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Arkansas Principal Preparedness to Identify and Assist Students with Mental Health Needs

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ARKANSAS PRINCIPAL PREPAREDNESS TO IDENTIFY AND ASSIST STUDENTS WITH MENTAL HEALTH NEEDS

A Dissertation Submitted
to the Graduate College
Arkansas Tech University

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of the College of Education

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Abstract

There is a growing need for children’s mental health services. With the majority of their time spent at school, educators are often the first adults in a child’s life to identify and assist students with mental health needs. However, oftentimes educators do not have the education and training needed to assist students with accessing quality mental health services. The purpose of this qualitative study was to examine the preparedness of Arkansas public school principals to assist students with mental health needs in this rapidly changing era of education. The participant sample of the study consisted of 133 Arkansas public school principals. Data was collected through a peer-reviewed survey instrument developed by the researcher. The current study results indicated that Arkansas public school principals need more education, training, and resources in order to help meet the needs of all students. The results of this study can be used by Arkansas educators, policy makers, and legislators to help with the decision-making process related to school-based mental health services across the state.
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CHAPTER 1

Research Topic and Statement of the Problem

The United States educational system works to provide students with a free and appropriate education to ensure that all children have the opportunity for academic, emotional, and social success (United States Department of Education, 2010). However, many American students suffer from mental health issues that impede their ability to meet the expectations of the current system. The most common health issues confronted by school-aged children in the United States are mental health disorders, such as: anxiety disorders, separation anxiety disorder, oppositional defiant disorder, attention-deficit hyperactivity disorder, mood disorder, depression, conduct disorder, Tourette syndrome, post-traumatic stress disorder, autism spectrum disorder, and substance abuse (Child Mind Institute, 2016; Centers for Disease Control and Prevention, 2018). According to the Child Mind Institute’s 2016 report, 17.1 million young people under the age of 18 are affected by mental health disorders before they reach adulthood. In fact, “One in five children suffers from a mental health or learning disorder, and 80% of chronic mental disorders begin in childhood” (Child Mind Institute, 2016, p. 1; Centers for Disease Control and Prevention, 2018). Over 50% of urban students may have serious learning, emotional, and behavioral problems that need to be addressed by schools (Freeman, Kim, Ryan, Kelly, and Montgomery, 2012). Many of these cases are undiagnosed or misdiagnosed, which often leads to the lack of appropriate treatment (Ghaemi, Khakshour, Abasi, & Hajikhani Golchin, 2015). Educators must find ways to provide access to quality mental health services in order to ensure equal opportunity for all students.
Students spend approximately 20% of their time at school, and schools serve as the leading providers of childhood mental health services in the United States (Ccrb, 2017; Lahey, 2016). Providing mental health supports at school eliminates some of the barriers that families may face when ascertaining services, such as transportation, access, and advocacy. According to Graham (2016), “Almost all children attend school for some time in their lives; therefore, school is the ideal setting for implementing collaborative interventions aimed at improving a child’s emotional development and mental health” (p.1). Given the amount of time that students spend at school, educators are sometimes the first adult in a child’s life that can help students access the mental health services that they need (Lahey, 2016).

Statement of the Problem

According to the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) Behavioral Health Barometer for Arkansas, in 2013-2014, approximately 28,000 (11.9%) adolescents aged 12-17 in the state had at least one Major Depressive Episode (MDE) within the year prior to being surveyed, which was an increase of 3.4% from 2010-2011. However, from 2010 to 2014, only about 9,000 of Arkansas adolescents with MDE (35.8% of all adolescents with MDE) received treatment each year for their depression within the year prior to being surveyed. This leaves 64.2% of Arkansas adolescents without the needed mental health services (SAMHSA, 2015). Of the small percentage of school-age children that receive help, nearly two-thirds are able to access the services only through school (National Association of School Psychologists [NASP], 2016).
Arkansas has recognized the significant need for and lack of training and awareness of mental health services throughout the state. In 2006, Arkansas began working on a better system of care for children that experience mental illness by creating a taskforce to identify solutions to the mental health crisis. The Children’s Behavioral Health Care Commission was formed and former First Lady Ginger Beebe held listening tours throughout the state to discuss mental health concerns with parents. The primary finding from the parent feedback gained from the listening tours suggested that school personnel need to know more about children with mental illness (Arkansas Advocates for Children & Families [AACF], 2007). Based upon the identified need for more training, the Arkansas Department of Education’s School Health Services Unit is now promoting the National Council for Behavioral Health’s “Mental Health First Aid” training (National Council for Behavioral Health, 2018). This evidence-based, public education program outlines the common risk factors and warning signs of mental illness, promotes an understanding of their impact, and offers supports. Similar to cardiopulmonary resuscitation (CPR), the training teaches a five step action plan to help participants learn how to support someone that is exhibiting signs and symptoms of a mental illness or emotional crisis (National Council for Behavioral Health, 2018).

**Purpose of the Study**

The purpose of this study was to examine the preparedness of Arkansas public school principals to assist students with mental health needs in this rapidly changing era of education. With the focus on the whole child, principals have to lead the way in establishing a climate that is conducive to mentally healthy children. According to Frauenholtz, Mendenhall, & Moon (2017), “An awareness of current levels of mental
health literacy among school professionals and areas in which educators could benefit from further training related to children’s mental health is crucial” (p.72). This preparedness comes at the perfect time for Arkansas educators as the state is focusing on mental health in the school. The authors explain that without adequate mental health knowledge, school staff may be unprepared to collaborate effectively with mental health professionals in the schools or respond appropriately when children, families, or colleagues seek their assistance (Frauenholtz et al., 2017). Simply stated, the current system is not meeting the needs of students with mental health issues (AACF, 2007).

To better understand perceptions among school leaders regarding the needs of students with mental health issues, this study focused on four major topics: (a) The importance of early intervention; (b) Challenges that schools encounter; (c) Stakeholder roles in school-based mental health; and (d) Implications for educators.

The ultimate goal of the study was to determine the extent to which Arkansas public school principals, as the gatekeepers of student services, need additional understanding, education, and/or training in order to identify students that have mental health needs and help them access mental health services.

**Significance of Study**

It is widely acknowledged that mental health and psychosocial problems profoundly affect learning and performance (Adelman & Taylor, 2012; Frauenholtz, et al., 2017). Research conducted in the United States and throughout the rest of the world indicates a relationship between mental health and academic performance among children and teens. Children who are mentally healthy are more successful in both school and life (National Association of School Psychologists, 2016). Ramirez (2014) estimates that
approximately four million children in the United States have a serious mental illness that could potentially cause difficulties in school, with their friends, or in their home. The Centers for Disease Control and Prevention [CDCP] (2018) define childhood mental disorder as, “all mental disorders that can be diagnosed and begin in childhood” and describe mental disorders among children as “serious changes in the ways children typically learn, behave, or handle their emotions” (p. 1). The symptoms of mental health disorders typically begin to manifest in childhood, but some may develop in later adolescent or teenage years. Some children with mental illness may not be recognized or diagnosed with one at all (CDCP, 2018).

Children with mental illness typically do not perform well in school and have difficulty with issues such as concentration, social interaction, and other daily activities (Ramirez, 2014). According to Cuellar (2015), “Children with emotional disturbance are more likely to have academic problems and are overrepresented in the special education system. Teens with emotional disturbance have the highest school dropout rates and are among the least likely to attend college” (p. 115). A study conducted in Chile by Murphy et al. (2015), showed that mental health was a compelling predictor of academic performance. The findings also indicated that students whose mental health improved between first and third grade had greater academic growth than their counterparts (Murphy et al., 2015).

Children who suffer from mental health disorders frequently face problems at school, such as poor grades, grade-level retention, frequent discipline referrals, lack of attendance, and even school failure (Child Mind Institute, 2016; Murphy et al., 2015). Children with mental illness and learning disorders often drop out of school, which can
lead to lifelong problems such as incarceration, unemployment, and a subpar quality of life (Bowers, Manion, Papadopoulos, & Gauvreau, 2013; Child Mind Institute, 2016; Carlson & Kees, 2013). According to the research, 70.4% of youth in the juvenile justice system are diagnosed with a psychiatric problem and 68% of state prison inmates never finished high school (Child Mind Institute, 2016). Students who drop out are not likely to continue receiving necessary mental health services (Bruns et al., 2016). Poor mental health is directly related to other health concerns, which can result in high stress, substance abuse, violence, and depression (Ghaemi et al., 2015). A quantitative study conducted by Ginzler, Garret, Baer, & Peterson found that 86% of homeless youth met the criteria for mental health disorders (as cited in Sulkowski & Michael, 2014).

Schools provide the opportunity for early identification of childhood and adolescent mental health problems (Stewart, Klaussen, & Hamza, 2016; Wateland, 2018). According to Puddy, Roberts, Vernberg, & Hambrick (2012), “Schools have been identified as a logical, efficient context for providing a significant portion of the basic interventions that constitute a comprehensive approach to meeting the needs of children with serious emotional disorders” (p. 3). For many children, educational settings provide the only access to mental health services. Current wellness and preventive interventions help schools to not only foster academic improvements, but also social-emotional development (Ghaemi et al., 2015). Cuellar (2015) states, “Most children spend much of their time in school. Because so much evidence points to a link between mental health disorders and poor academic and social outcomes, new mental health interventions have been designed to directly improve these outcomes, rather than simply target mental health
symptoms” (p. 120). Receiving mental health services in a school setting can reduce many of the barriers to treatment for students and their families.

The mental health concerns in Arkansas mirror those of the nation. According to the Arkansas Advocates for Children and Families [AACF] (2007) “There are approximately 60,000 children in Arkansas receiving some type of mental health services” (p. 4). Primarily, Arkansas children are facing adjustment disorders, temporary delays, or behavioral issues (AACF, 2007). For most of these students, their needs are adequately addressed through school-based mental health services, some type of early intervention services, or outpatient therapy (AACF, 2007). In 2013-2014, 11.9% of Arkansas adolescents, ages 12-17, experienced at least one major depressive disorder within the prior year (SAMHSA, 2015). This is almost 1% higher than the national average of 11.0% (SAMHSA, 2015). With the rising trend of mental health needs among Arkansas youth, it is critical that principals are prepared to help identify the early signs of mental health disorders and help them obtain the needed services.

Knowing the importance of mental health services and the role that schools play in meeting the needs of students at the national and state level prompts educators to pay close attention to the social and emotional development of children. Essential to the ability of adults to access mental health services is the building level leader. The school principal is the gatekeeper for education and advocacy, as documented by researchers (Schaffhauser, 2018; Harper, 2018; Berkowica & Myers, 2016; Yoder and Gurke, 2017). This study is significant in that the survey data collected on school principals’ awareness and understanding of mental health issues among students at all levels has the potential to yield insights into ways for educational leaders to better access critical information and
services for students. In addition, by understanding what principals know and are able to do with this information, state and local entities may have a better chance at reaching the key school personnel to provide accurate and timely information to those who can make the most difference for students and their families as they confront the challenge of mental health in the home and at school.

The role of the school principal has greatly evolved over the past few decades. In the first survey conducted by the National Association of Elementary Principals in 1928, the primary concern of school principals was their lack of physical space and resources (Schaffhauser, 2018). In 2018, the most recent surveys show that the primary concerns for principals are how to assist their students with emotional needs; how to manage student behavior; how to help students with mental health issues; the rising lack of student attendance at school; lack of parent supervision; and students experiencing poverty (Schaffhauser, 2018; Harper, 2018). None of these items appeared among the top concerns on the same survey conducted just ten years prior (Schaffhauser, 2018; Harper, 2018).

Today’s schools must not only provide safety in order for teaching, learning, growth, and development to take place, but must also work to ensure student, psychological and emotional safety, as well as mental health services (Berkowica & Myers, 2016). The shift in education to focus on the whole child has been recognized at local, state, and national levels. According to Yoder and Gurke (2017), “In the past two decades, much of education policy has narrowed its focus to standardized tests and accountability metrics, often leaving out the social and emotional development of students. Today, policymakers and educators are beginning to understand the value of
supporting the whole child, preparing students to be productive and happy citizens” (p. 2). The most caring school communities focus on reaching and teaching the whole child (Skalski & Smith, 2006). This Whole Child approach addresses both the social, emotional, physical, and cognitive development of students (Lewallen, Hunt, Potts-Datema, Zada, & Giles, 2015; Slade & Griffith, 2013; Skalski & Smith, 2006; McCloskey, 2012). This approach requires the entire community to work collaboratively to ensure that each child is safe, healthy, supported, engaged, and challenged (Association for Supervision and Curriculum Development [ASCD], 2019).

The National Policy Board for Educational Administration (NPBEA) released the new Professional Standards for Educational Leaders (PSEL) in 2015. Standard five of PSEL focuses on academic success, as well as overall student well-being. This standard focuses on creating a safe and healthy environment that meets the academic, physical, social, and emotional needs of all students (NPBEA, 2015). As a building leader, it is important that teachers are given the education and tools needed to be effective educators. As a result, standard six focuses on the Professional Capacity of School Personnel. This strand focuses on providing the training and support for teachers that enables them to meet the needs of the whole child (NPBEA, 2015). As mentioned later in chapter two, distributed leadership is an important framework for modern-day educational leaders. Standard seven discusses the Professional Community for Teachers and Staff. This standard focuses on empowering teachers and other school staff to take a collective responsibility approach to meeting the academic, social, emotional, and physical needs of each student, based upon the core beliefs, vision, and mission of the school (NPBEA, 2015).
One responsibility of principals is to promote a safe and caring school culture that includes high expectations and built-in supports for students and staff members who are struggling with life’s demands (Skalski & Smith, 2006). Mental health disorders not only affect individual students, they also impact the culture of the school. Therefore, it is important that schools adequately assist students with mental and behavioral health to ensure the best outcomes for the entire school (Fernandez & Vaillancourt, 2013).

Caparelli (2012) posed the question, “If 20% of children in schools will have a mental health disorder that will likely decrease their academic achievement, why hasn’t the field of school leadership placed more emphasis on the understanding of children’s mental health” (p.101)? The latest research is showing a growing need in the area of children’s mental health (Caparelli, 2012). Therefore, educators can no longer disconnect student academic achievement and social-emotional health. As educational leaders, principals are charged with leading the way of finding a way to meet all the needs of their students in order for them to have the opportunity to become successful.

While school leaders are realizing that students' social and emotional development is important for school success, a recent national survey of principals found that only 35% reported that their school had implemented a plan for embedding social-emotional learning into their school’s policies and classroom work (Blad, 2017). In fact, according to a study conducted by Blad (2017), principals reported several barriers to fully implementing social-emotional learning strategies into their curriculum, including lack of time, inadequate teacher training, and more research showing the correlation of social-emotional learning to academic success. It takes strong leadership to be able to create and sustain comprehensive, coordinated mental health services (Skalski & Smith, 2006).
Principals and other administrators must establish and promote school climates that support positive mental health and take the action steps needed to showcase their support (Skalski & Smith, 2006).

In Chapter Two, a review of research in this area will show evidence of the current need for mental health information and services to students, as well as the essential role school principals play in accessing this information and advocating for service in their schools. Chapter Three outlines in detail the plan for surveying Arkansas school principals with the goal of gaining insights into their understanding of mental health services for school-age children, including the survey instrument that will be used to collect these data, the methods for collecting data, and the timeline for completing the data collection stage of this study. Chapter 4 is a detailed analysis and interpretation of survey data, followed by Chapter 5 with lessons learned from this research, recommendations for Arkansas principals and other school leaders for meeting the needs of students with mental health issues through school-based programs, and professional development for educators and outreach to parents and the community.

**Terms and Definitions**

For the purposes of this study, the following terms have been defined to help the readers to understand the relationship between education and mental health services.

*Mental Health* refers to social, emotional, and behavioral health and the ability to cope with life’s challenges (NASP, 2016). According to Fernandez & Vaillancourt (2013), mental health is not just the absence of a mental illness, but rather a continuum that encompasses social, emotional, and behavioral health, as well as the ability to face life’s challenges.
**School-Based Mental Health** is the delivery of mental health interventions in a school setting (Capp, 2015). The Arkansas Department of Education (2016) defines school-based mental health as, “The provision of therapeutic interventions and preventions for students and families within the school setting with the purpose of equipping children for academic and social success” (Kindall, 2015).

**Public Stigma** is the prejudice and discrimination endorsed by society that affects a person (Corrigan, Morris, Michaels, Rafacz, and Rusch, 2012).

**Self-Stigma** is the harm incurred when a person internalizes prejudice placed on them by the general population (Corrigan et al., 2012).

**Major Depressive Episode (MDE)** is based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) definition, which is when an individual experiences a depressed mood or loss of interest or pleasure in their daily activities and had a majority of specified depression symptoms for at least two weeks in the past year (SAMHSA, 2015; DSM-V, 2013).

**Childhood Mental Disorder** is “all mental disorders that can be diagnosed and begin in childhood” (CDCP, 2018, p. 1).

**Title V – Medicare and Medicaid Reforms** – this act of The Helping Families in Mental Health Crisis Act of 2015 (H.R. 2646), resulted in the following changes in mental health reform:

1) Medicaid financing proposals including same day billing, partial raise of the IMD exclusion, and lifting the 190-day Medicare inpatient limit (Sec. 501, Sec. 503).
a. Mandates that states allow for same day Medicaid billing of psychiatric and primary care services when furnished at community mental health centers or federally qualified health centers.

b. Partially raises the Medicaid exclusion for reimbursement of care at Institutes for Mental Disease (IMD/“the IMD exclusion”) for psychiatric hospitals and acute-care units within state psychiatric hospitals that have an average length of stay of less than 30 days. In order for this provision to go into effect, the Centers for Medicare and Medicaid Services must certify that it would not result in any increase in federal Medicaid expenditure.

i. The reintroduced Helping Families in Mental Health Crisis Act contains new reporting and study requirements that are designed to prevent potential cost shifting from states to the federal government as a result of this new financing.

c. Eliminates the Medicare 190-day lifetime coverage limit on inpatient psychiatric hospital care. In order for this provision to go into effect, the Centers for Medicare and Medicaid Services must certify that it would not result in any increase in Medicare expenditure.

2) Improved coverage for psychiatric medications (Sec. 502)

a. The Secretary of HHS could no longer establish exceptions that permit Medicare Part D plans to exclude a particular covered Part D drug that is an antipsychotic or antidepressant, two of the six “classes of clinical concern.”
b. In administering its Medicaid formulary, a state cannot exclude or restrict access to a drug used for the treatment of specified mental health disorders other than a permitted prior authorization program.

3) Modifications to Medicare Discharge Planning Requirements (Sec. 504)
   a. Requires the Secretary of HHS to develop additional guidelines and standards related to the discharge planning process of psychiatric hospitals and psychiatric units. These must include standards surrounding the identification of outside services, efforts towards establishing relationships with community organizations, and coordination with the patient.

4) Modification to “Excellence in Mental Health Act” demonstration project (Sec. 505)
   a. The Demonstration Program to Improve Community Mental Health Services (previously passed into law as Section 223 of the Protecting Access to Medicare Act of 2014) will establish “certified community behavioral health clinics” according to specific criteria that emphasize high quality and evidence based practices which will make these clinics eligible for enhanced Medicaid funding through a new Prospective Payment System. H.R. 2646 would amend this program to increase the amount of eligible states from eight to ten, and increase the amount of demonstration years from two to four. (American Psychiatric Association, 2015).
CHAPTER 2

REVIEW OF THE LITERATURE

The purpose of this literature review is to examine the research on the relevant topics that impact school leaders’ ability to fully respond to the mental health issues of students. A historical perspective of responses to mental health of children and adolescents is necessary to set the stage for the review of related literature on four major topics: (a) the importance of early intervention; (b) challenges for school leaders; (c) stakeholder roles in school-based mental health; and (d) implications for educators.

The ultimate goal of the literature review is to examine the complexities associated with school principals’ ability to identify mental health issues among their students and to assist them in accessing the needed services at school. Efforts at the national level are explored, as well as implications for initiatives at the state level.

Historical Background

The Mental Health Parity Act (MHPA) was passed by Congress in 1996, and required group health plans with mental health benefits to provide the same coverage for mental health as other medical services. Instead of all employers complying with the law, some chose to no longer offer any mental health benefits (Arkansas Center for Health Improvement [ACHI], 2015). As a result, Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008, which expanded the requirements of MHPA. Although the MHPAEA offered additional protections for mental health and substance disorder benefits, the law did not require all health care plans to offer the benefits (ACHI, 2015).
In 2002, President George W. Bush created the “President’s New Commission on Mental Health” (President’s New Freedom Commission on Mental Health, 2003). The Commission expanded services offered under the No Child Left Behind (NCLB, 2002) and the Individuals with Disabilities Education Act (IDEA, 1975) reauthorization, and was established to make recommendations for providing mental health services to all Americans in need, with a primary focus on early childhood mental health interventions (President’s New Freedom Commission on Mental Health, 2003; United States Department of Education, n.d.). The Federal mandates outlined in NCLB (2002) also identified the need for educational reform and emphasized the emotional well-being of students in Title V (See Terms and Definitions Section). In addition, the Commission realized that children who experience mental health disorders are the most at risk of not succeeding in school (President’s New Freedom Commission on Mental Health, 2003).

According to The President's New Freedom Commission on Mental Health (2003), the goal of the commission was to gain a better understanding of public’s experiences with, concerns about, and hopes for the mental health care system. Although the act created awareness of the need for mental health services, it also helped showcase several barriers that exist for Americans trying to access mental health, such as: lack of parity for benefits, strict limits on treatment days/sessions, strict coverage limits, high co-pays and other expenses, provider drop out (low reimbursement), limited providers, difficult service authorization process, unskilled personnel, and pre-existing conditions/limits (President’s New Freedom Commission on Mental Health, 2003).

In Arkansas, the topic of childhood mental health was addressed in 2006, just three years after the New Freedom Commission on Mental Health was established with
the creation of The Children’s Behavioral Health Care Commission (Arkansas Advocates for Children and Families [AACF], 2007). The New Freedom Commission on Mental Health led the task of identifying solutions to the rapidly increasing mental health needs of Arkansas children. Former First Lady Ginger Beebe led focus groups with parents around the state to gain feedback and valuable insights on the mental health needs of their children and their personal experiences (AACF, 2007). As mentioned below, the result of this effort was an increasing awareness of the discrepancies in treatment of mental health services compared to other health services.

Regardless of the focus on mental health issues through First Lady Beebe’s interviews with parents and children, Arkansas families hit a major roadblock associated with benefits surrounding their mental health needs in the same year. The three primary concerns raised during the listening tour were difficulty obtaining an accurate mental health diagnosis, the lack of training in children’s mental health of Arkansas primary care physicians, and the lack of available child psychiatrists in the state (AACF, 2007). As a result, The Arkansas Mental Health Parity Act of 2009 (AR MHPA) was established and designed to create parity, or fairness, among health care providers and their treatment of mental illness (ACHI, 2015). According to ACHI (2015), in 2009 “Health plans that provide benefits for the diagnosis and treatment of mental illness must do so on the same terms as for the treatment of other medical illnesses and conditions” (p. 2). The parity outlined in AR MHPA is not required for preventative treatment, but the act includes frequency, coverage amount, and beneficiary exposure benefits (ACHI, 2015). This legislation helped level the playing field for mental health providers and patients.
With NCLB gone and the new focus on the “Every Student Succeeds Act” (ESSA) of 2015, the need for mental health services is continuing to be recognized at local, state, and national levels (U.S. Department of Education, 2018). According to Schaffhauser (2018), under ESSA, respondents to a recent survey said that they anticipated experiencing a lower impact on their role as principal than with NCLB. The participants also predicted that ESSA would have a positive impact on the focus on meeting the social-emotional needs of all students, including English language learners (Schaffhauser, 2018). There was no report on the impact of ESSA on mental health available at the time of publication.

The most recent legislation related to mental health in the United States was the creation of the Federal Commission on School Safety. Established by President Donald Trump on March 12, 2018, the goal of the Commission was to “review safety practices and make meaningful and actionable recommendations of best practices to keep students safe” (Federal Commission on School Safety, 2018, p. 6). To increase their knowledge and gain better insight into the needs of schools around the country, the Commission held a series of meetings with various stakeholders, travelled to schools to observe and learn more about current school safety practices, and held listening sessions around the country to receive direct input and feedback from the general public (Federal Commission on School Safety, 2018).

In addition to the creation of the Federal Commission on School Safety, legislators also passed two bills that were designed to protect schools, teachers, and students: HR 4909, Students, Teachers, and Officers Preventing (STOP) School Violence Act of 2018 and S. 2135, Fix NICS (National Instant Criminal Background Check
System) Act (Federal Commission on School Safety, 2018). The STOP School Violence Act was created to help school personnel and law enforcement identify and prevent school violence and provides more than $1 billion in grant funding through 2028 to implement and support evidence-based prevention programs in schools throughout the United States (Federal Commission on School Safety, 2018). The Fix NICS Act supports and strengthens the federal firearms background check system throughout the country by requiring federal agencies to share important information with the NICS which assists them in identifying people who are legally prohibited from purchasing or possessing firearms (Federal Commission on School Safety, 2018).

The work of the Federal Commission on School Safety falls into three categories: a) Prevent – preventing school violence; b) Protect and Mitigate – protecting teachers and students while mitigating the effects of violence; and c) Respond and Recover – responding to and recovering from violent attacks (Federal Commission on School Safety, 2018). One portion of the “Prevent” category deals with improving student access to school-based mental health. The Commission identified the lack of school-based or easily accessible mental health professionals, the importance of early identification of mental health disorders, and increasing use of telephonic and tele-psychiatry consultations through their listening sessions, site visits, and meetings. As a result, the Commission is supporting the work of Positive Behavioral Interventions and Supports (PBIS), Social-Emotional Learning (SEL) and character education, and increased access to school-based mental health services and providers with a focus on early identification and interventions. The Commission’s report contains issued
recommendations for continued improvement efforts in each of these areas for schools across the country (Federal Commission on School Safety, 2018).

Conceptual Framework

The role of the principal has become complex with the increased focus on student and teacher accountability and academic achievement. As a result, principals can no longer do their jobs alone (Hermann, 2016). The Distributed Leadership (DL) Conceptual Framework leadership approach works by encompassing teams, groups, and characteristics of an organization (Göksoy, 2015). DL is rapidly growing and is quickly becoming the preferred leadership model of this century (Bush, 2013; Bolden, 2011; Spillane & Mertz, 2015). As cited in Bush (2013), Bolden (2011), Hermann (2016), and Spillane & Mertz (2015), proponents of this theory, such as Gronn; Harris; Spillane, Halverson, & Diamond; Brown & Hosking; Beck & Peters; Gregory; Leithwood et al.; and Senge, to name a few, hold fast to the claim that shared leadership is required due to the complexity of educational institutions. As a result of this change, schools are simply too complex to be managed by one individual. Therefore, the responsibility for managing various tasks in the educational system is distributed among a host of individuals with different roles, skills, and abilities. The DL approach is based on the lack of ability to ascertain best single leader characteristics or behaviors (Göksoy, 2015).

Simply stated, DL is shared school leadership (Göksoy, 2015; Bush, 2013; Hermann, 2016; Bolden, 2011; Spillane & Mertz, 2015). The DL concept of leadership emerged from the Distributed Cognition and Activity Theory, with influences from Wegner’s Community of Practice and exists to understand how leadership takes place among people in a complex organization (Hermann, 2016). Bolden (2011), states that the
key contribution of DL is, “in enabling the recognition of a variety of forms of leadership in a more integrated and systemic manner” (p. 264). With the complex and increasing demands of the role of school principal, building leaders are finding ways to share the daily operations of the job with their staff (Hermann, 2016). With the DL approach, leaders serve in both formal and informal capacities and perform a variety of organizational functions. This approach offers all members of the organization an opportunity to serve as experts and collaborative leaders. Giving teachers the opportunities to lead grows them professionally. This approach, however, requires the willingness of principals to relinquish some of their authority and power (Hermann, 2016).

The issue of student well-being is too extensive for a single person to tackle alone (Harper, 2018). While schools are ideal locales to identify student needs, principals should not feel the pressure to work on the insurmountable array of issues by themselves (Harper, 2018). Not all school personnel are natural leaders or wish to serve in a leadership capacity. As educational leaders, principals are primarily responsible for distributing and defining leadership within their schools (Hermann, 2016). Identifying key leaders and building a strong, collaborative team is an essential skill for effective school leaders. DL focuses on how the leader and their followers work together to solve a problem or achieve a goal (Hermann, 2016).

**Early Intervention**

Children who have mental health issues that go untreated experience lasting effects into adulthood that could have been prevented if they had received assistance and support when their symptoms first appeared (Lahey, 2016; Arkansas Early Childhood
Research on mental health services for children reveals that schools are optimal places for identifying students early, which is essential to overcoming behavioral and emotional health concerns in young children (Garmy, Berg, & Clausson, 2015; Child Mind Institute, 2016; Stewart, Klassen, & Hamza, 2016).

According to The National Association of School Psychologists (NASP, 2016), one in five school-aged children experience mental health issues during their school years and schools provide an ideal place for mental health prevention, intervention, and communication between schools and families. Capp (2015) defines school-based mental health as, “the delivery of mental health interventions at schools” (p. 241).

Research overwhelmingly shows that provides immediate positive changes that lessen the future incidence of problems and increase the likelihood of positive outcomes (Ghaemi et al., 2015; Ramirez, 2014). Carlson & Kees (2013) state, “Identifying students early and intervening will not only ensure that they are mentally healthy, but they will also be in a position to focus on their academics, which would lead to positive outcomes” (p.9-10). Research indicates that not all early childhood intervention programs result in lasting academic improvements, but are shown to reduce antisocial behaviors. In a study conducted by Zigler, Taussig, & Black, (1992), early intervention programs aimed at reducing and preventing precursors of juvenile delinquency, such as drug use, aggressive, acting-out, antisocial, and moody behaviors, yielded promising results. Specifically, these interventions cited in the research consisted of cognitive and behavioral skills training, school-based mental health, parent-training programs, and programs that targeted reducing specific aspects of pre-delinquent behaviors, such as suspension, dropout, and substance abuse (Zigler et al., 1992; NASP, 2016). According to this
research, such programs may have an impact on future juvenile delinquency and crime rates (Zigler et al., 1992; NASP, 2016).

Studies also indicate positive effects of mental health interventions in early childhood, such as increased prosocial behaviors and decreased disruptive behaviors (Ghaemi et al., 2015; Ramirez, 2014). According to Arkansas Early Childhood Comprehensive Systems Social-Emotional Workgroup (2015), children who receive early intervention and support in preschool are more likely to graduate from high school, become employed, and earn more money. They are also less likely to become incarcerated or become dependent upon welfare services (Arkansas Early Childhood Comprehensive Systems Social Emotional Workgroup, 2015). Pre-Kindergarten expulsions are also reduced by more than 47% when students have access to mental health services (Ghaemi et al., 2015; Ramirez, 2014). However, the current reality is that most mental health providers are not trained in evidence-based interventions for children ages 0-5 (Arkansas Early Childhood Comprehensive Systems Social-Emotional Workgroup, 2015).

According to the Children’s Health Fund (2010), early identification is important for early intervention and benefits both students and their families (as cited in Ramirez, 2014). Jakovljevic, Miller, and Fitzgerald (2016) concurred, “Early childhood interventions that support the basic needs of children, including access to nutritious food, safe and affordable housing, quality child care, and regular health care, should be our top health priority if we want to ensure the well-being of future generations” (p. 459). Fortunately, due to the amount of time children spend in a childcare or school setting, along with the concentrations of students and trained personnel, many early childhood
programs such as Pre-K and Head Start are optimal places for early identification to occur and these programs have recognized the need to support the social-emotional needs of students (Child Mind, 2016; Jakovljevic, Miller, & Fitzgerald, 2016).

The collaborative goal between educators and mental health agencies is prevention. The World Health Organization’s Department of Mental Health and Substance Dependence (2002) defines prevention as, “to keep something from happening” (p. 7). However, they state that this definition can cause confusion in the field of mental health. Cuellar (2015) defined prevention in two parts when they stated, “One approach to mental health problems is prevention rather than treatment. This encompasses both primary prevention, or preventing mental health problems before they occur, and secondary prevention, which involves minimizing or correcting the course of a problem once it has begun to manifest” (p. 123). Both types of prevention require educators to have a solid understanding of the cause of mental health problems (Cuellar, 2015).

Many educators are beginning to recognize the negative impact that trauma can have on the mental and emotional well-being of their students (Rebora, 2018). A collaborative approach is essential when dealing with a child that has suffered from a traumatic experience. Schools that employ Distributed Leadership already have this collaborative framework in place, making it easier for a variety of school personnel to work together for the overall well-being of the child (Bolden, 2011; Spillane & Sherer, 2004). Moreover, according to Blad (2017), no child who is suffering from the result of trauma, or any psychological problem or mental illness can be taken care of by one single person. In fact, identifying and assisting a child with a psychological or psychiatric issue
is difficult even for the most trained and skilled personnel (Blad, 2017). Yet, one person can make a substantial difference for the child in identifying their symptoms and helping them access services (Blad, 2017). It is imperative that teachers and school administrators are afforded better training on mental health issues (Rebora, 2018). Our children’s mental health hinges upon it.

**Multi-Tiered Systems of Support**

Students who have emotional and behavioral disorders require prevention efforts such as multi-tiered systems of support (MTSS) to meet their diverse needs and to help close their achievement gaps (Benner, Kutash, Nelson, & Fisher, 2013). Similar to the Response to Intervention (RTI) process, MTSS employs a three-tiered system approach that can be used to identify and target academic issues, as well as social-emotional problems (Eber, Kyde, & Suter, 2010; Averill & Rinaldi, 2013; McIntosh & Goodman, 2016). Grounded in evidence-based practices of RTI and Positive Behavior Intervention and Supports (PBIS), students are grouped into three tiers (Benner, Kutash, Nelson, & Fisher, 2013; Eber, Kyde, & Suter, 2010; Averill & Rinaldi, 2013; McIntosh & Goodman, 2016). Tier 1 focuses on school-wide practices and core curriculum, while Tiers 2 and 3 provide increasingly intensive and individual interventions to students in need. The focus of Tier 1 is prevention and early identification of problems. Students in Tier 2 are those who needed more intensive services than those provided in Tier 1, so they receive additional supplemental instruction and intervention as an added layer of support. Students in Tier 3 receive need more intensive interventions in addition to that provided in Tiers 1 and 2 (McIntosh & Goodman, 2016; Averill & Rinaldi, 2013). Tier 3 often includes small group instruction and may or may not include Special Education
services (McIntosh & Goodman, 2016; Averill & Rinaldi, 2013). McIntosh and Goodman (2016) warn against the myths surrounding the tiers of the MTSS approach. They argue that many times, it is assumed that the tiers are separate, so students are either in Tier 1, Tier 2, or Tier 3. They propose instead that the tiers provide layered support, so students receive additional support in a combination of the tiers, based upon their individual needs (McIntosh & Goodman, 2016).

The success of MTSS hinges on the collaboration and support of adult stakeholders in the school system (McIntosh & Goodman, 2016; Eber, Kyde, & Suter, 2010; Averill & Rinaldi, 2013). Averill and Rinaldi (2013) state, “Working within the MTSS framework requires that all school district staff, including teachers, central office personnel, school leaders, and student support specialists, change the way in which they have traditionally worked” (p. 3). The MTSS approach requires district commitment to and ongoing planning of quality interventions and resource provision (Eber, Kyde, & Suter, 2010; McIntosh & Goodman, 2016). District and school leaders must establish consensus on MTSS practices and then work together to create the infrastructure and sustainability plan for the continuation of services (Eber, Kyde, & Suter, 2010; Averill & Rinaldi, 2013; McIntosh & Goodman, 2016). McIntosh and Goodman (2016) stated, “It takes a tremendous amount of time and resources from both the school and the district level to establish an integrated MTSS model” (p. 161). This team approach is essential to meeting the goals established in a MTSS.

**Challenges for School Leaders**

A primary role of principals is creating a learning environment where student academic success is the top priority. Indeed, this focus has been directly linked to strong
school leadership (Hermann, 2016). To be truly successful, students require not just academic achievement, but also social and emotional health (Fernandez & Vaillancourt, 2013). There are many challenges educators face when supporting mental health in their schools—from the lack of qualified providers to the access and delivery of mental health services—and, often, minimal support. These challenges must be confronted in order to determine educators’ next steps in promoting children’s mental health (Ghaemi et al, 2015; Adelman & Taylor, 2012; NASP, 2016; Meyers et al, 2015).

Four major challenges are cited most often in the literature on school-based mental health initiatives and programs: (a) lack of mental health providers (Adelman & Taylor, 2012; Ghaemi et al, 2015; Child Mind, 2016; Arkansas Advocates for Children & Families, 2007; Owen, 2015); (b) access to services; (c) delivery of services; and (d) lack of support. Understanding these challenges provides insight into the complexities faced by school leaders (Clopton & Knesting, 2006; NASP, 2016; Tran, 2014; Meyers, et al., 2015; Garmy et al., 2015; Frabutt & Speach, 2012; Freeman et al., 2012; Lahey, 2016; Center for American Progress, 2018; Jakovljevic et al.; Simon, Beder, & Manseau, 2018; Zigler et al., 1992; Lal & Adair, 2014; Arkansas Early Childhood Comprehensive System, 2015; Kramer, Kinn, & Mishkind, 2015; Massey, 2015; Centers for Disease Control and Prevention, 2018; Fernandez & Vaillancourt, 2013).

**Lack of Mental Health Providers**

The first challenge faced by principals in the lack of mental health providers in school settings (Ghaemi et al, 2015; Child Mind, 2016; Arkansas Advocates for Children & Families, 2007). This reality results in the need for educators to address mental, psychosocial, and physical health issues to ensure effective academic performance and
well-being of students. While schools provide prime access to students and families that need such services, there is a gap between children’s mental health needs and programs that can provide the needed services (Adelman & Taylor, 2012; Ghaemi et al., 2015). Education settings, specifically schools, are experiencing a critical shortage of child mental health practitioners, which leads to concerns of how to treat children in need. The Child Mind Institute (2016) found that there were “approximately 8,300 practicing child psychiatrists in the United States; the estimated number needed to satisfy the demand is 12,600” (p. 3). Schools must find creative ways to locate and partner with providers that understand and are trained in children’s mental health so that youth can receive the services needed to live healthy lives.

The current issue of limited childhood mental health providers is posing a colossal challenge for Arkansas children and their families. According to the Arkansas Medical Society, as cited by the Arkansas Advocates for Children & Families [AACF] (2007), there were only 23 child psychiatrists in Arkansas in 2007, 15 of which were located in central Arkansas. At the time of this survey, many adult psychiatrists were supervising the treatment of children without any specific training in pediatric mental health (AAFC, 2007). Moreover, many primary care physicians were tasked with treating mental illness on their own due to the lack of available child psychiatrists (AACF, 2007). According to Arkansas Advocates for Children & Families (2007), “Most primary care physicians are not trained in the specialty of childhood mental illness and are unequipped to effectively treat these conditions” (p. 6).

In Arkansas, the shortage of mental health professionals continues to be a problem more than a decade later. In 2015, a study conducted by James Owen reported
that there is a shortage of psychiatrists in Arkansas. He stated that The University of Arkansas for Medical Sciences (UAMS) produces approximately only ten psychiatrists each year. Out of these ten, only eight are able to stay in Arkansas for the UAMS residency program. Unfortunately, not all of those eight choose to stay and practice in Arkansas. Furthermore, not all of the psychiatrists that practice in Arkansas service children with mental disorders (Owen, 2015). Owen (2015) noted, “There is a severe shortage of mental health professionals in Arkansas, especially in more rural areas of the state” (p. 4). The state must continue to work to meet the growing demand of mental health services for its citizens.

In summary, the lack of childhood mental health providers has highlighted the need for school personnel to be able to intervene for students in crisis. Many times, teachers are often the first adults that students turn to when they have a need, yet they typically feel ill-equipped and inadequately trained to identify students in need and help them access the appropriate services (Frabutt & Speach, 2012; Freeman et al., 2012; Lahey, 2016).

Access to Services

The second challenge faced by school principals is access to service for students with mental health issues. Access is a critical issue, especially in rural areas in Arkansas and across the nation (Clopton & Knesting, 2006; NASP, 2016; Tran, 2014; Meyers, et al., 2015). The challenge that schools face when providing sufficient social-emotional supports is due to a lack of financial and material resources needed to provide adequate mental health services to students. In rural areas, finding and retaining highly qualified
mental health providers is challenging and high turnover is common (Clopton & Knesting, 2006).

In many rural areas, educational facilities may provide the only access to mental health in the community (NASP, 2016; Tran, 2014). According to Tran (2014), “Students are more likely to seek counseling when services are available in schools” (p. 1). Many times, children and families residing in rural settings live a significant distance from service delivery sites and do not have access to public transportation or childcare opportunities that are often found in more urban or suburban areas (Clopton & Knesting, 2006; Meyers, et al., 2015). If families have access to a personal vehicle, gas expenses can quickly add up if the child requires multiple services. Families in rural communities may also experience stigma tied to accepting help from people outside of their family or close circle of friends, as people with mental health issues are oftentimes considered to be weak or dependent, rather than the self-sufficient prototype preferred by most rural communities (Clopton & Knesting, 2006; Meyers et al., 2015).

Nearly eight million people who live in rural areas are considered to live in poverty, which increases the risk of exposure to a variety of adversities that enhance the risk of mental disorders (Nichols, Goforth, Sacra, & Ahlers, 2017; Ghaemi et al., 2015). Poverty is a risk factor for childhood mental health issues and is related to poor academic achievement and cognitive development. Poverty also increases the chance of adverse childhood events and other risk factors for developing mental illness. Jakovljevic et al. (2016) states, “The World Health Organization has declared poverty the single largest determinant of health for both adults and children” (p. 457). A student’s economic status
should never determine the type or level of mental health treatment options they are afforded.

According to the Arkansas Talk Poverty Report of 2017, issued by the Center for American Progress (2018), of the 2,898,630 people who live in Arkansas, 499,225, or 17.2%, live below the poverty line. In fact, in 2016, 17.2% of Arkansas families of four lived below the poverty line annual income of $24,340. For children, the percentage living below the poverty line was 23.5% in 2016 (Center for American Progress, 2018). This factor alone is an antecedent for many Arkansas children to begin their lives at risk for developing mental health issues due to poverty (Nichols et al., 2017; Ghaemi et al., 2015; Jakovljevic et al.; Simon, Beder, & Manseau, 2018).

Innovations in information and communication technology (ICT) are changing the delivery of health services (Lal & Adair, 2014). With today’s technology and digital opportunities, healthcare can be improved using telecommunication networks. This has expanded into the realm of mental health treatment via e-health services (Lal & Adair, 2014). According to Hollis et al. (2015), the growth in demand for mental health services exceeds the resources that are currently available. They predict that this gap will continue to increase up to 2020 (Hollis et al., 2015).

The use of telecommunications and other technologies has expanded the reach of services beyond the traditional clinical setting (Kramer, Kinn, & Mishkind, 2015). E-health services connect patients with providers in real time across geographical regions (Lal & Adair, 2014). For many rural areas and in places with a lack of mental health providers, this can afford children the opportunity to access services they would not have otherwise had a chance to receive (Kramer et al., 2015). E-mental health, as it is now
known, provides patients with greater choice and control of their healthcare. This type of change requires a cultural change in the way that mental health services are delivered (Hollis et al., 2015). However, if properly utilized, E-mental health can provide a promising glimpse into the future of mental health service (Lal & Adair, 2014).

**Delivery of Services**

Adding to the complexity of these issues is the third challenge for principals to meet the mental health needs of students, the delivery of services, including time and resources, within the school setting. The overwhelming, growing need for mental health services for children and youth can be a difficult obstacle for school districts. Schools are busy and complex settings with limited time and resources which can pose a challenge when trying to deliver mental services (Garmy et al., 2015). These challenges demonstrate the need for services to continue outside of school and youth need encouragement to meet behavioral and academic expectations from both within and outside of the school setting (Zigler et al., 1992). Student, school, parent, and community partnerships are vital to successful mental health treatment.

In Arkansas, there is a shortage of qualified providers to deliver mental health services to children, as many of mental health professionals are inadequately trained to provide the evidence-based interventions they need (Arkansas Early Childhood Comprehensive Systems Social-Emotional Workgroup, 2015). According to this working group’s 2014-2015 Strategic Plan, many mental health professionals lack the needed training treat early childhood students. In fact, the Strategic Plan noted results is the lack of support for interventions that have been shown to make a difference for students (Arkansas Early Childhood Comprehensive Systems Social-Emotional Workgroup, 2015).
Workgroup, 2015). Of 179 mental health professionals who attended an evidence-based treatment approach for children training in Arkansas, only 12% participants reported that they were comfortable assessing a child under the age of three for mental health services. Moreover, of the professionals surveyed, only 43% were comfortable serving children ages three to five. Of the entire group, 85% of the mental health professionals surveyed indicated that they were interested in additional training on mental health interventions for young children under the age of five (Arkansas Early Childhood Comprehensive Systems Social-Emotional Workgroup, 2014-2015).

**Lack of Support**

The fourth major challenge is principals’ lack of support for mental health services in schools. According to Massey (2015), the implementation and success of school-based mental health services is sometimes compromised by administrators who do not support such services for students. This issue has been documented in Arkansas through the work of the Arkansas Early Childhood Comprehensive System who state that educating and caring for children who have social and emotional problems can be challenging for educators (Arkansas Early Childhood Comprehensive System, 2015).

Current research shows evidence that the lack of training on mental health results has a direct impact on the level of support provided by all stakeholders, including classroom teachers and parents and guardians. When teachers do not have the mental health training that they need and parents are uncooperative or resistant to their child receiving services, children may experience trouble at home, in school, and in forming friendships. Their future success lies in the hands of the adults who can intervene early on their behalf (Massey, 2015; Centers for Disease Control and Prevention, 2018).
Consequently, the relationship between classroom teachers and heads of households is critical to raising awareness of mental health issues and securing services that make a positive impact on students at school and in the home. According to Wateland (2018), teachers reported, “the relationship between school and parents was the most important issue relating to students receiving mental health services” (p. 10). A strong partnership with parents can result in great outcomes for students. However, parents can also be the primary barrier to students receiving the needed mental health services; specifically, when they do not follow up with services, display a lack of respect, or if the parents are dealing with their own issues (Wateland, 2018). If the parents of the children with mental health issues are also mentally ill, the problems multiply. The family environment of mentally ill parents is generally more negative and less supervised, which leads to children internalizing or externalizing their problems. Simply stated, mentally ill parents have a negative effect on their child’s emotional and behavioral problems, the family environment, and adult-child interactions (VanLoon, Van de Ven, Van Doesum, Witteman, & Hosman, 2013).

Stigma can be another barrier to youth accessing mental health support and services. Corrigan et al. (2012) defined two types of stigma: public stigma, or “the prejudice and discrimination endorsed by the general population that affects a person,” and self-stigma, or “the harm that occurs when the person internalizes the prejudice” (p. 963). The majority of young people with mental health issues avoid seeking help due to the public and private stigmas attached to the disorders (Bowers et al., 2013). In fact, up to 60% of adolescents do not receive services due to stigma and lack of access (NASP, 2016).
In addition, stigma was the primary barrier to young people accessing mental health services, as evidenced by a study conducted by Bowers et al. (2013). Youth do not want their peers to know that they are receiving mental health treatment. Therefore, the stigma associated with mental health issues is more pronounced in rural, tight-knit areas (Nichols et al., 2017). The lack of training in children’s mental health among educators also contributes to stigma (Fraunholtz et al., 2017).

In summary, research by Corrigan et al. (2012) shows evidence that education helps to reduce stigma for adults and kids with mental illness. For adolescents, education and face-to-face contact with qualified mental health professionals were most effective. In youth, mindsets are not as fixed as adults, so they are more willing to adapt or change their beliefs. More recently, educational approaches to challenging stigma associated with mental illness have included replacing wrong assumptions with facts; interpersonal contact between general population and individuals with mental illness; and challenging the existing bias (Corrigan et al., 2012). Taylor (2017) states, “Schools are often the first line of defense for mental health concerns. To make students feel more comfortable seeking help, schools should start by attempting to eliminate the stigma” (p. 45). Students are more likely to seek help if they can easily access services at school, and if the assistance is provided in a familiar environment by trusted adults (Fernandez & Vaillancourt, 2013). Indeed, parents may also be more accepting of mental health services provided at school because of a reduced sense of stigma due to established relationships with school personnel (Tran, 2014).
Roles in School-Based Mental Health

Today’s schools work to meet the increasing emotional, social, and behavior needs of students in order for those students to succeed academically (Kindall, 2009). The roles of school personnel are paramount to the effectiveness of school-based mental health programs, as schools are the primary providers of children’s mental health in the United States (Lahey, 2016). Collaboration between educators and school-based mental health personnel is critical in ensuring that students are receiving the social-emotional support needed to benefit their learning (Nichols et al., 2017). Role confusion can be a challenge in smaller, more rural areas, where occupational roles overlap and dual relationships exist.

Principals are charged with the task of ensuring that school personnel have the training and resources necessary to support students needing mental health services. Principals oversee successful school operations and focus on student academic learning and achievement (Frabutt & Speech, 2012). However, as the gatekeeper and leader with a global perspective of the entire school operation, principals should also bring all stakeholders to the table to support the whole child. Unfortunately, school staff typically have limited knowledge of mental health related to children, have little to no training, and are not confident in their abilities to provide help and support to students in need of mental health services (Frauenholtz et al. 2017).

Research on effective mental health initiatives shows evidence of the potential of distributed leadership to meet the needs of children in and out of the classroom. Research documenting the roles of the teacher, school counselor, and school principal, especially those who service students in rural areas, indicates that challenges of information and
services are faced across the system (Frauenholtz et al., 2017; Lahey, 2016; Carlson & Kees, 2013; Alvoid & Black, 2014; Frabutt & Speech, 2012; Massey, 2015).

The Role of the Teacher

Teachers are often the first people in schools that can recognize when students are struggling, whether academically, socially, or emotionally. However, survey research has indicated that teachers and other school personnel have limited knowledge of mental health, particularly among children, and feel unprepared to support students with mental health needs (Frauenholtz et al., 2017). Lahey (2016) states, “All the mental-health services in the world won’t help if teachers don’t understand the nature of the services available in the school and can’t identify the students in need of intervention” (p. 2). Unfortunately, aside from the mandatory professional development related to reporting laws for child abuse and neglect, teachers receive little to no education or training related to mental-health warning signs or interventions (Lahey, 2016).

Many schools are proactively working to get their faculty and staff the mental health training they need to be able to assist students. The Fork Union Military Academy in Fork Union, Virginia, with the help of two mental health professionals, educators designed and implemented their own mental health curriculum that focuses on providing mental health first aid to their staff (Lahey, 2016). As a result, they now offer one eight-hour certification program in Mental Health First Aid and have trained nearly all of their faculty and staff in a two-year period (Lahey, 2016).

Teachers are not the only educators who feel ill-equipped when it comes to understanding children’s mental health needs. A study conducted by Frauenholtz et al. (2017) found that other key school personnel did not believe they had received adequate
mental health training and therefore were not prepared to assist children in distress. The study also showed that certified staff such as teachers, counselors, speech therapists, and other professionally credentialed educators had more confidence in their knowledge of children’s mental health than paraprofessionals, custodians, and other classified staff members (Frauneholtz et al., 2017).

The Role of the School Counselor

School counselors typically serve as the liaison between the school and outside mental health providers. They often serve on the front lines in helping students access services when they exhibit any type of social, emotional, or mental health issues. School counselors also serve as the primary contact for teacher referrals, parents, and other school personnel (Carlson & Kees, 2013). School counselors focus on standards related to academics, careers, and social-emotional supports. Oftentimes, it is hard for them to determine the most needed intervention for the student when they are struggling in the classroom. According to Donohue, Goodman-Scott, & Betters-Bubon (2016), “Academic concerns do not trump mental health concerns; both are important. Similarly, we cannot fail to act because a student with mental health concerns has not failed academically” (p. 142). While the majority of the mental health referrals go first to school counselors, they do not always feel equipped to provide the direct services to students.

In a study conducted by Carlson and Kees (2013), findings showed that most school counselors are comfortable with the issues that students bring to them and feel confident in their ability to adequately perform their jobs. School counselors indicated a greater amount of discomfort, however, when working with students diagnosed with
formal mental health disorders (Carlson & Kees, 2013). The counselors in the study attribute their lack of confidence in addressing mental health issues with students to their lack of training and preparation; even after completing graduate programs in school counseling (Carlson & Kees, 2013). The Carlson and Kees study of 2013 also found that 85% of the school counselors who participated in the survey reported that they do not have enough time to provide the needed services to their students due to the exhausting list of demands placed upon them by the school setting. Carlson and Kees (2013) noted that the counseling profession has identified the need for more training, standards, and supervision related to childhood mental health services in response to the increasing need for this expertise in schools.

While school counselors are often tasked with trying to provide the majority of mental health services in schools, they are also oftentimes the key to securing community-based mental health services for students (Carlson & Kees, 2013; Donohue et al., 2016). School counselors typically coordinate referrals to outside agencies to best meet the needs of their students (Carlson & Kees, 2013). Carlson and Kees’ 2013 study also found that school counselors welcome outside therapists as colleagues and partners as long as the outside providers understand how to function in a school setting and realize the critical role of the school counselor.

The Role of the Principal and Distributed Leadership

The role of the principal has evolved over the years from a building manager to an instructional leader, child advocate, team builder, coach, and visionary change agent (Alvoid & Black, 2014). As the building leader, the principal plays a vital role in ensuring that everyone works together to promote the well-being of all students. In a
study conducted by Frauenholtz et al. (2017), a high level of knowledge and understanding of children’s mental health among upper-level administration is essential to better supporting students’ emotional and educational well-being. One of the duties of a principal is to advocate for students’ needs. According to Frabutt and Speach (2012), “The visionary and operational leadership of the school principal is indispensable for mental health promotion in schools” (p. 167). As the gatekeeper for the school, advocacy for all students begins with the principal.

The role of the principal in supporting school-based mental health interventions is often uncertain and needs to be addressed by schools (Frabutt & Speach, 2012). The job of the principal has evolved over time and often seems daunting to individuals entering educational leadership positions. According to Massey (2015), “Today’s principal does not reflect what the principals of the 1960s, 1970s or 1980s looked like. They are no longer considered to be a building manager, but instead aspire to lead, to be team builders, coaches, and agents of change” (p. 63). As the role of the principal evolves, so must their understanding of the diverse needs of their students.

Principals face many challenges when dealing with school-based mental health. One obstacle is that most school administrators lack knowledge about mental health and the services that are provided in the school setting. A study conducted by Iachini, Pitner, Morgan, & Rhodes (2015) found that principals identified mental health as the primary need for students, teachers, and school staff. Specifically, the principals in the study identified the need for early identification of students needing mental health, as well as the need for teachers to manage and access services for their own mental health needs (Iachini, Pitner, Morgan, & Rhodes, 2015). According to Massey (2015), “With the
changes in expectations, insufficient training, and lack of support that principals feel they receive from their school district, many believe that the job is no longer sustainable. They feel unprepared for the demands that current leadership positions hold. No longer are principals only tasked with ensuring compliance and enforcement along with managing conflict, but they are responsible for student outcomes as well” (p. 63).

**Roles in Rural Areas**

In rural areas, the effect of mental health disorders on student success was found to be directly correlated to the level of collaboration among teachers and other support personnel, such as school counselors (Nichols et al., 2017). In addition, in rural areas, school support personnel such as school counselors and school psychologists have similar roles and goals in providing social-emotional supports to students. As a result, it can be difficult to determine which professional provides which services. This role confusion is compounded when the school contracts with outside agencies for school-based mental health services (Nichols et al., 2017). It is important that schools closely examine the roles of those involved in delivery of mental health services to determine who is most involved in the process (Freeman, et al., 2012).

**Summary**

Research on the roles of education stakeholders in schools shows evidence that a collaborative approach is crucial when dealing with mental health issues. Schools are ideal settings for collaboration to occur to prevent, detect, and treat children’s mental health disorders (Caparelli, 2012). Kindall (2009) states, “It is important and necessary for educational leaders and agency service providers to take strides in working as a collective team in order to meet the needs of students” (p. 75). However, collaboration
efforts are often difficult when dealing with mental health. Cuellar (2015) found, “Many researchers have noted problems with fragmentation, meaning that the medical, school, and justice systems do not coordinate treatment, screening, or prevention. For instance, many children with mental disorders face academic problems, yet these are not the focus of treatments in the medical system” (p. 117).

Educators must work together to ensure that the emotional and mental health needs of students are met. According to Taylor (2017), the lack of involvement by teachers and administrators is one of the most common forms of fragmentation when studying school based mental health approaches. Therefore, administrators must understand the roles of school counselors, school psychologists, and outside providers in order to best utilize the knowledge and skills of their personnel (Nichols et al., 2017).

The success of school-based mental health does not only depend on educators and mental health practitioners but hinges on involvement of the family. Positive parental involvement is a critical part of the process and has been associated with a reduction in risk of school dropout (Stewart et al., 2016). However, negative parenting skills can lead to an increase in children’s mental illness. According to Rohde (2013), family structure and dysfunctional parenting styles can adversely impact child psychopathology. If parents suffer from mental illness themselves, this further compounds the child’s ability to function without mental health treatment. According to Van Loon, Van de Ven, Van Doesum, Whitteman, & Hosman (2013), children whose parents have a mental illness are at higher risk of experiencing psychological problems. Van Loon et al. (2013) wrote, “Children with a mentally ill parent may more frequently experience negative emotions, including anger, fear, and sadness” (p. 1201). In addition, parents with mental illness
may not be able to provide as much support to their children and interactions between mentally ill parents and their children are worse compared to interactions of parents and children with no mental illness and often result in greater conflicts (Van Loon et al., 2013).

The role of the student is also vital when planning for or evaluating the success of school-based mental health services. According to Taylor (2017), “Students who understand their weaknesses and what they need to manage them will be successful both in the classroom and post-graduation” (p. 47). It is important to youth that they have a voice in mental health policy and practice within their schools (Bowers et al., 2013). Feedback obtained from adolescents is also essential to consider when evaluating programs (Garmy et al., 2015).

Implications

Despite the challenges posed to education professionals in a school setting, research shows that interventions provided at school can yield positive results for students and school based mental health programs can help eliminate many of the barriers to treatment faced by many youth and children (Carlson & Kees, 2013). School-based mental health programs can be beneficial even with structural constraints (Garmy et al., 2015). Bruns et al. (2016) agree, “Evidence is strong that school-based interventions can support positive social-emotional outcomes, which are related to academic success as well as healthy transitions to adulthood” (p. 166). Targeted interventions seem to be the key to successful school-based treatment. School-based mental health programs that target a specific problem and are gender and culturally sensitive are more effective than broad interventions that lack a focus (Ghaemi et al., 2015).
The implications of successful school-based mental health services can be hard to determine. In the study conducted by Bruns et al. (2016), the students with the highest risk of mental health that received intensive interventions were less likely to have academic problems in the future, as compared to the control group. However, the Bruns et al. (2016) study did not have a definitive conclusion on the effect of school-based mental health services on academic performance. Therefore, it is important to consider data other than academic achievement when evaluating mental health services, such as discipline, attendance, and students’ emotional well-being. According to Ghaemi et al. (2015), child discipline problems can be reduced by multifaceted intervention programs, which eventually lead to increased academic achievement.

According to Adelman & Taylor (2012), current mental health approaches place too much emphasis on individual treatment rather than treatment programs and therefore, are often fragmented interventions. The authors insist that a comprehensive concept can play a significant part in school improvement efforts. The researchers state that this focus on individual problems, “contributes to the widespread undervaluing of the human and social capital represented by students, their families, and a wide spectrum of other resources in the community” (Adelman & Taylor, 2012).

Conclusion

Research suggests that mental health may be a significant determinant of children’s academic performance (Murphy et al., 2015). Educators are starting to realize the impact that psychological problems can have on a child’s academic performance, behavior, and attendance (Ramirez, 2014). According to the Child Mind Institute (2016), “Schools must become the prime driver behind improving the mental health of America’s
children” (p. 2). Educators can no longer wait for children to fail before providing them with the services they need. Such an approach leaves students with substantial gaps that could have otherwise been filled through early intervention programs (Bruns et al., 2016).

According to NASP (2016), children who receive social-emotional support and mental health services have greater academic achievement. However, according to Powers (2012), we are not meeting the mental health needs of our students, as he states, “Considering the high number of students with untreated mental health disorders, the clear evidence of the interference this causes in school performance, and a clear legislative agenda for scientifically-based interventions along with the availability of such programs, the majority of schools are not providing effective mental health services and students remain untreated and at risk for failure” (p. 7). In order for these students to have a chance at success, we must focus on their social-emotional health first.

In a press release, KARK News (2018) reported that Arkansas Governor Asa Hutchinson stated, “Better access to mental health counseling for students must be a priority as Arkansas leaders look for ways to tighten security at public schools,” based upon a preliminary report that the Governor accepted from the Arkansas School Safety Commission. On March 1, 2018, Governor Hutchinson created the Arkansas School Safety Commission to develop ways to better protect the students in Arkansas classrooms. One of the focuses of the commission was student mental health and access to services. Governor Hutchinson stated that school counselors and mental health agencies must improve their coordination and cooperation efforts so that Arkansas students can be afforded the mental health services they need (KARK, 2018).
Reports cited in the review of the research conclude that educational leaders must identify signs of mental-health disorders early in a child’s life so that stakeholders can provide them with the care and support needed in order for them to succeed (Ghaemi et al., 2015; Ramirez, 2014; Carlson & Kees, 2013). To this end, Arkansas has recently taken the initiative to expand the opportunity for its citizens to participate in Mental Health First Aid USA training. This eight-hour training identifies the risk factors and warning signs of mental illnesses, helps its participants understand the impact of mental disorders, and outlines common supports (National Council for Behavioral Health, 2018). Similar to CPR, Mental Health First Aid prepares participants to intervene for a person in crisis and help them access assistance. Participants who are trained in in Mental Health First Aid do not diagnose or try to provide therapy, but rather help those in need seek out professionals trained in providing mental health services (National Council for Behavioral Health, 2018). If parents, educators, lawmakers, and the mental health community can continue to find ways to work collaboratively to advocate for school-based services, children could reap the benefits of the cooperative investment (Child Mind Institute, 2016).

In 2018, the Arkansas Department of Education received a $9 million grant from the Substance Abuse and Mental Health Services Administration to improve mental health services for children in the state (Arkansas Department of Education, 2018; Talk Business & Staff, 2018; Arkansas State University, 2018). The Arkansas Department of Education will receive approximately $1.8 million per year over a five-year period to fund the mental health initiative (Arkansas Department of Education, 2018; Talk Business & Staff, 2018). This program, to be implemented in 2019, called AWARE
Arkansas, plans to highlight youth mental health awareness, provide stakeholder training to assist with identification and service provision for youth, promote healthy youth development, and reduce violence among teens (Arkansas Department of Education, 2018; Talk Business & Staff, 2018; Arkansas State University, 2018). The funds from this grant will be concentrated in communities that are located in three different geographical regions in the state. The focus will be providing mental health services to approximately 10%, or 7,000 Arkansas students that experience mental health issues. The program will work to increase mental health screenings and expand mental health services both inside and outside of the school setting (Arkansas Department of Education, 2018; Talk Business & Staff, 2018; Arkansas State University, 2018). Positive Behavioral Interventions and Supports will be implemented which will target prevention efforts, reduce violence and the incidence of mental health problems, and improve community and family engagement (Arkansas Department of Education, 2018; Arkansas State University, 2018). The recently issued funds offer a chance for a promising future in the area of accessing children’s mental health services in Arkansas.

The chapter that follows is a presentation of the methods used in the survey of Arkansas principals, conducted with the goal of gaining a deeper awareness of their current understandings of mental health issues in schools and the availability of services to respond to students’ mental health needs. Chapter 4 is a discussion of the results of this survey as they relate to the issues discussed in this review of research. The final chapter, Chapter 5, includes interpretations and implications, future recommendations, a summary of the findings, and conclusions.
CHAPTER 3
METHODOLOGY

There is an increasing number of school-age children who experience mental health problems, and only a small portion of these children are receiving mental health services. According to the National Institute of Health (NIH), “1 in 5 children have had a seriously debilitating mental disorder at some point in their lives” (as cited in Ccrb, 2017, p. 156). Principals, teachers, and other school personnel have the opportunity to help identify children that have mental health needs early and can assist them in seeking appropriate treatment. However, the degree to which educators are equipped with the knowledge, skills, and training needed to help their students in this capacity is still somewhat unclear (Loades & Mastroyannopoulou, 2010). A study conducted by Frauenholtz et al. (2017) revealed “many school staff experience challenges in supporting students because of their limited mental health knowledge, particularly in the areas of symptom identification, psychotropic medication, and community mental health services” (p. 71). According to Carlson and Kees (2013), “Mental health functioning is increasingly acknowledged as a vital component of effective learning and academic success for all students in schools” (p. 63).

Purpose

The purpose of this study was to examine the understanding of children’s mental health services among Arkansas public school principals. The ultimate goal of the study is to determine whether or not Arkansas public school principals have the understanding, education, and/or training needed to adequately identify and to assist their students in need of mental health services.
This chapter describes the research design and methodology that was used for this study. It outlines procedures that were used to gather the data for the study, as well as the methods that were used to analyze the data that was collected. The chapter describes the following: (a) the research questions, (b) the research design used in this study, (c) the data collection and data analysis procedures, (d) the instrument used in the study, (e) the population and selection of the sample for the study, and (f) the ethical considerations associated with the study.

**Research Questions**

The guiding question for this research study was the following: To what extent do Arkansas public school principals have the knowledge, skills, and dispositions to educate stakeholders and advocate for school-based mental health services?

**Research Design**

This research design was qualitative and provided Arkansas principals with the opportunity to explain their level of knowledge, skills, and dispositions related to mental health services for students enrolled in their school. The survey data collection design was chosen intentionally. With the rapidly increasing number of students dealing with mental health issues, educators need to have an understanding of what their role is in supporting the whole child. Qualitative data collected through research takes into account the relevant work that takes place each day through a concise set of questions focused on the problem. Patton (2015) describes the benefits of qualitative research in the following manner: “Qualitative inquiry documents the stuff that happens among real people in the real world in their own words, from their own perspectives, and within their own contexts; it then makes sense of the stuff that happens by finding patterns and
themes among the seeming chaos and idiosyncrasies of lots of stuff” (p.12). School principals from across the state were invited to respond to the survey with the goal of collected sufficient data to be able to identify the patterns and themes related to the challenges that principals face related to student mental health.

Data Collection / Data Analysis

I constructed a survey that was emailed to all public school principals in Arkansas. The Arkansas Leadership Academy (ALA) assisted me by providing a list of email addresses for all Arkansas principals. (See Appendix A for correspondence with ALA). The survey consisted of a series of both closed- and open-ended questions that were expected to tell a qualitative story of principals’ understanding and access to mental health service for students (Patton, 2015). The perceptual survey data outlining the educators’ personal experiences was collected and analyzed to determine trends in levels of mental health knowledge and training that Arkansas principals have received.

The data was analyzed qualitatively to look for emerging patterns or themes. Patton (2015) states, “Qualitative analysis transforms data into findings. No formula exists for that transformation.” (p. 521). Descriptive analysis of the survey data was conducted as well as qualitative analysis of the open-ended responses using content analysis and frequency counts. Interpretation of the data is presented in detail in Chapter 4.

Instrumentation

According to Patton (2015), “In qualitative inquiry, the person conducting interviews and engaging in field observations is the instrument of the inquiry” (p. 33). For this study, qualitative methodology was employed in the design of the survey
instrument. (See Appendix B for the invitation letter to participants and survey instrument). I created and piloted the survey prior to administration to determine content validity. Burns et al. (2008) states that content validity “is best performed by experts (in content or instrument development) who evaluate whether questionnaire content accurately assesses all fundamental aspects of the topic” (p. 249). Adjustments were made based on the feedback received from the participants in the instrument pilot. The survey was administered to all Arkansas public school principals. The electronic survey was administered via Google Forms and survey data was collected for two weeks. At the end of the two-week period, the researcher had enough participation for a representative sample, so the survey was then closed.

The survey included both closed and open-ended questions. The beginning sections of the survey consisted of items related to participant demographics. The next section included categorical constructs and open-ended questions related to the mental health training, education, and perception of effectiveness of the participants. The same questions were asked of each respondent, and participation was voluntary.

Demographic information was collected at the beginning of the survey to determine participants’ background information. Participants were asked to identify their job title, years of experience in education, age of students they educate, and location of school they are employed in. Participants were then asked a series of questions specific to their level of education and training in mental health, as well as their perception of their effectiveness to meet the mental health needs of their students.
The Role of the Researcher

According to Patton (2015), in qualitative research, “The inquirer’s skills, experience, perspective, and background matter” (p. 33). The reason that I chose this study is because of my background, experience, skills, and training. As a former school counselor who later decided to become a principal, I see the needs of children through a different lens than most administrators. With a background in supporting mental health services, I realize that children’s behaviors are manifestations of much deeper issues that must be addressed before they can achieve academically. Yet, for many of my peers, the growing number of students experiencing mental health and behavioral disorders is overwhelming. The majority of the teachers in my school building have expressed their frustration with not being able to understand and to assist children who are experiencing mental health issues. The tasks of trying to move students to grade-level academic performance and to meet social-emotional needs are daunting for most.

The idea of reflexivity is based upon the relationship between the researcher’s position and the population group, as well as how the researcher’s backgrounds, experiences, and decisions that impact the meaning and context of the research (Berger, 2015). The degree of the researcher’s familiarity with the participants’ experiences could potentially influence all aspects of the study. In surveying other Arkansas principals, I must examine this idea of reflexivity and understand that my personal experiences and biases may influence my study and research findings if I am not fully self-aware. My goal is that the research findings of this study will depict the current reality in Arkansas and will help our state to make decisions in moving forward to support children’s mental
health. A reflection on my positionality as it relates to the results of this study are explored in detail in Chapter 5.

Participants

Arkansas public school principals received the survey and were invited to participate. At the time of the data collection stage of the study (November 2018), 998 potential participant emails were provided through Arkansas Leadership Academy. This number compares positively with the Arkansas Department of Education Data Center data collection for 2017-2018, which documented 1060 school principals across 1,053 K-12 public schools in Arkansas (Arkansas Department of Education Data Center, 2017-2018).

Study participants were asked to provide their years of school leadership experience, level of school they work in, and school demographics. Out of a total of 998 invitations to participate, 133 school principals responded to the survey. With 13.3% responding, it was determined that an appropriate sample size was obtained. The informed consent/permission to participate was provided electronically at the beginning of the survey (See Appendix C for the Informed Consent Form).

Data Collection Timeline

The survey was emailed to a current list of Arkansas principals provided by the Arkansas Leadership Academy for a week during November 2018. The survey data was collected via a Google Survey and converted to an Excel spreadsheet for coding purposes. Themes in responses were analyzed and put into an outline format for the purposes of providing a rich description of respondents’ mental health knowledge, skills, and dispositions identified in the survey. The outline was color-coded by level of school
and sorted by years of experience. Results of the survey are discussed in Chapter 4 of this dissertation, followed by lessons learned and recommendations for action and future research in chapter 5.

**Ethical Considerations**

This study is intended to contribute to the literature regarding school based mental health and the level of education and training of Arkansas public school principals. The information and data collected will be kept in confidence and no identifying information was used. No sensitive questions were asked of respondents. Participation in the survey was voluntary and there was no risk to participants in this research study. Permission was granted through the Institutional Review Board (IRB) prior to conducting any research.

**Limitations**

This study had several limitations. First, the study was qualitative in nature and therefore may lack reliability and validity data when compared to quantitative studies. As a result, this study could have earned more credibility if coupled with quantitative research. For example, a quantitatively designed survey could have been employed, coupled with subsequent statistical analysis, to offer evidence that might have helped strengthen the findings gained from the qualitative research instrument used in this study. Next, the analysis of the data and findings is subjective, and a more objective system could provide greater reliability. Also, the results of the study are specific to Arkansas public school principals and should not be generalized to other states.

Additionally, it should be acknowledged that self-report bias may exist in the results as the participants’ responses could be a result of their recent experiences with
certain mental health providers. Therefore, the findings of this study may be influenced by the characteristics of participants who volunteered to participate in this study. It should be noted that their characteristics or views might differ from the other Arkansas principals that did not volunteer to participate in this study.
CHAPTER 4

RESEARCH FINDINGS

The goal of the research was to determine the extent to which Arkansas public school principals have the knowledge, skills, and dispositions to educate stakeholders and advocate for school-based mental health services. This study documents the perceptions, experiences, and training of principals in the area of mental health. In this chapter, the context of the study and the findings of the research are discussed.

Overview of the Study

Educators are often the first adults on whom students depend and turn to when struggling with mental health issues. The challenge arises when adults are not properly trained to address the mental health concerns (Lahey, 2016). Mental health is developed early in a child’s life and elementary school educators play a significant role in ensuring that students have the opportunity to achieve mental wellness and positive behavioral health (Fernandez & Vaillancourt, 2013). Many educators depend upon the expertise and assistance of qualified, trained mental health providers to assist their students in need. For many students, school-based mental health services can help address and treat their mental health concerns. In fact, access to school-based mental health services and supports has a direct impact on students’ physical and psychological safety; as well as their social-emotional learning and academic performance. Children who are struggling physically, socially, emotionally, or psychologically simply cannot learn to their optimal ability (Fernandez & Vaillancourt, 2013).

School principals play a substantial role in assisting students in accessing mental health services as gatekeepers of programs at individual schools. Principals often depend
upon teachers, school counselors, and other personnel to make referrals concerning students’ school-based mental health needs. In order to best meet the needs of all students, school personnel need appropriate training in mental health basic skills, information on the topic of emotional and mental health, and established systems referring students to colleagues who specialize in mental health when mental health problems surface (Thiers, 2018).

**Findings and Discussion**

The qualitative findings from the principal survey are presented in seven major areas: (a) Participant Demographics, (b) Principal Preparedness (c) Referrals for School-Based Mental Health Services, (d) Staff Mental Health Training Needs, (e) Available School-Based Mental Health Resources, (f) Effective School-Based Mental Health Strategies, and (g) Additional Information Needed to Better Support Mental Health.

**Survey Findings 1: Participant Demographics**

![Figure 1](image-url)
The participants for this study included all Arkansas public school principals. There were 998 emails obtained through Arkansas Leadership Academy and surveys were sent out with a participation rate of 13%. Of the 133 participants who responded, 50 were new principals with one to five years of experience; 34 had six to 10 years of experience; 21 were in years 11 to 15; 18 participants had 16 to 20 years of experience; and the smallest group, only 10, had over 20 years of experience as a principal. To put it in perspective, 63.2% of the participants in this study have been a principal for ten years or less (See Figure 1). In addition, the majority (61.7%) have only served in their current position for one to five years (See Figure 2). Over half (54.9%) of the respondents lead
an elementary school, 25.6% serve in a high school, and 19.5% stated they were in a middle/junior high school (See Figure 3).

**Survey Findings 2: Principal Preparedness**

Arkansas public school principals lack training and preparedness in the area of mental health. Over half of the respondents reported that they had taken zero or one courses related to psychology or mental health. Less than half (38.6%) reported that they had completed two or three related courses. Only 3.8% of the participants had taken four to five courses in the areas of psychology and mental health, but 8.3% reported that they have taken more than five (See Figure 4).
When asked if they felt that they would benefit from additional mental health training, 87.9% reported that they felt it would be beneficial. Only a small portion (9.1%) of participants reported that they did not feel that additional training would be beneficial for them. One principal specifically stated that they have too much on their plate already and that they have counselors in the area for these types of services (See Figure 5).

Four of the participants provided additional insight into the question posed about possibly receiving additional training. Three of those that responded were elementary principals with 16-20 years of experience and one was a principal of a middle/junior high school with 1-5 years of experience. One person responded that they were currently receiving additional training provided through Ozark Guidance Center. The middle/junior high principal stated that it depended on exactly what type of training would be provided. One experienced elementary principal stated, “Yes, if specifically focused on what to look for in students who are struggling with mental health issues. Also, I see value in a focus on community building and developing a school culture that is supportive to mental health and resilience.”
The survey asked the principals if they had attended any professional development on the topic of mental health. The majority (69.2%) stated that they had, while 30.8% reported that they had not. To determine the perceived quality of professional development that principals had participated in, the respondents that answered that they had attended professional development related to mental health were asked to rank how well they felt that the training prepared them to assist students with mental health issues (See Figure 6).

![Figure 6](image)

A Likert scale was used in which 1 represented “Not Prepared” and 5 represented “Very Prepared.” Three respondents (3.2%) gave an answer of 1, or “Not Prepared.” Only one participant (1.1%) reported a value of 5, or “Very Prepared.” Almost half (47.9%) of the surveyed principals chose a value of 3, or “Somewhat Prepared,” followed by 30.9% reporting a value of 4, or “Prepared,” and 17% assigning a value of 2 or “Somewhat Unprepared” (See Figure 7).
To determine their self-perceptions of preparedness, principals were asked how prepared they feel to refer students in need of mental health services to a qualified mental health provider. Again, a Likert scale was used in which 1 represented “Not Prepared” and 5 represented “Very Prepared.” The majority (69.7%) of the participants responded with values of 3 (“Somewhat Prepared”) and 4 (“Prepared”), followed by 15.9% reporting a 2, or “Somewhat Unprepared.” Once again, the smallest percentages were reported in the more extreme categories of a (“Not Prepared”) and 5 (“Very Prepared”) (See Figure 8).
To determine additional self-perceptions of preparedness, principals were asked how prepared they feel to identify students in need of mental health services. Once again, a Likert scale was used in which 1 represented “Not Prepared” and 5 represented “Very Prepared.” Most participants fell right in the middle of the scale. The highest percentage (38.5%) of the participants responded with values of 3 (“Somewhat Prepared”), closely followed by 32.3% choosing a value of 4 (“Prepared”). Only 15.4% reported a 2, or “Somewhat Unprepared.” Similar to the previous two questions, the smallest percentages were reported in the more extreme categories of a (“Not Prepared”) and 5 (“Very Prepared”) (See Figure 9).

The final question in this category asked principals if they felt that principal preparation programs need to add additional courses related to mental health into their required coursework. The majority of the participants (85%) answered yes, that additional courses should be added. Only a small percentage (12%) answered “no.” One experienced middle/junior high level respondent wrote in “All.” An elementary principal stated, “Maybe not a full course, but some training regarding social services and other
mental health issues in public schools.” One high school principal with 1-5 years of experience responded, “Many districts now have mental health professionals within the district to assist and evaluate students.” Another experienced elementary principal added, “I think only job embedded training is beneficial here. More courses by college professors wouldn’t be worth much. Training early in a principal’s career so he/she is actually practicing strategies and responding to coaching from a mental health professional would be beneficial” (See Figure 10).

**Survey Findings 3: Referrals for School-Based Mental Health Services**

<table>
<thead>
<tr>
<th>What percentage of students in your school receive mental health services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>132 responses</td>
</tr>
</tbody>
</table>

![Pie chart showing percentages of students receiving mental health services](image)

The participants in the study were asked to report the percentage of students in their school that receive mental health services. The majority (84.1%) reported that 1%-25% of their students receive services. Another 9.1% reported that 26%-50% of their students currently receive mental health assistance. The final 6.8% of respondents said that they did not know how many of their students receive mental health services. No principal in the study reported that over 50% of their students receive services. These findings correspond with the reported 1 in 5 students that experience mental health issues,
as reported by the Child Mind Institute (2016) and The Centers for Disease Control and Prevention (2018).

To determine which staff members refer students for mental health services, principals were asked who typically makes the mental health referrals in their building. Participants were asked to mark all that apply from the choices of principals, assistant principals, school counselors, and/or teachers. Overwhelmingly, school counselors were the most chosen staff members who make mental health referrals (91.7%). Principals were next with 43.6% noting that they refer students for mental health services, followed by teachers (24.8%), and assistant principals (19.5%) (See Figure 12).
Survey Findings 4: Staff Mental Health Training Needs

Figure 13

Principals were asked if they felt that their staff would benefit from mental health training. Almost all of the participants (95.5%) said yes, that they feel additional training would benefit their staff. Only 3.8% replied “no.” One elementary principal with 6-10 years of experience wrote, “We are an academics facility not a mental health facility, so I do believe it is important for my staff to recognize mental health issues so they can make informed recommendations for their learners.” No other specific responses were reported for this question (See Figure 12).

Survey Findings 5: Available School-Based Mental Health Resources

Figure 14
To determine whether or not educational leaders in Arkansas feel they have the resources they need to help students in need of mental health services, they were asked whether or not they felt that they have the resources available in their schools to meet the mental health needs of their students. Right at half (49.6%) of the participating principals responded with “no,” while 39.8% reported “yes” (See Figure 13). Of the 14 specific, open-ended responses received related to this survey question, all were provided by elementary principals with the exception of one middle/junior high principal one high school principal. One elementary level principal simply stated, “We have school-based mental health services.” When analyzing the open responses from this question, several themes emerged among the findings and were categorized for discussion below.

**Severity.**

Four of the Arkansas principals surveyed in this study reported that whether or not their schools had the available resources for mental health services was dependent upon the severity of the mental health issues that students face. One participant reported, “We can meet the mental health needs of the majority of our learners, but a small percentage are clinical for which we do not have the time or resources needed to best meet the needs of this small percentage while ensuring the safety of all learners.” When asked if they felt that they had the needed available resources, one responded replied, “To some extent. It depends on the severity.” The high school principal that provided a specific response simply stated, “Not for students with severe mental illness.” While most of these responses yielded the finding that students that suffer from severe mental health disorders are not afforded the resources needed to address their mental health need,
one participant noted that they know where to refer students if they find that they cannot meet the needs of their students.

Providers.

The extent to which principals felt they had the available resources needed to help students with mental health needs was also dependent on the mental health providers they have access to. Quality and availability of mental health providers is key to assisting students with mental health needs. The middle/junior high level principal that provided a specific response stated, “Our school counselors do an outstanding job; however, they are not mental health providers so we refer ours out to local providers. We have 5 providers who currently come into our school to provide services.” Finding providers that are good in a school setting is important school-based mental health. One respondent agreed when they wrote, “Most of the time, it can depend on the person helping us provide. We are very lucky to have the support this year but in years past has been more difficult.”

Another issue with some providers deals with which students they will treat. As evidenced by responses throughout the research findings, it appears that the type of insurance and pay source that a student has determines whether or not they can receive services and if they qualify, can determine the amount and quality of the treatment they receive. When discussing whether or not they have the available resources needed to help meet their students’ mental health needs, one elementary principal answered, “Those who have established Medicaid have access to SB therapy with OGC, but those without Medicaid or those with private insurance have limited resources.”
Growing need.

Six principals surveyed indicated the growing need for mental health resources in their schools. One participant stated that they have the needed available resources but they are not sufficient to meet the growing need in their school. Another concurred, “Yes, but need more training and help for students with the most severe issues.” One principal responded with a specific suggestion for improved resources when they stated, “Yes, but we always need more. There’s a need for 7-9 of our 720 students to have an Alternative Learning Environment (ALE) where their learning and mental health needs could be met.”

While some principals felt that they had resources, but could use more, another simply stated that they do not have enough services. One respondent reported, “We are seeing a growing need for more resources to help meet the mental health needs of our students.”

Survey Findings 6: Effective School-Based Mental Health Strategies

To determine the types of strategies that principals have attempted and which ones have been successful when helping students in need of mental health services, the survey asked Arkansas principals to describe the most effective strategies that they have used to improve students’ mental health in their schools. Several themes emerged among the strategies provided by principals that participated in the study.

School-based mental health.

When describing their most effective strategies to improve mental health for students, eight principals that participated in the survey specifically mentioned school-based mental health services. Six of the eight principals that responded were elementary
level; one was middle/junior high level; and one was high school level. They discussed
the therapy sessions provided by licensed clinical counselors. The middle/junior high
participant shared that they have counseling services on-site and are starting to conduct
monthly on-site visits with a doctor. Another principal spoke of the importance of the
relationship with mental health providers on campus when they stated, “We work closely
with our provider, OGC, and our SPED department.” Many of the strategies discussed in
the remaining sections all reference school-based services.

**Personnel.**

There were an abundance of references to school personnel listed in the survey, as
60 specific comments were made in reference to this topic. While some of the
stakeholders are employed inside the school building, others are contracted out with local
agencies and providers. Regardless of the employer, it was evident throughout the
findings that it is crucial that all of the employees and providers referenced in the study
must work together in order to ensure appropriate and adequate mental health services for
all students.

**School counselor.**

As referenced in Survey Findings 3, school counselors typically make referrals for
students with mental health needs (See Figure 11). They are also often the linchpin of
making sure that all parties come together to ensure that students’ needs are met.
Oftentimes, school counselors are the first person that a student is referred to if there is a
suspicion of mental health issues. School counselors provide counseling services to
students and make referrals to more highly specialized providers when needed. Such
strategies were referenced by 20 participants in the survey. The specific responses made
in reference to school counselors were from principals of all levels and with differing years of experience. One elementary principal stated, “Our counselor works with individual students, small groups, and whole groups to develop positive character, process issues, and provide resources to students.” Many times, school counselors provide preventative services and work proactively to catch students early who display characteristics of mental health disorders.

With all of the demands of the modern-day school guidance counselors, many lack the ability to devote much time to meeting the mental health needs of their students. In Arkansas, state officials are advocating for school counselors by asking administrators to reduce some of the “extra” duties that have been assumed by school counselors in recent years. Some principals are recognizing this and are taking action to assist school counselors in being able to better support students’ mental health needs. One middle/junior high level principal who participated in the study reported, “I have a full time counselor (i.e. counseling is all she does). I think it is CRITICAL to limit the extraneous duties of our school counselors.”

District social worker/psychologist.

As the need for mental health services continues to grow, more schools are recognizing the need for full-time trained personnel to assist with students’ mental health needs. As a result, districts are beginning to employ their own mental health personnel, such as social workers, and psychologists. Districts that choose this option have greater flexibility with the amount of students to serve and the time allotted for mental health services in their schools. In this study, two principals indicated that the use of these
district mental health practitioners is an effective strategy in working to meet the mental needs of their students.

**Collaborative school team.**

Throughout the study, the importance of a collaborative approach to mental health treatment was highlighted. Along with the growing need for mental health services, schools are also recognizing that it takes everyone working together to address the social-emotional needs of all students. In the findings, participants of this study spoke of a “team approach” and a “WRAP around support system” as effective strategies used in their schools. One elementary principal noted that they have a counseling degree which has helped them tremendously in assisting students with mental health needs. The same participant also spoke about a Behavioral Interventionists who assists them with mental health situations as needed. Another elementary-level respondent spoke about a Behavioral Interventionist, but noted some limitations when they stated, “We have the use of a behavioral mental health therapist that can assist with these students but only if they are sped students. We also have some outsourcing for mental health care at our school. They provide therapy and we have a Dr. that comes to school once a month to help with medication.”

The efforts of the school team must be coordinated and work to focus on a whole-child approach. One middle/junior high principal describes this collaborative approach in their school, “The school counselor, student services coordinator and principal meet every other week, or more often if needed, to touch based on students who are receiving school based services and to discuss any “at risk” students. Teachers email any one of us to share info on a student whom they feel may need ‘checked in on’. The student services
coordinator does not have a mental health degree, but does hold a teaching license and worked as a case worker at one point. Working together as a team, we try to connect students to whatever services they need. Sometimes the school counselor can meet the students’ needs, sometimes the coordinator is the one checking in on students weekly or as needed, and sometimes students are referred to school based counseling services through and outside provider.”

**Outside agencies/mental health providers.**

The most effective strategy referenced by principals in the study was that our outside agencies and private mental health providers. There were 33 specific responses in the findings that outlined agencies, such as OGC, Youthbridge, Therapeutic Family Services, Life Strategies Behavioral, and Consolidated Youth Services. Specific counseling strategies, such as family counseling, one-on-one counseling, and group counseling were also referenced in the findings. Principals of all school levels and with a variety of levels of experience mentioned having both case managers and therapists on their campuses provided by outside agencies. Some schools mentioned that their outside providers were only on their campus once a week; while others noted that they have providers on-site multiple days per week. Some stated that they receive daily services from an outside provider.

While the mental health services provided directly to students by the outside providers are important, many participants in the study discussed their strong partnerships with the outside agencies as key to a successful working relationship. Most respondents spoke positively about the effectiveness of the services provided by the outside agencies. One high school principal stated, “Our students meet with counselors from outside
agencies, they do a good job of meeting our needs. Our staff also does a good job of listening and dealing with our students until they feel it needs to be referred but this is where more training is needed.” Another high school level participating principal shared, “I work together with Therapeutic Family Services counselors and my students to make sure we are providing the best possible mental health care that we can. Together we create a plan of action for any students that are struggling with mental health related problems.”

The ability to access outside providers has allowed many schools, particularly those in areas with limited training and resources, to provide more in-depth services to their students with mental health needs. For many school practitioners, qualified therapists that come into the school offer an additional support. One principal shared, “I rely on OGC quite a bit. I talk to the students and attempt to help them in any way I can. I really don’t know beyond that. My level has so many moving parts in the heads of the kids. It is very hard to deal with them. We do need an in-house paid mental health specialist. The regular high school counselors are not equipped to deal with all of this.”

Although most of the services provided by outside agencies benefit most students and staff, there are a couple of limitations that occur when contracting with an outside agency. One elementary principal reported, “We do have an outside counseling provider come into our school. Unfortunately, they can only see students who are on Medicaid. They cannot see students who have private insurance.” Sometimes, the services are helpful, but the school staff members continue to lack the training on how to best support students receiving school-based mental health services, as evidenced when one middle/junior high principal responded, “We have a contract with a mental health
provider that is located on our campus. Once we have a student that has mental health issues they are readily available to assist in whatever services we need. Even though we have them on campus, our staff is not trained on the strategies they can use to help the students out.” Another respondent concurred with the lack of staff training when they stated, “Our students meet with counselors from outside agencies, they do a good job of meeting our needs. Out staff also does a good job of listening and dealing with our students until they feel it needs to be referred, but this is where more training is needed.”

Safe place.

Seven participants in the study listed a safe place or cooling off area as an effective strategy used to meet their students’ mental health needs. Used as a preventative intervention for students that quickly escalate or withdraw, these rooms can provide additional support for students in need. One elementary principal reported, “Calm room and sensory room have helped tremendously. We also are starting to implement SEL curriculum. Biggest help has been the addition of a behavioral interventionist on staff.” Other participants listed calming strategies, a sensory room for decompression, cooling off areas and positive words of encouragement, and using a time out away from the classroom. As more schools take a proactive approach to discipline, more districts may implement similar strategies as a behavior management or behavior intervention tool.

Training for teachers.

Teacher training is key for effective behavior and mental health support. As discussed later in this chapter, the need for additional training for staff on the topic of mental health is imminent. However, for some proactive schools in Arkansas, teacher
training has already proved to be an effective strategy for better supporting students’ mental health needs. Ten principals reported specific responses related to teacher training in the survey findings. Awareness of mental health alone is crucial. Generalized training in areas such as growth mindset and reducing stressors in students were listed as helpful tools. One middle/junior high level principal responded that they train their staff on ways to identify students who would benefit from mental health services and educate them on how to handle situations from there.

While generalized training was reported to be helpful, two participants reported that specific programs such as Conscious Discipline and Capturing Kids Hearts have been used to assist educators in managing student behavior. One middle/junior high principal stated that their staff had just been trained in Capturing Kids Hearts. An elementary principal reported, “We adopted Conscious Discipline years ago. That program helps teachers understand how to regulate their own emotions and then in turn be able to teach students how to self-regulate. Our school family talks a lot about emotional health and feelings. That has helped tremendously in this high poverty, high needs school.”

**Tiered mental health system.**

A tiered system of mental health support is becoming more common in schools, as educators are using such an approach in academics as well. Interventions are based on specific student needs and are monitored for effectiveness similar to academic interventions. One respondent stated, “We treat students needing mental health services like our student needing academic services. They move through the Response to Intervention (RTI) process with our counselor before referring to Mental Health outside
of school.” Another participant described their tiered approach when they reported, “Our Tier 1 mental health instruction is generic, as it should be. However, once a student reaches a place where they need Tier 2 mental health services, we begin to do focused peer groups and individual counseling. The focused peer groups are effective most students in Tier 2. We still have a lot of students that need more mental health assistance. Those students are referred to outside agencies.”

Other principals who participated in the study made reference to this tiered approach in the data collected through the survey. One principal spoke about a strong Tier 1 social-emotional curriculum that they are using entitled, “Choose Love.” Another spoke about the importance of getting students referred for the services they need as soon as possible.

**Preventative education/intervention.**

Taking a proactive approach to mental health is the best way to ensure that educators can be as prepared as possible when dealing with the mental health needs of students. The more training and education that educators have, the better they can support and intervene for students experiencing a mental health crisis. By providing mental health education for staff and students, building relationships with students, implementing positive behavior supports, and increasing parental involvement, students will have a better system of support to help them with their social-emotional needs. In this study, 33 (48%) participants provided specific responses related to the effectiveness of preventative education and intervention programs in their schools. The responses were grouped into themes and discussed in the following subsections.
Mental health education.

In order to know how to best help students, educators must be trained on mental health needs. However, educating students on social-emotional learning is also an effective strategy that schools in Arkansas are using to help support mental health in schools. Specific responses related to the effectiveness of education were provided 20 times in this study. One elementary principal stated that they are simply working to be proactive and talking about issues. The findings show that character education programs, guidance groups and lessons, and effective advisory programs provide natural avenues through which to educate students on topics such as conflict resolution, good listening techniques, differences, and making good choices, as well as how to handle anger, hurt, and conflict. Teaching students that they have value, increasing awareness of mental health issues, and providing access and availability of individuals to talk to students in need are also noted strategies among participating principals. One high school leader reported that their school holds a mental health week and do some public service announcements on it to promote it to stakeholders.

More recently, specific programs are being introduced into schools that were reported as effective strategies. Conscious discipline strategies were listed by a participant. Three respondents listed a social-emotional learning curriculum entitled “Capturing Kids Hearts” that teaches educators how to deal with students, as an effective education tool. One principal said that they are implementing the Jesse Lewis Choose Love Movement that teaches coping strategies for anger and/or anxiety. Another respondent shared that they were participating in the BX3 pilot program. One high school principal explained, “We use the Heartbridge curriculum taught by our ALE
instructor in a class period offered daily and with our entire student body in an assembly once per week. The Heartbridge program instructs students in the Growth Mind Set.” An elementary principal explained a program they are using when they shared, “Use of Kagan team building activities impacts the learning environment and supportive atmosphere experienced by all students. We have a counselor who is focused on family issues much like a social worker and she coordinates testing which frees up our campus counselor to work with students. We also have Western Arkansas Counseling and Guidance on campus with one therapist and one caseworker.”

**Relationships.**

One surprising, but encouraging finding from this study was the amount of Arkansas public school principals that discussed the relationship building that educators are engaging in with students in schools all across the state. The findings show 21 participants who discussed the implementation and use of adult mentors, mentor relationships with staff members, mentoring, clubs, and advisory groups into their schools. Others discussed building relationships with teachers that allow one-on-one time for them to build trust and connect with students on a higher emotional level.

Knowledge of students is not only a component on the Arkansas teacher evaluation system, but it is a critical piece of relationship building with students. The findings from the survey indicate that schools are working to find ways for staff to get to know students and are having success with doing so. One elementary principal stated, “We try to provide a safe and nurturing environment where we get to know the students as individuals, along with their support systems.” One important component of this process was noted by a high school level participating principal when they shared,
“Keeping teachers informed of information pertaining to their students that could affect their mental health.” One middle/junior high level principal shared how they are working on getting to know students better when they reported, “Conversation & communication. Finding the history of the student and knowing what triggers their stress. Providing safe places to de-stress and availability to our school counselor.”

Creating a safe and supportive environment is also a component of the Arkansas teacher evaluation system and was reported in this study multiple times as an effective strategy for supporting students with mental health needs. One elementary principal shared, “Creating an emotionally supportive environment at school, Positive Behavior Reinforcement, Build relationships with students and families.” One high school principal spoke about how they are working to ensure that they speak to students every day, even if it is just a “hi.” They noted that they are working to always offer help and assistance. Another high school level respondent discussed developing a positive rapport with students so that they feel comfortable letting educators know if they need assistance. In their school, they are working to get them engaged in clubs and activities. One middle/junior high school administrator said that they have an open door policy between administration and counselors with students. All of these strategies help to increase communication between students and staff, and helps with early identification of serious issues such as mental health disorders.

**Positive behavioral interventions and supports (PBIS).**

Positive behavioral interventions and supports (PBIS) is a multi-tiered approach to providing social, emotional, and behavioral support to students. The goal is to improve social, emotional, and academic outcomes for all students, including students
with disabilities and students from minority or underrepresented populations (OSEP Technical Assistance on Positive Behavior Interventions and Supports, 2017). In schools all across Arkansas, PBIS is rapidly becoming part of their normal daily operations. In this study, 14 participants spoke of the use of behavioral charts, behavior contracts, behavior plans, positive reinforcement, classroom meetings, safe environment, and extra support that typically exists in a PBIS school. One principal spoke about using needs assessments for students while another listed how they are incorporating “seeking first to understand.” All of these strategies were reported as effective in schools around the state.

**Parent involvement.**

The findings from the survey report a consensus in the importance of parent involvement in assisting and supporting students with mental health needs among all school levels. In the study, participants reported using strategies such as parent conferences, working with the parents to create a structured environment, calling the parent or case worker so that students can have a therapy session with them, and having an open door policy for students and parents as tools to increase the partnership. One principal described their approach when they shared, “Working with the school-based mental health staff to help students and their families find and receive services to support and improve mental and behavioral health.” The importance of a collaborative approach is recurring and evident throughout the findings of this study, which is an integral part of the Distributed Leadership Conceptual Framework.

**Survey Findings 7: Additional Information Needed to Better Support Mental Health**

To determine how to assist Arkansas principals in supporting improved mental health among their students, the survey asked the participants to share what they needed
to know more about in order to better support children’s mental health in their schools. There were 124 comments and suggestions provided through the open-response questions contained in the survey instrument. When sorting through the research findings, several primary themes emerged which give insight into what might best help Arkansas principals in supporting their students with mental health needs.

**Access/treatment providers.**

From the data, it is clear that Arkansas principals feel that their students need better access to services, as well as more providers to help treat mental health disorders. Around 10% of survey participants provided specific comments regarding the need for more access and treatment options for their students. One of the biggest challenges that the participants noted was the discrepancy in treatment options for uninsured and underinsured students and families. Principals seem frustrated with the fact that insurance companies and policies often dictate the types of services that are provided to students. Those with private insurance appear to be the most underserved population. One elementary principal stated, “Our students that have private insurance cannot receive affordable services. It’s a very frustrating system to navigate.” Another agreed, “We need to be able to service our students who have private insurance better. Most of the school based counseling is only for Medicaid eligible students. This make is difficult for our families to find the time outside of school to see mental health professionals.” Yet another principal reported, “We need help with children who do not have Medicaid that are potentially mentally ill as well as children whose parents do not want OGC services even if they do have Medicaid.”
In addition to the need to serve all students, regardless of pay source or insurance reimbursement rate, ten Arkansas principals specifically reported in the open-response question that they need better access to mental health services, such as access to assistance and programs offered outside of school and support services that are located closer to their community. In rural areas, this can be a difficult obstacle for school administrators to navigate. Not only do the outside provider locations pose a challenge for some students, but participants also shared that they have a need for additional avenues in which to provide mental health care inside of the school facilities. The increased need for additional providers for students under age 18 was another noted item by a high school level principal who participated in the study. One respondent specifically mentioned Attention-Deficit Disorder (ADD) and Attention-Deficit Hyperactivity Disorder (ADHD) treatment as high need areas.

**Attitude/perception.**

As noted in the literature review in Chapter 2, there is often stigma attached to mental health disorders and treatment. In order to move forward with treating children’s mental health deficits, attitudes and perceptions toward mental illness must change. In the study, one principal talked about the importance of changing negative behaviors. This can apply to student and adult behaviors, attitudes, and perceptions. Another principal who responded in this category had a substantially different opinion than the other participants in the study, as evidenced by their comment, “I do not think that schools are the place for supporting mental health. We are here to educate children and have enough of a challenge with the regular students. In my opinion, students with mental health should be in a separate school with counselors on staff and therapist.”
Funding.

One of the hot topics in Arkansas education right now is funding. Everyone seems to be lobbying for the same decreasing pot of money each year. Therefore, it has become more difficult for legislators to determine where to best spend tax payer funds.

In recent months, Arkansas was awarded a $9 million grant for school-based mental health (Arkansas Department of Education, 2018; Talk Business & Staff, 2018; Arkansas State University, 2018). Educators and legislators are recognizing the need for early services. The findings from this study, however, show that Arkansas principals need more knowledge on how to obtain more funding for mental health services in their schools, especially when funds are limited. Another thing noted multiple times in the research data gathered through this study was how schools can work to fund their own mental health therapists. Eight participants provided specific responses related to the need for additional mental health funding. One middle/junior high principal stated, “I need to know more about additional options and/or funding to get more mental health assistance on campus.” Principals from all school levels stated that they could use any help that they could get related to funding and would like to research using grant money to hire a full-time mental health professional.

Legislation.

As previously mentioned, Arkansas legislators have been dealing with the topic of mental health in recent legislative sessions. However, the ever-changing laws, funding sources, and strategies when dealing with students’ mental health needs are concerns of several Arkansas principals. One study participant explained what would help them to be able to better support mental health of students when they stated, “Legislation that would
support public schools in ensuring safety for all learners and that would require parents of learners with severe mental issues to obtain services and complete programs set up for the learner from professionals trained in the field of mental health issues.”

**Resource availability.**

The findings from the data collected through this study indicate that Arkansas principals need more available resources to better support their students with mental health needs. There were 18 specific responses related to the need for more available resources. The findings show that principals not only would principals of all school levels like to know more about resources that they can help students access, but they also need assistance with resources to help parents, as well as resources for them as educators. The survey participants reported that they would also like to know more about how to allocate more to mental health services when resources are limited.

**Parent involvement.**

One important component of treating mental health issues among students is involving the parents in the treatment plan. The findings of this study show that Arkansas principals need assistance in how to involve parents in the mental health service provision for their students. In addition to increasing the involvement of parents, the survey participants said that they would like to know how to better educate parents in ways that they can assist their children. In addition, the respondents reported that they would like to know more about how to get the parents on board with mental health services when their child has an identified need as well as “how to get the parents of the students to follow through with mental health processes.”
**Personnel.**

Without qualified mental health professionals, students are unable to receive the proper treatment. While many of the research participants indicated that they utilize outside mental health agencies and providers in the school setting, most reported that they do not have enough mental health personnel due to the growing number of students with mental health needs. One respondent stated, “As the rate of children who need assistance I think it’s important for districts to have qualified personnel on their staff to better meet the students’ needs [sic].” When speaking of the need in their school, one high school principal reported, “This is an issue that my school does not have enough personnel to address effectively. We need someone who can concentrate on this issue all day long.”

The lack of qualified providers in the schools required to meet the growing mental health needs has resulted in districts around the state deciding to hire their own mental health professionals. School guidance counselors have so many other responsibilities that they are unable to devote the time needed to counseling students. One principal shared, “School counselors need to be free of administrative/secretarial duties (registrar, testing coordinator, etc.) in order to fully devote their time to school counseling. Our district has added the student services coordinator position as well as a career coach to assist in fulfilling these needs.” Another respondent agreed, “I believe schools should have to have mental health professionals in schools full-time. I think with the growing number of behavior issues, it is imperative. The counselors are so overwhelmed with everything they’ve got, we need folks who are focused ONLY on mental health and being proactive, not just reactive.” This growing need may change the way that districts make personnel decisions in the future.
Growing and diverse student needs.

As mentioned throughout the research findings from this study, it is apparent that there is a growing need for mental health among students in Arkansas schools. These growing and diverse student needs have exploded over the past few years, leaving many educators without knowing what to do to best support all kids. One principal shared, “The mental health needs of today have grown, it seems, exponentially in the last several years, due to trauma.” In order to assist students, educators have to be able to know what issues students are facing as well as how to help them when the need arises.

More training opportunities.

Perhaps the greatest need expressed through the findings of this research study is that of additional training on the topic of mental health. Of the 70 responses related to the need for more mental health training, some of the areas of training need expressed in the findings were: A general understanding of mental health, more training on the clinical side of mental health, training on early identification and intervention of mental health in children, additional training on preventative strategies for educators, and specific training on how to work with students in crisis or with mental health disorders. All of these areas will be explored in greater depth in the following subsections.

Training on the understanding of mental health.

Understanding mental health in general is a challenge for many school leaders. In the survey, one middle/junior high principal reported that they held a Master’s degree in school counseling, but still indicated that they would benefit from additional training. That same participant also stated the importance of allowing school counselors to be free of administrative and secretarial duties so that they can fully devote all of their time to
counseling students. An elementary principal stated that they had personally conducted a lot of research, sought out professional development opportunities, and had been a foster parent, which all contributed to their greater knowledge and understanding of mental health. However, they stated that for many school administrators, being privy to that type of knowledge and training is not a reality. They shared, “The typical building principal and teachers are NOT prepared for what we are currently seeing in our schools. The mental health needs of today have grown, it seems, exponentially in the last several years, due to trauma. Many teachers, especially, are not equipped to work in schools like mine (high poverty, high mobility, high minority, high needs in general, high trauma, high discipline incidences, etc.). This results in teacher frustration and inability to cope with student issues on a day-to-day basis. Teacher turnover is higher for schools like mine, resulting in greater student trauma and needs. It is a very vicious, never-ending cycle.”

The need for general mental health training was a recurrent theme in the research findings. Educational leaders said that they are in need of training in ways to determine what help is needed and appropriate for the students, as well as how to educate the parents in how to assist their children. The lack of knowledge on how to help students in need can be a frustrating challenge for educators. One principal stated, “As educators we don’t have the background to know why kids respond in certain ways. My daughter moved into education from a psychology background and is better equipped as a rookie teacher than I am as a 30 year veteran.”

*Training on the clinical side of mental health.*

Although schools are clearly educational institutions, Arkansas principals feel that faculty and staff could benefit from training that deals with the clinical side of mental
health treatment. From how diagnoses are made, to medication decisions and the newest forms of mental health, multiple principals shared that this information could better help them assist their students with mental health issues. One of the high school principals in the study said they would like to know what happens in mental health facilities when they force the most severe kids out that they do not know how to help rather than providing them with a higher level of care.

In the survey, specific examples of clinical training were provided in the findings. One elementary principal who participated in the study stated, “It would be beneficial to know more about the clinical side of mental health services, knowing what resources are available, proven methods of incorporating mental health care in the RTI process.” Another elementary level respondent provided specific clinical information they would like when they listed, “how to respond to a 5 year old with schizophrenia, strategies for bipolar disorder, how meth affects brain development, etc.” As the need for mental health continues to increase, so does the likelihood for the need for additional clinical mental health training for educators.

*Training on early identification and intervention.*

The research data included many responses that signified the importance of early identification and intervention in children’s mental health. In recognizing the importance of intervening for students as soon as possible, the findings of the research indicate that Arkansas principals need training in how to identify students with mental health needs early as well as how to provide specific interventions for them. One participant stated, “I feel like I need more training in how to recognize signs of mental health in students and
have better tools to address these needs.” Another said, “I need to know more about additional options and/or funding to get more mental health assistance on campus.”

In addition to training to help them recognize the early warning signs of mental illness, the participants reported that they would like to know more about coping strategies that they can help teach their students. One respondent requested the need for, “Training in what to look for as alerts for mental health problems in students who might appear to be alright. Need to know how to balance instructional issues with mental health issues across all personnel so that concerns are not overlooked with tragic or hurtful results.” Another concurred, “Recognizing/understanding characteristics of various mental health issues - emotional abuse and trauma specifically. Specific strategies to share with parents and teachers. Navigating the various systems and resources that are available to public schools.”

*Training on preventative and specific mental health strategies for educators.*

The findings from the research suggest the need for additional training on preventative and specific mental health strategies for educators. The administrators included in this study reported that they would like to know more about the causes of mental health issues among their students as well as how to help them overcome their mental health problems. The 32 principals who provided specific responses on this topic spoke about the need for more training on social/emotional curriculums and how to act immediately when dealing with a child in crisis. Some of the respondents indicated the need for behavior intervention including creating behavior plans and goals.

Some of the specific strategies that participants reported that they need more training on include: de-escalating explosive students, students dealing with neglect and
sexual abuse, students that have severe anger issues, students with Autism-Spectrum Disorder, emotionally disturbed children, students that have experienced trauma, and students considering suicide. One recurring theme in this category is the training needed for principals on how to effectively deal with students in crisis. Many times, these students are in a fragile state and need immediate assistance. Educators are often the first adults that can intervene for students in this situation. Therefore, it is important that they have the tools and training to know how to properly assist students to help them rather than exacerbating the situation.

One of the challenges for educators reported in this research was how to help the students with mental health needs, while also ensuring the rights and learning of the other students that may be affected by the behaviors exhibited by the students with mental illnesses. One participant stated that they need additional training on “How to support students with mental illness while meeting the needs of other students in the class/school.” Another said they need additional help as evidenced by their response: “How to effectively deal with these issues. Sometimes it feels like there is nothing you can do to discipline these students because they do not conform to regular discipline. These students have way more rights than other students at our school. We spend the most time disciplining these students and they take away from the learning of others. It is hard for me as administration to know what to do to make sure each party gets the education they deserve.” The findings indicate that this balance is often difficult for educators to maintain and therefore, they need additional training to help them better support all students.
CHAPTER FIVE

CONCLUSIONS

A child’s mental health is developed early in their lives and school personnel play a vital role in ensuring that students have access to quality mental health services when the need arises. Children who are struggling emotionally or with mental health issues are unable to learn to their optimal ability (Fernandez & Vaillancourt, 2013). Education Week Research Center (2015) found, “Developmentally valuable unto themselves, such social and emotional skills are also integral to the acquisition of skills and knowledge related to academic achievement” (p. 2). Although they are often the first person to identify or intervene for a child with mental health issues, many educators do not receive the type of training they need to respond appropriately to students’ mental health challenges (Thiers, 2018).

The goal of this study was to determine the extent to which Arkansas public school principals have the knowledge, skills, and dispositions to educate stakeholders and advocate for school-based mental health services. For this qualitative study, Arkansas public school principals from around the state were surveyed and 133 responded with feedback on the mental health concerns in their schools. The findings of the research were presented in detail in Chapter 4. This information was intended to help school districts, superintendents, principals, school counselors, and teachers better understand the mental health needs that exist in schools across the state. In addition, one goal of this study was to produce findings that might be used to provide board members, legislators, and other policymakers with data that will potentially help guide their decision making processes and ultimately help increase funding and other resources for school-based
mental health services in Arkansas schools. This chapter includes interpretations and implications, recommendations for future research, and conclusions.

**Interpretations and Implications**

**Effective School-Based Mental Health Strategies**

Access to school-based mental health services improves student success not only physically, but socially, emotionally, and academically as well (Fernandez & Vaillancourt, 2013). The research provided insight into several things that Arkansas public schools have been doing to assist their students with mental health needs that have yielded positive results. One of the best supports and resources mentioned by principals in the study is school-based mental health services. Most schools still outsource their mental health services to a private provider and have a partnership where the school provides the mental health personnel space on campus to provide the needed mental health services to students. However, the growing trend seems to be for school districts to hire their own mental health professionals who are actual employees of the district instead of a mental health agency. One of the primary benefits of this approach is the flexibility of the provider to be available at all times rather than just certain days of the week. The district then has the option of whether or not to bill for the provided services to recoup some of the expense of hiring additional staff.

According to the findings of this research, a collaborative school team was one of the most successful approaches to helping students with mental health concerns. These teams typically focus on the whole child and meet regularly to discuss students who are receiving school-based mental health services, as well as any others who are considered “at risk.” School personnel, such as teachers, principals, school counselors, mental health
therapists, behavioral interventionists, school social workers, and student service coordinators were all noted as critical to this collaborative team approach.

The school counselor was perhaps one of the greatest resources for assisting students with mental health needs mentioned in this research study. Oftentimes, school counselors are the first to identify to refer students for mental health services. School counselors typically focus on preventative services and take a proactive approach when teaching guidance lessons and conducting small group sessions. Many times, they counsel individual students until they feel that they need a more intensive level of care and then make needed referrals for mental health therapy. According to Shafer (2017), “Counselors can partner with principals and teachers to foster a school culture that mitigates anxiety and fosters positive mental health” (p. 5). However, with the overwhelming demands of current school counselors, their time spent on assisting with mental health is often limited. As a state, Arkansas is going to have to continue to work to lessen the extra job duties of the school counselor in order to free them up to focus on students with the most critical mental health issues.

Another successful strategy that many Arkansas schools are now using is a proactive approach to discipline. The use of Positive Behavior Intervention Supports (PBIS) and other preventative programs that focus on the social-emotional wellbeing of students is yielding promising results for some districts. One component of this approach is providing a safe place or cooling off area for students with mental health needs. Shafer (2017) stated, “Schools are increasingly designating safe, quiet spaces for students to retreat when they are feeling overwhelmed” (p. 5). This preventative approach helps provide a critical intervention to assist with student de-escalation and/or withdrawal.
While proactive approaches are helping many students, this study shows that many teachers and other educators do not have the education or training needed to introduce and teach these skills or curriculum components to their students.

Another successful approach mentioned in this study is the implementation of MTSS. With the current focus on RTI in districts across the nation, behavioral RTI is becoming just as essential as academic interventions and supports. There are a growing number of programs and companies that are writing social-emotional curriculums based on this tiered approach. Just as finding research-based academic curriculums and program are critical for schools, it is equally as important for schools to research each program carefully and consider the needs of their students and school personnel before purchasing or adopting any curriculum or intervention program.

One of the most impactful and effective strategies mentioned in this study is the focus on intentional relationships between school personnel and their students. According to Capp (2015), a couple of challenges that schools face is in determining how to provide effective mental health services and in understanding how mental health issues affect academics and relationships with other students and teachers. Many respondents in this study also discussed bringing in adult mentors, mentor relationships with staff members, clubs, and advisory programs as avenues to build meaningful relationships with students. Building trust and connecting with students on a higher emotional level helped form deep adult-student connections. This approach was reported to help students become more engaged and involved in school and extra-curricular activities. The study showed that strong, positive relationships also help to increase communication between
students and adults, as well as assisting with early identification of mental health disorders.

Involving parents in their child’s mental health treatment is another effective strategy that some Arkansas schools reported in this research study. Some of the ways that schools are reaching parents is through phone calls, conferences, and face-to-face conversations. This focus on parent involvement fits well into the collaborative approach discussed earlier in this chapter.

Although the principals involved in this study reported several effective strategies that they are employing to meet the mental health needs of their students, there are still many needs that schools across the state continue to face when it comes to school-based mental health services. The next few sections focus on needs that were identified through the survey and outlined in the research findings. In order to best meet the needs of all Arkansas students, educators, as well as policymakers and other stakeholders, should pay particular attention to these needs and work together to identify solutions that will help move our state forward.

**Education and Training**

Arkansas public school principals are continually working to improve the mental health of their students. However, this research showed that in order to lead in this capacity, educators need more training, mental health personnel, and resources. Principals need assistance in accessing effective strategies for shaping and sustaining and interdependent relationship among children’s mental health, the culture of their schools, and the academic achievement of their students (Fernandez & Vaillancourt, 2013). Unfortunately, many educational leaders have not received the mental health education
and training needed to face the growing mental health challenges of their students. A study conducted by Caparelli (2012) found that aspiring school leaders may graduate from their preparation programs without even a working vocabulary or understanding of school-based mental health. If principals are expected to lead in advocating for the growing number of students with mental health needs in their schools, they must have more education and training on this critical topic.

In the study, most Arkansas principals reported that they have taken few educational courses related to mental health. In addition, few if any principal preparation programs require any courses related to social-emotional learning or mental health. According to Caparelli (2012) this is a common issue in other areas as well, as evidenced in his statement, “Addressing children’s mental health needs does not appear to be even a minor focus for some principal preparation programs or for the national bodies that guide curriculum in educational leadership” (p.173).

As a result of the lack of mental health education and training for many Arkansas principals, they are often left without knowing how to help their students with mental health needs. In addition, they may not know how to identify a child in crisis and how to intervene in an emergency situation. Caparelli (2012) stated, “Armed with no training about SMH funding and services and only a minimal grasp of the importance of unmet mental health needs, a school leader may have no reason to seek funding for prevention, early intervention, or intensive services” (p. 166). Just as students come to school in dire need of intense academic intervention, the same is true for their social-emotional health. If these needs go unmet, students are at risk of not being able to succeed in school.
The findings of this study show a need for Arkansas higher education principal preparation programs to consider adding courses that better equip educational leaders to serve students with social-emotional and mental health needs. In addition, based upon these findings, the Arkansas Department of Education should consider requiring some professional development on how to identify and assist students experiencing mental health difficulties. Without proper education, training, and support, principals lack the skills needed to ensure that all students have the opportunity for academic success. Caparelli (2012) stated, “Our future generations rely on their K-12 school leaders not only to ensure their academic and vocational preparation but to recognize and value their emotional and behavioral well-being as fundamental for their success” (p. 174). The principals in this study overwhelming voiced their need for more training and awareness. They specifically requested additional training in the following areas: a general understanding of mental health, the clinical side of mental health, early identification and intervention, and preventative and specific mental health strategies for educators. As a state, educators must come together and continue to voice these needs until additional education and training are available. This is critical to being able to ensure that all students have the opportunity for success.

**Students Not Served**

Access to school-based mental health services and supports directly improves students’ physical and psychological safety, social-emotional learning, and academic performance. (Fernandez & Vaillancourt, 2013). Unfortunately, for many children in Arkansas, their access to services is limited due to insurance guidelines and lack of financial resources. This study showed that many school-based mental health providers
in Arkansas only serve students that receive Medicaid services. The problem is that there are many other students who have insurance plans that do not cover mental health or they have high deductibles and co-pays that make access to services unaffordable. The findings also show that even the students that receive Medicaid benefits and have access to services are now receiving less frequent therapy sessions and a lower level of care due to recent Medicaid funding cuts and new requirements. With the growing need for school-based mental health services, it is more critical than ever that students are afforded the services they need. If we are truly serious in this state about providing a quality education to all students, we must find a way for all students to have access to quality mental health services.

Resource Availability

The findings of this study show a need for more school-based mental health providers in Arkansas public schools. Many participants in the study shared that they simply do not have enough support and resources to ensure that all students receive the mental health services that they need. One issue is that there simply are not enough mental health providers to meet the growing need; particularly children’s mental health needs. Another barrier to accessing qualified providers is funding. Centers for Disease Control and Prevention (2013), there is approximately $247 billion spent each year on childhood mental health in the United States. While many Arkansas schools are researching ways to hire their own mental health professionals, there is no funding from the state to offset this expense. Without additional funding or grant assistance, most districts are unable to afford additional services and are therefore completely dependent upon a partnership with mental health providers. In rural areas and in regions of the state
that have limited resources available, this is an ongoing issue that Arkansas principals are struggling with.

Coupled with trying to find ways to overcome the lack of funding afforded for school-based mental health, school districts in Arkansas are working to change legislation related to this area. Simply stated, the only way to get more funds is for the legislators to re-designate funds for the purpose of school-based mental health services. From this research, a need for additional training for educators in the area of mental health was repeatedly noted. One respondent said that they felt that Arkansas legislators should support the schools in requiring that parents of students with severe mental health issues get their children the services that they need. In addition, legislation could mandate some required coursework in mental health to be completed in principal preparation programs and/or through professional development tied to teacher licensure.

Several principals who participated in the study indicated that while they were satisfied with the quality of services provided for the majority of their students, they were still lacking assistance for their most severe mentally ill students. While outpatient therapy provided in schools is typically enough to intervene for students, there are some that need more intensive services. Without access to resources to help these students, those that are the most in need of assistance could be left without critical intervention. The lack of provider issue indicated in the survey findings coincides with the review of the current literature mentioned in Chapter 2. If Arkansas schools intend to meet the needs of all of their children, we must find a way to get more providers into our schools, particularly those located in rural areas where transportation is often a barrier to services.
Recommendations for Principals

Principals can no longer meet all of the needs of their students alone (Hermann, 2016). The Distributed Leadership (DL) approach helps educational leaders in assisting the whole child through its framework for building capacity. The findings of this study suggest that principals need to find opportunities for additional mental health training. Hermann (2016) states, “Improvement to principal preparation programs, teacher preparation programs, and even staff professional development should be explored to better equip administrators and teachers for the current roles in education today” (p. 95). Advocating at the local, state, and national levels may be required to obtain the funding and legislation needed to drive this process forward. In Arkansas, with the recent grant commissioned for mental health, it appears that the time is right to act now.

Based on the findings of this study, along with the literature related to the DL framework, I strongly recommend that principals embrace DL and seriously consider this collaborative approach to meeting the mental health needs of students. This conceptual framework can also be extended into the realm of how to provide professional development related to mental health to their staff. Embracing the talents of stakeholders in the building only strengthens the leadership of the entire school and allows principals more time and flexibility to better know and understand the needs of their students.

Arkansas principals should also explore how to best lobby for additional funding and legislation to improve mental health in public schools. Platforms such as the state education association could be potential avenues for advancing change. Principals can talk to their legislators, as well as the state board of education, to share the findings of this study and other current research related to the growing mental health crisis in the
state. With the recent grant money allocated to improving mental health in Arkansas schools, now is the time to act!

**Recommendations for Future Research**

Based on the findings of this study and the subsequent discussion, there are several areas for future research that could add to the findings of this study. A similar follow-up study could be conducted on the need for additional mental health education and training for other educators, such as teachers and school counselors. Another similar study could also be conducted using the same instrument from this study to survey public school principals in other states and compare them to Arkansas. A comparative study could also be conducted that would examine schools that hire their own mental health personnel compared to schools that only contract with outside mental health providers. Another interesting quantitative study could be conducted to determine how many Arkansas kids are not receiving the needed mental health services due to insurance restrictions and/or lack of funding. Finally, it would be helpful to research the number of mental health providers in Arkansas that would actually be needed to meet the current and growing need for school-based mental health services.

**Summary and Conclusion**

Hermann (2016) stated, “Educational leadership is complex” (p. 16). In today’s public schools, educational leaders must focus on many more things than the management and daily operations of their school. With the focus on principals being educational leaders rather than managers, academic success has become the priority for many school systems. In Arkansas, state report cards are issued each year with a letter grade attached to each school and district. With high stakes testing and increasing
accountability being placed on students to perform at high levels, being an educator in today’s world is difficult at best.

According to Iachini, Pitner, Morgan, and Rhodes (2015) “Principals are critical to school improvement efforts, yet few studies aim to elicit their perspectives on what contributes to teaching, learning, and broader school improvement” (p. 40). With the focus on academic testing, oftentimes the issues that hinder student success are overlooked. However, schools starting to realize how psychological problems impact a child’s academic performance, behavior, and attendance (Ramirez, 2014).

As leaders of the building, principals should lead their staff in helping identify and assist students with mental health needs. With little to no education on the topic of mental health, educational leaders are perplexed on how to tackle this huge obstacle that exists for many of their students. Lack of resources, funding, and supportive legislation add to the seemingly insurmountable task. However, legislators, policy makers, and educators around the state are beginning to recognize the mental health crisis that we are facing in our schools. It is my hope that the findings of this research study will help move our state forward in providing additional training, funding, and support for school-based mental health. Until we find a way to work together to create solutions, we will not be able to ensure our mission of success for all of our students. The future of Arkansas public education depends on us taking action now.
References


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APPENDIX A
Correspondence with Arkansas Leadership Academy

Email Addresses
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To: Carolee Brash <cbrash@ark.edu>

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From: Carolee Brash <cbrash@ark.edu>
Sent: Friday, October 22, 2010 8:55 AM
To: Jennifer Renee Taylor Medeiros <jrt004@uark.edu>
Subject: RE: Email Addresses

(Signed in Zoho)
APPENDIX B
Invitation to Participate and Survey Instrument

Thank you for agreeing to participate in ARKANSAS PRINCIPAL PREPAREDNESS TO IDENTIFY AND ASSIST STUDENTS WITH MENTAL HEALTH NEEDS, A Building Level Administrator Perspective Survey. Your response will help me complete the qualitative research needed to study my dissertation topic, understanding what Arkansas school principals need to help their students that need mental health services. This study is being completed through Arkansas Tech University, Advanced Leadership Studies. I will use the data obtained through this survey to analyze Arkansas principals' level of understanding of mental health services. If you agree to take part in this study, the survey should only take approximately 20 minutes to complete. The study could potentially offer benefits to the state in guiding professional development to meet identified needs related to understanding and assisting students with mental health needs.

Please be honest and transparent in your responses. There are no "right" or "wrong" answers. All information obtained through this survey will be kept confidential. No identifying school district, building level, or individual data will be collected. The data and results will be securely stored by the researcher until June 1, 2019. In the event of any publication or presentation resulting from the research, no personally identifiable information will be shared.

Taking part in this research study is voluntary. No costs are associated to any participant of the study. No monetary compensation is provided for participation in the study. There is no research funding for this research study. If you choose to take part in
this research, your major responsibilities will include responses to the survey items included in the survey link. If you choose to take part in this research study, you have the right to stop at any time. If you decide not to participate or if you decide to stop taking part in the research at a later date, there will be no penalty or loss of benefits to which you are otherwise entitled.

Should you have any questions about this survey or regarding your rights as a research participant, please contact me at cbrasell@atu.edu or cbrasel@yahoo.com. If you prefer, you may also contact my dissertation chairperson, Dr. Ellen Treadway, at etreadway@atu.edu or 479-880-4901.

I look forward to your participation in this survey. For more information about participation in a research study and about the Institutional Review Board (IRB), a group of people who review the research to protect your rights, please visit Arkansas Tech University's IRB website at: https://www.atu.edu/research/human_subject.php. Included on this website under the heading "Participant Info", you can access federal regulations and information about the protection of human research participants. If you do not have access to the internet, copies of these federal regulations are available by calling Arkansas Tech University at 479-968-0319.

The initial question will be the Informed Consent to participate in the survey. If the question is answered “Agree”, the participant will continue to the survey. If the participant answers “Disagree”, the survey will end.

ELECTRONIC CONSENT

Please select your choice below. You may print a copy of this consent form for your records. Clicking on the “Agree” button indicates that
You have read the above information

You voluntarily agree to participate

You are 18 years of age or older

☐ Agree

☐ Disagree

Questions

1. How many years have you been a Principal?
   a. 1-5 years
   b. 6-10 years
   c. 11-15 years
   d. 16-20 years
   e. 20+ years

2. Which type of school do you lead?
   a. Elementary School
   b. Middle/Jr. High School
   c. High School

3. How long have you held your current position?
   a. 1-5 years
   b. 6-10 years
   c. 11-15 years
   d. 16-20 years
   e. 20+ years
4. What percentage of students in your school receive mental health services?
   a. 1%-25%
   b. 26%-50%
   c. 51%-75%
   d. 76%-100%
   e. I do not know

5. How many college courses have you taken related to psychology or mental health?
   a. 0-1
   b. 2-3
   c. 4-5
   d. More than 5

6. In your school, who typically refers students for mental health services (Check all that apply)
   a. The Principal
   b. The Assistant Principal
   c. The School Counselor
   d. Teachers
   e. Other

7. Have you attended any professional development on the topic of mental health?
   a. Yes
   b. No
If you answered "Yes" to the question above, how well do you feel that the training helped prepare you to assist students that have mental health issues?

1                                2                             3                           4                           5
Very Unprepared                                                                                Very Prepared

8. As a building principal, how prepared do you feel to identify students in need of mental health services?

1                               2                             3                           4                           5
Very Unprepared                                                                                Very Prepared

9. As a building principal, how prepared do you feel to refer students in need of mental health services to a qualified mental health provider??

1                               2                             3                           4                           5
Very Unprepared                                                                                Very Prepared

10. Do you feel that you would benefit from additional mental health training?
    a. Yes
    b. No

11. Do you feel that your staff would benefit from additional mental health training?
    a. Yes
    b. No
12. Do you feel that Principal preparation programs need to add courses related to mental health into their required coursework?
   a. Yes
   b. No

13. Do you feel that you have the resources available in your school to meet the mental health needs of your students?
   a. Yes
   b. No

14. What are the most effective strategies you use to improve students’ mental health in your school?

15. What do you think you need to know more about in order to better support children’s mental health in your school?
APPENDIX C

Informed Consent

Online Survey Informed Consent Form

You are invited to participate in a web-based online survey about the preparedness of Arkansas public school principals in assisting students access mental health services. This is a research project being conducted by Candra Brasel, a doctoral student at Arkansas Tech University. It should take approximately 15 minutes to complete.

PARTICIPATION
Your participation in this survey is voluntary. You may refuse to take part in the research or exit the survey at any time without penalty. You are free to decline to answer any particular question you do not wish to answer for any reason.

BENEFITS
You will receive no direct benefits from participating in this research study. However, your responses may help us learn more about Arkansas principal preparedness to assist their students in need of mental health services.

RISKS
There are no foreseeable risks involved in participating in this study other than those encountered in day-to-day life.

CONFIDENTIALITY
Your survey answers will be stored in a password protected electronic file. No names (of participants or school districts) are asked on the survey document. Responses to the survey will remain confidential, and no one except the researcher will know who participated in the study. All responses will be reported in aggregate and/or with pseudonyms. No identifying information will ever be revealed.

CONTACT
If you have questions at any time about the study or the procedures, you may contact my research supervisor, Dr. Ellen Treadway via phone at 479-880-4901 or via email at etreadway@atu.edu. If you feel you have not been treated according to the descriptions in this form, or that your rights as a participant in research have not been honored during the course of this project, or you have any questions, concerns, or complaints that you wish to address to someone other than the investigator, you may contact the Arkansas Tech University Institutional Review Board at 215 West O Street Russellville, Arkansas 72801, or email the chair at mkuroki@atu.edu

ELECTRONIC CONSENT
Please select your choice below. You may print a copy of this consent form for your records. Clicking on the “Agree” button indicates that
• You have read the above information
• You voluntarily agree to participate
• You are 18 years of age or older

☐ Agree
☐ Disagree