why there is an overreliance on punishment, and why a focus on prevention is difficult to achieve.

Weist, Stiegler, Stephan, Cox and Vaughan (2010) detailed the implementation of an Expanded School Mental Health (ESMH) initiative in two Baltimore elementary schools. The authors provide a real-world example of the school’s experience implementing evidence-based prevention strategies at each level of intervention. Weist et al. found that implementation of tier 1 and 2 strategies were hampered by both teacher turnover and busy curriculum schedules, which led to inconsistent execution. The authors argue that while the need for comprehensive services in schools is clear, there are dimensions of school infrastructure and program implementation that should be addressed.

Nabors, Reynolds and Weist (2000) used focus groups to gauge the quality and effectiveness of an Expanded School Mental Health (ESMH) program in three Baltimore high schools. Along with students receiving and not receiving services, Nabors et al. also conducted focus groups for administrators, parents, and therapists. Stakeholder perceptions about four specific topics were investigated: positive aspects of the program, suggestions for improvements,
how to influence “hard to reach” youth, and ideas for measuring outcomes. Across the board, participants reported that utilizing mental health services resulted in positive outcomes and protective factors in students. Some identified areas of improvement were more consistency of services during the week as well as extended hours after school and through the summer. Participants also made suggestions for helping the program to overcome the stigma associated with participation in therapy.

Stormshak, Conell, Veronneau, Myers, Dishion, Kavanagh, and Caruthers (2011) examined the impact of the EcoFIT model, an ecological approach to family intervention and treatment, in three public middle schools. This model includes interventions at the universal, secondary and tertiary level, the effects of which extend beyond the school milieu to improve family functioning at home. The study investigated the intervention effects over a three-year period, and found that this approach had a positive impact on problem behaviors and substance use. The results also suggested that the transition from elementary to middle school is an appropriate time to continue parenting skills interventions.

While these researchers focused on programs that include interventions at all three levels, other researchers focused on programs at specific levels. Dix, Slee, Lawson and Keeves (2012) studied the implementation of a school-wide mental health curriculum, KidsMatter, in 96 Australian elementary schools over a two-year period. Questionnaires were given to teachers and parents several times throughout the study to get information about students’ school engagement, implementation of the initiative, impact on the school in general, impact on teachers and families, and the impact on students’ social-emotional competence and mental health. Results indicated that those schools that implemented the program well also had improved student academic performance. Those schools that did not implement the program well did not
see the same gains. The findings indicated that the quality of implementation is a significant factor in academic outcomes, although more research is needed to support this claim.

Erickson and Abel (2013) used a qualitative approach to describe the implementation of a suicide prevention program and depression screening at a high school in Minnesota. The article details the data that led the counseling department to implement a program, the programs they researched and ultimately decided upon, and the classroom curriculum that was created. Erickson and Abel stated that the screening consistently identified about 10% of the students to be at risk for depression, and presented the follow-up care that counselors engaged in with families to ensure communication and collaboration. Erickson and Abel also reported statistics from an independent survey indicating that the reports of depression and suicide attempts had dropped in the school population. In addition, counselors reported that students increasingly were seeking help for themselves or a friend, and that the feedback about the program from students was overwhelmingly positive. Erickson and Abel also offer some practical recommendations for counselors who are interested in implementing a similar program in their schools.

As a tier two intervention, Augustyniak, Brooks, Rinaldo, Bogner and Hodges (2009) examined the implementation and effectiveness of the Prepare Curriculum, used in group counseling for youth with internalizing and externalizing behavioral concerns. Participants for the group intervention were referred by self, parents, and/or school personnel. For those in the intervention group, paired sample t-tests showed a significant decrease in the Behavioral Assessment Systems for Children (BASC) self-report of internalized distress, including locus of control, social stress, anxiety, clinical maladjustment and global emotional symptoms. No differences were found for those in the control group. Augustyniak et al. also examined the
validity of emotional regulation, defined as the ability to inhibit, subdue, minimize or prolong a particular emotional state, as a mediating factor for child and adolescent pathology and as a treatment consideration. The results suggested that cognitive self-regulation is a potent factor in mediating adjustment for both adolescents and younger children.

Utilizing tier two group interventions, Cheney, Flower and Templeton (2008) examined the effectiveness of Gresham’s (2005) recommended metrics in the social and behavioral realm. These metrics include absolute change, percentage of non-overlapping data points, percentage of change, effect size and reliable change index. The participants in the study were 127 first through third graders in elementary schools in the Puget Sound area that had been identified due to the results of a behavior screening. The researchers implemented the Check In/Check Out intervention, along with periodic check-ins during the day that allowed for constant feedback throughout the day. Cheney et al. found that percentage of change and effect size were the most useful metrics in measuring students’ response to intervention. These metrics identified 67% of the participants as responding to the intervention. Moreover, Cheney et al. found that more than half of the responders made positive gains on behavior ratings and most of the responders were not identified for special education, indicating that this intervention is appropriate for helping to prevent emotional and behavioral disorders.

Martens and Andreen (2013) documented the implementation of the Positive Behavior Intervention and Supports (PBIS) program at an elementary school in Minnesota and its effect on student outcomes. Similar to Cheney et al. (2008), this study utilized the Check In/Check Out intervention in order to increase the opportunities for adults to prompt positive behavior and give feedback to their students every day. Students identified for this intervention were unresponsive
to the universal intervention the school implemented previously. Martens and Andreen indicated that this intervention limited inappropriate referrals to special education.

Froiland (2011) documents two case studies of tier three interventions implemented by full-time school psychologists with large caseloads for elementary school children experiencing attention difficulties and school refusal. Each case study describes the presenting problem, how the problem was analyzed, the intervention utilized, and an evaluation of the intervention. In each instance, the school psychologist was able to have a lasting impact on the social and emotional functioning of the student, thereby providing promising evidence of a problem-solving model that can be utilized in schools.

Overall, some of these studies were interested in determining the effectiveness of particular interventions for their populations, such as KidsMatter (Dix et al., 2012) and Prepare Curriculum (Augustyniak et al., 2009). Other studies focused on comprehensive program implementation, rather than a specific intervention’s effectiveness, as Weist et al. (2010) did in their investigation of the Expanded Mental Health Services model implemented in Baltimore schools and Stormshak et al. (2011) in their study of the implementation of the EcoFIT program.

The quantitative studies used a variety of data gathering tools, including surveys (Repie, 2005; Slade, 2003) and behavioral screenings (Cheney et al., 2008). Others focused on changes in attendance, academic performance and discipline referrals as the result of an implemented intervention (Froiland, 2011). In addition, many of the studies were longitudinal with individuals participating in a particular intervention for a length of time (Cheney et al., 2008; Martens & Andreen, 2013) or completing surveys at several points over a period of time (Dix et al, 2012). In general, all of these studies found that school-based interventions had a positive effect on individual functioning. While two studies examined teacher and parent perceptions of
the programs (Weist et al., 2010; Dix et al., 2012), none of them focused on counselors’ perceptions.

Those researchers who utilized a qualitative approach used case studies (Froiland, 2011), focus groups (Nabors et al., 2000; Massey et al., 2005), and narratives to describe implementation, results and contextual factors that supported implementation (Weist et al., 2010; Erickson & Abel, 2013). Instead of investigating the effect size of particular programs, these studies focused on the story of how an intervention was implemented and how it worked through both the experience of the individual and a group of people (Creswell, 2012). Froiland (2011) documented the detailed implementation of different interventions, while Erikson and Abel (2013) and Augustyniak et al. (2009) documented individuals’ reactions to interventions. The effectiveness of the implementation was determined by participant feedback and adult perceptions, dependent upon the kind of approach utilized.

**School counselors & youth mental health.** Repie (2005) investigated the perceptions of regular and special education teachers, school counselors and school psychologists on the presenting problems of students and the effectiveness of services offered in schools. He found that school counselors believe that services offered in school are more effective than ineffective, but that teachers and psychologists believed the opposite. In addition, Repie found that the most frequently available services in schools are the evaluation of emotional and behavioral problems, individual counseling and crisis intervention. The most infrequently utilized services are family counseling and mental health psychoeducation. Repie argues that school systems must create mental health programs based on needs assessments in order to support students with their mental health needs, especially those who fall onto the continuum in the less intense range.
Without this support, students may resort to unhealthy choices, such as aggression, self-harm, and substance abuse.

Brown, Dahlbeck & Sparkman-Barnes (2010) surveyed both school counselors and administrators to identify their perceptions about counselor competence regarding adolescent mental health and perceptions about working collaboratively with outside mental health providers. The survey results revealed that counselors and administrators expressed a fairly large difference in perception of competence. Counselors agreed that they were adequately trained to provide group counseling to students, were able to identify students in need of mental health services, and considered themselves to be mental health professionals. Administrators agreed to a much lesser extent. Interestingly, though, the majority of participants, both counselors and administrators, did believe that school counselors were responsible for treatment of the whole child, including academic, career, personal, and mental health issues. The findings of this study support the belief that there continues to be confusion about the role that counselors should be playing in schools, which has shifted from being reactive to being proactive and preventive. Dialogue to determine the definition of the counselor’s role is recommended so that counselors’ skills within schools can be effectively utilized.

Carlson & Kees (2013) surveyed school counselors to examine self-reported training in and comfort with mental health counseling interventions. Counselors reported that the three issues they were most comfortable dealing with included academic concerns, relationship concerns and stress management. The three issues they were least comfortable dealing with were immigration concerns, addiction and substance use, and spirituality. In working with particular Diagnostic and Statistical Manual, fifth edition (DSM-V) diagnoses (American Psychiatric Association, 2013), counselors reported the most comfort working with anxiety
disorders and cognitive disorders and the least comfort working with factitious disorders (acting as if having disorder by exaggerating symptoms), sleep disorders, and schizophrenia or other psychotic disorders. Regarding confidence in counseling skills, the three skills rated the highest included consultation with parents, teachers and administrators, collaboration/teamwork and ethical practice. The three skills rated the lowest were using the DSM-V to diagnose client issues, family counseling, and treatment planning. The survey results also indicated that while school counselors feel they are qualified to provide mental health counseling to students, “the nature of their job precludes them from doing so on a large scale” (p.218).

The research on school-based mental health programs within the prevention science framework shows promising results. However, there are significant difficulties in successfully implementing and sustaining these programs. Massey, Armstrong, Boroughs, Henson and McCash (2005) examined the experiences of service providers in schools in the implementation of mental health services in a large, urban district. Massey et al. utilized focus groups to collect the data, and participants included service-providing staff, program supervisors, social workers, counselors and school psychologists. Data analysis identified some consistent challenges to effective delivery of services, including determining the organizational placement of the program, determining lines of authority and accountability, and obtaining organizational support. The data analysis also highlighted some significant differences in experience of in-school and out-of-school service providers, including a program’s integration into the school, sustainability efforts, and concerns about informed consent and confidentiality. Massey et al. suggest that collaboration of the entire staff, including administrators and teachers, will assist in successful implementation of a mental health program.
The majority of studies reviewed regarding school counselors and youth mental health were quantitative, and utilized surveys and questionnaires to gather data about perceptions regarding youth mental health (Repie, 2005) and personal competence in supporting these students (Brown et al., 2006; Carlson & Kees, 2013). The one qualitative study sought to identify perceptions of challenges in program implementation from a variety of sources, including non-school personnel, school counselors, social workers and school psychologists (Massey et al., 2005).

**General Analysis**

In general, school-based mental health services have become a focus of more research in the last two decades. For this author’s research, the qualitative methods implemented produced the most compelling results. Whereas the quantitative studies asked specific questions to obtain measurable data, the qualitative studies explored and developed an understanding of a central phenomenon (Creswell, 2012). The overall impact of the quantitative studies is critical, as these studies prove the significance of early intervention and prevention efforts in schools. However, while particular interventions implemented in schools produced positive results, the needs of schools may be different among communities, and therefore these specific interventions may not be helpful in the broader sense. Both quantitative and qualitative studies in this critique show the power of the interventions within the tiers of prevention and Response to Intervention frameworks (Cheney et al., 2008; Froiland, 2011), however the qualitative studies also examined effects from the participants’ point of view (Creswell, 2012). “We conduct qualitative research when we want to empower individuals to share their stories, hear their voices, and minimize power relationships” (Creswell, 2012, p.48). Individuals’ experience is critical to implementing effective and appropriate interventions in schools, and these studies provide a model from which
other researchers and schools can begin their own implementation. Interestingly, the voice that is missing in this review is the school counselor. School counselors work in every school, as opposed to social workers and school psychologists, and therefore their voice is critical since student well-being is their purview.

Across all of the studies, several similar limitations were noted. For those studies implementing the same intervention across several sites, facilitator reliability and integrity came into question (Weist et al., 2010; Stormshak et al., 2011). While the step-by-step intervention should have been implemented exactly the same way, facilitator style could have affected the data. Additionally, some studies only included a treatment group; in other words, there was no comparison group against which to determine effect size (Augustniak et al., 2009). Finally, another major limitation when studying school-based programs is that there are always other interventions being implemented at the same time, that are external to what is being researched (Dix et al., 2012). At times, researchers indicated that it was difficult to determine whether the effects were in response to the intervention being studied or to a different one. While these are important limitations to consider, many of them are unavoidable when conducting longitudinal research in schools.

**Outstanding Questions & Issues**

In looking at all of the studies reviewed, researchers continue to struggle with is how to address the growing mental health needs of children and adolescents. Since mental health has a significant impact on learning and many youth rely on receiving services in schools, schools must rise to the challenge. All of the studies, both quantitative and qualitative, show the effectiveness of school-based interventions, which suggests that schools must make mental health promotion a priority, and personnel must gain more experience in implementing
programs. In addition, many of the studies emphasized the need to determine how the characteristics of the interventions and the participants relate to different outcomes. Wells et al. (2003) and Durlak and Wells (1998) did find that some interventions had negative or neutral effects; schools must find evidence-based programs with a proven effectiveness. Due to time and money constraints, schools need more information, as well as general frameworks, to make progress towards implementing specific interventions.

Quantitative studies are implemented to answer a specific question (Creswell, 2012), and therefore many of the outstanding questions from this research review have to do with what happens next. In addition, many of the studies show support for school-based prevention and intervention programs for mental health. Many researchers indicated that it will be important to continue discussing how schools can efficiently implement these interventions due to the multiple, competing demands on staff time.

Based on this review, research in the area of school-based mental health has primarily been focused on program evaluations to determine the effectiveness of particular interventions and programs. As this review shows, school-based mental health interventions are mostly effective. However, there are two main areas of research that have not been addressed. First, as Eber et al. (2002) state, why haven’t schools adopted the tiers of intervention model if it has proven its effectiveness? In addition, why is the focus on prevention difficult to achieve? Second, the school counselor experience is missing. These are the personnel who address and support student mental health every day. It is imperative to understand what they are experiencing every day, and to hear from them about what has been helpful and challenging in supporting these students. The qualitative description of participants’ experiences, and how
these interventions fit into the larger framework of a comprehensive mental health program utilizing Response to Intervention, still needs to be studied.
Chapter 3

Methodology

Every school was unique, and therefore has different needs and supports to offer students. In addition, each student presents a unique context within which counselors must create supports and a plan to assist them. This research was not intended to measure the effectiveness of specific interventions, but rather to explore what school counselors are experiencing as they work with students with mental health needs and what strategies they utilize. Therefore, this study sought to answer the following questions: What are the experiences of school counselors who provide support to learners who struggle with mental health issues? In what ways do school counselors perceive their roles as shifting as they work with these students? Finally, how do guidance and counseling services and programs support the academic achievement of students struggling with mental health issues?

Since the primary interest of this research is the investigation of a particular phenomenon and participants’ experience with it, the researcher utilized an interpretive paradigm (Merriam, 2002). This paradigm does not see reality as being fixed and measurable, but rather as constantly in flux and different for each individual at different times (Burrell & Morgan, 1979). This paradigm helped the researcher understand the meaning the social world has for individuals (Merriam, 2002), and therefore explained the phenomenon through individual participant understanding, rather than through observer action (Burrell & Morgan, 1979). In addition, this paradigm is not concerned with conflict and change, but rather assumes that the social world is methodical and consistent in order to focus exclusively on the individual subjective experience (Burrell & Morgan, 1979).
Research Design

A qualitative design allowed individuals to tell their stories so others’ can learn the meaning the participants hold about the issue (Creswell, 2012). Also, a qualitative design assisted in giving a complex and detailed understanding of the issue at hand to make sense of a particular phenomenon (Merriam, 2002). Thus far, as identified in the literature review, the counselor’s perspective has been absent from the research. Since this study sought to understand what school counselors are experiencing from their perspective, the participants’ voice was critical (Hoepfl, 1997). In addition, this study was not interested in determining how many counselors are using which interventions, but rather sought to describe their experience using interventions as they support students with mental health issues. Rich description (Hoepfl, 1997), a characteristic of qualitative research, accounted for the nuances of individuals’ experiences in supporting students in a way that quantitative research cannot. Therefore, the end product gives readers a better understanding of what counselors are experiencing in their jobs, and why they are or are not utilizing either tiers of intervention or Response to Intervention (Gresham, 2004) to address their students’ mental health needs.

Research Tradition

I used General Inductive Analysis (GIA) for the study. Thomas (2006) states that “the primary purpose of the inductive approach is to allow research findings to emerge from the frequent, dominant, or significant themes inherent in raw data, without the restraints imposed by structured methodologies” (p. 238). For this research, I was interested in what themes emerged from the interview data in order to identify school counselors’ experience of working with students with mental health issues. I was not interested in creating a narrative of counselors’ lived experience, as one would through a phenomenological study, because every counselor has
a different set of resources and the specific needs of the student population vary. Ultimately, I was interested in identifying common experiences to describe the phenomena of working with students with mental health issues. GIA was helpful in developing a theory about the underlying experiences from the interview data (Thomas, 2006).

Participants

For this research, I purposely selected three participants utilizing the criterion sampling strategy (Miles & Huberman, 1994), one in which participants were chosen based on predetermined criteria. Each participant had at least seven to ten years of experience in the school counseling field and work in suburban Massachusetts high schools. The years of experience was key as student mental health needs have increased exponentially in the past few years and documenting the counselor’s experience through this change was critical. Counselors new to the profession would not have this context. The participants were recruited from the researcher’s neighboring schools who participate in the Middlesex League Guidance Directors’ Group. All members of this group are leaders or directors of their school’s guidance and counseling departments. The members of this group are Arlington, Belmont, Burlington, Concord-Carlisle, Lexington, Melrose, Reading, Salem, Stoneham, Wakefield, Watertown, Wilmington, Winchester, and Woburn. This group meets on a monthly basis to discuss current issues both state and school-wide to get feedback and advice. Within this group, a variety of schools from varying socioeconomic statuses are represented.

Given that socioeconomic status influences the resources and structure of schools (Kozol, 1993), it was important to have representation from across the socioeconomic spectrum. Therefore, I created a table (Appendix A) to organize the income levels of each town in the Middlesex League Directors’ Group. To determine the median household income categories, I
looked up each town’s median household income according to the United States Census Data from 2008-2012. Each town was given a rank, and then I broke this larger group into three subgroups. The top four towns all had median household incomes above $100,000, the middle five towns all had median household incomes of between $85,000-$100,000, and the bottom four all had median household incomes of below $85,000. As such, each participant worked in a town of differing median household incomes; the categories of income were greater than $100K, between $85-100K, and less than $85K.

The sample for this study was small as the purpose of the study was to discover the story of what is going on in the field in detail. One limitation to the small sample size was that the results may not be generalizable to all counselors in suburban settings. In addition, while counselors represented towns with a range of median household incomes, all participants work in suburban schools. The restriction to suburban schools helped to focus the research, however, the results may not be helpful to counselors from urban or rural districts. Finally, choosing counselors with at least seven years’ experience was important to tell the story of what is going on and how the field has changed. However, a limitation was that some of these counselors may not have had the same education and training that newer counselors have in the field of counseling psychology, thereby limiting their capacity for self-efficacy in supporting these students.

**Recruitment & Access**

Participants were recruited from the Middlesex League Guidance Director’s Group. This group was chosen as I am a member of the group from Concord-Carlisle High School, and the group represents a variety of median household incomes. I separated the participants into income categories (Appendix A) and then I randomly selected one participant from each income
category. The three chosen participants represented a substantial difference in income. In other words, I did not want the participants between tiers to only represent a few thousand dollars difference in income.

In order to gain access to each school site, I emailed the principals of the schools. Principals’ emails were found on the school’s websites. A description of the study and the consent form (Appendix B) were included for him or her to sign, giving me permission to conduct the research at the site and with the participant. Information in the description of the study included why the site was chosen, what the researcher will accomplish during the study, how much time will be spent at the site, how the results will be used and reported, and what individuals at the site will gain from this research (Creswell, 2012). All results will be shared with the participating schools, as well as other interested schools, at the completion of the dissertation.

Once the principals gave me permission to conduct the research at their site, I asked the counselors to sign the consent form that included a full description of the research problem and purpose, as well as information about the time commitment, the data to be collected, potential disruptions, protection of confidentiality, and what the individual might gain from participating in the study (Appendix C). In addition, the consent form described the right of the participant to withdraw from the study at any time. Participants received a $25 gift certificate to Amazon at the conclusion of the interviews.

**Data Collection**

The researcher conducted three semi-structured interviews with each counselor at a time and site of their choice. Each interview lasted about sixty minutes. I conducted each interview and recorded them using a digital recorder. I also took notes during the interview to identify
topics for probing questions and for use after the interview for clarification purposes. Interviews were transcribed immediately after they were conducted.

The first interview (Appendix D) covered background information about the counselor, including his or her educational experience as well as years of experience, and the school, including demographics and faculty and staff employed there. The next set of questions were on the topic of adolescent mental health, seeking information about the participants’ perspective on students’ issues and what he or she believes to be the most salient issues at his or her site. We then moved to the mental health services that are offered both at the school and in the community at large. Questions in this section sought to identify what interventions are already being utilized to address students’ needs, and whether the community has helpful resources for support as well. Finally, I asked participants about their efficacy in working with these students. Specifically, I was interested in whether or not counselor’s believe they have the skills to assist these students and what issues are the most difficult to support. In addition, I asked counselors to identify the challenges associated with supporting these students within their role as a counselor in a school.

The second interview (Appendix E) sought to gather more in-depth information about specific cases the counselors have worked on during their career. Prior to the interview, I asked counselors to think about particular cases from the past, one that was fairly easy and one that was challenging. In this interview, I asked the counselor to recount the case, identify what supports were the most helpful, and identify any roadblocks they encountered. In addition, I was interested in getting more details about the supports and interventions in the school and how extensive the support is for students. For those who identified using tiered interventions and
supports in the first interview, I sought specific information about whether or not the school utilizes a Response to Intervention framework to assess student progress.

A third interview was conducted as a way to clarify previous answers, to check for accuracy of interpretations, and discuss any further topics that arose in the coding process. The questions in this interview were dependent upon the coding and analysis from the first two interviews. As we moved through each interview, I was able to obtain more detail about the counselor and their experiences working with adolescents with mental health issues. In the end, I anticipated having a lengthy and rich description about their experience, with some similarities and differences among the participants.

**Data Storage**

All interviews were digitally recorded and transcribed by me to maintain confidentiality of the participants. The digital recordings, transcriptions and analysis were kept on my personal computer that is password protected. Any field notes taken during the interview were kept in a locked cabinet in my private residence. In addition, a backup set of electronic transcriptions and analysis were kept in a secured Dropbox account. Any recorded interviews and copies were kept in my private residence at all times, and transcriptions occurred in private as well. All students and staff were given a pseudonym to protect their identities. All recorded interviews will be destroyed at the acceptance of the dissertation, other than the informed consent, which will be kept for three years.

**Data Analysis**

Data analysis began at the completion of each round of interviews and transcriptions. The transcribed interviews were printed, and each interview transcript was read and re-read. For the first set of interviews, an open coding process (Strauss & Corbin, 1990) was utilized, during
which time I identified and tentatively named categories into which the data will be grouped. Words and phrases were grouped by theme, and created the initial framework for analysis. This type of coding fit well with the goal of General Inductive Analysis, which is to create meaning through the development of categories from the raw data (Thomas, 2006). These initial codes were written in the margins and I used “in vivo names,” exact words used by the participants (Creswell, 2012), or a related word. Next, I used axial coding to generate categories or themes that were similar among all participants, a process that created a “big picture” of the phenomenon (Strauss & Corbin, 1990). The segments of the transcription that were originally identified during open coding were highlighted and grouped together if similar. These categories might have kept the original code used or they might have been re-named. This two-step process was also utilized for the second and third interviews.

I anticipated that with each interview and each round of coding I would have a more detailed description of school counselors’ experience working with students with mental health issues. With the first interview, I gained some general knowledge about the issues counselors are facing, how counselors are intervening with students, and their sense of self-efficacy in working with these issues. I anticipated that there would be differences in how the participants work with students, and that this would influence their sense of self-efficacy. In the second interview, as I asked for a more details about particular cases, I anticipated that I would get more detailed information about the same topics. I expected that identifying similarities and differences in the cases would lead to more information regarding self-efficacy, role definition, and student outcomes. Finally, the analysis of the third interview, a process of member checking and filling in gaps, would be the final pieces in creating the big picture of counselors’ experience.
Trustworthiness

Several strategies were implemented to ensure trustworthiness of the research. First, each participant was interviewed several times, and therefore, the research took place over a period of time. This process of prolonged engagement helped me in building trust with the subjects, as well as allowed me to make decisions about what was salient and relevant to the study (Creswell, 2012). Second, member checking (Creswell, 2012), a process through which participants check the credibility of the findings and interpretations, was also helpful to check for accuracy. In the third interview, I asked participants for feedback on the initial analysis that I conducted on the first two interviews. Thirdly, in writing the findings, I used “thick description” and direct quotes from the interviews in order for the participants’ voice to be heard and experience to be understood. Finally, my Northeastern and professional colleague Dan Simone acted as a peer reviewer, to be an external check on the research process (Creswell, 2012). Dan reviewed the analysis and conclusions, and asked questions to push my thinking. In many ways, he acted as a “devil’s advocate,” someone who asked difficult questions, which was an important feature for this researcher who has been entrenched in the data for a length of time.

The most significant threat to internal validity was researcher bias. While the research was not being conducted at the researcher’s site, being a professional in a similar role, personal bias could have impacted the data analysis. As a professional in the school counseling field, I frequently encounter adolescents with mental health issues, and have felt frustration and helplessness with supports and outcomes offered within the school. I work in a wealthy district, and therefore, we have been able to ask for additional resources and to create new programs, however this may or may not be the case in other districts. None of the counselors I interviewed work at my school and I had no intimate knowledge of the student cases prior to the interviews.
However, throughout the data collection, I could have felt similarly or differently to those I am interviewing. The journal allowed me to be reflexive by keeping a record of my experiences, reactions, and any biases that begin to emerge (Morrow, 2005).

In order to limit researcher bias, I kept a journal of notes and reflections (Rajendran, 2001; Morrow, 2005). The journal helped me to reflect on the interview process and analysis of the data on an ongoing basis. I wrote my own thoughts about what I was hearing and experiencing, and highlighted interesting data points along the way. By writing in the journal, I made sure that the analysis of the participants’ description truly reflected their experience. In addition, while taking field notes during interviews, I utilized a two column format (Rajendran, 2001). The left column was for me to highlight information from the participant that spurred a probing or clarifying question. The right column was where I wrote my own thoughts about the interview. It was important to remain an outsider to the data analysis process, and not allow personal preference or personal knowledge to leak into the interpretation and analysis of the data (Rajendran, 2001). Prolonged engagement and member checking also helped to offset potential researcher bias.

**Protection of Human Subjects**

The participants in this study were adults, and therefore are not considered part of a vulnerable population; however care was still taken to address the confidentiality and protection of the subjects. Consent to participate was gained through an informed consent process (Appendix C). In addition, I discussed the potential risks and benefits associated with participation in the study, including the time commitment associated with participation and the potential benefit to their students, respectively. To minimize feeling coerced to participate, subjects were told that they could withdraw from the study at any time. I also stressed that non-
participation in the study would not exclude them from accessing results from the research at the conclusion of the study. Participant confidentiality was ensured through the use of pseudonyms and I took the appropriate steps to safeguard transcripts and data, such as giving pseudonyms to the students being discussed. In order to obtain IRB approval, I followed the guidelines as outlined by Northeastern University and the National Institute of Health to ensure respect for persons, beneficence, and justice.
Chapter 4

Adolescent mental health is critical to school success. As the incidence of mental health issues in adolescents rises, schools must find a way to support and educate these students. The purpose of this study was to get a better understanding of how school counselors are supporting students with mental health issues in high schools. In order to achieve this goal, the following research questions were formulated:

1. What are the experiences of school counselors who provide support to learners who struggle with mental health issues?
2. In what ways do school counselors perceive their role as shifting as they work with these students?
3. How do guidance and counseling services and programs support the academic achievement of students struggling with mental health issues?

Study Participants

Data for this research was collected through a series of three interviews with three participants. The three participants, Lisa, Nancy, and Jim (pseudonyms), were chosen using criterion sampling from the Middlesex League Guidance Directors Group. Lisa works at a high school in a medium-sized town that is 15 miles north of Boston. Lisa earned a Master’s Degree in Counseling Psychology and has been a school counselor for 13 years. The 2013-14 school year was Lisa’s first year at the school and it was her first year in the director position. Lisa described the town as traditional middle class, with little racial diversity and a conservative viewpoint. On average, about 88% of students go onto a four-year college right after graduation and another 8% go to a two-year institution, including the state universities and local private colleges. In the counseling department, there are 5 other counselors, each with a caseload of
about 280 students. Lisa has a caseload of 150 students due to her other responsibilities as director. Other support staff in the building includes a full-time social worker that does individual counseling with special education students, and a full-time school psychologist, who is responsible for all psychological testing.

Nancy works in a small town about 10 miles north of Boston. Nancy has earned a Master’s Degree and a Certificate of Advanced Graduate Studies (C.A.G.S.) in Counseling Psychology, and is currently in her ninth year as a school counselor. She has worked at her current school for all nine years, and two years ago took over the Department Chair position when the previous director retired. Nancy described the town as a mix of white and blue collar families, and “right smack dab in the middle class.” She reported that 76% of the graduating students go one to a four-year college, while another 18% go onto a two-year college, with most attending the institutions within the state college and university system. Currently, Nancy has three other counselors in the department, each with a caseload of about 175 students, while Nancy works with a caseload of about 150 students. Other support staff in the school includes a half-time School Adjustment Counselor, who is in the building two and a half days per week to meet with students individually, and a full-time School Psychologist, who does psychological testing, some individual counseling, and group counseling in the Stride programs.

Jim works at a high school in a town less than 10 miles north of Boston. Jim earned his Master’s Degree in Counseling Psychology, and has earned an additional 30 graduate credits as well. He has been a counselor for 13 years, and served as Director of Guidance for grades 6-12 for the past 3 years. Jim described the town as a small, suburban community of middle and working class families with a high percentage of Caucasian families of Irish and Italian descent. He reports that on average 78% of graduating students go to a four-year college, while another
14% attended a two-year college directly after graduation. Most students enroll in the state colleges and universities, as well as local private colleges. There are 4 other counselors in the high school, with a caseload of about 230 students each. As director, Jim has a small caseload of students, however, this will no longer be the case in the near future. Additional support staff includes one full-time and one part-time School Psychologist who are both responsible for all of the psychological testing for the high school. The full-time School Psychologist also does individual counseling with students in special education.

Findings

Transcripts were reviewed and initially coded prior to the next round of interviews being completed. After the completion of the third round of coding, codes were collapsed into five general categories: 1) role and responsibility of school counselors, 2) experience with mental health issues, 3) Response to Intervention, 4) current supports and interventions, and 5) how to better support students. Each category includes themes and subthemes, which describe the experience of these three counselors as it relates to their work supporting adolescents with mental health issues. In order to more fully explain the themes and sub-themes of these categories, excerpts from the interviews will be included.

Role and Responsibilities of School Counselors

Five main themes surfaced in this category: a) “wear many hats,” b) no such thing as a typical day, c) struggle to see kids regularly, d) administrators’ perception of the role, and e) the changing profession.

“Wear many hats.” Nancy’s words resonated with all of the participants in her description of the counselor role in her statement, “the counselor wears many hats.” All of the counselors indicated that they provide many different types of assistance for high school
students. More specifically, all participants identified assistance in the same three categories: academic, college/career, and social/emotional. While these are the overarching responsibilities of school counselors, participants also mentioned that their responsibilities include dealing with day-to-day issues that arise, being an advocate for the student, attending special education and 504 meetings, conducting crisis interventions, supporting students in transition, and other individually-based services. Participants also cited non-counselor responsibilities that they have to complete, many of which are clerical duties. These included data entry, putting together and sending transcript packages to colleges, coordinating English Language Learner (ELL) services, and doing duties. While the counselors have many responsibilities, there was agreement regarding priorities across the participants. Jim summed it up well when he stated, “I think paying attention to students’ academic progress, but also the social/emotional needs of students, and you know helping students prepare for the future. Those are the biggest things.”

**No such thing as a typical day.** While participants were clear about the domains within which their responsibilities lay, Lisa and Nancy also stated that there was no such thing as a typical day. As Nancy stated, “I could have a day where I want to check in with 9th graders and the whole day could be 15-minute appointments. Or I could have 3 college planning appointments.” Even with what looks like a busy day of meetings, participants still felt that they couldn’t predict what their day would be like. Nancy stated, “We have a calendar in an appointment book, and so students make appointments. So, you pretty much know what you are walking into. I say that with a little bit of laugh because you never really know what you are walking into.” Similarly, Lisa stated, “We often come in thinking we’re doing five college appointments, and then that doesn’t happen.” Therefore, even the best laid plans can get derailed due to a student in crisis or an unplanned appointment. As Lisa described it, “These are the
things that just come our way. So, even with the social/emotional stuff, you still have to squeeze in the college stuff and the academic piece because the parents, you know the students are kind of in your face. You have to address it.” Jim did not go into specifics regarding this topic.

**Struggle to see kids regularly.** Each participant discussed how challenging it was to see kids regularly. In each school, the daily schedule does not give students free time during the day, which could be utilized to meet with counselors. Instead, students get pulled out of class and therefore miss instruction. At Jim’s school, he stated “they do come out of class in terms of individual appointments. We encourage them not to do so during major subjects…but the culture here is not such that teachers put up too much of a fight if you pull them out of an academic class, as long as it’s not like a habitual pattern.” Therefore, while the practice is accepted, it does not allow for regular appointments with students. Similarly, Nancy mentioned that students are encouraged to leave their electives in order to see their counselor; however, she stated “they have to be careful about not leaving the same ones so often that they are losing too much instruction.” For Lisa, there is less cooperation from teachers. She stated, “teachers are very clear that they want students in their classroom and they are not to miss classes to come see us. Well, how are we supposed to see kids?” In order to help students, counselors need to meet with them; therefore, without this time, counselors are left in a difficult predicament. As Lisa said, “it’s an issue that I am battling here.”

Lisa and Nancy mentioned that counselors in their school go into classrooms to deliver direct instruction regarding age-appropriate topics regarding transitioning to the high school and college and career topics. Both participants said that counselors do not meet with their own students in this format. As Nancy said, “when you go in the classroom, it’s just whomever you get.” This model adds to the feeling of not being able to see students on their own caseloads
regularly. Jim said that there is no classroom instruction time for his counselors. His frustration is summed up by this statement, “we have no classroom time. We don’t have study halls or directed studies…so how are we going to deliver a guidance curriculum?” While the other two participants have an opportunity to deliver a large amount of information to students in a group format, Jim and his counselors do not. Therefore, they must rely on continued individual meetings to get the information necessary to students.

Lisa and Jim also lamented the high caseloads that their counselors work with, adding another level of difficulty in servicing all students. As Lisa said, “the way our guidance department is structured right now, I think it’s too much. Our caseloads are way too high for the amount of responsibilities that we have.” In discussing something that would make the counselor’s work more successful, Jim said, “An additional guidance counselor, just in terms of caseload. A reduced caseload is probably the biggest thing.” Nancy did not mention the caseload as being a hindrance as the ratios in that school are much lower.

Two participants clearly stated that the roles and responsibilities of the counselors are not easily achieved within the confines and logistics of the school, which creates lots of frustrations. Lisa described it as a “true battle,” while Jim said it was a “constant struggle.” Without the ability to see students regularly, Lisa stated that some students are not serviced, especially in the social/emotional realm. While Nancy did not directly use these kinds of words, she did discuss similar topics including a lack of frequency with meetings and the desire to want to work more with her own caseload.

**Administrators’ perception of school counselor role.** When asked about whether or not their perception of the school counselor’s role in the school was the same as the administrators’ perception, there was a mixed response. Both Lisa and Jim felt that the perceptions were very
different. Jim stated that counselors were seen as “glorified clerks,” while Lisa believes that administrators just forget what counselors do. In her case, the administrators view counselors as college experts, as opposed to trained mental health professionals. For Nancy, though, the counselors in her school are the first people that administrators go to, stating, “we are the first line of defense.”

**Changing Profession.** With the increase in adolescent mental health issues, and the role and responsibilities of the school counselor, participants were asked to reflect on the profession and whether or not it has changed. Both Lisa and Nancy believed that it had. Lisa stated that the change in the administration’s perception of the counselor’s role has had the biggest impact. In the past, counselors were seen as an integral part of the child’s team. Now, Lisa said, “there is such an emphasis on the college piece…I feel like sometimes we are kind of bypassed.” She recounted a story in which the guidance counselor was not brought into a situation when a student was threatened by another student. The family was extremely upset that the counselor did not reach out to them; however, the counselor was never informed of the situation. When confronted, the administration did not understand why the counselor should have been involved.

Nancy also felt that the profession has changed, but more so in the number of responsibilities that counselors must juggle. Over the past few years, she has seen an increase in the number of administrative and paperwork tasks, such as Educational Proficiency Plans (EPPs), 504 plans, testing and proctoring, and data entry. Nancy said, “a little while ago, I just had time to do it all. You know, it’s just more of the stuff that you don’t necessarily want to do, and less of the time for the things you want to do, which to me are the counseling and developmental guidance piece.” Jim did not believe that the tasks for counselors have changed much over the years, however, the amount of work has certainly increased. He stated, “I think
what we are being asked to do, or to pay attention to, and to know has increased…just what we are being asked to do with the number of issues that are out there.” In further reflecting on his experience, he said, “we never have had significant resources for mental health. So, that’s kind of why counselors like working here because they like doing the counseling. But sometimes it’s just too much!”

Summary. In general, the themes suggest that counselors find it difficult to complete their job due to the multitude of things they are responsible for, the logistics of the school, and the perceptions of others. Participants felt that their caseloads were too high to be proactive with every student, which causes frustration. As Lisa stated, “I just want to make sure that I am able to meet the needs of all students.” In addition, there is a perceived lack of understanding from administrators as to what counselors are trained to do, what they actually do on a daily basis, and what parents expect them to do. The participants felt that the demands of the job have changed, however the number of responsibilities and the caseload numbers have not. This has led to feelings of being overwhelmed and exasperated. This led Nancy to lament that they are “spread very thin,” Jim to say, “it’s just too much,” and Lisa to say, “there’s only so much we can do.”

Experience with Mental Health Issues

In discussing each participant’s experience with mental health issues, six major themes emerged, including: a) most common mental health issues, b) “drastic increase,” c) reasons for issues and increase in number, d) counselor self-efficacy, and e) challenges and roadblocks associated with providing support.

Most common mental health issues. All three participants stated that anxiety is one of the most common mental health issues that their students present with. In fact, for each participant, it was the first issue that they stated. Jim went into more detail when he said, “you
know we have students who have all out anxiety disorders, but I would say also generalized 
anxieties.” Nancy also stated that she has seen an increase in anxiety in her population, saying  
“it is like every year, it is more.” Lisa connected anxiety with an increase in school phobia, 
saying “school phobia has definitely increased…whether it’s school phobia or anxiety, they go  
hand-in-hand.”

Both Lisa and Jim also mentioned depression as a common mental health issue among  
their student populations. Jim stated, “depression for sure…on a daily basis. I mean, pretty  
much that’s pretty frequent.” Nancy included depression in her list of common mental health  
issues, but did not feel it was as common as anxiety. Lisa did not specifically mention  
depression.

Another common mental health issue mentioned by two participants was obsessive-  
compulsive disorder (OCD), although there were differing views of its prevalence. Nancy  
believed this issue to be more prevalent than Jim. Lisa did not specifically mention OCD,  
however, she did mention the related issue of self-harm and cutting. She said, “I think this is a  
general problem in many schools and teenagers in general, but here, I feel like it’s…I won’t say  
extreme, but it’s definitely a lot more than what I have seen in my previous school. I’ve never  
experienced the volume of kids who are cutting in school and have blood dripping on the floor.”  
Jim also mentioned self-harm, stating “we have had a pretty consistent number of students that  
self-harm, cut, that sort of thing.” Individual participants also mentioned other mental health  
issues that their students present with, including eating disorders, suicidal ideation, drug and  
alcohol abuse, self-medication with drug and alcohol, and Oppositional Defiant Disorder, but  
these were not collectively offered by all of them.
“Drastic Increase.” All three participants believe that there has been an increase in the number of issues that students present with in regards to mental health. Lisa said, “we’ve definitely seen a drastic increase in the mental health issues.” Nancy agreed, stating that she believes the number of students that present with issues has increased. Similarly, Jim stated that “it’s increased. My experience has been that mental health issues for a fairly significant number of students is a big obstacle to them doing their best in school. I think I’ve seen the number of diagnoses increasing.”

Participants were also asked about whether the severity of the issues has worsened over time. Both Lisa and Jim did not feel they could clearly answer that question. Lisa stated, “I question that myself…I do feel like more kids are being hospitalized now than what I saw before. So, in that sense, I think the severity has increased. I just don’t know if it’s because there is more of a focus on it.” Similarly, Jim agreed that there is more of a focus now, but was not able to say whether or not the issues were more severe. He stated, “I don’t know that I could really say that. I’m not sure I have a firm grasp of that.” Nancy emphatically stated that she believed the severity of issues has worsened, but was less clear about why. In the end, she felt that it just has become harder to help students now than it was in the past.

**Reasons for issues and increase in number.** Four major sub-themes were identified by participants as to the reasons behind adolescent mental health issues and its increasing prevalence. The first sub-theme is pressure and stress. Lisa stated that “there’s just a lot of pressure on kids now compared to before.” She believes that much of this increased pressure is due to the competitiveness of college admissions, and the pressure that begins in the freshman year to achieve academically. It is a combination of parent expectations and college expectations that is creating an increased level of stress. Nancy was less clear on where the pressure and
stress was coming from, stating “I can’t put my finger on why, but I think in general, life is more anxiety provoking.”

Jim mentioned that family stress and dysfunction seems to be a major contributor to student stress. He stated, “you know, the times that I have seen the biggest problems with mental health, there’s almost always some sort of real dysfunction going on in the families.” Lisa agreed that family stress can significantly impact an adolescent’s mental health. She discussed the family composition, and stated, “I can’t help to wonder how much there’s a lot more people where both parents are working full time or parents who are split and the kids are balancing living in different households.” Nancy also agreed that family stress is a contributor, stating “they come from a not-so-tight family and they’re just struggling to live their everyday life.” She also discussed the fragility of some students due to family dysfunction, and wondered about the connection between mental health issues and how coddled a student was at home. In speaking about one specific student, Lisa mentioned “I think they get into the big bad world of high school and it’s not that big and that bad. You know, I have a senior and she can’t…I’m worried that she’s going to college next year, and her mom is not going to be there. And I don’t think she’s going to make it. I think that definitely plays into it.”

Another sub-theme that emerged was how difficult it is for adolescents to achieve balance. Nancy stated, “I think kids have a lot more on their plate then they used to. They’re being pulled in a hundred different directions.” Lisa found balance to be related to the high expectations that are placed on kids. She stated, “I mean, you have to take all of these high level classes because they look good, but then you have to play three sports, and you have to balance all of this. There is just too high of expectations to fit all of this into one day.” Similarly, Jim discussed high expectations and balance, saying “we’re not like a high pressure cooker
environment like other districts in terms of this school, but I still think there’s a lot of pressure academically to you know live up to whatever peers or family pressures.” Lisa mentioned that this lack of balance was difficult to manage because “sometimes they don’t even necessarily know that they’re just so overwhelmed by that stuff, but it’s pretty clear when you look at all that they’re doing.”

A third sub-theme that arose is what Jim described as the “increasingly complex world that the kids live in.” Each participant discussed that the way in which the world is changing is contributing to an increase in mental health issues. Jim believes that technology and social media play a significant role, saying, “we’re bombarded with images and I think that not all of them are healthy images. I think that images can have a negative impact on a kid’s psyche.” He also proposed the idea that there is an increase in bullying that has coincided with social media. Lisa, on the other hand, stated “I think they’re expected to be more adult-like in doing these super wonderful things. They’re doing a lot of things that maybe 5 or 10 years ago would have been stuff that you’re doing in college.” Finally, Nancy believes that the complex world has led to less understanding of the exact reason an adolescent is struggling. She stated, “we’re looking and looking and we can’t understand what’s triggering things. The parents are looking, the student is looking, I’m looking, the outside therapist is looking, and no one is finding this major trigger. Yet their anxiety is so bad, they can’t function.”

A final sub-theme that emerged was that there is more awareness of adolescent mental health issues. Lisa wondered aloud, “Sometimes I wonder, have these issues always been here? Now, there is more of a focus on it.” Jim agreed, stating “I think there’s more awareness around mental health issues, even in the last 12 to 13 years. I do think that there is a lot going on that was previously ignored or was never addressed. So, you know, part of that is a greater
awareness of things.” He wondered if this greater awareness has contributed to an increase in more mild and situational issues, stating “I think what we’ve seen an increase of is just sort of your everyday type of things.”

Counselor self-efficacy. With the increase in mental health issues that participants are experiencing in their schools, it was necessary to identify their sense of self-efficacy in supporting these issues. It was clear that the participants felt they had the training and skills necessary to counsel students in two main areas: a) the “day-to-day stuff” and b) mild and situational issues. The first sub-theme of “day-to-day” stuff was expressed by all three participants. Nancy stated “I feel like I can really help them break down a problem, and they can walk out 9 times out of 10 and say ‘OK, I feel better about that.” Lisa agreed, saying “the immediate stuff, I feel like I have it.” Similarly, Jim felt that he has the ability to help kids reframe situations. He indicated, “we’re well equipped to handle those things that are going on in their life, and just how to get them to approach things, think about things.”

The second sub-theme of mild and situational issues encompasses more intense issues. Lisa stated that she felt most equipped to support anxiety, stress, and school phobia because she encounters it so often, specifying, “the more you deal with something, or working with students on certain issues, the more comfortable you are with it.” Jim said that he felt most equipped to support students with generalized anxiety and situational depression. Similarly, Nancy felt well equipped to support anxiety, and also mentioned suicidal ideation and family issues as additional areas of self-efficacy. She agreed with Lisa regarding experience, stating “I feel comfortable with most everything that walks through the door…I think it’s more experience.”

Participants identified chronic or more deep-seated issues as areas in which they do not feel they have the skills or are not comfortable supporting. One topic that Lisa feels least
equipped to support is drug counseling. She indicated, “I can do the initial stuff. I certainly talk to students about their usage, but when it comes to that they truly need help and it’s a real problem, like that is out of my realm.” Nancy feels least equipped to support students who exhibit violent behavior because she is not a behavioral specialist. In discussing one particular student, Nancy said, “Colleges are calling me. It’s a really had thing for me to be able to, like am I comfortable saying he’s 100% fine? I’ve really struggled with that.” Jim identified trauma and sexual assault as issues that he does not feel equipped to support due to the severity of the issues. He felt he could support the student’s emotional needs in the moment, but not the longer term therapeutic needs of the student. He stated, “I think the more immediate…sort of the student just had a complete meltdown is ok…[but] looking at some of the work that our school psychologists do, I don’t have the skills that she has.” Lisa summed up the lack of self-efficacy well, stating, “I feel like I have the counseling skills to help students in need, but then it gets to a certain point where it just gets out of my ability to help them.”

**Challenges and roadblocks associated with providing support.** Participants identified four main areas of challenges and roadblocks as they support students with mental health issues: a) school-wide challenges, b) counselor role and responsibilities, c) challenges with parents and families, and d) challenges specifically related to students not attending school.

Regarding school-wide or systemic challenges, one sub-theme that emerged is a lack of additional resources and support staff which makes it difficult to support all students. While each school has at least one full-time school psychologist, that person is dedicated to psychological testing and counseling students who qualify for special education. As Lisa stated, “We have guidance and we have special ed, but we have nothing in between.” In discussing the resources at her school, Nancy stated “we work with what we have, and I think we’ve developed
a standard that’s ok, but I think if we had more resources we would be in a better place.” Jim said “I think that is a source of big frustration for us…there’s not enough staffing for us to address those issues sufficiently.”

In a similar vein, a lack of time with students due to the daily schedule was mentioned. For Nancy, having restrictions on time students can be out of class inhibits her ability to effectively support these students. “The time factor…to work with them, to not really have quality time and consistent time is a roadblock.” Jim stated it simply, “Not enough time, not enough resources.” When asked directly about whether or not she has adequate time to work with students, as the head of the department, she said her reaction would be the same. However, when she thought about it from her counselors’ perspectives, she said, “I don’t think the counselors know any better. If you were to ask them, I think they’d say yes. They are working really hard.”

For Jim and Lisa, the school’s priorities for funding are a roadblock to providing support. Jim stated, “I feel like there’s really not enough support for what we are doing…that it’s not seen as being essential as the classroom.” Therefore, funding tends to go to the classroom, and things related directly to state mandates, like standardized testing and evaluations. Lisa agreed, identifying that it is difficult to support students, not because people don’t care, but because of a lack of funding. She stated, “it’s the money piece really when it comes down to it. Because I think everyone sees the point, it’s just what is the money and where is it coming from. Then other people are saying we need smaller math class sizes…”

Another sub-theme regarding challenges and roadblocks is a lack of understanding among teachers and administrators of the students’ issues and needs, and the impact these issues have on a student’s functioning. Jim stated, “we have an administration that doesn’t understand
mental health, like in the least. They don’t have the training, they don’t have the background…they don’t understand the impact…that’s an unfortunate piece, and I feel like I am fighting an uphill battle.” Jim also mentioned that teachers focus more on their course and curriculum, as opposed to the student’s individual needs. He stated, “teachers have a great sense of equity. They want everyone to be treated the same.” They believe that in order to be accurately assessed in the course, they must complete the course as outlined, therefore no accommodations should be made. Lisa felt that while people might understand mental health in general, it was the individual student’s issue and what that specific student needed that was a roadblock to teachers. “They [issues] are all so different and understanding them all…even if you’re just talking about anxiety, that comes in so many different forms. What works for one child, may not work for another child…a roadblock is getting teachers to understand all of the differences.” For Lisa, another challenge in working with teachers is their understanding of what the student is experiencing. “I think there’s a feeling out there that kids are lazy or they are being manipulative. It’s like, a kid has to go to the extreme before a teacher will realize that accommodations need to be made.” In talking about his first case, Jim made a similar statement, saying “some teachers were resistant just to accommodations. I think they saw him as, maybe, taking advantage of some things.” Nancy did not mention either as an issue.

In regards to counselor challenges, all three participants identified that responsibility for supporting these students rests with the guidance counselor due to a lack of additional support staff. As Lisa says, “everything falls on the guidance counselors. Unfortunately, there is only so much we can do.” Nancy agreed, stating “definitely, most of the counseling falls on the guidance counselors.” Similarly, Jim stated that he is the only option for his students. He said, “we don’t really have anything to offer here other than your guidance counselor.” Both Jim and
Lisa lamented the challenges in doing this work due to counselors’ large caseloads. In discussing supporting students emotionally, Jim stated, “I think the counselors really try to do a good job addressing that with the caseloads they have…it’s difficult because we don’t know what’s going on unless the students come in.” Lisa agreed saying, “my caseload is way too high for the amount of responsibilities that I have…I don’t think we see as many issues as what’s really out there.” When asked directly whether or not they had adequate time to support these students, all three participants said no. In fact, Nancy went even further by saying that while she liked the mix of responsibilities that come with the job, so much is added to her plate every year. She indicated, “it’s a disservice to them as we have more and more things to do.”

Participants also expressed a feeling of being overwhelmed with all they have to manage with high caseloads and a lack of adequate time and resources. Nancy stated that in the past, “I just had time to do it all…now it’s more of the stuff that you don’t necessarily want to do and less of the time for the things you want to do.” Jim agreed, saying “Sometimes it’s just too much.” Lisa seemed resigned to the situation by saying, “We are doing the best we can with what we have.”

Another area of challenges and roadblocks involves parents and families. In discussing individual cases and the challenges in supporting these students, each participant mentioned difficult parents or family situation. In Nancy’s first case, she attributed many of the student’s issues and behaviors to his mother’s controlling nature. Nancy described his issues as “trying to gain a little bit of independence and control of his life…he was kind of sabotaging and just rebelling.” Similarly, Jim’s first case also had a very controlling mother who seemed to be the root of the student’s issues. In their individual meetings, Jim said “it would always come back to how much he hated his mother, and he had to get away from her.” In contrast, Lisa attributed her
student’s issues to a lack of parental support. She stated, “I don’t know if she ever had the love and the great family bonding that many people have, and I think that she just feels it’s her against the world and she really has to fend for herself.” Jim’s second case had a similar lack of parenting that led to a difficult relationship. He described the student’s disdain for his mother by saying, “if you watch him, when his mother speaks, you can tell that he hates her. What she has done to him, the level of hurt that he has, because of what his mother has done, is palpable…I’ve never seen that so clearly.”

For both Lisa and Jim, family secrecy is a big roadblock to supporting students. Lisa stated, “I think that there is a culture to hide things here. I think in some communities it is openly talked about. Here, I think it is a little bit of ‘No, I can handle this.’” She went to discuss how this hiding of issues makes it very challenging to identify kids that really need help. Jim felt that his community is in denial at times. He stated, “I think that there are bigger problems than people are willing to admit. It’s kind of secretive in terms of not really talked about or naming the elephant in the room.” Many times, he has heard from parents, “That’s a private matter…it’s not something you guys need to deal with.” Nancy did not mention secrecy specifically, but did state that she felt there was a cultural component at play in her community that makes it challenging to help students. The students are afraid that parents will be upset for, as she describes it, “airing their dirty laundry or talking.”

Another challenge relates to the amount of buy-in from the parents. Jim stated, “We get not enough response from families on these issues. I feel like you know very frustrated, like ‘You’re not going to do anything about this?’” He wondered aloud if this lack of buy-in was due to a lack of understanding of the impact of mental health issues on a student’s success. Nancy stated that her community was a mixed bag of responsiveness, indicating “sometimes we’re met
with resistance and sometimes we’re met with ‘Thank you so much. We didn’t know. We wouldn’t have done this.’” In general, though, she stated that supporting students can be frustrating because of a lack of control regarding what happens outside of the building. Lisa, on the other hand, stated that she felt the majority of parents typically follow through with recommendations for outside counseling; however, that is mostly because the situation with the student is fairly dire at that point anyway. She stated, “once we get to that point that we are truly referring [to outside therapy]….I think they just kind of feel like they don’t have a choice.”

A final challenge is related specifically to students not attending school. Each participant brought up this subset of students as a particularly problematic one to work with. When asked directly, each participant said that the biggest challenge is just getting them into the building. For Lisa, this leads to the inability to build a trusting relationship with the student. She said, “if we can’t get them in the building, then it’s hard to make that relationship, to be able to work with them a bit more closely.” Nancy brought up the cycle that occurs with non-attendance, indicating, “if they have enough anxiety one day they won’t come to school and then they are anxious about the school work they missed, and it starts to become a cycle.” Jim also mentioned the academic work, but focused on longer term issues with non-attendance. He stated, “a huge problem there also with attendance is what happens to the academic work? How do you track what the student has done, needs to do, and what work is essential for the student to know and have mastered to move on? If the attendance is sporadic, the work is sporadic.” The frustration is summed up best by Lisa’s statement, “You can’t help when they are not here.”

Each participant said that it becomes especially challenging because parents are not always forthcoming or are not supporting the school’s effort to get the student in. In Lisa’s secretive community, she believes that the “biggest issue is sometimes we don’t know until it’s
“too late.” Nancy’s school does not have a school resource officer, therefore, “we have to really count on the parents to be able to assist us in getting them in. In some cases, they aren’t able or they are not willing.” Jim brought up that some parents enable the behavior, saying “one of the biggest issues is the parents and the parents cooperating with the school, but also holding the line with the kids at home.”

**Summary.** Participants agreed that there has been an increase in the number of mental health issues that their students present with, especially anxiety. There was also agreement that much of increase is due to factors outside of the school, although it may also be related to school. Participants felt that they had the training and skills to counsel students individually in most cases, disregarding any chronic or deep-seeded issues. However, participants identified several challenges and roadblocks that prevent them from effectively supporting students so that they can achieve academically and personally.

**Response to Intervention**

Participants were asked about their use of Response to Intervention and tiered supports several times during the interviews. All participants indicated that they knew about the Response to Intervention model and what it encompassed. However, all three participants also said that it is not being utilized at all or well in their school for either academic or social/emotional support. Three themes emerged regarding why Response to Intervention (RTI) is not currently utilized: a) time and resources, b) training and awareness, and c) model of services.

**Time and resources.** All three participants stated that time and resources are a factor in not implementing and utilizing the Response to Intervention model. Lisa stated that she has the ideas, but does not have the time to implement them. She lamented, “there’s too many
responsibilities…that make it difficult to do everything that I want.” Similarly, Nancy indicated that it was both time and resources that prohibited her school from trying again to implement the model. She stated, “it’s fallen by the wayside because time has been allotted to other things. Yeah, I guess I would say those two things, time and resources.” Jim cited time and resources as well, saying that there is no funding for counselors to complete work in the summer when the demands of the daily job are not more pressing.

**Training and awareness.** For Jim, a lack of training and awareness of the Response to Intervention model is the main reason why the district has not supported this model. Instead, he says that “we do talk about tiered levels of support, but not RTI in particular, and nothing formal.” It was unclear why there was no awareness about RTI. Nancy, on the other hand, indicated that her district tried to implement the Response to Intervention model, but the success of the program was limited. Since then, the model has not been utilized. She stated, “it’s not that it’s not seen as something beneficial or needed. I think it just hasn’t taken…it just hasn’t worked.” Lisa did not bring up training or awareness as a reason for not implementing the model.

**Model of services.** Lisa indicated that the main reason she believes the Response to Intervention model has not been implemented is because the guidance department is using an outdated developmental model of guidance programming. This model was traditional over a decade ago; as Lisa described, “what I was doing in my previous school 10 years ago.” As new administrators and staff are coming in, they are questioning why the model has not been utilized. Lisa also mentioned that there is disparity among stakeholders about what the model should look like. However, she followed that up, stating, “I’m hopeful we’re going in the right direction with new leadership.” Nancy, on the other hand, felt that her school’s failed attempts were due to a
lack of a formalized process and interventions to utilize. Jim did not mention how services are
delivered as part of his answer.

**Summary.** While all participants were aware of the Response to Intervention model and
the Massachusetts Model for Comprehensive School Counseling Programs, none of their schools
were utilizing either model to address academic or social-emotional issues. Participants cited a
lack of time, resources, and training to implement such a model and a lack of administrative
awareness of the model. In addition, due to the logistics of the current model of service delivery
and the daily schedule, the Response to Intervention model does not fit. Without all of these
being addressed by the school district, it is unlikely that the model will be implemented, as
Nancy witnessed in her school.

**Supports and Interventions**

Since none of the participants utilized the Response to Intervention model to support
students’ social and emotional needs, it was important to identify how they are supporting these
students. In these conversations, three main themes emerged: a) individual, reactive model of
services, b) making connections, and c) needs not met.

**Individual, reactive model of services.** Several sub-themes emerged as participants
detailed how students are currently supported in their schools. The first sub-theme that emerged
was regarding the most utilized supports. All three stated that individual student meetings with
an in-house support person are the most utilized support at this time. For Nancy and Lisa, this is
a referral to either the school psychologist or social worker. As Lisa said, “We tend to, you
know, use that as a support because we don’t have a ton of other supports.” Unfortunately, for
Lisa, the social worker typically works only with special education students, therefore, the
guidance counselors are the most utilized support for general education students. Nancy
indicated that sometimes the “heavy hitters” are referred to the part-time School Adjustment Counselor. Unfortunately, this counselor only works Wednesday through Friday, as Nancy puts it, “it gets tricky because if it’s a heavy hitter that needs somebody on a Monday, then she’s not available.” Students need help when they need help, therefore asking them to wait a day or two to talk to someone is impossible. So, even though the School Adjustment Counselor is a helpful, Nancy stated “if it’s that kind of student, then we’ll keep them on our own.” Therefore, at Nancy’s school, the most utilized support tends to be the guidance counselor. Similarly, at Jim’s school, since the school psychologist only works with special education students, the guidance counselor is the most utilized support. For all three participants, referring to an outside therapist is also a very common support for students.

A second sub-theme that emerged regarding the current model was the lack of universal prevention programs. Without universal prevention programs, counselors are constantly in a reactive mode. As mentioned earlier, one of the challenges the participants identified when trying to support students with mental health issues is that due to the role and responsibilities, counselors basically wait for the students to come forward. Without the universal prevention programs to identify students who potentially need help, schools are utilizing a “wait-to-fail” model in order to identify students who need help. As Nancy said, “prevention isn’t there. We are reacting all the time. That’s what you do when you don’t have enough people.”

Lisa stated that her school has added some additional courses to the curriculum, but they are not specific to guidance or mental health. Instead, the school implemented a “decisions courses for freshmen about making healthy decisions...except it’s not just taught by health teachers.” In addition, there is a freshman advisory program that meets 3 days per cycle to assist students in the transition to high school. Nancy stated that her school does not have any
universal programs, however all sophomores must complete a half-year health course. In addition, her school does not currently have an advisory program, however she and a colleague started a peer version of advisory to mentor incoming 8th graders. Unfortunately, she stated, “it’s been slow growing, and we haven’t had a lot of support to do stuff in school.” Jim stated that his school currently does not have any universal preventive programs implemented. He is interested in implementing one called “40 Developmental Assets,” however due to the cost, he would not be able to buy this one directly. Instead, he would have to develop his own.

Another sub-theme that emerged was related to tier 2 and 3 interventions in the school. These are targeted interventions for specific populations of general education students who are at risk of developing more severe issues. Lisa and Jim do not have any tier 2 or 3 interventions; however, both schools have targeted programs for special education students with emotional disabilities. Lisa said, “for a district that brags about focusing on behavioral health, we’re behind the times with support services.” Nancy’s school, on the other hand, has an alternative program called Stride that is for both general and special education students who benefit from a small classroom environment and more personalized attention than in the main stream. There are two classrooms for the program, and students are divided by class: one for 9th and 10th graders, and one for 11th and 12th graders. Stride is the only alternative program for general education students. The school also has a program for students in special education with significant developmental disabilities.

A final sub-theme relates to family communication and outreach regarding mental health issues. Each participant indicated that their department conducts a few or a series of evening programs that covers everything about the college search and application process. However, none of them focused on adolescent mental health. Jim stated, “that is a huge gap…we have
nothing that really addresses the mental health aspect enough.” Nancy indicated that the school has tried to offer some evening programs for parents, however, “sadly, they’re not well-attended.” Lisa stated that when she does a Parent Coffee, she allows the parents to guide the conversation. However, “the parents that would be attending these are parents whose kids are focused on college.”

Making connections. Each participant also identified the most successful support in the school, and stated that the programs’ ability to foster connections and relationships between students and adults was the reason for their success. For Nancy, it is the Stride program, an alternative program for regular and special education students. Students receive most of their education in a small, separate classroom with two teachers and a paraprofessional in the room. Nancy cited the structure given by the program, firm consequences, and the ability to make connections with adults as the main reasons why it was helpful for one of her students. This student had attendance problems, low confidence, low perception of self, and depressive tendencies. His mother is very controlling and also struggles with her own depression. Nancy’s perception was that “he needed someone to kind of help him along the way…like initiate the task, and then let’s complete it, let’s follow up. And so here, he’s getting that help, he’s made a connection with an adult who is a great role model, and he is teaching him by letting him do it.” Nancy stated that before the student entered the program, she met with him once or twice per week, and spoke with his mother a few times per week. Now, she only meets with him once per quarter, just to check in and make sure things are going well. When asked directly, Nancy stated that she did not think he could have been successful without the program.

Lisa stated that there currently were no successful interventions for general education students, but that the Student Supportive Program (SSP) for students with diagnosed emotional
disabilities in special education has been successful. Academics take place in the mainstream, and students are assigned to a learning center where they receive academic and therapeutic support. The program has a part-time counselor and part-time special education teacher. Lisa’s student is diagnosed with Oppositional Defiant Disorder, anxiety and depression. This student has experienced a lot of trauma, domestic violence, and loss, and has a very unstable home life. While the case is still ongoing, and she still is not succeeding academically, Lisa believes that the program has still been successful for this student. In her opinion, “she’s responding in the sense that she’s making relationships. There are people who are able to calm her down at times. Her biggest problem is outside of school, not in school because she is a smart girl.” Before entering the program, Lisa stated that the guidance counselor assigned to the case before her was spending a significant amount of time with the student and working on the case. Now, the counselor’s time is minimal, and focuses more on coordinating meetings with people and checking in infrequently with the student and those that are working with her.

Jim stated that most successful interventions at this school are the individual guidance counselor meetings. Jim recounted a case of a student who was diagnosed with bipolar disorder and whose father had committed suicide when the student was young. This student had a toxic family environment in which his mother was very controlling and his brother had serious behavioral issues. On average, Jim spent about an hour per week with the student in individual meetings. Although the student was not comfortable meeting with someone weekly at first, regular meetings allowed him to begin to trust someone else and make a connection. Jim described the meetings by saying, “it was not a huge amount of time, but it was regular. I would say it did serve a purpose for him, definitely…I think he heard a lot of negative things, in other
areas of his life, and I think getting some reinforcement was good for him. In the end, I felt like he was really finding himself.”

**Needs not met.** Each participant also discussed the least successful support in their school, and the common theme was that students’ needs were not met through that programming. While Nancy felt that Stride is the most successful intervention in the school, she also stated that it only works for certain kids. In her words, “I don’t think it’s that successful for everyone. I think it really works in some cases. I think there’s too much of a random mix in there for it to work for everyone.” In other words, with so many different presenting issues, students’ needs are not being met because of the way the program is set up. For one student with anxiety, Nancy connected the student with Stride as a way to help her attendance and make connections. Unfortunately, after a couple of days, the student was scared to go back. From Nancy’s perspective, “it’s such a diverse crowd and that didn’t help her anxiety.”

Lisa stated that the Therapeutic Support Program (TSP) is the least successful program. This program is also only for students with a diagnosed emotional disability in special education. Similar to Nancy’s Stride program, students in this program have their academics in a separate classroom and receive therapeutic support from a full-time social worker. Unfortunately, as with Stride, there is an abundance of presenting issues in the group, and the number of students entering the program continues to grow. “We don’t have the staff to accommodate all those kids and unfortunately the program is not as successful as it could be…these are our heavy hitters…there’s not enough people to help all of the needs.”

Jim also felt that his most successful intervention, individual counselor meetings, was also the least successful intervention for a few reasons. The most difficult population of students does not get their needs met due to a lack of staffing. Jim stated “I would say that ever since the
adjustment counselor left, those kids have been high and dry. Those also tend to be the most heavy duty kids for us…I think that there are some that are not getting as much as they need. I think the counselors have tried to fill that gap, and see students as often as they can. I don’t know that it’s quite enough. I just think we’re pulled in too many directions.” Without frequent meetings, some students are not making connections and are not getting their needs met.

One group of students that all participants felt were not getting their needs met was students with attendance issues due to school phobia, hospitalization, or any other mental health issue. As Jim said, “It is a need. It’s most definitely a need. I would say every counselor may have a couple of students in that boat. We may be talking 10 to 15 students now. I consider that need.” Nancy stated that not having some sort of transition program for these kids is a “huge disservice” and Lisa stated that these students’ needs are “being met to the best that we can do right now.” Each participant lamented transitioning a student back to school without programming to help them. Lisa summed it up by saying “It’s all on the guidance department. So, the student comes…leaves the hospital, comes here the next day, meets with the guidance counselor and that day goes into the mainstream classes.” Nancy recounted a story of a girl who spent an entire quarter sitting in the guidance department during the school day. Unfortunately, there was only so much that the counselor could do to help her, but was unable to due to the other students she works with and other responsibilities she has to address. As Nancy said, “her guidance counselor did her very best to like be that person, but, you know, she has a job to complete and it’s not that.” Similarly, at Jim’s school, things are handled on a case by case basis, but without a specific program, students “find a place that they can go when they’re not in class that’s safe and comfortable, and they have access to people. We definitely don’t force them
to go right back in the class. I would say that there’s a balance there too.” While this approach is individualized to the student’s need, it is not programmatic, and therefore, not monitored.

**Summary.** Participants rely on an individual, reactive model of services to support students with mental health issues. With a lack of additional support staff and programming, this typically results in the guidance counselor conducting individual counseling with students. Participants indicated that they are not using any universal prevention programming to proactively identify students in need. Instead, students must come forward and self-identify or counselors rely on teacher, parent or peer referral. There is also a lack of tier 2 or 3 interventions implemented and utilized in these schools to support students who are at risk of developing more serious issues. This need is especially felt in supporting students who have attendance issues due to a hospitalization, school phobia, or truancy. In addition, there is little family outreach from the school regarding adolescent mental health, and when there is, there is a lack of interest in the topic from the community. Participants agreed that the supports and interventions that have been successful focus fostering connections and building relationships. In addition, supports and interventions that have not been successful were too broad in scope, and therefore, the student’s individual needs were not met.

**How to Better Support Students**

Much of the final interview was focused on questions about the current needs of guidance counselors to feel supported and to be able to do their jobs more effectively, as well as to identify what counselors believe would be the most helpful for students in an ideal world. Within these discussions, two areas of need emerged: a) what guidance counselors need, and b) what students need.
What guidance counselors need. In these interviews, it was clear that all three participants felt as if guidance counselors needed more support in order to do their jobs more effectively. Both Jim and Lisa stated that an additional guidance counselor would be imperative in order to lower the caseloads of counselors. Jim stated, “I truly believe that having an additional counselor be greatly helpful.” Similarly, Lisa stated, “I think a lower caseload is definitely helpful.” Nancy’s counselors have a caseload of about 50 to 100 students fewer than at either of the other schools. She did not mention caseload or an additional counselor as a factor.

Similarly, all three participants identified that the addition of a full-time school adjustment counselor or social worker dedicated to working only with general education students would be the most helpful. In a previous conversation, Lisa discussed how difficult it was for counselors to connect with outside therapists. By having a full-time social worker in the school, “we’re working more as a team as opposed to always referring out, which is important to be able to do.” Jim felt similarly about this need for in-house support, stating “In-house counseling, people that are connected to the school, connected to the teachers, know the teachers, know the way the school works.” He also believes that having an adjustment counselor would make the guidance counselor’s role more manageable. “I think having an adjustment counselor that could do some counseling that would be able to take some things off our plate.” Similarly, Nancy also specified that by even changing the part-time adjustment counselor to full time would be helpful. “Even a full-time social worker or adjustment counselor…that would be a lot. It would help a lot, an extra support person for referrals.”

Another sub-theme that emerged was related to professional development, with both Jim and Lisa stating that this would help counselors to better support their students. Jim felt that
much of the current professional development offered is specific to teachers. Instead, Jim offered that “we need a professional development program that sees school counselors as just as important as teachers. Part of that is budgeting…and also recognizing that…the professional development that’s relevant for classroom teachers is not necessarily going to be the same as what we need.” Lisa mentioned that additional professional development would be helpful so that counselors can “better understand things.” In further discussing this, it was clear that she felt the counselors needed “refresher” courses to have a better understanding of what students are experiencing. Nancy did not mention professional development specifically as a need.

A final sub-theme that emerged was in regards to the programming to address the variety of mental health needs presented by students. When asked directly, all three participants clearly stated that there were not enough programs to utilize within the school. Lisa went into more detail, comparing her experience at her current school with her experience at her former school that had more resources available, and said, “that made my life so much easier knowing that when a kid came to me, I could do all the initial stuff, but then I would have resources to give them in-house, whereas we’re lacking in that.”

**What students need.** While all participants felt that additional programming would assist them in doing their jobs more effectively, they also believed that it is what struggling students need to be successful. In our discussions about individual cases, each participant declared that the student could not be successful without programmatic intervention. Some of the potential outcomes could have been not caring about school and even dropping out. Lisa believes that additional programming will provide students with the additional support services and “more time to make connections with adults” that she believes they need to be successful. Nancy indicated that programs need to address issues separately, as opposed to trying to address
all issues together. As she said, “it’s too much of a one-size-fits-all for all the issues that are in there. It doesn’t always help everybody.” Jim stated, “if you had those kinds of programs, I think that we could handle a lot of the more severe cases we see.” Therefore, this could mean fewer students needing an out of district, which costs the district a lot of money.

All three participants stated that there is a need for a transition program to assist students who have missed a significant amount of school. In response to many of the challenges of working with these students stated above, the transition program would offer a consistent contact person for the student and family to build a relationship with. Nancy believes that it is important for someone to be checking on the students every day. She believes “a consistent contact person is helpful…having a relationship with somebody that’s going to always be the person.” She also believes that it is out of the realm of what is possible for a guidance counselor to do within their daily responsibilities, and therefore, it must be someone else. For Lisa, the transition program would allow for more time for these students to build relationships, something that many of them do not have. When asked what these students need to be successful, she simply said, “more support services, but also more time for them to make connections with adults.” For Jim, the transition program addresses the current ineffective model of having the counselors take on all of the responsibility in supporting this student in the transition back. He stated, “it takes the efforts of an entire group to really come to the table and say what is going to work best in this situation, with this family.” In this model, consistent expectations from school and home can be drafted and enforced. Finally, this program would offer a separate room to reduce the anxiety some students feel about returning to school. As Nancy stated, “part of the struggle of getting here is knowing they have to walk into class or be given a stack of work.”
**Summary.** In discussing how students can be better supported within their school, participants felt that counselors needed additional staff to lower their caseloads and to take some of their responsibilities off their plate. In addition, professional development would help counselors to stay knowledgeable and up-to-date on current issues and training. Finally, participants felt that additional programmatic interventions were needed so that they can do their job most effectively, especially a transition program for those students for whom attendance is an issue. For students, participants also stated the need for programming that gives them support and facilitates relationship building, two things that were noted as being essential for success. There is a need for more than one program, as not all student needs can be addressed by the same intervention. Finally, each participant felt that implementing a transition program for students with attendance issues was a priority for their school.

**Chapter Summary**

This chapter highlights the findings that answer the three research questions posed. The mental health issues of adolescents are increasing, as is the severity of the issues they are facing. Unfortunately, the model of school counseling services has not changed as the needs of students have changed, and the services that were utilized in the past, are not working now. When programmatic interventions have been available for students, those programs that are individualized and facilitate relationship building have been the most successful. Yet these programs and tiered interventions, especially for general education students, are few and far between. With mostly individually-based services, guidance counselors have too many responsibilities to address and too many students to work with, such that they cannot effectively address all students’ needs. This mismatch between counselors’ time and responsibilities has left school counselors feeling overwhelmed and general education students underserved.
Chapter 5

The purpose of this study was to identify how high school counselors are currently addressing the increasing mental health issues of their students so that they can be academically successful. Based on the goals, the theoretical framework, and qualitative methodology of this study, the following research questions were articulated:

1) What are the experiences of school counselors who provide support to learners who struggle with mental health issues?
2) In what ways do school counselors perceive their role as shifting as they work with these students?
3) How do guidance and counseling services and programs support the academic achievement of students struggling with mental health issues?

This study explored the state of the school counseling profession by focusing on the counselors’ experiences as they support students with mental health issues. As federal, state and local educational mandates continue to be introduced and as the issues that adolescents present with continue to increase, it is important to understand if the profession, the way it is currently set up, can sustain the pressure. Participants were randomly chosen in three different median income levels from the Middlesex League Guidance Director’s Group. Massachusetts students have scored very well on the Program for International Student Assessment (PISA), scoring the best in the world on the reading literacy assessment (Massachusetts Department of Elementary and Secondary Education, 2013). Studying how these schools support their students emotionally could potentially highlight innovative practice for other districts. By choosing only three participants, I was able to converse at length about the programs and interventions they utilize, the challenges and roadblocks they face, and their perception of the state of the profession.
through interview questions and discussions about particular student cases. The remainder of this chapter will propose conclusions based on the research findings, as well as identify implications for practice and future research opportunities.

**Conclusions and Discussion**

Three significant conclusions were drawn from the research findings: a) in order to support all students academically, schools must support all students emotionally; b) the model of school counseling services has not progressed as our knowledge of how to support students has evolved; and c) programmatic interventions can work for general education students when they are systematically need-based and focus on relationship building.

**CONCLUSION 1: In Order to Support All Students Academically, Schools Must Support All Students Emotionally.**

The first conclusion of this study is that in order to support all students academically, schools must support students emotionally, which supports previous research about the relationship between academic achievement and mental health (Hoagwood, Olin, Kerker, Kratochwill, Crowe & Saka, 2007; Dix, Slee, Lawson & Keeves, 2012). In outlining individual cases of struggling students, participants identified significant barriers to learning, including mental illness and family dysfunction, which made academic achievement almost impossible. As the student’s history was discussed, each participant highlighted the necessity of emotional support so that the student could be academically successful. Successful support could have been as comprehensive as a programmatic intervention or as simple as individual weekly counseling session with the guidance counselor. By utilizing either end of the support spectrum, counselors treated the social-emotional needs of the student as a significant and crucial factor in his or her academic outcomes. Participants were also asked what they would have foreseen for
the student if that support had not been provided, and each participant predicted poor outcomes, such as dropping out of school or failing grades. While students with attendance issues present a unique set of difficulties in regards to academic outcomes, the basic philosophy of support is the same. Participants indicated that while there are academic accommodations to be utilized, none of them will be helpful without also addressing the social-emotional needs of the students.

Barriers to learning are problems or situations that make it difficult for students to concentrate and learn, and therefore find academic success. With one in five adolescents suffering from some sort of mental health issue, many more suffering from non-clinical issues (or issues that are not diagnosable), and the incidence of mental health in adolescents continuing to rise (Evans, Foa, Gur, Hendin, O’Brien, Seligman & Walsh, 2005), mental health is a significant issue and barrier to learning. Moreover, few adolescents receive care through the mental health system (Knopf, Park & Mulye, 2008) due to the stigma surrounding getting help, lack of insurance, and/or unstable living conditions, such as homelessness (Schwarz, 2009). So, while some schools question whether it is their responsibility to address students’ mental health issues, schools are an important setting for mental health support to address this barrier to learning and promote success for all students (Gresham, 2004).

While addressing barriers to learning is not a new concept, recent research shows that providing emotional support can have a positive impact on academic outcomes (Hoagwood, Olin, Kerker, Kratochwill, Crowe & Saka, 2007; Dix, Slee, Lawson & Keeves, 2012). The research indicates that emotional support that is intensive and targets students, families and teachers (Hoagwood et al., 2007), and is implemented with fidelity and consistency (Dix et al., 2012) lead to the most significant gains in academic achievement. Nabors, Reynolds and Weist (2000) also concluded that utilizing mental resources in school led to positive outcomes and
increased competencies for students. Participants in their research also indicated that
consistency of services were critical to student success. Froiland (2011) verified that emotional
support can be the solution to academic underachievement. He detailed two student cases that
demonstrated that when the social-emotional issues were addressed, positive academic outcomes
followed.

Findings from this current study provide support for previous research indicating that
emotional support positively impacts academic achievement (Hoagwood, Olin, Kerker,
Kratochwill, Crowe & Saka, 2007; Dix, Slee, Lawson & Keeves, 2012). Participants discussed
first-hand experiences of providing support for individual students that ended up being crucial to
their eventual positive outcome. In some cases, it was programmatic support, and in others,
support was individual counseling. All participants predicted poor outcomes, in some cases as
extreme as dropping out, if the emotional support had not been utilized. In fact, in two cases,
even though the emotional support was offered, the student did not always take advantage of it
and still struggled academically. Unfortunately, participants also mentioned that while they do
the best they can, due to the nature of their responsibilities and large caseloads, there are still
groups of students whose needs are not known or are not addressed.

CONCLUSION 2: The Model of School Counseling Services Has Not Progressed As Our
Knowledge Of How To Support Students Has Evolved.

The second conclusion from this research is that how schools are offering services to
students has not progressed as our knowledge of how to support students has evolved through
previous research and literature. Participants indicated that the demands of the profession and
the volume of work have increased in recent years, yet how they support students has not
changed. In some cases, there is no additional support staff, leaving all counseling and
coordination of student services to the guidance counselor. Participants indicated that they have not implemented any universal preventive interventions to support all students, and that their services focused mostly on more intensive support for those students who are already having difficulty. In addition, while participants were aware of the Response to Intervention model, they did not have the time, resources or training in order to implement it. Moreover, participants indicated that myriad responsibilities, large caseloads of students, and scheduling issues did not leave room for anything other than reactive services. Finally, participants mentioned that there is a lack of understanding of the training and skill set that school counselors have, which makes advocating for and implementing changes difficult.

Another factor that is playing into the lack of change is the perception of the role of the school counselor and a general lack of understanding about adolescent mental health and its impact on achievement. For some participants, the administrator’s perception of the counselor’s role and responsibilities is very different than the counselor’s perception, as has been discussed in previous research (Brown, Dahlbeck & Sparkman-Barnes, 2010). In the best case scenario, the perception was incomplete, and in the worst case scenario, the perception was a lack of awareness of competencies. Participants indicated that they have the skills and experience to address almost any issue that they encounter and provide the necessary emotional support, with a few exceptions. Participants also identified that there continues to be a lack of investment from the district in additional time and resources.

Literature over the past few decades has made recommendations on how to better address students’ mental health issues through prevention science (Coie, Watt, West, Hawkins, Asarnow, Markman, Ramey, Shure & Long, 1993), and the use tiered interventions and the Response to Intervention model (Gresham, 2004; Gresham 2007). Moreover, defining the school counselor
role and identity and changing the model of school counseling services have been suggested by several important national organizations, including the American School Counselor Association (ASCA) and the Center for Mental Health in Schools at UCLA. ASCA (2003) states that school counseling programs are preventive in design, developmental in nature and driven by data with consistent monitoring of student progress. In addition, for high schools, ASCA recommends that counseling programs be focused on delivering services through an almost equal amount of time with individual student planning, responsive services, and classroom or group work. Only a small amount of time should be spent on indirect service support.

This description of services is similar to that of the Response to Intervention model, which proposes preventive interventions to counteract risk factors and reinforce protective factors, such as resiliency and prosocial skills, of students to promote mental health (Gresham, 2004). In other words, it is not just about addressing the issues that arise, but ensuring that all students have the emotional support they need in order to be academically successful. In addition, the model utilizes data of individual’s lack of response to an intervention as the basis for more intensive intervention. The Center for Mental Health in Schools at UCLA (February, 2011) takes it a step further to propose a comprehensive intervention framework that proposes that community and family involvement is an equally critical component of child and adolescent mental health. In both frameworks, preventive interventions and data are utilized to promote prosocial behaviors and identify those needing more intensive intervention. Current literature argues that effective mental health services have two critical components, a focus on the prevention and treatment of dysfunction, as well as the promotion of positive adaptive functioning (Kazdin, 1993).
Existing research shows that universal preventive interventions can have a positive impact on student functioning, especially when they are focused on mental health promotion as opposed to prevention, used a whole-school approach and were implemented over a longer period of time (Wells, Barlow & Stewart-Brown, 2003). Moreover, the most effective interventions target students, parents, and teachers, and focus on multiple contexts (Hoagwood et al., 2007). However, the literature also highlights some of the challenges to successful implementation, including teacher turnover, busy curriculum schedules, and inconsistent execution (Weist, Stiegler, Stephan, Cox & Vaughan, 2010). Previous research has shown that a systemic, tiered intervention model can be effective in schools (Eber, Sugai, Smith & Scott, 2002; Weist, Stiegler, Stephan, Cox & Vaughan, 2010; Stormshak, Conell, Veronneau, Myers, Dishion, Kavanagh & Caruthers, 2011), as can targeted interventions to address particular issues (Augustyniak, Brooks, Rinaldo, Bogner, & Hodges, 2009; Froiland, 2011; Dix, Slee, Lawson, & Keeves, 2012; Erickson & Abel, 2013). Even with a national push to accurately define the role and change the model of counseling services in schools, there continues to be a disconnect between administrators’ and counselors’ perception of competence (Brown, Dahlbeck & Sparkman-Barnes, 2010).

The findings from this study indicate that the Response to Intervention model has not been realized in some high schools yet, even though counselors were aware of the model and its recommendations. While the old model may have worked in the past, the increasing number of students needing support has made the old model inefficient and has left counselors feeling overwhelmed. Unfortunately, while all participants were aware of the need for school-wide, universal preventive interventions, no programs have been implemented them due to systemic and logistical challenges. Thus, even though the current literature and research points to the
necessity and success of these types of interventions, schools have not made the investment in time or staff to implement them. Therefore, not all students are getting the emotional support they need in order to promote prosocial behaviors and prevent dysfunction.

Counseling programs are also not utilizing a full range of tiered interventions to address the range of student issues. In addition, counselors are not measuring students’ responses to interventions to identify where adjustments need to be made. As mentioned above, participants are aware of Response to Intervention and the benefits of tiered interventions, however, there is little support from the district to implement any additional support services. Instead, school counselors have limited resources to utilize, leaving the counselor alone in trying to solve the student’s issues. In other words, counselors are feeling overwhelmed and unsupported, which has left many students underserved. Without adjustment to funding priorities and the model of services to better manage the demand, this conclusion is likely to continue.

CONCLUSION 3: Programmatic Interventions Can Work For General Education Students When They Are Systematically Need-Based And Focus On Relationship Building.

The third conclusion of this study is that programmatic interventions can work for general education students when they are systematically need-based and focus on making connections. This conclusion further supports the notion of the Response to Intervention model that the intensity of the intervention must match the intensity of the presenting issue (Gresham, 2004). Two of the three participants, Lisa and Nancy, discussed programs within their school that students can utilize. Jim’s school does not offer any programmatic interventions. At Lisa’s school, the programs offered are only available for special education students and have been an effective resource for the students to utilize. However, her school does not offer any programmatic interventions for general education students. Nancy’s school
offers a program that both general and special education students can use. In both cases, the small classroom environment, access to counseling, and the opportunity for check-ins were the interventions the students needed in order to overcome their barriers to learning. In both cases, though, these programmatic interventions did not always work. Interestingly, Nancy stated that the same program that had been so successful for one student was not successful for another. It was not an appropriate match for the some students’ needs. In addition, all participants indicated that there were not enough programs within their school for students with mental health issues, especially at the second tier of intervention. Moreover, according to participants, those programs that schools have are overburdened with too many students and not enough staff, and are addressing too many different issues to be effective for all students that need additional support. In other words, one programmatic intervention cannot address all of the needs that are presented.

Whether or not programmatic interventions were available, all participants discussed the importance of making connections in relation to a student’s success. In discussing individual cases, participants identified that successful interventions all fostered relationship building and making connections with an adult. For many of these students, there was significant family dysfunction and stress, and therefore, a lack of a role model and connection at home. Whether the connection was with a guidance counselor, a support staff member in a program, or an outside therapist, this connection seemed to be one of the key components to a successful intervention.

Each participant indicated one group of students that needs programmatic intervention immediately is those who have attendance issues. Some students returning to school after an extended absence, are expected to begin attending classes immediately, which can worsen already heightened levels of anxiety and depression. Students who are not expected to return to
class immediately spend their days in the guidance department or another safe space. In both cases, the students receive little emotional or academic support, which are critical to a successful transition back to school. In addition, participants indicated that the counselor caseload and daily responsibilities are too numerous for individual counselors to be able to monitor this transition.

The theoretical framework that guided this study indicates that interventions must be conceptualized based on intensity level and purpose, and that the goal is to match the intensity of the intervention with the intensity of the presenting problem (Gresham, 2004). By using this framework, schools may reduce the need for more expensive intervention and treatment later. Interventions at the secondary tier are utilized to give short-term assistance to individuals to help them deal with their current difficulties better than if they had faced them alone, and focuses on group rather than individual intervention (Caplan, 1964). The tertiary level of intervention is reserved for those individuals who have an established mental illness. All three levels of care, including the first level of primary prevention, create an effective care framework. Current literature supports these levels of intervention to support student mental health in schools (Gresham, 2005; Augustyniak, Brooks, Rinaldo, Bogner & Hodges, 2009; Froiland, 2011; Saeki, Jimerson, Earhart, Hart, Renshaw, Singh & Stewart, 2011).

Existing research shows that interventions at both the secondary and tertiary level can be effective. Durlak and Wells (1998) found that secondary prevention programs produced positive effects, with participants experience reduced problems and increased social competencies. Augustyniak et al. (2009) showed that group counseling interventions found a significant decrease in internalized distress for students that participated. In addition, Cheney, Flower and Templeton (2008) found that many students who participated in a daily Check In/Check Out intervention, showed positive gains on behavior ratings for general education students. This
study also indicates the importance of connections and relationships to academic and social-emotional outcomes. At the tertiary level of intervention, Froiland (2011) showed the power of individual interventions that had a lasting impact on the social-emotional functioning of the students.

The findings of this study support the current research that interventions at different tiers of support can be effective for general education students when they are designed to address a targeted issue. More specifically, this study showed that effective programmatic interventions can eliminate the need for a referral to special education, as well as reduce the effect and duration of mental health issues. In addition, the current study indicates that programs that try to address too many different issues or too many students at once are ineffective. This study also suggests that making connections and building relationships is critical to student success. Finally, the findings indicate that implementing programming at the second tier of intervention can give the support to guidance counselors they need in order to address the needs of all of their students, not just the neediest students.

Summary

Three main conclusions were drawn from an analysis of the data from this study. First, this study found further support for the notion that in order to support all students academically, schools must also support them emotionally. The second conclusion is that the model of school counseling services has not progressed as our knowledge of how to support students has evolved. The final conclusion is that programmatic interventions can work for general education students when they are systematically need-based and focus on relationship building. These conclusions support the theory that tiers of intervention and Response to Intervention could be an effective
framework to support students with mental health issues, however, the conclusions also highlight that the framework is far from implementation if logistical issues remain the status quo.

**Implications for Practice**

There are several implications that result from the above conclusions in the areas of support, advocacy, and program implementations. The findings are relevant to guidance counselors, building and district administrators, and state and federal lawmakers, as well as school counseling graduate programs across the country.

The first implication from this research is that counselors need support if they are to implement effective interventions and the Response to Intervention framework. There needs to be more discussion and support for school counselors from national and state level organizations, such as American School Counselor Association (ASCA) and the state associations, and the United States Department of Education and its state counterparts. Discussion and advocacy should focus on the current state of adolescent mental health, the difficulty guidance counselors have in supporting these students, and the current literature and research about the effectiveness of tiered interventions. This discussion must also be pushed mainstream, so that the issue can be discussed in large forums, just as standardized testing, teacher merit pay, and vouchers have in recent years. These organizations must also offer professional development opportunities for counselors and administrators regarding adolescent mental health issues, the Response to Intervention model, and effective programmatic interventions.

In addition to support from federal and state organizations, district and school administrators must invest in additional staff and resources in order to address the needs of all students. Administrators must make additional guidance and support staff a priority in their budgets in order to lower caseload numbers and provide alternative counseling support for
general education students. In addition, administrators must also consider hiring additional staff for programmatic interventions that are implemented. Programs will not be effective and students cannot make connections if programmatic interventions are understaffed or improperly staffed. Finally, in order for the comprehensive framework to be fully realized, school administrators must give the guidance department the time to brainstorm and plan the services so that they meet the needs of their populations, as well as the time to implement, collect data and make adjustments to them, accordingly.

The second implication of this study’s findings is that guidance counselors must better advocate for their and their students’ needs. In order for school district and building administration to fully understand the issues that guidance counselors are facing, counselors need to speak up. They need to be given a platform for their voices to be heard, but they also must not shy away from speaking up when they need something. Individuals who work in a helping profession may not naturally lean towards speaking up, as the nature of the job and the issues we support are known to be challenging. And, as one participant stated, “they [counselors] just don’t know any better.” However, it is imperative that counselors find their voice so that their leaders understand their needs and can support them as change is implemented. Formal and informal presentation of data will assist them in this process.

A third implication of this study is that school administrators must find the time in the weekly schedule to allow for universal prevention programs to be implemented. For this study’s participants, there is barely enough time in the day for counselors to see their students without them missing instructional time. In addition, there is little time to complete classroom guidance at two of the schools, with lessons focusing solely on college topics, while at the other school, there is no classroom time. Due to the immense impact that mental health issues have on
academic achievement, even those issues that do not meet clinical standards, it is critical that students are also given lessons in social-emotional learning. By focusing on mental health promotion, as opposed to mental illness prevention, all students will learn effective coping strategies to increase resiliency.

A fourth implication is that schools must implement and hire staff for programs at the secondary tier of intervention. While every school must identify its own students’ needs, it is clear from this research that a transition program for those students who have attendance issues is imperative. This population of students is one of the most challenging to work with because they are out of school so often and it is difficult to help them when they are absent. However, implementing a program that has both emotional and academic support to help students get back on track after a psychiatric hospitalization, a medical issue, a concussion, or school phobia, will ease much of the pressure on guidance counselors and free up more of their time to work with other students. In Massachusetts, several schools in the Metrowest Boston area have already implemented such programs, including Brookline High School, Concord-Carlisle High School, Wellesley High School, and Weston High School. Many of these schools are currently participating in a study with Brookline Mental Health, which is collecting data from the program leaders for quantitative analysis. In addition, Bridgespan, a non-profit organization, is creating and will be publishing an implementation guide for schools to utilize. Both of these resources will help counselors and administrators to advocate for and implement similar programming.

Another implication of this study is the need for schools and counseling departments to also focus on mental health with families and the community. Evening programs and informational sessions with parents tend to focus solely on the college process, if these sessions are offered at all. Part of this is in response to what the community is demanding; however, it is
also a problem of time. Counselors are using their own personal time at night to offer these programs, and therefore can only offer a limited number of programs. However, even at the one school that has offered programs about adolescent mental health in the past, the community did not show up for it. Participants were clear: the community’s focus is on college. Therefore, the burden is on schools to put as much emphasis on information sessions about mental health as they do about college. Schools should utilize community resources, such as the Parents Association, to fund and jointly host these sessions.

A final implication from this research is that all of the responsibility for student mental health cannot rest solely with the guidance department. Mental health is a complex and challenging issue to address, and since counselors have so little time with students, it must be a school-wide and community initiative to address. Schools must tap into additional adult resources within the building in order take some of the pressure off of the guidance counselors. Teachers need to learn more about adolescent development and building relationships with students through professional development opportunities in order to increase the likelihood that every student will find at least one connection with an adult in the school. At CCHS, the school has developed a comprehensive advisory program for grades nine through twelve, as well as created a freshman orientation program that focuses on team building and a holistic approach to student well-being. This could be a model for neighboring schools that are interested in getting additional faculty and staff involved in promoting student mental health. The literature indicates that fractured, piecemeal delivery of services will not be effective, but a comprehensive framework of support that includes the school, the family, and the community resources, such as local therapists and/or hospital can address the complex set of factors that influence student performance. These stakeholders must partner to discuss current issues and needs in order to
offer effective wraparound support to students who are struggling. Without all three components working together, any effort by the guidance counselor to support a student with mental health issues will be thwarted.

**Practitioner and Scholarly Significance**

As a guidance counselor in a public school for over 10 years, I have been particularly impacted by the effects of mental health issues on adolescents. In my first few years, I could count on one hand the number of student with mental health issues that needed significant intervention. As time passed, I felt a change, and not just because of the tragedies my school endured several years ago. It seemed to me that more students were struggling, issues were getting worse, and I felt that I was barely keeping my head above water most days. In the school I work in, we have even implemented some programmatic interventions and universal prevention measures, but it still is not enough.

The purpose of this research was to get a better sense of what others in the field were experiencing, and to identify how other schools were addressing the mental health needs of their students. I had expected to get a better understanding of how interventions and programs are used in other schools, and to identify how counseling services have shifted as student needs have changed. Just as my school utilizes some interventions, I thought that other schools would be in a similar position, but that they would offer a different perspective on implementation and utilization. I was surprised to find that the state of supporting students with mental health needs is actually worse than I originally thought. Not only are schools not utilizing the Response to Intervention framework, but they do not offer tiered interventions to address student needs. In addition, there is no additional support staff to help with the increased social-emotional needs of students. Caseloads remain high, and support remains low. And yet, the counselors’ caseloads
in this study are even lower than the national average, which was 471 students in 2011 (U.S. Department of Education, 2011). Unfortunately, even with all of the literature and research about best practices in supporting student mental health, schools have retained a reactive model of services that is inefficient and ineffective.

In completing this research, I hope to give a voice to counselors who feel that they have not been able to do the job that they are trained to do: namely, support the needs of all students, not just those with the most significant issues. I will share my results with my own colleagues and administrators, and specifically to the Clinical Team, a group of administrators, counselors, and special educators who meet weekly to discuss individual student cases. Once per month, this group could discuss more general issues within the school, and identify groups of students whose needs are not being met through current programming or curriculum. In addition, this group can identify how to measure students’ responses to interventions implemented so that data can be collected and shared with school and community stakeholders. The goal of these meetings will be to try to build the framework so that our services are comprehensive and cohesive framework.

I will also share the results with the Guidance Director’s Group, from which the participants were chosen. I encourage them to share the information with their school leaders as well, so that they have a better understanding of the counselors’ experience supporting these students. Each participant offered thoughtful ideas about how to better support students emotionally in schools, through additional staffing and programmatic interventions. The findings and conclusions of this research will assist department leaders as they advocate for change in their school. I also encourage the group to share ideas with each other of programs and interventions that work, as well as reach out to neighboring schools.
I am also interested in speaking at conferences, such as the MASCA annual conference or other local conferences focused on school mental health, to highlight the findings and conclusions. It is important for more people in the field to understand the Response to Intervention model and its application to mental health in schools. While many may be aware of the theory, this presentation would identify concrete ways in which it can impact their work. In conjunction with presentations, I also would like to offer professional development courses for directors and counselors in other districts to help them on their road of change. The courses would be a workshop for counseling departments and/or administrators could identify what interventions they currently offer, where the gaps in support are, and what new ideas they have to begin the process of creating a comprehensive framework. It is clear that there continues to be a lack of understanding of the skills and training that guidance counselors have, as well as a lack of understanding of what students need. Working together on this project will bring the work that counselors do and the support their students need to the forefront. The previous literature, research and current findings included in this thesis, will assist counselors and administrators as they advocate for changing the model of service delivery.

Recommendations for Future Research

The findings of this study identify the gap between literature and practice in supporting adolescent mental health needs in schools by highlighting the school counselor experience. There are several areas where additional research is necessary in order to continue the conversation of school guidance services.

1) This study only included three participants, which allowed for several interviews with each in order to reach a deeper level of understanding of their experiences. This would not have been achieved with more participants and fewer interviews with each.
However, a small number of participants limits the generalizability of the school counselor’s experience in supporting students with mental health issues. Future research should focus on identifying the experience of counselors in different settings, including urban and rural schools, and participants should represent different states across the nation. Current literature and research continues to talk at counselors, however this future research will bring their voice to the forefront.

2) One voice and perspective that was missing from this research is the district- and/or school-level administrator. This research highlighted differences between counselor and administrator perspectives on the role of the counselor in the school, and a lack of understanding about student issues and their impact on school success. Future research should focus on adolescent mental health from the administrator’s perspective, and why service delivery is slow to change even though current research and literature advocate for it. Identifying why change is so difficult to achieve, and where ideas differ and overlap between administrators and counselors will be critical to future changes.

3) Another area to focus on is schools that already utilize the Response to Intervention framework for mental health issues. This research can focus on the framework’s implementation in practice, and highlight some of the benefits and challenges associated with its usage. Moreover, questions surrounding its origins are significant – Who introduced the idea? How long did it take to implement? What steps did the school take to do so? What systemic changes were necessary to support this change, if any? Another option would be to conduct a case study or action research study to detail the framework’s implementation in one school. This research could highlight
best practices and potentially lead to an implementation manual for schools to utilize as they move towards using this framework.

4) Each participant indicated that in-school programmatic interventions will allow them to change the focus of their daily work to support all students. One potential area of research is to interview counselors and administrators in schools that offer programs for students. This research could focus on the programs they offer, what issues they address, and why these interventions work. With descriptions of the programs and their benefits and challenges, researchers could create a resource for other schools to utilize as they consider implementing programs. Sharing ideas, instead of reinventing the wheel, is always easier considering the restraints on administrators’ and counselors’ time.

5) A final area of further research should be a quantitative analysis of implementing universal prevention and programmatic interventions. Special education costs are rising, which puts a strain on the rest of the district’s budget. This research could examine the cost analysis of hiring additional staff to run programs versus the cost of sending students to out of district placement. Can more students with significant issues be kept in-house with programmatic interventions, thereby saving the district money? With money being a significant factor in school counseling service delivery, this would give counselors and school-level administrators hard data to advocate for their budgetary needs with school committees.

**Conclusion**

As adolescent mental health issues continue to rise, schools will continue to be called upon to provide services to support their students emotionally so that they can achieve
academically. This research highlights that even though current literature and research have proposed new ways of supporting this growing number of students through proactive and systemic support, some school counseling departments continue to only be able to respond reactively to student needs. The Response to Intervention framework offers one way for schools to address the social-emotional needs of their students proactively, however, implementation will require substantial systemic change. School counselors and social-emotional learning must be given the same focus and support as teachers and academic learning. If changing the system allows school counselors to more effectively support and advocate for their student, then it is imperative for school leaders to discuss how it can be realized in their schools. It is my hope that this research will be the first step in helping to create that change.
References


Individuals with Disabilities Education Act of 1990 (P.L. 101-476).
Individuals with Disabilities Education Improvement Act of 2004 (P.L. 108-446).


APPENDIX A – MEDIAN HOUSEHOLD INCOME (DIRECTOR’S LEAGUE)

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Dear Principal,

I am writing to request access to your school in order to conduct a research study. The following information is provided so that you can decide whether you wish to grant me access for my study.

I am interested in interviewing the Director, Chairman, or Leader of the Guidance Department at your high school. The purpose of this study is to better understand what school counselors are experiencing as they support students with mental health issues. I will interview participants on three separate occasions. During these interviews, we will discuss adolescent mental health issues in your school and the interventions you utilize to support these students. We also will discuss specific cases in more detail. All interviews will be conducted in a quiet, private location, specified by the participant, and will take about one hour each time.

There is no foreseeable risk or discomfort for those that choose to participate, nor is there a foreseeable benefit. However, all the results will be shared in the hopes that it will give you some insight into the current state of our profession and into some successful programs being utilized by others. Participants will be given a pseudonym to protect their identity throughout the interview process and in the final written document. The recorded interviews will be kept on my personal computer that is password protected, and I will maintain full confidentiality. The interviews and all data will be destroyed after three years.

Participation in this research is completely voluntary, and participants can withdraw at any time. They will be given a $50 gift card to Amazon as soon as the final interview is complete.

If you have questions about this study, please feel free to contact me at furey.a@husky.neu.edu or 617-312-8581. If you have any questions about your rights in this research, you may contact Nan C. Regina, Director, Human Subject Research Protection, 960 Renaissance Park, Northeastern University, Boston, MA 02115. Tel: 617.373.4588, Email: n.regina@neu.edu. You may call anonymously if you wish.

If you agree to grant me access to your site, please sign your consent with full knowledge of the nature and purpose of the procedures. A copy of this consent form will be given to you to keep.

__________________________________  ______________________
Signature of Principal                Signature of Researcher

__________________________________  ______________________
Printed Name                          Printed Name

__________________________  ______________
Date                              Date
APPENDIX C – PARTICIPANT CONSENT FORM

Dear Participant,

I am writing to invite you to participate in a research study. The following information is provided so that you can decide whether you wish to participate in my study. Please be aware that you do not have to participate if you do not want to, and if you decide to participate, that you can withdraw at any time.

I am asking you to be in this study because you are the Director, Chairman, or Leader of the Guidance Department at your high school. The purpose of this study to is to better understand what school counselors are experiencing as they support students with mental health issues. If you decide to take part in this study, I will interview you on three separate occasions. During these interviews, we will discuss adolescent mental health issues in your school and the interventions you utilize to support these students. We also will discuss specific cases in more detail. All interviews will be conducted in quiet, private location, specified by the participant, and will take about one hour each time.

There is no foreseeable risk or discomfort for those that choose to participate, nor is there a foreseeable benefit. However, all the results will be shared with you in the hopes that it will give you some insight into the current state of our profession and into some successful programs being utilized by others. You will be given a pseudonym to protect your identity throughout the interview process and in the final written document. The recorded interviews will be kept on my personal computer that is password protected, and I will maintain full confidentiality. The interviews and all data will be destroyed after three years.

Your participation in this research is completely voluntary. You do not have to participate if you do not want to and you can refuse to answer any question. Even if you begin the study, you may withdraw at any time. You will be given a $50 gift card to Amazon as soon as you complete the final interview.

If you have questions about this study, please feel free to contact me at furey.a@husky.neu.edu or 617-312-8581. If you have any questions about your rights in this research, you may contact Nan C. Regina, Director, Human Subject Research Protection, 960 Renaissance Park, Northeastern University, Boston, MA 02115. Tel: 617.373.4588, Email: n.regina@neu.edu. You may call anonymously if you wish.

If you wish to participate, please sign your consent with full knowledge of the nature and purpose of the procedures. A copy of this consent form will be given to you to keep.

_____________________________  ______________________________
Signature of participant agreeing to take part  Signature of Researcher

_____________________________  ______________________________
Printed Name  Printed Name

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Date  Date
<table>
<thead>
<tr>
<th>Topic</th>
<th>Subtopic</th>
<th>Question</th>
</tr>
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<tbody>
<tr>
<td><strong>Counselor Background</strong></td>
<td>Education</td>
<td>Q1  What level of education have you attained?</td>
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<td></td>
<td>Q2a</td>
<td>If you completed a counseling degree, what kinds of courses did you take? Describe them.</td>
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<td>Q2b</td>
<td>If you did not complete a counseling degree, describe the training that you had prior to taking this job?</td>
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<td></td>
<td>Professional Experience</td>
<td>Q1  How many years have you been a school counselor?</td>
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<td>Q2</td>
<td>How many different schools have you worked in?</td>
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<td>Q3</td>
<td>How many years have you been at your current school?</td>
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<tr>
<td><strong>School Background</strong></td>
<td>Demographics</td>
<td>Q1  What type of community does this school serve (ie., white collar, blue collar, mixture)?</td>
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<td>Q2</td>
<td>What percentage of the graduating class attends a 4-year university? 2-year university?</td>
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<td>Q3</td>
<td>What percentage of students go straight to employment out of high school?</td>
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<td></td>
<td>Q4</td>
<td>What are the most popular colleges for your students to attend? Why?</td>
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<td>Faculty/Staff</td>
<td>Q1  What is the student to teacher ratio? Or how many students does a teacher teach per semester?</td>
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<td>Q2</td>
<td>How many counselors are in the guidance department? What is the caseload?</td>
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<td>Q3</td>
<td>Please describe the role of the school counselor. What are their responsibilities? Describe a typical day.</td>
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<td>Q4</td>
<td>What other support staff does the school employ (ie., social worker, school psychologist)?</td>
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<tr>
<td><strong>Adolescent Mental Health</strong></td>
<td>Personal Perspective</td>
<td>Q1  Since you have been working in this field, what has been your experience working with students with mental health issues?</td>
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<td>Q2</td>
<td>Do you think the number of issues you see have increased or decreased? Why?</td>
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<td>Q3</td>
<td>Do you think the issues have become more severe? Why or why not?</td>
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<td>Issues at site</td>
<td>Q1  What are the most common mental health issues that your student population presents with?</td>
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<td>Q2</td>
<td>What mental health issues have become more prevalent over time? Which ones are less prevalent?</td>
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<td></td>
<td>Q3</td>
<td>What challenges are associated with these issues?</td>
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<td>Q4</td>
<td>What issues are the most difficult to support system-wide? Why?</td>
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<td>Topic</td>
<td>Sub-Topic</td>
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<tr>
<td>Mental Health Services</td>
<td>School-based services</td>
<td>Q1 For the most common presenting mental health issues, how does the school currently support these students academically? Emotionally?</td>
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<td>Q2 Does the school do any universal interventions? (ones that targets all students)</td>
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<td></td>
<td>Q3 What more targeted interventions, if any, does your school offer students?</td>
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<td>Community services</td>
<td>Q1 Describe the services in the community that students can utilize. Do families know about them? Are they collaborative with the school?</td>
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<tr>
<td>Counselor efficacy</td>
<td>Self-efficacy</td>
<td>Q1 Do you feel that you have the skills to assist these students in need?</td>
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<td>Q2 What issues do you feel the most skilled at assisting with? Why? Least skilled with? Why?</td>
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<td>Q3 If you completed a counseling graduate degree, what do you feel were the most helpful courses that you can draw upon now?</td>
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<td>Personal experience</td>
<td>Q4 Personally, what issues are the most difficult for you to support? Why?</td>
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<td>Q1 Do you feel that, based on your role definition, you have adequate time to work with these students? Why or why not?</td>
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<td>Q2 What are the challenges that you face in working with these students in regards to your role?</td>
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<td>Topic</td>
<td>Subtopic</td>
<td>Questions</td>
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<tr>
<td>Case #1</td>
<td>Student History</td>
<td>Q1  What pseudonym would you like to use for the first case?</td>
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<td>Q2  How old is the student currently? What year in high school?</td>
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<td>Q3  Does this student have a diagnosed disability?</td>
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<td>Q4  Is this student currently on a CAP, 504 plan or IEP (or utilize other accommodations)?</td>
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<td>Q5  What is the family history of this case? Are there other members with diagnoses?</td>
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<td>Q6  Tell me the history of this student as you know it. You can start prior to high school or from 9th grade.</td>
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<td>Q7  Do you have any general clinical impressions that you want to share with me about this case?</td>
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<td></td>
<td>Supports Implemented</td>
<td>Q1  What supports and interventions did you implement for this student?</td>
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<td>Q2  How did the student respond to these interventions?</td>
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<td>Q3  Describe the time you spent on this case on a weekly basis? What were you spending your time on? Describe the parent contact you had. Did you utilize any community supports?</td>
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<td>Strengths &amp; Challenges</td>
<td>Q1  What were the strengths of how this case was handled?</td>
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<td>Q2  What were the challenges that you faced?</td>
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<td>Result</td>
<td>Q1  If this case is still ongoing, how is he or she currently doing?</td>
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<td>Q2  If this case is not ongoing, how did he or she fare throughout high school or through the interventions?</td>
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<td>Topic</td>
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<td>Question</td>
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<tr>
<td>Case #2</td>
<td>Student History</td>
<td>Q1  What pseudonym would you like to use for the second case?</td>
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<td>Q2  How old is the student currently? What year in high school?</td>
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<td>Q3  Does this student have a diagnosed disability? If yes, what is it?</td>
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<td>Q4  Is this student currently on a CAP, 504 plan or IEP (or utilize other</td>
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<td>accommodations)?</td>
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<td>Q5  What is the family history of this case? Are there other members with</td>
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<td>diagnoses?</td>
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<td>Q6  Tell me the history of this student as you know it. You can start</td>
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<td>prior to high school or from 9th grade.</td>
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<td>Q7  Do you have any general clinical impressions that you want to share</td>
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<td>with me about this case?</td>
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<td></td>
<td>Supports Implemented</td>
<td>Q1  What supports and interventions did you implement for this student?</td>
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<td>Q2  How did the student respond to these interventions?</td>
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<td>Q3  Describe the time you spent on this case on a weekly basis? What were</td>
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<td>you spending your time on? Describe the parent contact you had. Did</td>
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<td>you utilize any community supports?</td>
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<td>Strengths &amp; Challenges</td>
<td>Q1  What were the strengths of how this case was handled?</td>
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<td>Q2  What were the challenges that you faced? Any roadblocks or hurdles?</td>
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<td>What got in the way?</td>
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<td>Result</td>
<td>Q1  If this case is still ongoing, how is he or she currently doing?</td>
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<td>Q2  If this case is not ongoing, how did he or she fare throughout high</td>
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<td>school or through the interventions?</td>
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<td>Topic</td>
<td>Sub-Topic</td>
<td>Question</td>
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<tr>
<td>Supports in School</td>
<td>Interventions</td>
<td>Q1 In the last interview, you mentioned ________intervention. Could you please clarify…? Could we go into more detail about…?</td>
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<td>Q2 In general, which interventions do you utilize most frequently? Why?</td>
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<td>Q3 Which interventions do you believe to be the most successful? Why?</td>
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<td>Q4 Which interventions do you believe to be the least successful? Why?</td>
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<td>Q5 Is there a group or groups of students whose needs you believe are not being effectively addressed?</td>
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<td>- What are their needs?</td>
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<td></td>
<td>- How are you currently addressing them?</td>
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<td>- What ideas do you have that you think would be more effective?</td>
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<tr>
<td>Response to Intervention</td>
<td>Q1 Does your school utilize Response to Intervention to address academic issues?</td>
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<td></td>
<td>Q2 Do you use RTI to address mental health issues?</td>
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<td>- If yes, how are you measuring responsiveness? Who is responsible for deciding this? Describe the data that you are collecting and how it is being collected.</td>
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<td>- If no, describe how you assess student success or response to the interventions. Describe.</td>
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</table>
APPENDIX F – INTERVIEW #1 SCRIPT

Hi. Thank you for agreeing to participate in my study. This purpose of this study is to gather information about the experience of high school counselors in supporting students with mental health issues. As such, this first interview will cover a variety of topics, including personal background information, school supports and interventions and other related topics.

I will be recording this interview with this digital recorder. Before we move on, do you agree to be recorded?

I will also be taking written notes during the interview. I can assure you that all responses will be confidential and only a pseudonym will be used when quoting from the transcripts. I will be the only one privy to the tapes which will be eventually destroyed after they are transcribed. My co-researchers will also help to review the transcriptions, but they will not have access to the audio files and only your pseudonym will be attached to the transcript. To meet our human subjects requirements at the university, you must sign the form I have with me. Essentially, this document states that: (1) all information will be held confidential, (2) your participation is voluntary and you may stop at any time if you feel uncomfortable, and (3) we do not intend to inflict any harm. Do you have any questions about the interview process or this form?

We have planned this interview to last about 60 minutes. During this time, I have several questions that I would like to cover. If time begins to run short, it may be necessary to interrupt you in order to push ahead and complete this line of questioning. Do you have any questions at this time?

Great. The first set of questions pertains to your educational background.

Q1: What is the highest level of education that you have attained?

*If the participant has completed a counseling degree:* Describe the courses that you took as part of your counseling degree.

Did you complete a practicum as part of your program?

*If the participant has not completed a counseling degree:* Describe the training that you had prior to this job?

Q2: How many years have you been a school counselor?

Q3: How many different schools have you worked in?

Q4: How many years have you been at your current school?

Now, I want to get some information about your school and community. This information will be useful as I begin to analyze the data that I collect.

Q5: What type of community does your school serve?
Q6: What percentage of your graduating class attends a 4-year college directly after high school?

Q7: And the percentage attending a 2-year college?
Q8: And the percentage going straight to the work force?

Q9: What are the most popular colleges that your students attend?
    Why?

Q10: How many students do teachers teach per semester?

Q11: How many school counselors do you have in the guidance department?
    What is the caseload?

Q12: Please describe the role of the school counselor?
    What are their responsibilities?
    Describe a typical day.

Q13: What other support staff does the school employ (social workers, school psychologists, school adjustment counselors)?
    What are their roles?

Now that I have a better understanding of the community you serve and the school you work in, I want to now discuss adolescent mental health. The purpose of this portion of the interview is to understand your personal perspective on the issue, and the challenges that your school and community face.

Q14: Since you began working in this field, what has been your experience working with students with mental health issues?

Q15: Has the number of students with issues increased or decreased?
    Why do you believe that this has happened?

Q16: Do you think the issues have become more severe over time?
    Why or why not?

Q17: What are the most common mental health issues that your student population presents with?

Q18: Which issues have become more prevalent over the past few years?
    Which issues have become less prevalent?

Q17: Describe the challenges that are associated with these issues. These can be academic, social, or otherwise.

Q18: Which issues do you believe are the most difficult to support system-wide?
    Why?
Q19: For the most common presenting issues, how does the school currently support these students academically? And how does the school support them emotionally?

Q20: At this time, do you utilize any universal interventions at your school? In other words, are there any interventions or preventative measures that you use with the entire school population? Please describe the intervention and its purpose.

Q21: What more targeted interventions does your school provide, if any? Please describe what these interventions are and the typical population it serves.

Q22: Describe the services in the community that students can utilize. In your opinion, do families know about them? Do families tend to utilize these services when they are recommended? Do you find these community services to be collaborative with the school?

The final section of this interview relates to your sense of self-efficacy in supporting students with mental health issues, as well as your ability to support these students under the constraints of your job.

Q23: Do you feel that you have counseling skills necessary to assist these students in need?

Q24: What issues do you feel the most equipped to support? Why? What issues do you feel the least equipped to support? Why?

Q25 (For those participants who completed a counseling degree): In your counseling degree program, which courses do you feel prepared the most for working with students with mental health issues?

Q26: Personally, which issues do you find the most difficult to support? This is not necessarily the ones you feel the least equipped to support, but which ones present the most challenges. Why?

Q27: Based on your role definition, and from what you told me previously about a typical day, do you feel that you have adequate time to work with these students? Why or why not? Do you have adequate resources? Why or why not?

Q28: What are the challenges and roadblocks that you face in working with these students in regards to your role?

That is the end of my questions for the first interview. Do you have any questions for me?
OK. In preparation for the next interview, I would like you to think about two cases in particular that we can discuss in detail. You should try to choose one case that was fairly straightforward, and one case that was more challenging. These cases should have occurred during the past few years. If it’s helpful, you may want to bring some notes or information with you. Please make sure to assign the students pseudonyms so that we can protect their identities and maintain confidentiality.

Any final questions?

Thank you for your participation.
APPENDIX G – INTERVIEW #2 SCRIPT

Thanks again for agreeing to continue to the second interview. Last time we covered some personal background, as well as information pertaining to the school you work in and the supports that are offered to students with mental health issues. In this interview, we are going to discuss these further. I am, once again, going to be recording this interview with this digital recorder. Before we move on, do you agree to be recorded?

Great. At the end of the last interview, I asked you to think of two student cases that we could discuss in more detail. Are you prepared to discuss these cases?

Q1: What pseudonym would you like to use for this first case?

Q2: How old is the student currently?
   What year is he/she currently in high school? OR How long ago did this student graduate?

Q3: Does this student have a diagnosed disability?
   If so, please explain what it is or they are.

Q4: Is this student currently (or were they) on a Curriculum Accommodation Plan, 504 plan or Individualized Education Plan?
   Does the student utilize other accommodations?

Q5: Please explain the family history of this case.
   Are there other family members with significant diagnoses? Please explain.

Q6: Tell me the history of this student as you know it. You can start prior to 9th grade, or begin when they entered high school.

Q7: Do you have any general clinical impressions about this case that you want to share with me?

Now I want to discuss the supports and interventions that you utilized to assist this student.

Q8: What supports and interventions did you implement for this student? Please be specific and, if possible, discuss in order of when you implemented them from earlier to later.

Q9: How did the student respond to these interventions?

Q10: Please describe the time you spent on this case on weekly basis.
    What were you spending your time on?

Q11: Describe the parent contact you had.

Q12: Did you utilize any community resources?
If so, please describe which ones.
If not, why not?

Q13: In your opinion, what were some of the successes of the handling of this case?

Q14: What were the challenges you faced?
   Did you encounter any roadblocks in supporting this student?

Q15: Is this case currently ongoing?
   If yes, how is he/she doing academically and socially?
   If no, how did he/she fare throughout high school and through the interventions?

Q16: Is there any information that we did not discuss that you think would be helpful for me to know, or that you want to add?

Thank you. Now, let’s move to your second case.

Q17: What pseudonym would you like to use for this first case?

Q18: How old is the student currently?
   What year is he/she currently in high school? OR How long ago did this student graduate?

Q19: Does this student have a diagnosed disability?
   If so, please explain what it is or they are.

Q20: Is this student currently (or were they) on a Curriculum Accommodation Plan, 504 plan or Individualized Education Plan?
   Does the student utilize other accommodations?

Q21: Please explain the family history of this case.
   Are there other family members with significant diagnoses? Please explain.

Q22: Tell me the history of this student as you know it. You can start prior to 9th grade, or begin when they entered high school.

Q23: Do you have any general clinical impressions about this case that you want to share with me?

Now I want to discuss the supports and interventions that you utilized to assist this student.

Q24: What supports and interventions did you implement for this student? Please be specific and, if possible, discuss in order of when you implemented them from earlier to later.

Q25: How did the student respond to these interventions?
Q26: Please describe the time you spent on this case on weekly basis. What were you spending your time on?

Q27: Describe the parent contact you had.

Q28: Did you utilize any community resources? If so, please describe which ones. If not, why not?

Q29: In your opinion, what were some of the successes of the handling of this case?

Q30: What were the challenges you faced? Did you encounter any roadblocks in supporting this student?

Q31: Is this case currently ongoing? If yes, how is he/she doing academically and socially? If no, how did he/she fare throughout high school and through the interventions?

Q32: Is there any information that we did not discuss that you think would be helpful for me to know, or that you want to add? Thank you. I now want to talk with you more generally about the supports and interventions that your school utilizes to support students with mental health issues. First, after going through the transcript from the first interview, I have some clarifying questions about what we discussed.

Q33: Last time, you mentioned _________. Could you please clarify…? Could you please go into more detail about…?

Now, I’d like to ask you some new questions.

Q34: In general, which mental health interventions do you utilize the most? Why?

Q35: In your opinion, which mental health interventions are the most successful? Why?

Q36: In your opinion, which mental health interventions are the least successful? Why

Q37: Is there a group or groups of students whose needs you believe are not effectively being addressed? What are the needs?

Q38: How are you currently addressing them?

Q39: What ideas do you have that you think could be more effective?
Now, I want to focus on Response to Intervention. Have you ever heard of RTI?

If not:
Response to Intervention…

Q40: Does your school utilize this framework to address students’ academic needs?
   If yes, please describe what you are using it for and how it is being utilized?

Q41: Do you utilize an RTI framework to address mental health needs?
   If yes, how are you measuring responsiveness?
   Who is responsible for determining this? Or who oversees this process?
   Describe that data that you are collecting and how you are collecting it.
   In your opinion, is this framework helpful? Why or why not?

   If no, please describe how you assess student success and/or their response to interventions that you have implemented?