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The Perceptions and Experiences of School-Based Mental Health Professionals in 9-12 Schools in Arkansas

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THE PERCEPTIONS AND EXPERIENCES OF SCHOOL-BASED MENTAL HEALTH PROFESSIONALS IN 9-12 SCHOOLS IN ARKANSAS

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Abstract

Mental health services for students in secondary schools has been and is continuing to be an issue in public schools today (National Association School Psychologists [NASP], 2019). Over 10 million students between the ages of 13 to 18 have a mental condition they will need a school-based mental health (SBMH) professional to help them deal with while they are in school (Walker, 2019). In schools, the most common disorders being identified with children and adolescents are: (a) attention-hyperactivity disorder (ADHD), (b) bipolar disorder, (c) depression, (d) anxiety, and the access to treatment for most of these children is limited (Walker, 2019). In addition to the disorders mentioned above, according the U.S. Department of Health and Human Services, adolescents also struggle with psychological factors like stress, bullying, family problems, learning disabilities, alcohol, substance abuse, and suicide (NASP, 2019). Many schools want to address student mental health issues, but may not have adequate student support services staff (e.g., counselors, social workers, school psychologists) to provide the level of support needed for many students (Crepeau-Hobson, Filaccio, & Gottfried, 2005; Walker, 2019). The U.S. Department of Health and Human Services addresses other serious mental health problems like suicide, and how these incidents are increasing in schools (NASP, 2019). This qualitative study addressed the perceptions and experiences of SBMH therapists and counselors in Arkansas'9-12 secondary schools as they diagnosed, treated and served their students. As well as, what did SBMH professionals perceive as barriers for the delivery of those mental health services. There were five high school counselors (n=5) and five SBMH therapists (n=5) that participated. All participated in a demographic survey, and interview questions were

informed by the literature and used an open-ended format through the qualitative method (Patton, 2002). Findings in the study relate to: (a) increase in the number of severe mental health issues, and SBMH professional's caseloads have increased; (b) parents are important; (c) administrative paperwork and duties have changed. The perceived barriers were: (a) preventing quality services for students (b) perceived barriers to getting students SBMH services which focused on access, stigma and the financial aspects serving students.

Key words: mental health, school-based mental health (SBMH) professionals, school counselors, school-based therapists/psychologists, school-based mental health services, adolescents

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CHAPTER 1: INTRODUCTION

Background of Problem

Mental health services for students in secondary schools has been and is continuing to be an issue in public schools today (National Association of School Psychologists [NASP], 2019). The enormity of the mental health problem in schools cannot be understated (Walker, 2019). Over 10 million students between the ages of 13 to 18 have a mental condition they will need a school-based mental health (SBMH) professional to help them deal with while they are in school (Walker, 2019). In schools, the most common disorders being identified with children and adolescents are: (a) attention-hyperactivity disorder (ADHD); (b) bipolar disorder; (c) depression, and (d) anxiety, and the access to treatment for most of these children is limited (Walker, 2019). In addition to the disorders mentioned above, according the U.S. Department of Health and Human Services, adolescents also struggle with psychological factors like stress, bullying, family problems, learning disability, alcohol, substance abuse and suicide (NASP, 2019). Many schools want to address student mental health issues, but struggle to meet the demands as they do not have adequate student support services staff (e.g., counselors, social workers, school psychologists) to provide the level of support needed for many students (Crepeau-Hobson, Filaccio, & Gottfried, 2005; Walker, 2019).

Along with the mental health issues listed above, schools also deal with violence with adolescents (Lenhardt, Farrell, & Graham, 2010). School shootings have also brought an awareness to mental health issues for students in the U.S. (Lenhardt et al., 2010). In one study about school climate and school shooters, Lenhardt et al. (2010) found that the lack of structure and a shortage of emotional resources in place in schools

was part of the problem. Having adequate school-based mental health services may have prevented some of these specific triggers for violence and school shooters inside secondary schools (Lenhardt et al., 2010). The research shows, there is a real and direct connection between secondary school safety and school-based mental health services (Lenhardt et al., 2010).

The U.S. Department of Health and Human Services addresses other serious mental health problems like suicide, and how these types of incidents are increasing in schools (NASP, 2019). Of those students who do need help with these types of mental health issues, almost 75% of them get that help inside of schools (NASP, 2019; Kann et al., 2017). In public schools, 80% of youth in need of mental health services may not receive them because, historically, mental health services have been disproportionately provided to only the most severely impaired (Fertman & Ross, 2003; Walker, 2019). This issue demonstrates a good reason to address school-based mental health care because children, adolescents, and many of these children diagnosed with mental illness fail to seek help (Kusumakar, LeBlanc, Poulin, & Santor, 2007; Kann et al., 2017). The critical need, and the importance of having places for students to go if they are experiencing distress, and helping them find these safe places is so important (Kusumakar et al., 2007). Students need opportunities to seek help, such as a place with SBMH services, because students need that support to be successful in the school setting (Kusumakar et al, 2007; NASP, 2019). SBMH professionals treat, diagnose and guide students in the educational setting and are an important part of schools today (NASP, 2019). However, little is known about their experiences in serving students. It is important to know what the perceptions and experiences are from Arkansas' SBMH professionals while they

diagnose, treat and serve students in grades 9-12 in Arkansas' schools. While studying these professionals, it also important to know what they believe to be barriers for the delivery of mental health services to Arkansas secondary students in grades 9-12.

Statement of the Problem

SBMH professionals treat, diagnose, and guide students in the educational setting for secondary students in Arkansas' schools. However, little is known about secondary SBMH professionals' perceptions and experiences in Arkansas 9-12 schools; therefore, it is important to explore the lack of resources for SBMH professionals while working with secondary students in the 9-12 educational setting in Arkansas, along with the barriers that may point to the lack of resources these SBMH professionals face in providing treatment and services to Arkansas' 9-12 grade students.

Purpose of the Study and Research Questions

The purpose of this study is to understand SBMH professionals' perceptions and experiences as they work inside of inside of Arkansas'9-12 secondary schools. The research questions to be explored in this study are:

1) What are the SBMH professionals' perceptions and experiences as these professionals diagnose, treat and serve their students in grades 9-12 in Arkansas?

2) What do SBMH professionals perceive as barriers for the delivery of mental health services to Arkansas secondary students in grades 9-12?

Definition of Terms

- Mental Health: includes one's psychological, emotional, and social well-being (A Y Magazine, 2016).

- School-based mental health (SBMH) professionals: School counselors, school social workers, school psychologists are the individuals who serve most of school-based mental health treatment and services. These professionals focus on how students can be successful in schools, and how students' mental health impacts their ability to succeed in schools (NASP, 2019).
- School Counselors: vital members of the education team inside of the school. They help all students in the areas of academic achievement, career and social/emotional development, ensuring today's students become the productive, well-adjusted adults of tomorrow (ASCA, 2019a).
- School-based therapists/psychologists: work within schools helping students overcome behavioral, emotional or social problems that interfere with success at school and at home. School-Based Therapy includes: individual and group therapy, family counseling, risk assessments as needed (suicidal or homicidal), specialized training and support services for parents and teachers, collaboration with other community providers, and referral to additional community resources (NASP, 2019). Depending on the degree plan, the terms school-based therapist and school-based psychologist are used interchangeably throughout the literature, but for this study, the term school-based therapist will be used.
- School-based mental health services: Services that support students' specific needs such as social relationships at home and school, as they function in an educational setting, enhancing a healthy state of mind, building a positive school climate by helping students feel nurtured and safe (NASP, 2019).

- Adolescents: The World Health Organization defines any person between the ages of 10 and 19 as an adolescent (Encyclopedia Britannica, Inc., 2019).

Significance of the Study

This study may assist students, educators, administrators and SBMH professionals currently in Arkansas 9-12 school systems today. This study may impact future educational leaders, students, educators and SBMH professionals in Arkansas' secondary schools by finding out what the SBMH professionals' perceptions and experiences are and use this information to improve mental health services and/or help students that are served, diagnosed and treated in these school systems. Also, by knowing and discovering the SBMH professionals' perceived barriers, mental health services for students may be improved and/or help students by understanding what is preventing the students from getting the treatment they need. Finally, in a broader sense, this study may also be transferable to students and SBMH professionals outside of Arkansas.

Assumptions

In this qualitative, phenomenological study, it is assumed that the SBMH professionals understand the questions posed by the researcher and will answer the questions candidly and truthfully based on their experiences serving students in Arkansas 9-12 secondary schools. Also, it is assumed that the SBMH professionals will be experienced in the issues relating to Arkansas' 9-12 secondary school students, such as typical classroom settings, and also understands appropriate, development, behaviors, and interactions of students in that setting. Finally, it is also assumed that the SBMH professionals will have training and education related to the specific needs of Arkansas 9-12 secondary school students.

Limitations

There are several limitations to consider in this study. First, SBMH professionals are from 9-12 secondary schools in Arkansas, so the results may be specific to Arkansas due to their experiences and being from different schools around Arkansas. Second, the data collected from interview responses will be self-reported and from the personal experiences of the sample group. Ultimately, this study and its results may have transferability and could be replicated in other areas of Arkansas.

Delimitations

The participants for this study will be four to five counselors and four to five school-based psychologists that serve grades 9-12 in 6A and 7A secondary schools in Arkansas. The study will run through March 2020.

Summary

The need for adolescents to receive mental health services from SBMH professionals inside of schools is well-documented in the literature (Fertman & Ross, 2003; Bowers, Manion, Papadopoulos, & Gauvrea, 2013; NASP, 2019 ;Walker, 2019). Therefore, it is important to discuss and understand SBMH professionals' experiences and perceptions as 75% of students receive SBMH services inside of schools (Kann et al., 2017; NASP, 2019). Specifically, this study will address the perceptions and experiences of SBMH therapists and counselors in Arkansas'9-12 secondary schools as they diagnose, treat and serve their students in grades 9-12 in Arkansas. As well as, what do SBMH professionals perceive as barriers for the delivery of mental health services to Arkansas secondary students in grades 9-12?

CHAPTER 2: LITERATURE REVIEW

The literature regarding SBMH professionals was reviewed and summarized according to the historical background of the SBMH profession and the professionals that shaped it. This review also encompasses the common issues impacting students and current trends and data from past and current research. In addition, information is presented that addresses the treatment of students inside and outside the school setting, along with the barriers that SBMH professionals face when providing treatment to schools and students.

School-Based Mental Health Services

School-based mental health (SBMH) services are defined by the Arkansas Department of Education's school-based mental health advisor, Dr. Betsy Kindall (2015), 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" (p. 9). SBMH services are provided by SBMH professionals, typically school counselors and school therapists, who are specifically trained on students' behaviors and how those behaviors affect learning in the school setting (NASP, 2019). SBMH professional balance the primary goal of school (i.e., to educate students) with the knowledge that trauma and mental health issues can interfere with that goal and impair learning (Wong et al., 2007)

In 2011, Merikangas et al. (2010) found the prevalence of childhood mental health issues in the US to be as high as 20% for all children, and underserved children were not getting the services they needed 75-80% of the time (Perfect & Morris, 2011; Baker, 2019). Since all children are required to be in school and also have transportation

to that school, schools are a great place for assessment for SBMH services and therapeutic services (Zirkelback & Reese, 2010). Of course, with SBMH services, treating students at school for mental health issues eliminates the need for transportation for students, insurance and the social stigma problems that come along with students seeking SBMH services (Wong et al., 2007). Research shows that young students receive their first services from the mental health system inside of schools around the ages of 9-13 (Burnett-Zeigler & Lyons, 2011).

The History of SBMH in Schools

School-based mental health services have made a great deal of progress over the past century to become an intrinsic part of the education of children and adolescents in schools (Sedlak, 1997). The following outlines the evolution of SBMH health services in US schools from its start in the early 1800s to present day.

Early school-based mental health services. Mental health service workers in schools goes back to the 1800s, where early mental health professionals were actually teachers who visited the schools and were called school social workers (Perfect & Morris, 2011). As schools incorporated middle class and poor students into high schools, schools began to see a need to change the way education was delivered to students (Sedlak, 1997). The general public wanted schools to be a place where all of the needs of their children were being met which included social, emotional, and physical health (Carlson, Paavola, & Talley, 1995)

In the late nineteenth century, the concept of social services in schools was evolving, and these services were actually developed to address the mental issues that

immigrant children were having in public schools at that time (Sedlak, 1997). Soon after, guidance counselors came into the spotlight to help transition students from school to college and/or the labor market (Sedlak, 1997; Minkoff & Terres, 1985). Public schools were one place where all the children's needs (health, emotional, social, and educational) could be met and could be provided to large groups of students (Carlson et al.,1995). As such, the professions of school psychologists, guidance counselors, and social workers developed in conjunction with each other in the beginning of the 1900s to help with student issues, which at the time, were derailing student's and schools' progress (Carlson et al., 1995). A great deal of these social and emotional services was adopted by schools and put under the heading of "pupil services" (Carlson et al.,1995).

Evolution of SBMH services from 1960 to present day. During the 1960's, two central concepts helped to push mental health services forward: (a) making mental health and social welfare services legitimate professional organizations and (b)the flow of state and federal monies defined the way schools delivered student mental health services for the next few decades (Minkoff & Terres, 1985; Sedlak, 1997). Mental health care for children continued to develop in the nation with John F. Kennedy bringing attention to the need for prevention for children suffering from mental illnesses in schools in 1961 (Levine, 2013). Even at that time in U.S. history, around 7%-12% of children under the age of 14 suffered from mental health issues (Levine, 2013). In 1964, the National Defense Education Act of 1958 (NDEA) brought counseling back to focusing on helping students in the labor market, but counselors wanted to include all students in their counseling services, not just focus on vocational needs for students (Minkoff & Terres, 1985). Counselors' roles changed again from the middle to the late 1960s by including

school dropouts, students who were disadvantaged economically and academically, and students who were also college bound (Minkoff & Terres, 1985).

In the 1970s, several significant parallel changes happened in education and with SBMH professionals. Specifically, two pieces of legislation added to the requirement that schools provide mental health to students with disabilities—Section 504 of the Rehabilitation Act of 1973 and the Education of the Handicapped Act in 1975 (Lear, 2007). This legislation added to responsibilities, time constraints, and changes to the profession for SBMH professionals (Lear, 2007). The Educational Amendments of 1974 also pushed counselors into the classrooms, which became known as "teacher-counselor working relationships in career education" (Minkoff & Terres, 1985, p. 426) Further, as schools struggled to meet the needs of students' mental health issues, special education became a direct way for the delivery of psychological services inside of schools with the incorporation of the Education of All Handicapped Children Act of 1975 (P.L. 94-142) (Minkoff & Terres, 1985; Carlson et al., 1995). This particular act has been both beneficial and harmful to comprehensive psychological services in public schools (Minkoff & Terres, 1985; Carlson et al., 1995). Disabled students did receive a more inclusive education, but these students did not get everything the act promised them; further, there were problems with funding, regulations with federal and state government, and confusion of how the main points in the act would be shared and handled (Moody, 2012).

In 1978, The President's Commission on Mental Health went to underscore that adolescents, especially poor and minority students, were underserved in our country and did not receive mental health services (Levine, 2013). Even if these adolescents did get

identified for services, mental health service organizations did not have mental health professionals or other personnel who were able to give these particular adolescents the help they needed because the services were fragmented (Levine, 2013). Through the 1970s and 80s, national, local and state level, governmental mandates and court clarifications made a series of directional moves and investments to synchronize services for children (Minkoff & Terres, 1985; Sedlak, 1997). Put down into legislation of the time, two laws (Public Law 94-142 , also known as the Education for All Handicapped Children Act, and the Individuals with Disabilities Education Act (DEA) required states and districts to provide equally comprehensive mental health, social, emotional, medical, and "other services considered "related" to, or supportive of, academic education as entitlements to children ruled eligible (Sedlak, 1997, p. 359). These specific federal laws were taken and developed at the state level which developed the investments in mental health services and expanded the client groups, with the ability to include students ages 0-26 (Sedlak, 1997).

Comprehensive mental health services continued to move into the spotlight in the mid 1980's and continued to grow into the 1990s through a national movement to bring mental health services to youth (Weist & Christodulu, 2000). These programs were called expanded school mental health programs and embodied treatment, prevention, assessment, and incorporating the regular education system in treating students (Weist & Christodulu, 2000). It was also during this time that Expanded School Mental Health Programs entered into the spectrum of services for students (Weist & Christodulu, 2000). Now, schools would also bring community mental health centers, health departments, and other social services into SBMH services by linking them all together, which was an

important step to helping students with mental health issues (Weist & Christodulu, 2000). State and federal funding, and funding from professional organizations and the private sector, pushed forward the movement of mental health care and comprehensive health in schools (Weist & Christodulu, 2000).

Through the 2000s, the need for SBMH services came in to question through research on why students' mental health needs were continuing to not be met with all the resources and laws that had been put in place and had been created to protect against this very situation (U.S. Department of Health and Human Services, 2000). At this time, research was pointing out that one in 10 adolescents and children were afflicted with mental illness, and the illness was likely severe enough to cause some of those adolescents' difficulty in their lives (U.S. Department of Health and Human Services, 2000). For this reason, the US Department of Health and Human Services (2000) asserted that schools must ensure our health system responds to children's mental health as it does to the needs of their physical body, noting that children and youth between ages 1-19 would be impacted the most by not receiving mental health services.

Initiatives like the Educate America Act of 1994 and President Bush's New Freedom Commission on Mental Health in 2002-2003 decidedly emphasized that schools would need to focus mental health services for struggling students as well as provide students and/or adolescents with these services while they were in school (Perfect & Morris, 2011; Stephan & Weist, 2007). Continuing into the early 2000s, initiatives focused on the fragmentation of services and how the delivery system was ineffective for students (Stephan & Weist, 2007). The more modern approach to SBMH services is

focused on a balance of social, emotional, career and academic areas (Paisley & McMahon, 2001; ASCA, 2012; NASP, 2019).

As SBMH developed and changed, another legislative act was introduced in 2013 and reaches into the present day, shaping what the next steps would be for SBMH services. Specifically, the Mental Health in Schools Act of 2013:

> Amends the Public Health Service Act to revise a community children and violence program to assist local communities and schools in applying a public health approach to mental health services, including by: (a) revising eligibility requirements for a grant, contract, or cooperative agreement; and (b) providing for comprehensive school mental health programs that are culturally and linguistically appropriate, trauma-informed, and age appropriate. Requires a comprehensive school mental health program funded under this Act to assist children in dealing with trauma and violence. Makes only a partnership between a local educational agency and at least one community program or agency that is involved in mental health eligible for such funding. Sets forth assurances required for eligibility, including that: (a) the local education agency will enter into a memorandum of understanding with at least one relevant community-based entity that clearly states the responsibilities of each partner; (b) the program will include training of all school personnel, family members of children with mental health disorders, and concerned members of the community; and (c) the program will demonstrate the measures to be taken to sustain the program after funding terminates.

Requires grantees to comply with the health information privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Requires the Administrator of the Substance Abuse and Mental Health Services Administration to develop a fiscally appropriate process for evaluating grant program activities, including: (a) the development of guidelines for the submission of program data by recipients; and (b) the development of measures of outcomes to be applied by recipients in evaluating programs, to include student and family measures and local educational measures.

Also, around the same time (2010-2013), the American Affordable Care Act (ACA) also authorized $200 million to develop the scope of services already in school-based health clinics and to identify new clinics, specifically focusing on large groups of children and families eligible for Medicaid (Vaillancourt & Kelly, 2014). “Schools can seek reimbursement for specific services delivered to Medicaid-eligible students; therefore, school districts may be able seek reimbursement for services already provided by school-employed mental health professionals” (Vaillancourt & Kelly, 2014, p. 63). The main focus of the ACA was providing the essential intervention services to a majority of students in the school and not replacing additional resources from partnerships with community providers school-based health centers (Vaillancourt & Kelly, 2014).

Specialization and Roles of SBMH Professionals

The relationship between schools and all the professionals in those schools--including the services delivered in schools by psychologists, counselors, and social workers--have been described as strained, working-well, and everywhere in between for

quite some time in America's SBMH history (Minkoff & Terres, 1985; Sedlak, 1997). All SBMH professionals and school staff all have the ultimate goal of helping students be successful and productive in their lives inside and outside of schools (Sedlak, 1997). However, school counselors and school-based therapists/psychologists (the focus of this study) have distinct roles based on their professional organizations' standards as well as state legislation and requirements for each. Thus, even though counselors and SBMH therapists may have similar degrees; their jobs are slightly different (American School Counselor Association, 2012). This is important to understand within the context of this study because both types of SBMH professionals are included as possible participants, though each may provide different interventions and services in their roles in the SBMH setting. Their roles are further outlined below.

School counselors

Even though all SBMH professionals work together in treating students, in most cases school counselors do not engage with students in long-term therapy like SBMH therapists do, even though they are qualified to do so. Counselors have administrative duties and other job assignments in schools like giving state student assessments, student scheduling, checking students' grades, and verifying grade point averages for students; these duties can take up a great deal of their time inside the school day, leaving no time for long-term counseling with students (American School Counselor Association, 2012). School counselors deliver developmentally appropriate activities and services directly related to students or indirectly for students as a result of the school counselor's interaction with others (ASCA, 2019a). These services and activities can help students learn the *ASCA Mindsets & Behaviors for Student Success* and increase students'

attendance, discipline, and achievement (ASCA, 2019a). The direct services that counselors deliver are individual interactions between school counselors and students like counseling, instruction, appraisal, and advisement (ASCA, 2019a) Another way counselors work with students is through indirect services provided for students as a result of the school counselors' contact with others through referrals, collaboration, and consultations (ASCA, 2019a). Counselors also address students' academic, social, and emotional, and career needs as students progress through schools (ASCA, 2019a).

The American School Counseling Association (ASCA) suggests that school counselors should work to build strong relationships with community mental health providers, including SBMH psychologists/therapists (American School Counselor Association, 2012). The ASCA National Model (2012) suggests that school counselors should establish referral programs for students diagnosed with mental health needs, and both entities should work together in their respective job capacities to effectively benefit the child (American School Counselor Association, 2012). It should be noted that SBMH therapists and school counselor have similar roles in providing student services per the ASCA National Model, but counselors do not deal with the billing aspect that SBMH therapists do (American School Counselor Association, 2012). In Arkansas specifically, school counselors, based on the newest piece of legislation from the repeal of ACT 190, shall spend 90% of time with students and have direct contact with students, and in that time with students, counselors should be providing direct and indirect services to students, leaving about 10% for administrative activities during student contact days (ACT 190, 2019).

Credentialing and accreditation. In most states across the United States, school counselors must hold a Master of Education in Counseling; this is a two-year degree (beyond the Bachelor's) that focuses on a combination of hands-on experience and learning in the classroom setting (All Psychology Schools, 2019). A teaching certificate is required for school counselors in some states as well, but not all (All Psychology Schools, 2019) To become a licensed professional counselor (LPC), an additional two years of practical experience is required after the Master's degree is required by most states (All Psychology Schools, 2019). The Council for Accreditation of Counseling and Related Educational Programs'(CACREP) accredits higher education programs that train counselors.

School-based therapists/psychologists

School-based therapists help students overcome social, behavioral or emotional issues that interfere with success at school and at home (NASP, 2019). These SBMH professionals are skilled in family counseling, individual and group therapy, risk assessments specifically dealing in suicidal or homicidal issues, support services for parents and teachers, collaboration with other community provider and also linkage to additional community resources (NASP, 2019). SBMH psychologists help students, educators, families, and members of the community deliver both long-term, short-term and chronic issues that students may face (NASP, 2019). They are also focused and exceptional at dealing with families and educators, as well as community providers (NASP, 2019). Also, school psychologists work primarily with populations with special needs; the National Association of School Psychologists suggests that school-based therapist positions are often funded through special education funding (School

Psychologist, 2019). School psychologists also have major roles in observing the progress of special needs students and planning interventions for their social-emotional success (School Psychologist, 2019).

Credentialing and accreditation. For school-based therapists/psychologists, certification guidelines and licensing requirements vary by each state (All Psychology Schools, 2019). School psychologists receive specialized advanced graduate degrees that are exactly the same as counselors, but school psychologists typically complete either a specialist-level degree program that adds up to 60 graduate hours or a doctoral degree that may contain up to 90 hours, and both may have a 1200 hour supervised internship program (NASP, 2019). Most of these SBMH professionals are educated in concepts such as student discipline, education law, crisis response, students with disabilities, classroom and behavior management, group and one-on-one counseling, school safety and cultural competence (National Association of School Psycologists, 2019).

Common Issues SBMH Professionals Encounter and Diagnose in Schools

In the end, every single SBMH professional (counselors and therapists/psychologists) deliver most of the SBMH services in schools (NASP, 2019) All are trained in the areas of how students function and learn in schools, and how mental health impacts the students in those schools (NASP, 2019). In general, the services students use the most focus on developmental concerns and how students experience certain life stressors (Fertman & Ross, 2003; ASCA, 2012; NASP, 2019). Common issues SBMH professionals encounter and diagnose in schools are outlined below.

Attention deficit and hyperactivity disorder (ADD/HD)

Attention deficit disorder (ADD) and Attention deficit /hyperactivity disorder (ADHD) are known as legitimate and prevalent disorders among children and adults (Brown, 2008). ADD is a cognitive disorder affects the executive function of the brain (Brown, 2008). These disorders create a pattern of chronic difficulties in completing daily tasks; ADD is considered to be under the heading of ADHD because it is also inattentive and a subgroup of ADD (Brown, 2008). ADHD has six components that outline the disorder: activation, focus, effort, emotion, memory, and action (Brown, 2008). Activation means, generally speaking, events that involve time and tasks—for example, prioritizing and being able to start and finish tasks (Brown, 2008). Activation also refers to focusing on those tasks, regulating alertness, sustaining effort, and being able to process ideas a reasonable speed (Brown, 2008). The component of emotions relates to being able to manage one's own emotions and frustrations. The memory component of ADHD involves accessing recall of information and using working memory; people with ADHD struggle to do this (Brown, 2008). Action refers to how people with ADHD struggle with monitoring and controlling self-action (Brown, 2008).

Merikangas et al. (2010) noted that attention-deficit/hyperactivity disorder is one of the most common mental health issues children struggle with, with 8.6% affected (as compared to 3.7% for mood disorders, 2.1 % for conduct disorders, 0.7% for panic disorder or generalized anxiety disorder, 0.1% for disorders related to eating. Boys have about a 2.1 times greater chance of suffering from attention-deficit/hyperactivity disorder than girls, while girls had two times higher rates of mood disorders than boys (Merikangas et al., 2010). Students who struggle with ADHD can have trouble with

behavior, attention to instruction, finishing tasks, turning in work, and impulsivity (Merikangas et al., 2010).

Anxiety

Anxiety came to be recognized as a mental health disorder in the 19th century (Himmellhock, Levine, & Gershon, 2001). Anxiety is described as excessive worries and fears that cause significant stress, and that stress affects daily life; for students, that stress impairs school success (McGuinness, 2016). Specifically, anxiety is associated with events that may not allow optimal growth and development in children (McGuinness, 2016). Anxiety is categorized in several ways: generalized anxiety disorder (GAD), agoraphobia, panic disorders, and posttraumatic stress disorder (Huberty, 2019b; McGuinness, 2016) The primary component of anxiety is worry with the belief that future events will have negative outcomes (Huberty, 2019b; NASP, 2019). Signs of anxiety include "worry, problem-solving difficulties, [difficulties with] concentration, restlessness, task avoidance, rapid speech, irritability, withdrawal, no participation, failing to finish tasks, stomach aches, rapid heart rate, headaches, muscle tension, [nausea], and sleeping issues" (Huberty, 2019b, p. 6).

Most anxiety disorders go unrecognized and are not treated (McGuinness, 2016). Huberty (2019b) found that anywhere between 3-20% of adolescents suffer from an anxiety disorder. Most adolescents who suffer from anxiety also go on to suffer from anxiety in adulthood as well (McGuinness, 2016). Young adolescent girls tend to have two to three times the rate of anxiety disorder than adolescent males (McGuinness, 2016). The number of students who do not come to school because of anxiety, depression, or physiological symptoms due to anxiety and/or depression ranges from 2-5% (Wimmer,

2019), and when schools realize that anxiety and depression are the reason for not coming to school, this issue should be addressed immediately (Wimmer, 2019). In 2010, the National Institutes of Health (NIH) reported that anxiety-related disorders are the most common in students ages 13-18 (Baker, 2019; Perfect & Morris, 2011), and only half of those children with the disorders assessed had received treatment with a mental health professional (Merikangas et al., 2010).

Depression

Depression, also called major depressive disorder, is a serious and common medical illness that negatively affects how one thinks, feels and acts (American Psychiatric Association, 2019). Depression can be displayed in physiological, cognitive, and behavioral patterns (Huberty, 2019a). The most common symptoms that adolescents suffer from when they have depression are lack of interest in activities, irritability, down in mood, difficulty getting along with others, rebellion, sleep difficulties, physical ailments, feelings of inadequacy, lack of concentration, feelings of guilt, and thoughts of death and even suicide (Huberty, 2019a). In schools, it is the most under-identified health problem for adolescence because it can be mistaken for lack of motivation (Huberty, 2019a). If left untreated, it can have long-term effects on academic performance, social relationships and personal relationships (Huberty, 2019a).

Research also reflects there is a plausible connection between anxiety and depression disorders, and genetic factors for these disorders are common in adolescents (Axelson & Birmaher, 2001). Depression and anxiety disorders are known as disorders of emotion or "internalizing disorders" (Axelson & Birmaher, 2001, p. 67). Both of the disorders came into existence together, and for that reason, are hard to separate from each

other and seemed to be discussed in literature simultaneously because of their connection with each other (Himmellhock et al., 2001). Approximately 25-50% of youth with depression also suffer from anxiety too (Huberty, 2019a; Axelson & Birmaher, 2001). Lack of treatment of anxiety disorders can lead to the adolescent to become depressed and adversely affect adolescents' lives in school, with friends and with family (McGuinness, 2016). Research demonstrates that though depression and anxiety are discussed together, anxiety may come before the depression onset—in fact, most disorders, in general, precede depression (Axelson & Birmaher, 2001) .

Since anxiety and depression are linked, depression can be mistaken for lack of motivation and may go unnoticed just like anxiety (Huberty, 2019a). Severe depression, if left untreated, can result in mood swings, suicide and being withdrawn, but most depression episodes may not even be noticed, and adolescents are not likely going to refer themselves for mental health services (Hubert, 2019a). Also, people with depression are 20 to 30 times more in danger of committing suicide than the most people without depression (Udoetuk, Idicula, Jabbar, & Shah, 2019). Although the risk of suicide is higher with depressed students, most adolescents do not follow through with suicide (Huberty, 2019a). Suicide attempts are also difficult to predict (Huberty, 2019a).
Most students start having symptoms of depression around the ages of 11-14 (Huberty, 2019a). In one large study across 39 states, the overall pervasiveness of sad or hopeless feelings of the students was around 31% of students (Kann et al., 2017). Depression episodes can last just a few weeks, or even months or years (Huberty, 2019a). Depression does affect students in the classroom and can affect their grades and social connections with other students (Huberty, 2019a). In both anxiety and depression, there is a "negative

bias in information processing" (Axelson & Birmaher, 2001, p. 70). That is to say, adolescents who suffer from anxiety may have an elevated amount of negative self-talk and sense of awareness, feel awkward in social situations, and expect to be not liked by their peers (Axelson & Birmaher, 2001).

Suicide/suicidal ideation

Suicide is when a person takes his/her own life (Sanchez-Terule, Garica-Leon, & Muela-Martinez, 2014). Suicidal ideation is having thoughts or thinking about killing one's self (Hawton et al., 2012). In several research studies, there are some common components of suicide, such as, genetics, vulnerability, psychiatric and/or psychological issues, familial factors, and social and cultural factors (Hawton et al., 2012).

Along with the prevalence of depression and anxiety as disorders that affect students, suicide is the second leading cause of death in the world for adolescents ages 15-29 (Udoetuk et al., 2019; Hawton et al., 2012). In the United States it is considered the second highest cause of death for adolescents from ages 10-25 (Udoetuk et al., 2019). According to the Centers for Disease Control and Prevention (2017), men and adolescent boys from age 15-24 years can take their own lives at a rate that is four times higher for girls and women. Approximately 25% of young people have reported thinking about suicide and having suicidal thoughts, which shows that suicidal ideation is a part of some adolescents' thinking (VanGeel, Vedder, & Tanilon, 2014). Adolescents that do try suicide have a higher risk of mental health problems and future risk of suicidal behaviors (Hawton et al., 2012; VanGeel et al., 2014; Udoetuk et al., 2019). Further, adolescents between the ages of 12-26 with low self-esteem were more likely to have future suicide attempts than those who did not have low self-esteem (Victoria et al., 2019). Finally,

research shows that previous suicide attempts are a strong indicator for future suicide attempts, and bullying (both cyber and traditional) is a considerable reason for suicide attempts leading to completed suicides as well as hospitalizations (VanGeel et al., 2014; Udoetuk et al., 2019).

Trauma. Trauma refers to a two-pronged issue: a problem of adaptation as well as exposure (Spinazzola, Ford, Zucker, & vanderKolk, 2016). Trauma is the experience of developmentally harming, emotionally disturbing events that can be of an interpersonal nature (e.g., sexual or physical abuse, emotional abuse, verbal abuse, neglect, war, community violence, loss of a parent/caregiver; parental addiction, parental mental illness; Spinazzola et al., 2016). These exposures often happen inside the child's caregiving system and may incorporate educational neglect as well as emotional and physical neglect (Spinazzola et al., 2016). In fact, interpersonal victimization is the most prevalent form of trauma exposure with most of these experiences for children coming from the home environment (Spinazzola et al., 2016). In 2001, the Department of Health and Human Services estimated that around 903,000 children were maltreated in America, and that may be a gross underestimation (Spinazzola et al., 2016). It is still not clear and is still relatively unknown how many children or adolescents develop post-traumatic stress disorder (PTSD) after being harmed by trauma (Alisic et al., 2014).

Complex trauma exposure can lead to severe, chronic problems with children including relational, cognitive, perceptual, behavioral, psychological, and overall self-regulation (Spinazzola et al., 2016). Being exposed to complex trauma in childhood also may go on to impact these children as adults, and these adults continue to exhibit many deficits and a wide range of psychiatric problems (Spinazzola et al., 2016). There is some

evidence to support that boys and girls differ where trauma is concerned, with girls suffering more than boys (Alisic et al., 2014).

Effects on students' academics/school performance and their futures. Students suffer in school and outside of school when they do not receive the mental health treatment that they need. Adolescents can internalize all of the road blocks in their lives, which can be frustrating for students and lead to low performance in school (Adelman & Taylor, 2002). According to the National Alliance on Mental Illness, mental health issues are responsible for at least half of all the instances students drop out of high school (Baker, 2019). Further, the lack of mental health services can have long-lasting effects on these adolescents and their lives as they move into adulthood (Kataoka, Zhang, & Wells, 2002). If left untreated, some of the effects of mental illness in adolescents could exasperate problems like not being able to keep and maintain a job, continued untreated depression and other disorders, not being entirely engaged in society as adults, and possibly even lead to suicide (U.S. Department of Health and Human Services, 2000; Fergusson & Woodward, 2002; Merikangas et al., 2010; Kann et al., 2017). This is another reason why early treatment is so critical for students.

Treatment of Students' Mental Health Issues

Treatment of students' mental health issues can vary greatly from student to student depending on the disorder or issue that the students are struggling with in the school setting, social setting or at home (Bowers et al., 2013). Treatment of mental health services encompasses medication, physical health, reaching out to families and the community (Bowers et al.,2013)

Medication and psychotherapy

Along with treatment, it is important to mention medications can help in managing several mental disorders and work in helping people with mental health disorders to get better (National Institute of Mental Health[NIMH], 2019). Treatment can also incorporate psychotherapy (also called “talk therapy”) and brain stimulation therapies which are not so common (NIMH, 2019). In some instances, psychotherapy can be a good option for treatment (NIMH, 2019). Selecting the best treatment plan should be based the individual needs of a person, and the care they are receiving from their mental health professional(s) (NIMH, 2019).

Multi-Tiered Systems of Support

In the 1980’s, SBMH moved into a movement called Wrap Around Services where social workers, school nurses, and psychologists would provide all of the school mental health services that were essential in serving students’ needs in schools (NASP, 2019). The term Wrap Around Services eventually evolved to multitiered system of supports (MTSS). Comprehensive mental health services can be provided through MTSS via SBMH professionals. MTSS encapsulates the perpetual need for treating the whole child, and this embodies physical and mental health together (NASP, 2019). Specifically, schools can promote mental wellness and address and intervene before problems escalate or become chronic (NASP, 2019). Essentially, the goal is to provide adequate staffing of SBMH professionals because it is important for the quality and benefit of these services (NASP, 2019). In a MTSS, collaboration between schools and communities is critical in building and maintaining the full continuity of mental health services for students (NASP, 2019). Mental health providers also depend upon the collaboration between schools and community mental health providers as well because this is how students would get

adequate treatment inside and outside of school (NASP, 2019). Usually, community providers are able to go far beyond what schools are able to give students in the terms of supplementary or intensive services (NASP, 2019).

A MTSS approach helps build collaboration while making services that are provided in school are suitable to the learning context and services provided after school hours are also supported in the school setting (NASP, 2019). Partnerships tend to be more supported when coordinated by SBMH professionals (NASP, 2019). Each member of the SBMH team makes a valuable contribution, and this creates expert and comprehensive service delivery. This teamwork not only reduces gaps, redundancy, and conflict, but this team work lessens gaps, repeated services and conflict while minimizing stress on families by acknowledging and communicating to essential caregivers and individuals that make decisions in reference to their child's development (NASP, 2019). Figure 1 below shows what a MTSS would look like inside a school system (NASP, 2019).

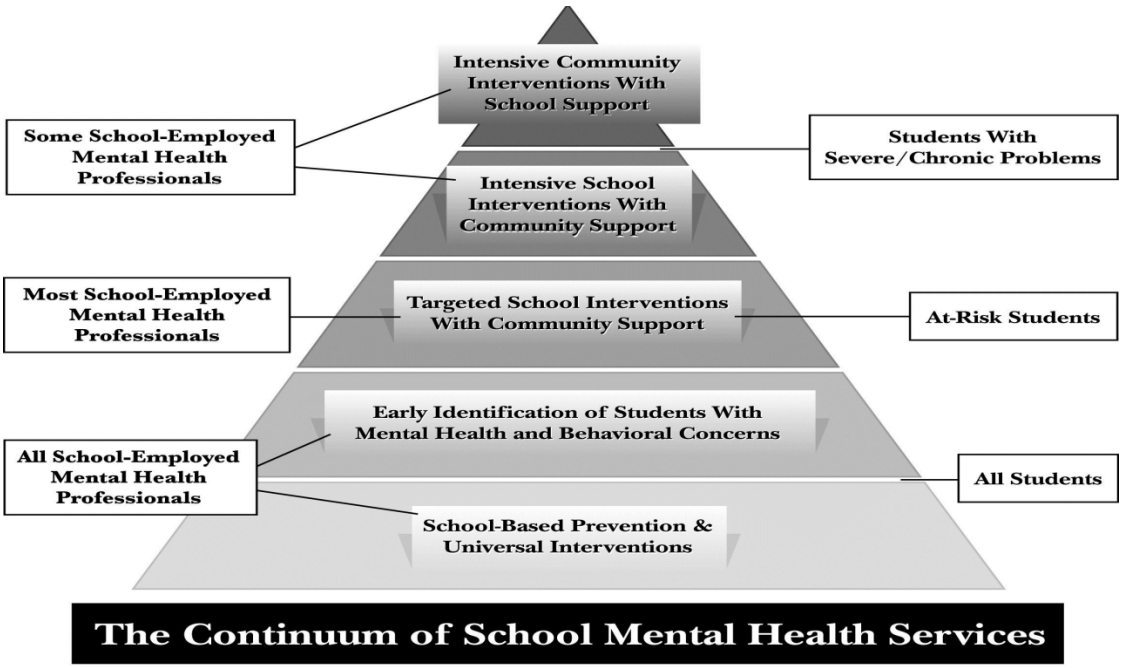

Figure 1. The Continuum of School Mental Health Services (NASP, 2019).

Treatment of students by SBMH professionals in Arkansas

Because the proposed study will be conducted in Arkansas, it is important to understand how students' mental health issues are addressed in this state. The Arkansas Department of Education has a School-Based Mental Health Model for all schools in the State of Arkansas, and all schools are required to follow this manual to secure services for students and guide them through that process (Arkansas Department of Education [ADE], 2012). This process is actually inside a manual called *The School Based Mental Health Manual* (ADE, 2012). This manual offers schools a step-by-step road map of how to get, maintain, and serve students in the school setting and outside of the school setting using recommended best practices (ADE, 2012) it also explains how schools are to provide the services when it comes to SBMH therapists (ADE, 2012). The ADE (2012) states there are three ways that schools can obtain prospective SBMH programs and services: (a) the school district as Medicaid provider; (b) a school District/Provider Partnership, and (c) a combination of the above models. If the school district is the Medicaid provider, then that school will take care of the billing for SBMH services (ADE, 2012). If the SBMH services are a combination of a school/provider partnership, schools will typically contract out the services and billing to a mental health clinic in that student's community (ADE, 2012). Some schools provide services to students both ways—they either bill the services and hire the SBMH professional or contract the services out (ADE, 2012).

By law, Arkansas schools can have one certified full-time equivalency (FTE) therapist per 500 students, and the certified therapist would have a caseload of 20-30 students (ADE, 2012). Some districts may not be able to follow the guidelines exactly as

ADE outlines them, and there is a recommendation that they develop a plan including a timeline of how the school district will reach these goals in the future (ADE, 2012). ADE (2012) also recommends when schools have mental health providers working in conjunction with the school district, they should divide their time between direct services such as diagnostic evaluations; individual, group and family therapy; assessments and coordination of treatment planning; and referrals to appropriate mental health/community services (which are considered billable time) and indirect services such as early intervention, education, prevention, classroom observations, in-service trainings, and parent education (which are considered non-billable time; ADE, 2012). *The School Based Mental Health Manual* also outlines exactly what billable and non-billable services are and what percentage of that time is billable and non-billable. This is critical information for school districts have as they keep track of costs related to mental health; this way, districts can ask therapists to do about 30% of non-billable time (ADE, 2012). Billable services, as best practice, would need to include the other 70% of the therapists' time. The billable direct services include.

Barriers for Students Seeking SBMH Services

There are several common reasons high school students do not seek services for themselves, and there are several barriers that students deal with along with their families, when they are trying to get the services they need. These barriers (i.e., cost of care, stigma, and limited resources) are outlined in detail below.

Cost of care

The cost of mental health care is a major barrier to why students do not get the help that they need (Services Administration Substance Abuse and Mental Health, 2013).

Providing intervention and treatment for children with mental health issues costs the U.S. $247 billion a year, and that includes healthcare, special services, and the juvenile justice system. Unfortunately, the U.S. spends less than 1% of that money on preventative research (Services Administration Substance Abuse and Mental Health, 2013). In the 1980s and 1990s, the largest single source of payment for mental health care came from state and local government (Services Administration Substance Abuse and Mental Health, 2013). By 2005, state and local government was the third largest funder, behind Medicaid and private insurance (Services Administration Substance Abuse and Mental Health, 2013). Out-of-pocket spending on mental health services was higher than Medicare spending (Services Administration Substance Abuse and Mental Health, 2013). Out-of-pocket spending is what local consumers pay for health care services insurance will not cover, like a co-payment (Services Administration Substance Abuse and Mental Health, 2013). In 2005, out-of-pocket spending was about $14 billion with Medicare spending only around $9 billion (Services Administration Substance Abuse and Mental Health, 2013). As a matter of fact, Medicaid can be ineffective and inefficient and costly for school districts (Lear, 2007).

When it comes to cost of SBMH care, most of the students with special needs are protected through federal laws and civil rights laws, which over the last 30 years, protects these students and guarantees SBMH services (Lear, 2007). Because funding for school health programs typically comes from the public school's entire budget, and not from the public health budget, school health programs tend to compete with academic agendas, and with laws like No Child Left Behind, this can make it difficult task for schools (Lear, 2007). At the state level, legislatures do weigh in on policies that deal with school health

services, but usually it is on issues like sex education and mental health screening (Lear, 2007). States can and do weigh in on how mental health services money is spent and may do so with grant initiatives too (Lear, 2007). State executive agencies can also impact school health services through Medicaid and State Children's Health Insurance Programs (SCHIP) that can allow school-based providers to be reimbursed for their expenditures (Lear, 2007). Even with these financial allowances, school health programs are typically poorly managed, ineffective, and under staffed (Lear, 2007). In addition, where Medicaid is concerned, billing for services can be complicated and costly, and some school districts do not have the staff to handle this complex pursuit (Lear, 2007).

Stigma

Stigma is a real and distinct barrier to students seeking school-based mental health, or other types of mental health services, even if they go outside of the school setting (Bowers, Manion, Papadopoulos, & Gauvrea, 2013) Stigma is the "beliefs and attitudes about mental health and mental illness that lead to negative stereotyping of people and to prejudice against them and families" (Bowers et al., 2013, p. 165). Help-seeking behavior is influenced by stigma. (Bowers et al., 2013). About one in five young people may suffer from a mental illness issue, and a great deal of those do not seek help because of the stigma surrounding this issue (Bowers et al., 2013). In fact, the number one cause for young people (47.8%) not seeking help for a mental health issue was the stigma behind getting the help that they need (Bowers et al., 2013). The number two reason for not seeking help (23.1%) was students did not know where to find the help at in their school (Bowers et al., 2013). Researchers agree that if a student did not have a mental illness, the next barrier for young people would be what the student's peers would

think, and then, students not being aware that they have a mental illness, again another facet of stigma that is a powerful deterrent for adolescents (Bowers et al., 2013).

An important part of dealing with stigma is reducing stigma by working on mental health literacy and challenging negative stereotypes inside secondary schools (Pinfold et al., 2003). Pinfold et al. (2003) found that having short workshops produced positive changes in students' attitudes toward mental health issues. These types of workshops focus on helping students find less-stigmatizing ways to address students with mental illness, such as teaching students to use common feelings (like sadness, loneliness, and scared) to describe the students with mental illness instead of using labels, and having students diagnosed with a mental illness issue (like depression and/or schizophrenia) discuss their personal experiences (Pinfold et al., 2003).

Limited resources

Another barrier for students being able to access SBMH services is the limited opportunity for SBMH professionals to address mental health issues due to the responsibilities of school counselors' shifting from social emotional toward academic achievement only (National Association of Secondary School Principals, 2019). By 2014-15 school year, the widening gap for services was reflected in the data that everyone counselor was expected to serve 482 students (National Association of Secondary School Principals, 2019). The American School Counseling Association states that schools should have one counselor for every 250 students (National Association of Secondary School Principals, 2019; American School Counselor Association, 2012), so the caseload for school counselors is creating a shortage of counselors. Further, increased caseloads for those who decide to remain in schools is

overwhelming and limits access for students who need this support in their lives (National Association of Secondary School Principals, 2019).

Benefits for Students Seeking SBMH Services

There is a growing body of evidence that supports a direct connection between students' mental health and student outcomes, specifically their academic, social, and emotional learning (World Health Organization, 2005; Wong, et al., 2007; Dix, Slee, Lawson, & Keeves, 2012). In fact, one study on SBMH interventions found that if the interventions lasted up to one year and were targeted, intensive, and included teachers, students, and parents, the interventions would more likely have a positive impact on academic success as well as on the student's mental health (Burnett-Zeigler & Lyons, 2011).

SBMH professionals understand that students are developing key parts of their self-identity, and because of that, interpersonal relationships are particularly vulnerable (Wong et al., 2007). For high school students, the sense of self is critical, and students need to be linked to therapist and counselors-including external service providers to help them stay in school (Baker, 2019). School-based mental health services can help students deal with issues like trauma, and support the school by delivering services that can be both interventive and supportive to that student (Wong et al., 2007). Children who receive services inside of schools have greater improvement and outcomes than those children who do not receive services (Zirkelback & Reese, 2010).

Another way SBMH professionals help inside schools and the community is through helping parents deal with their child who has a mental health issue like ADD and ADHD (Zirkelback & Reese, 2010). SBMH professionals can direct parents where to go

for extensive help, address minor and major mental health issues, and be a school contact on how that student is performing inside of school (Zirkelback & Reese, 2010). School therapists and school counselors are specially trained to help students inside of the school framework (NASP, 2019). Having these SBMH professionals work in schools' benefits students because it enhances their success in academics, problem-solving skills, physical and psychological safety as well (NASP, 2019). These professionals help students with their social-emotional learning skills, connections to adults, positive connections with each other, resilience, and over-all mental wellness (NASP, 2019).

SBMH professionals also deal with social and emotional-learning programs to help students in schools. Social and emotional learning programs (SEL) are designed to address student mental health issues and have been developing and researched for well-over 40 years (Dix, Slee, Lawson, & Keeves, 2012). Some studies reflected that these social and emotional programs offer benefits to students both socio-emotionally and academically if the programs are well-planned and implemented inside of schools (Dix et al., 2012).

Also, there is some discussion in the research on positive behavioral strategies and supports (PBIS) for students with behavioral issues that also may have mental health issues as a way to support students and teachers (Burnett-Zeigler & Lyons, 2011). PBIS is considered school-wide process and way to target group interventions for around 5-15% of students who may be likely to struggle with mild and severe behavioral and emotional problems in the classroom (Burnett-Zeigler & Lyons, 2011). Typically, the PBIS process allows all SBMH professionals to understand how to address, treat and develop a plan for these struggling students by having specific data from teachers and

counselors about that students' difficulty in the classroom (Burnett-Zeigler & Lyons, 2011). This is another way that SBMH professionals expanding the way a student can be utilizing SBMH services (Burnett-Zeigler & Lyons, 2011).

Because this research study is about high school SBMH professionals, it is important to understand how SBMH professionals can help high school students specifically. High school is also a gateway into adulthood, going to college, and entering the workforce, especially as students begin breaking away from their parents and expand and define their independence (ASCA, 2019b). Students are making decisions about who they will be, what they are best at, and what they will do after high school (ASCA, 2019b). While in their adolescent years, students are evaluating their abilities, strengths, and skills (ASCA, 2019b). During these critical years, it is important for adolescents to have guidance (ASCA, 2019b). High school counselors are exceptional at dealing with adolescent development, strategies that enhance learning, and helping students build social and self-management skills as they move through high school (ASCA, 2019b). Counselors provide education, intervention, and prevention activities, which can be weaved into all parts of students' lives (ASCA, 2019b). Counselors help students gain attitudes, knowledge, and skills they will need to be successful in their career and academic lives (ASCA, 2019b). High school counselors interact with teachers and parents on intervention of students' academic and social/emotional needs and can identify early roadblocks to learning and developing skills that are essential for academic achievement (ASCA, 2019b).

Theoretical Perspective

The theory that informs this study is Urie Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner, 1986) Ecological Systems Theory created systems to make sense of the connections between the individual and the systems that influence the individual (Berk, 2013). There are three systems that Bronfenbrenner uses to explain the "bi-directional nature of child development: (a)the microsystem, (b) the mesosystem and (c) exosystem" (Berk, 2013, p. 27).

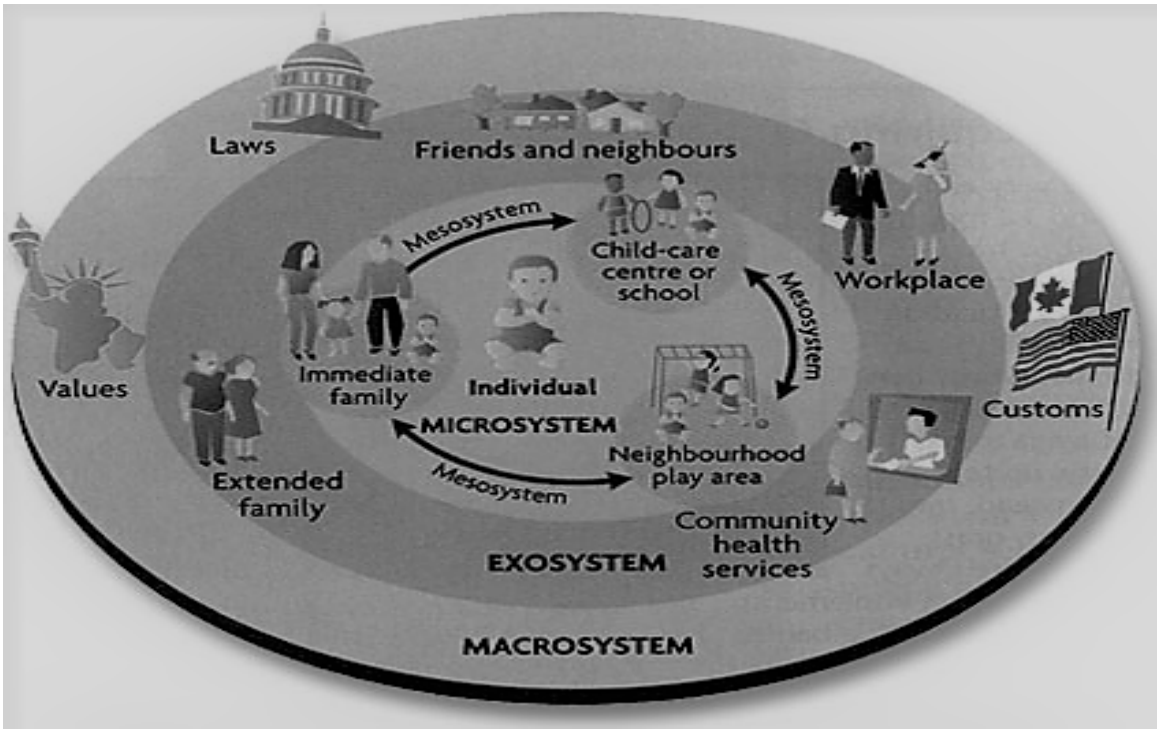

Figure 2. Bronfenbrenner's Ecological Systems Theory Model (Berk, 2013, p.27)

The microsystem is the core and inner most level of the environment and embodies the idea that the activities and patterns surrounding a child are interconnected (Berk, 2013). In fact, children affect adults' behavior and vice versa (Berk, 2013). They are intertwined in their personalities, activities, and behavior, and each impacts the other (Berk, 2013). The next level in Bronfenbrenner's model is the mesosystem (Berk, 2013). The mesosystem emphasizes the link between microsystems, like the place where the

child lives, goes to school, and in their home and the interactions between those entities (Berk, 2013). If a child is well taken care of at his/her home, the daycare that the child goes to will likely also have positive interactions with the child; these interactions will likely support the development of the child (Berk, 2013). Lastly, there is the exosystem, and this system includes all the outer elements that impact the child although they never directly interact with the child (Berk, 2013). Some of those elements that impact the child would the parent's place of employment, church, welfare or health organizations in the community, or the child's more informal relationships like friends, social networks, and extended family members (Berk, 2013)

Because of the direct connection between the child, home, and school, the ecological systems theory has moved to the forefront in the world of child development and into the school because it defines and explains a great deal of how the surrounding world impacts children and their development inside and outside of schools (Berk, 2013). An ecological perspective brings the environmental and the individual into central co-existence, and it also brings together the interlocking relationship they maintain (Newes-Adeyi, Helitzer, Caulfield, & Bronner, 2000) The ecological perspective adds a guide to practice as well as a framework for school-based mental health (Gampetro, Wojciechowski, & Amer, 2012) In this perspective, the ability for individuals to be healthy depends on these two elements: the environment and individual, so distinctly, it is reflected in the environment and through significant factors like society, culture, family, and community (Gampetro et al., 2012).

This theory is important to this study specifically because schools are a part of the mesosystem and are also places where mental health services are delivered to children

(Cappella, Frazier, Atkins, Schoenwald, & Glisson, 2008). Schools reach families and support children and are a place where children's mental health and development also connect with their home-life and their community (Cappella et al.,2008). The ecological theory distinctly pulls together the students' lives in school and at home, connecting schools, families, and communities by "bridging these ecologies" (Cappella et al. , 2008, p. 35). This connection and how SBMH professionals serve students is the focus of this study. In recent research, this theory is used in discussing and addressing the challenge for adolescents is that they have to stay healthy in the midst of all the stressors in life like a chronic illness, limited social or economic resources, and the effect of the environment (Gampetro et al., 2012) School-based mental health services is a connecting factor for the "bidirectional" relationship that Bronfenbrenner's ecological theory creates and embodies (Berk, 2013).

Summary

The literature review for this qualitative study starts with a focus on how SBMH professionals' roles have developed through history, and how those roles have evolved to be an integral part of school systems because of the complexities and wide-range of services students need and will use inside of schools today (Sedlak, 1997; World Health Organization, 2005; American School Counselor Association, 2012; NASP, 2019). The literature review continues to discuss what school counselors and SBMH therapists may recognize as specific disorders that impact students' educational processes and affect students' academic performance (Axelson & Birmaher, 2001; Adelman & Taylor, 2002; Center for Disease Control and Prevention, 2017; Kann, et al., 2017; Udoetuk et al., 2019; National Association of Secondary School Principals, 2019).

Following students' needs that are identified for services, and discussion of the most common disorders SBMH professionals will see inside of public schools, there is a review of the treatment issues such as a) medication and psychotherapy; b) Multi-Tiered System of Supports (MTSS), and c) Arkansas Department of Education's School Based Mental Health Model (NASP, 20119; ADE, 2012; National Institute of Mental Health, 2019). Also, along with treatment services, there is a review of barriers to SBMH services such as a) cost of care, b) limited resources, and c) the stigma attached to mental health services (ADE, 2012; Services Administration Substance Abuse and Mental Health, 2013; Bowers et al., 2013; NAMI, 2019). Also, outlined in the literature review are the benefits of having SBMH professionals inside of schools, such as academic success, student outcomes in their social and emotional learning, connections with community, teachers, parents, self-concepts, and future plans (Wong, 2007; Zirkelback & Reese, 2010; ASCA, 2019b; National Association of Secondary School Principals, 2019; NASP 2019).

The final discussion point in this literature review is a detailed explanation of Urie Bronfenbrenner's Ecological Systems Theory because Bronfenbrenner's theory is the theoretical underpinning of this qualitative study, and also included is an explanation of how this theory connects and illuminates the research questions shaping this study (Bronfenbrenner, 1986; Berk, 2013).

CHAPTER 3: METHODOLOGY

The purpose of this study was to understand the perceptions and experiences of SBMH professionals in 9-12 schools in Arkansas. This qualitative study used personal interviews of 8-10 SBMH professionals as the data collection method. Specifically, 4-5 secondary counselors and 4-5 secondary school-based therapists/psychologists in Arkansas' secondary schools from grades 9-12 were participants in this study. The two research questions guiding this particular research were as follows: (a) What are the SBMH professionals' perceptions and experiences as these professionals diagnose, treat and serve their students in grades 9-12? and (b)What do school-based mental health professionals perceive as barriers for the delivery of mental health services to Arkansas secondary students in grades 9-12? This study followed all rules and regulations regarding research ethics and received approval from the Arkansas Tech University IRB prior to recruitment or data collection.

Research Design

Because this study focused on the perceptions and lived experiences of school-based mental health professionals in Arkansas' secondary schools, qualitative, phenomenological methods went well with the depth of information required to investigate this topic. Qualitative research methods facilitate detailed, deep study of a topic, and the instrument was the researcher (Patton, 2002). Qualitative methods involved fieldwork, observation, interviews, and artifacts (Patton, 2002). A phenomenological study was committed to "understanding the social phenomena from the actor's own perspective" (Patton, 2002, p. 69). Also, phenomenology asked "what makes something what it is and without which it could not be what it is" (Patton, 2002, p. 104). Because

the intent of this study was to discover what school-based mental health professionals knew, and how they knew it; only those specific professionals lead the researcher in the direction to find out what was happening in larger secondary schools in Arkansas. A phenomenological perspective considered the common relationships in the "human experience" and worked hard to understand those experiences, and "how people experience what they experience" (Patton, 2002, p. 106). In this study, there was a systematic process of collecting data via demographic surveys and face-to-face interviews to answer questions concerning about counselors and school-based therapists.

Participants

The persons that were selected to participate in this study were 10 SBMH professionals. Specifically, there were approximately 5 secondary school counselors and 5 secondary school-based therapists/psychologists were interviewed for this study. School psychologists and school counselors both provided services that supported student learning and encourage healthy social and emotional development in students' teenage years (Wake Forest University, 2019). These SBMH professionals may counsel students one-on-one and implement programs at the high school level and after high school (School Psychologist.com, 2019). While there were some differences in their roles (as explained in Chapter 2), both of these SBMH therapists dealt with responding and preventing crisis situations (School Psychologist.com, 2019). Sampling from these two groups of SBMH professionals allowed for the discovery of what they perceived and experienced in the secondary school setting and gave a richer picture of what was happening in Arkansas' secondary schools as it pertained to student mental health services.

Sample

The SBMH counselors and therapists had 1-35 years of experience and were selected from larger secondary schools in Arkansas classified as 6A or 7A schools from the Arkansas Activity Association (Arkansas Activities Association, 2019); these schools served over 44,000 students. The participants in this study were selected from larger school districts because over half of the funds from schools came from local property taxes, and the way the system of funding was set up for districts, this structure generated differences in the amount of money they received among states, among school districts within each state, and even among schools within specific districts (Biddle & Berliner, 2002). Due to funding structures in public schools, the larger districts were more likely to have the staff and monetary resources that it tool to sustain a school-based therapist on site because they had more property taxes to fund another resource (Biddle & Berliner, 2002).

Sampling method

Participants in this study were secondary counselors and school-based therapists/psychologists that served 9-12 grade secondary students in 6A and 7A schools as described by the Arkansas Activities Association. Convenience sampling was used in this study to select participants. Convenience sampling was appropriate because counselors/school-based therapists who met the criteria above and volunteer to participate were selected for this study (Creswell & Creswell, 2018).

To recruit participants for this study, the names and email addresses of counselors and school-based therapists were acquired through the Arkansas Department of Education (ADE). The ADE's school-based mental health resource department generated

a list of counselors throughout Arkansas and sent that via email to ensure that all addresses were current. Another email was sent to the School Based Mental Health Services Coordinator for the Arkansas Department of Education requesting a list of the names and email addresses of school-based therapists in Arkansas. Further, an email was sent to all counselors and school-based therapists in the 6A and 7A secondary schools that were identified through the Arkansas Activity Association, and there were usually 33 schools in this classification during any given year in Arkansas (Arkansas Activities Association, 2019). After all of the contact names were collected from those selected schools identifying the counselors and school-based therapists, an invitation email went out to SBMH counselors and therapists currently practicing in Arkansas 6A and 7A containing only 9-12 grade students. The recruitment email was sent out on three separate occasions over a one-month period until enough participants responded for data saturation to be reached. When a counselor and/or therapist indicates he/she was willing to participate in the study, a time was set up to conduct the interview and an email with the demographic survey was sent out the participant prior to the interview.

Data Collection

Data collection occurred using electronic demographic surveys and followed up with interviews.

Survey

Three SBMH professionals and a faculty member from Arkansas Tech University reviewed the demographic survey instrument for clarity and appropriateness before distribution. The survey consisted of 15 questions. Questions 1-4 represented demographic questions that address age, gender, and race. Questions 4-7 addressed level

of education, experience level, and years in counseling or school-based psychology/therapy work in high schools. Questions 8-15 examined the training experiences and certifications and associations that the counselors and school-based therapists were a part of in their profession. No student information was acquired. Survey questions were moved to Appendix A.

Face-to-face interviews

Interviews were conducted at a time and place that was agreeable for the participant. Interviews were recorded with a digital recorder. The interview recording was sent off for transcribing to a company called Transcribeme.com. Interview questions were informed by the literature and used an open-ended format through the qualitative method (Patton, 2002). The open-ended interview questions were shared with a peer and a faculty member from Arkansas Tech University for revisions and suggestions prior to conducting interviews. Those suggestions were taken into consideration and the interview questions were modified at that time.

Interview questions. The interview questions used for this study were as follows:

1. How much time do you spend delivering school-based mental health services to students with the most need?
2. What constraints hinder your abilities to deliver mental health services?
3. What is the most difficult part about your job?
4. How do you feel about your job in your secondary school?
5. Do you feel more needs to be done for secondary students and/or the profession, if anything? Please provide examples and explain.
6. What are the limitations in providing services to students?

7. How do parents impact your ability to provide services to students?

8. What types of mental health services does your district/school provide to students? Provide examples and explain.

9.How has your job role changed over the time that you have worked with school-based mental health services? Provide examples and explain.

10. What types of mental health services do high schools provide?

11. From your experience(s), what role do you think school counselors or school-based psychologists should have in school-based mental health, if any? Please provide examples and explain in detail? *

12. From your experience(s), what are the benefits of having counselors and/or school-based psychologists in secondary schools? *

13. Is there anything in this interview that you would like to add that has not been covered?

14. Is there anything in this interview that you would like to add that has not been covered?

15. Is there anything in this interview that is a barrier to delivering the services that students need that you would like to add that has not been covered?

The questions with asterisks were adapted from Cothrell (2014).

Credibility

Building credibility through multiple sources of data ensures authentic information and enabled the researcher to find the patterns and themes needed to share quality data (Patton, 2002). It was necessary for qualitative research to be trustworthy,

reliable and objective (Patton, 2002). Credibility was essential to ensure the authenticity of the work as well (Creswell & Creswell, 2018).

In this study, the researcher-built credibility via the use of expert reviewers for the interviews and surveys (as noted above), member checking, and engaging in a reflexivity exercise. For member checking, the researcher sent back the developed or partially developed product to the participant outlining themes and/or significant findings and asked the participants to check for accuracy and have those sent back to the researcher (Creswell & Creswell, 2018). Conducting an additional follow up interview with the participants also added more credibility to the study by allowing the participants to give additional feedback on the findings (Creswell & Creswell, 2018).

Reflexivity

Reflexivity means "to reflect on" (Hamby, 2018). It was the way of "emphasizing the importance of self-awareness" (Patton, 2002). He also went on to narrow the lens even more by focusing on the "ownership of one's perspective," noting that reflexivity included the "what I know and how I know it" (Patton, 2002). Reflexivity allowed for the author to demonstrate his/her perspective, knowledge about themselves and a deeper awareness of their cultural and/or political views (Patton, 2002). This was important for credibility so the reader had an awareness of where the author's journey had taken them, their perspective, and why the topic was important to the author and that they were trusted (Patton, 2002).

In this section, I disclosed information to help the reader understand who I am, and how I know what I know (Patton, 2002). I was raised in small town by parents who

have traveled the world because my father was in the military and our family went wherever my father's job took us. My parents stayed married my entire life, and my father worked outside the home, as my mother suffered from severe depression that eventually lead to agoraphobia for her. Neither of my parents sought help for my mother for this issue, and I believe it was because of the stigma that came with seeking help for a mental illness or being labeled crazy. Only much later in her life did my mom finally seek help and recover from this debilitating psychological issue. I also felt compelled to disclose that I have a daughter who had suffered from crippling depression and anxiety, and in my family's journey to help her, I had also been touched by mental health professionals in all areas from SBMH professionals, and outside of school, mental health professionals. These professionals worked together to assist in helping my daughter deal with these mental health issues, and it has been a long journey through medicines, services, treatments with failures and successes.

In my professional life, I have been in public education for 27 years serving students in many different capacities and levels. I have been a teacher for 14 of those years, and I have been in public school administration for 13 of those years. Over the past 27 years in education, I have seen students who have struggled with mental illness, been suicidal, and needed compassion and help in understanding their unique problems and issues. I have also noticed an increase in students with various mental health issues such as anxiety, depression, attention deficit disorder, bipolar, reactive attachment disorder and numerous other issues that were even more serious, such as suicidal ideation. I have always been the type of person who wanted to help, not just because of my own personal connection to mental health issues, but also because I believe schools could better serve

students if the perceptions of SBMH professionals were known and studied. I felt I did, in some small way, add to what was already known on this issue in order to help students who struggled with mental health issues. I know this topic was real and valuable because some students were not receiving the help that they needed and/or deserved through our current system. I wanted to add to the body of work done on this topic to share and discovered what information may benefit students and/or this profession.

I work with several SBMH professionals. We worked closely on student cases and also with students who were placed in mental health facilities for extended times and/or short-term stays. I believed our relationships were very professional and congenial. I perceived the 9-12 mental health professionals in a light of respect, and I viewed them as an authority on student mental health because they helped students stay in school and get the education that our educational system required of all students. The professionals in SBMH had the same degrees that private mental health professionals had and decided to service students in the 9-12 grade setting to help students grow, manage their mental health, and also help teachers and other professionals manage the care that these students needed in the medical and/or mental arena.

Data Analysis

The data collected for this study was transcribed, coded, and sorted into themes using the constant-comparative method, which allowed for the researcher to methodically organize the data and search for significant patterns and themes (Patton, 2002). The data was "first delimited and then, if necessary, carefully extended by a return to data collection according to the requirements of theoretical sampling" and the "theoretical criteria emerge grounded in the data" (Lincoln & Guba, 1985, p. 344).

Summary

This qualitative, phenomenological study examined the important perceptions and experiences from Arkansas' SBMH professionals while they diagnosed, treated, and served students in grades 9-12. While studying these professionals, barriers were uncovered and delineated for these mental health professionals as they delivered services to Arkansas' larger 6A and 7A schools with secondary students in grades 9-12. This chapter described the methodology, including the instruments used to discuss and conduct the research. The study incorporated a demographic survey and face-to-face interviews to reveal the experiences and perceptions of these SBMH professionals. The four to five counselors and four to five school-based therapists/psychologists that serve Arkansas' 9-12 grade students in 6A and 7A schools as they are defined by the Arkansas Activity Association.

CHAPTER 4: RESULTS

Having SBMH professionals in schools can enhance student success in academics, problem solving skills, physical and psychological safety and overall-mental wellness (NASP, 2019). Since this study is about SBMH professionals' perceptions and experiences with high school students, it is important to note that students at this age need guidance, and SBMH professionals can give students this guidance and identify early roadblocks to learning and developing skills that are so important for academic achievement (ASCA, 2019b). However, little is known about secondary SBMH professionals' perceptions and experiences in Arkansas 9-12 schools; therefore, it is important to explore SBMH professionals' perceptions and experiences working with secondary students in the 9-12 educational setting in Arkansas. The purpose of this study was to understand the perceptions and experiences of SBMH professionals inside of Arkansas'9-12 secondary schools. The research questions explored in this study were:

1) What are the SBMH professionals' perceptions and experiences as these professionals diagnose, treat and serve their students in grades 9-12 in Arkansas?

2) What do SBMH professionals perceive as barriers for the delivery of mental health services to Arkansas secondary students in grades 9-12?

Sample Information

Ten participants were interviewed for this study--five SBMH therapists and five high school counselors. Convenience sampling was used in this study to select participants. Convenience sampling was appropriate because counselors/school-based therapists who met the criteria and volunteered to participate were selected for this study (Creswell & Creswell, 2018). Since data saturation had been reached after 10 interviews,

no more participants were recruited for this study. Data saturation occurs when no new information was collected (Creswell & Creswell, 2018).

Tables 1 and 2 encapsulated the demographic information for all participants in this study. Nine were females and one was male; further, nine were Caucasian and one was Hispanic. Seven belonged to a professional organization in their field, and three did not. All ten participants had counseling and/or SBMH therapy experience in grades 9-12 in 6A and 7A schools in Arkansas. In terms of experience in counseling and SBMH therapy, participants ranged from two to 24 years. Seven participants had experience in rural schools, and three had experience in suburban schools. Four participants had worked in Title 1 schools, which indicated there is a high poverty rate inside of those schools.

Table 1

Participant's Demographic Information

Participants	Age	Race	Gender	Years of Work Experience	9-12 High School Counselors	9-12 SBMH Therapist
1	63	Hispanic	Male	15		Yes
2	54	Caucasian	Female	22	Yes	
3	30	Caucasian	Female	2	Yes	
4	36	Caucasian	Female	9		Yes

5	33	Caucasian	Female	11		Yes
6	49	Caucasian	Female	13	Yes	
7	52	Caucasian	Female	12	Yes	
8	53	Caucasian	Female	24	Yes	
9	41	Caucasian	Female	18		Yes
10	34	Caucasian	Female	12		Yes

Table 2

Participant's Demographic Information

Participants	Level of Education	Title I School Experience	Type of Schools	Licensed therapist in State of AR	Professional Organizations
1	Doctorate Level	No	Rural	Yes	AACC or ARMEA
2	Master's Degree	No	Suburban	Yes	ASLA
3	Master's Degree	No	Rural	Yes	ASCA & ARSCA
4	Master's Degree+18 hours	Yes	Suburban	Yes	NCCA, EGAHA
5	Master's Degree	Yes	Rural	Yes	NBCC
6	Master's Degree & Specialist Degree	No	Rural	Yes	ASCA
7	Master's Degree	No	Suburban	Yes	None
8	Master's Degree	Yes	Rural	Yes	ASCA
9	Master's Degree-current doctorate student	Yes	Rural	Yes	None
10	Master's Degree	No	Rural	Yes	None

Findings

The findings in this study were outlined by themes that emerged from the data that was collected. The themes that emerged were connected to the two research questions mentioned above in this chapter. There were six themes that emerged from research question one. There were two themes related to research question two. The themes had several sub-themes and are discussed below.

RQ 1: What are the SBMH professionals' perceptions and experiences as these professionals diagnose, treat, and serve their students in grades 9-12 in Arkansas?

While studying the perceptions and experiences of SBMH professionals as they diagnosed, treated and served their students, several themes emerged from the data gathered from SBMH therapists and high school counselors. Some of the themes that the data revealed were specific to both SBMH professionals and some were different. There were nine interview questions that were used to collect the data to help answer this research question. The interview questions that related to research question one was 1, 4, 5, 7, 8, 9,10, 11, and 14. After going through the data produced by the answers to interview questions' from each of the SBMH participants, the themes that emerged to answer research question one were: time is important, perceptions and experiences about the job and assisting secondary students, suggestions for improvements in SBMH professionals' jobs, changes in job roles, experiences and interactions with parents, while treating and serving students, and serving and treating students (see Table 3).

Table 3

Research Question 1 Themes and Subthemes

Themes	Subthemes
Time is important	
Perceptions and experiences about the job and assisting secondary students	Job satisfaction Secondary students "need SBMH services"
Suggestions for improvements in SBMH professionals' jobs	
Changes in job roles	Number of students' "mental health issues has increased" School demographics and poverty issues Threat assessments
Experiences and interactions with parents, while treating and serving students	"Parents not being supportive" "Parents being supportive"
Serving and treating students	The most difficult issues to treat Least challenging issues to address One-on-one direct services

Note: Quotation marks represent in vivo codes

Time is important. When discussing their perceptions and experiences with diagnosing, treating and serving high school students**,** all high school counselors and SBMH therapists (10/10 participants) felt that time was an important factor and resource in helping students with SBMH issues. The reasons were slightly different between the two SBMH professionals. Both types of SBMH professionals in this study seemed to think time was centered around their students, and how much they could see them while they were in school. Each type of SBMH professional needed time with students to be

effective in their jobs. Both SBMH professionals also discussed time in different ways. Their issues with time and need for time were shared in Table 4. Participants and quotes were labeled together.

Table 4

SBMH Professionals' Descriptions of the Way They Perceived Time

SBMH therapists' scheduling and issues related to time	High school counselors need more time for supporting and connecting with students
"Students need more time with the therapist for a positive outcome" Participants 1,5,10	"It's about having positive interactions with kids" Participants 2, 3, 6,7,8 "Quality not quantity" Participants 6,7 "Building that rapport" Participants 8,2 "Students just want to come in and talk" Participants 3,6,8,2,7
"The window of time with HS kids is a class period or two" or "limit services to one class period" Participants 4,10,9	"Students need time to feel comfortable with their counselor" Participants 8,2
"Time is important to help students process out some of the things they do in treatment" Participants 1,5,7,9, 10	"Large number of students" "300 to 450 students to one counselor" Participants 2,3,8
"Takes time to finish up sessions" Participants 1,5,7,9, 10	"We need more time with the kids" 2,3,6,7,8 "more time to get the students career ready" Participants 6,7

Note: Quotation marks represent in vivo codes

The quotes in Table 4 highlighted the differences between high school counselors and SBMH therapists' roles. High school counselors had direct access to students and could call the students directly out of the classroom at any time that they needed to speak to a student, while SBMH therapists had to schedule the time with the student and check students out through the office, which was time consuming. SBMH therapists did not

have direct access to students like high school counselors did. Two SBMH therapists in this study had offices on the high school campus where they worked on a daily basis; however, three of the SBMH therapists in this study contracted out services with the school district they worked for, did not have any direct access to students in their caseload and were not housed on the high school campuses they served.

SBMH therapists discussed time in terms of how long the high school student needed to "process mental health issues" they were dealing with because SBMH therapists were limited in the "amount of time they could use to meet and treat students in one class period." For high school students, class schedules are different for every single student. SBMH therapists were limited to how many classes they were allowed to take a student out of for therapy. They also discussed needing more time to have a "positive outcome for that student." Scheduling the student's time and getting time with students was one of the major mitigating factor discussed by the therapists in this study.

High school counselors, however, spoke about the use of time as a way to "support and connect with their students." High school counselors wanted to have time with students to "come in and talk." They felt the time they had with students was about having "positive interactions" with their students because they did not typically meet with students for one entire class period like SBMH therapists would and did not help students "process out" deep traumatic incidences either. High school counselors felt that their time was very limited, due to the fact, they have so many students ("300 to 450" per counselor). SBMH therapists did not have that number of students in their case load, so their time was more focused on a lower number of students with more severe mental health issues. High school counselors needed more time with their students because they

speak to them about standardized tests that they have taken, career choices, direction of their lives, and getting them graduated and on to the next phase of their lives. They also used that time to help with minor mental health issues like anxiety, students' problems or issues with other students, fights with parents, and other stressors that high school students encountered.

Perceptions and experiences about the job and assisting secondary students. While studying the perceptions and experiences as they diagnosed, treated, and served high school students, high school counselors and SBMH therapists responded to how they felt about their job and working with secondary students. As they responded, all SBMH professionals (10/10 participants in this study) noted they liked their jobs or they loved the work they did every day with secondary students. These professionals also discussed the fact that secondary students need SBMH services. Both of these sub-themes are described in detail.

Job satisfaction. All of the SBMH therapists and counselors (10/10) in this study seemed to like their jobs and were satisfied with the job that they do. They also seemed to enjoy being around the other counselors and people in the buildings they worked with every day. All of the SBMH professionals in this study (10/10) felt like they had support. One counselor also mentioned the school schedule offered her time with her family and her support in the building. Participant 7, a high school counselor stated:

> "I love the school calendar. You know, that was one of the reasons I chose education. I want to be a wife and a mom and have family and kind of enjoy that time with my own children. I like the team I work with. I like what I do."

Participant 2, a high school counselor also stated: “I feel pretty good about it. I think that I and all of the counselors here, you know, we come to work every day and do the best job that we can every day.” Participant 1, a SBMH therapist, mentioned one of the reasons he liked his job was because he was “actually on the high school campus with all other employees who were fulltime and able to build deeper and longer lasting relationships with students.” Participant 1 discussed the SBMH therapy model in his school. He was one of the few SBMH therapists who was located on the actual high school campus with the students. He said:

> I love it. Now, I'm biased, but I- I feel like the model we have here in our school is the best model that can be implemented. And, I understand with finances and just locations and resources available and that sort of thing can dictate how school-based mental health is implemented in the different secondary schools. But I'm actually an employee of the school, all the benefits of a school teacher or whatever. But I think what makes it so fulfilling for me is I'm here at school all day, every day. So, I think to me that's what makes me to be very satisfied with my job here is just the availability I have to the students and the rapport I have with the faculty and staff.

Another high school counselor, Participant 3, also stated: “My experience so far has been, especially as my first job, and I'm loving it. It's good. This is definitely the area that I enjoy the most.”

Secondary students need SBMH services. All SBMH professionals (10/10 participants) in this study reported that high school students needed the services that the SBMH professionals delivered to students. They felt because of the “adolescent

developmental stage" of 9-12 graders, these students needed SBMH "services the most because of added life stressors." Students at this age had more "crisis situations and were vulnerable." Participant 9, a SBMH therapist, discussed why this was the most challenging group for whom to provide services, and why those services were needed:

> I think it's probably one of the most challenging environments, but one of the most needed environments. I think that you know, high schoolers with sort of that adolescent developmental stage are harder to engage at times, but I think that's also an area where there are lots and lots of added stressors, and those students are some of the most vulnerable in terms of meeting those coping mechanisms.

Participant 6, a high school counselor, discussed what she would like to see with her secondary students, and why these services were needed for secondary students:

> It would be really nice if we had the opportunity to be proactive about things as like suicide awareness and coping skills and study skills. Perhaps, just being able to go out and do mini lessons on some things. I feel like now my job is more reactive. I see students when they are in crisis mode instead of doing anything to prevent that. Now, we have kids who-who are crisis when we see them.

Participant 8, a high school counselor, revealed the gravity of her work with secondary students:

> I'm, all of us in this office, we have all the training to be, we're not LPCs, but we have the training to work with our kids as mental health professionals. I think my role, our role, is if a child is in need, we would see them two or three times. If we cannot resolve that issue, and they need more in depth counseling, we refer them

> to an outside agency, because I have around 400 kids. And, I can't devote three days a week, all semester to one kid, that's not fair. I have too many other kids who need me also. So, we refer out. So, my role is more a triage. And then I move them on, and hopefully, we can resolve whatever their issue is, but if we can't, they we try to move them on

Participant 3, a high school counselor, that discussed why she enjoyed this age group, and why they need these services provided to them:

> I love this level of students. I love that they're starting to get to a part in their life that they can work through a lot of things and we just are kind of there to guide them. I just love the environment. I love the different things that I need to do that'll go into, hopefully making them successful adults once they leave us.

Suggestions for improvements in SBMH professionals' jobs. The SBMH professionals in this study had no shortage of suggestions for how to improve the profession or ways to help students in secondary schools. Both high school counselors and SBMH therapists had several ideas of what would be best for the students they served. Table 5 captured the specific and different improvements that were suggested for SBMH professionals' jobs.

Table 5

Participants' Individual Quotes about Improvement in SBMH Professionals' Jobs

Participants	Quotes
SBMH Therapists	
1	"I think more therapists in the school that can stay there all day, every day, plus long-term, being employed long-term."
4	"Be more proactive instead of reactive-get to kids before something happens" "more access to students."
5	"I think the teachers should probably be educated more about mental health, and about behavior." "different things to look out for, red flags."
9	"I think we need to be implementing K-12 SEL programs because when you start with a kindergartner-doing social/emotional learning."
10	"SBMH therapists all over the state be in a consultant role with our educators, whether that is one-on-one with this particular English teacher who's having difficulty with some management of school-based mental health kids in her classroom."
High school counselors	
2	"We need more counselors. We need more school-based mental health professionals."
3	"We need more counselors in schools for the health and well-being of students."
6	"Making sure that students have more options and programs for them because we need to do more for students"
7	"Inform parents about social media and technology-there needs to be more awareness with technology and the way it impacts students."
8	"Take away administrative duties, so we can be addressing students' social, emotional and educational needs."

As demonstrated in the quotes from Table 5, each of the SBMH therapists and high school counselors had individualized opinions on how improve their jobs. One SBMH therapist (Participant 1) believed SBMH therapists should be on the school campus with the students. This participant wanted to see more therapists on high school campuses right along with high school counselors:

> I just think it'd be much more effective to have more therapists in the school all day, every day. And nothing against the agencies, because they do what they can do, and they can't help. They can't force people to work for them and to stay with them. But, something that thankfully we haven't seen in a couple years, but three or four years ago, I know in one of our schools we're contracted with the community agency. They had- I want to say they had like eight therapists that year, just every couple of months a therapist would leave and go to another job. So, they'd place another one. I think more therapists in the school that can stay there all day, every day, plus long-term, being employed long-term. And like myself, this is my 13th year here, so being here that long, with students; they learn who I am in 9th grade, and so it's a continual stability with them and with the faculty and staff and administration. So, I just think, if something could be done, to have more therapists in the school all day, every day, that that would really, really help.

Participant 4, a SBMH therapist, felt that there needed to be more access to SBMH services for students:

> You know, after there's an issue or there's only kids that were referred through the school counselor for certain issues that we have seen. So, we'll have kids come

> and say, "Hey, I know you see Ben, or can I talk to you?" You know, because their friends have told them like, "Oh, I, I trust this person. I feel comfortable." And it's like, well, sorry, I can't see you. You know, and so I just think maybe if we have more access. Especially the high school kids. There's a lot going on in their lives that they don't necessarily tell anybody about. And so, I think that if it was easier access for them to have, or for them to have easier access to some of those services. I think would be helpful. I think that there's a lot of stuff that goes on in their homes that they would probably come and talk to you people about instead of really just kind of suffering in silence.

Participant 5, a SBMH therapist, felt that teachers should be educated more and included adding more professional development:

> I think the teachers should probably be educated more about mental health, and about behavior. I know they get some of that in professional development and stuff, but I think that they could use more of that. You know, different things to look out for, red flags, that kind of thing.

Three of the five high school counselors in this study wanted to see all their administrative duties taken away so they could have more time with students. Participant 2 addressed the amount of student that high school counselors served, administrative duties, and why there needed to be more counselors in Arkansas' secondary schools:

> I really feel that, and you know I've talked to other counselors across the state. I really feel that we really need to have more school counselors. I mentioned a minute ago that most counselors in my district have a caseload of 450 kiddos and

> that's just a lot to keep up with, so I feel like we need more counselors. We need more school-based mental health professionals. We need more time to visit with the kids and less time doing administrative duties.

Two of the five SBMH therapists in this study wanted the implementation of social and emotional learning programs implemented starting in Kindergarten, so the behavior changes would be clearly seen in the 9-12 grades. Participant 9, a SBMH therapist, reiterated social and emotional learning (SEL) needs to be implemented K-12 because:

> I think we need to be implementing K-12 SEL programs because when you start with a kindergartner-doing social/emotional learning-and that's consistent throughout -you don't necessarily see those changes in kindergarten, second grade through fourth grade. Where you really look at those behavior changes is ninth grade, 10th grade, 11th grade. When you work with those students from elementary school on, I think that that will impact those high school coping mechanisms. I think that, that your fighting will go down; I think that tantrums and meltdowns will go down. So, I think that's something that needs to be started from the beginning.

Two SBMH therapists believed that high schools needed to implement mental health classes with high school students and ways to reach out to that age group to let them know how to find, access and receive services. Participant 9, a SBMH therapist, discussed changes that should be done to help students' success:

I think that some of the most important services that school-based mental health or therapists can provide to high schools get looked over because they're not considered treatment services-and that's consultation with our educators. I would love to see our school-based mental health therapists all over the state be in a consultant role with our educators, whether that is one-on-one with this particular English teacher who's having difficulty with some management of school-based mental health kids in her classroom.

Changes in job roles. The SBMH professionals' experiences and perceptions about their job roles were just as individualistic as the improvements they suggested in Table 6. As they worked in Arkansas' 9-12 schools**,** participants noted the job of SBMH professionals in secondary schools had changed over time.

Table 6

Participants' Individual Quotes about Changes inside SBMH Professionals' Jobs

Participants	Quotes
1	"One thing is I think there's more support for me personally and more interventions available. Some of the tiered interventions, for example, and now we have threat assessments too."
2	"The large number of students that we have who have mental health issues. I'm talking serious mental health issues Bipolar, schizophrenia. We have students who have been in treatment facilities multiple times dealing with the suicidal students, so all of those we have seen the numbers drastically increase."
3	"I am new at this job, so my responsibilities are growing as I grow in this job."
4	"The demographics of the town are changing. And so, you're starting to see a lot more, lower income stress and poverty."

5	"I'm so busy. I'd say it's gotten busier over the years. Which isn't necessarily a good thing, but there's definitely a need there. I mean the paperwork process has changed just because insurance companies are always changing requirements and different things."
6	"I think we do more testing now. I know we do more testing now than we did. You're looking at has quadrupled from one test to four. 10 days per test."
7	"I think social media, you know technology changes are in their lives and our lives tremendously. I don't think a lot of parents are aware of what is out there and what all consumes their kids' time and energy and the dangers and the chaos that can be created in social media, and the distractions of technology and the availability, and you're on call all the time, they're brains."
8	"I have more administrative duties than I had in the past."
9	"Our district changed and we expanded our program and opened a district wide school based mental health program. I have gone from being a direct practitioner to an administrator, and I provide support during emergencies."
10	"I think the services that we have provided changed. We used to have designated group times, and now schools don't want kids out at the same time. On the mental health side of things, there are different expectations of services that have become more difficult to justify for kids"

Though the changes mentioned were comprehensive and specific to each SBMH professional, the changes participants discussed can be broken down into three general categories: (a) number of students' mental health issues has increased, (b) school demographics, stress, and poverty, (c) threat assessments.

Number of students' mental health issues has increased. Counselors and SBMH therapists in this study all dealt with a variety of student issues, including poverty, bullying, technology, issues with other students, and relationships (i.e., friendships and

romantic relationships). SBMH professionals also addressed student safety, violence, and disorders like ADHD, anxiety, anger issues, and depression. They also dealt with suicide and suicidal students. With all of the issues that secondary students face, all of the SBMH professionals spoke about how the numbers of student mental health issues had increased.

Participant 5, a SBMH therapist, said "it's gotten busier over the years. Which isn't necessarily a good thing, but there's definitely a need there." Participant 2, a high school counselor, said that the number of students that were seen with mental health issues like "bi-polar, suicide and ones that go in and out of treatment facilities" was significantly higher than in the past. Participant 2 talked about what she saw in high schools as she discussed the changes since she had been a secondary counselor in her high school:

> So, I would say one of the biggest differences in my job now, and when I first started, I mentioned earlier is just the large number of students that we have who have mental health issues. And I'm talking serious mental health issues like bipolar and schizophrenia. We have students who have been in treatment facilities multiple times dealing with the suicidal students, so all of those we have seen the numbers drastically increase." Participant 5 discussed how much busier she was: "I'm so busy. I'd say it's gotten busier over the years. Which isn't necessarily a good thing, but there's definitely a need there."

Technology had become a big issue for Participant 7, a high school counselor, who alluded to the fact that it "consumes kids' time and energy and the dangers and the chaos that can be created in social media, and the distractions of technology." Participant 7, emphasized that technology has changed her role, and mentioned social media specifically, and how it impacted the number of students that she served, and how this changed her workload and increased it. Participant 7 discussed technology and what that brought to the high school counselors' role:

> Again, I think social media, you know technology changes are in their lives and our lives tremendously. I mean part of me feels like parents are more disengaged. I think technology is the easy thing to say. I don't think a lot of parents are aware of what is out there and what all consumes their kids' time and energy and the dangers and the chaos that can be created in social media, and the distractions of technology and the availability, and you're on call all the time, they're brains. I think there used to be more awareness maybe. Even as I say they're disengaged; you know then here at school we're trying to help them be aware. Do you understand what Snapchat and Instagram and what all these things are? And a lot of parents don't.

One SBMH therapist, participant 9, mentioned that her job had become more administrative and evolved in to her running the SBMH program and providing clinical support in emergencies, so the number of students being seen had increased. Participant 9 said: "So, I have gone from being a direct practitioner to an administrator, and I just provide clinical support during emergencies."

School demographics and poverty. SBMH professionals in this study also helped students deal with the stressors and pressures they faced as they went through various developmental stages in their lives. Some of these stressors and pressures related to their lives at home and stemmed from poverty. These changes brought poverty to high schools and with poverty came different stressors for students. Participant 4, a SBMH therapist, stated that the "demographics in the schools in which he/she worked in the district had changed," and now, they see more "low-income stress and poverty issues." Participant 1, a SBMH therapists felt like he "does more social work" too and felt that there was "not a great deal of social workers in his area", so he had to do that type of work and "help those students meet basic needs like clothing and food." Participant 4, a SBMH therapist, watched a school's demographic population change and poverty became the most pressing issue that she was addressing. She discussed the changes in her town and job:

> And now, the demographics of the town are changing. And so, you're starting to see a lot more lower income stress, poverty. And it's interesting to just see how the school is dealing with it in general." Another SBMH therapist, participant 5, agreed with high school counselors that it was the "sheer number of issues, and the issues that they saw and treated had become more severe.

Threat assessments. SBMH professionals in this study also addressed student safety and violence, as these have increased inside of Arkansas' 9-12 schools. They spoke about treating students' anger issues and problems stemming from the violence that students saw and/or dealt with in their lives. Participant 1, a SBMH therapist, discussed the concern that students with mental health issues needed to be identified to help with the safety of schools with "threat assessments." Participant 5, a SBMH therapist, stated

that teachers need to be taught specifically about the "suicidal, homicidal red flags." Participant 5 continued to discuss anger: "I think what stands out is anger and behavior issues specifically because it seems like that's what I mostly get like behavior classroom type and ALE type setting of kids."

One SBMH therapist (Participant 1) discussed threat assessments, and how they has evolved over the years to come to the forefront of school's expectations of assessments that SBMH therapists currently address in schools:

> I understand too as they get older, they're capable of more things than when they're younger. I started looking online, and I found the Salem Kaiser model in Oregon, and the school actually sent me and two of my colleagues out, and we went through an intensive training. And it's a tiered intervention where and when I do a threat assessment, either a principal or assistant principal is in with me, the resource officer, and a school counselor. Then we, you know, make an educated decision among the four or five of us. And- and so that sort of thing has changed.

Experiences and interactions with parents while treating and serving students. Interacting with parents was a topic that all SBMH professionals (10/10) in this study wanted to discuss, and each elaborated on several elements that parents brought to their role in serving, diagnosing, and treating students in secondary schools. All SBMH therapists and high school counselors (10/10) in this study had encountered both supportive and unsupportive parents while they served secondary students. These sub-themes are described in detail in this study.

Parents not being supportive. According to the participants in this study, parents played an important role in the success of SBMH therapists and high school counselors' successful treatment and service of high school students. Both types of SBMH professionals sought to solicit parents' cooperation as they diagnosed, treated, and served high school students. Legally, SBMH therapists are required to have parental consent to diagnose, serve, and/or treat high school students that are not 18 years old. However, participants reported there were times when parents were not supportive and actually hindered the treatment of their child or refused treatment and/or to give consent for their child to receive services. Participant 1, a SBMH therapist, revealed the problems he/she and the students faced when parents were unsupportive:

> I guess several things. One, you can work with the child here, at school, and make improvements, but if the parent is not inclined or have any ambition or desire to change the environment at home, I guess the old saying, you're beating your head against the wall. You help the student here, but then they go back to the same environment and, uh, especially like for the breaks and summer break and that sort of thing. Participant 2, a high school counselor, went on to discuss unsupportive parents: "We have had instances where parents did not want to have a mobile assessment done on a student who is suicidal. We've had parents who blame the teachers and/or us for their child's not graduating or passing a class."

Participant 3, a high school counselor, discussed another issue with parents not being supportive:

> We have some parents who, we will tell them that their kid is really struggling. Sometimes kids will come in your office, and they, they want you to speak with

their parent. They just don't know how to approach them. And so, in doing that, I think they're hoping to get the help that they are asking for, and we have parents who are really just- struggle with the thought of that, and we have parents who still are in that frame of mind of our business needs to stay at home. You don't go tell somebody about it-regardless of how they're acting out. So, it's those parents who don't get them that help-their kid's in our office every day.

Participant 8, another high school counselor, also discussed non-supportive parents:

> For me, what's hard to deal with, are the kids who are living in homes with parents who are not present. They may live in the home, but they're not present. The other thing is, are those children who come from those homes perhaps, who have been kicked out. We have homeless kids. We have kids who are homeless, that's tough. Because there are so few options for them- going back to what I said earlier, so many, so few things that are available to kids to house them, and mom has kicked them out. You're 18. Well, they're not competent to raise themselves at this point. So, we've got kids who are couch surfing, or I had a kid live in a car. Okay, we've had kids living in, in the street really. Live under the bench over at the McDonald's for a while, and we know that**.**

Participant 4, a SBMH therapist, also discussed what happened when parents checked out of their children's lives:

> Then, you have parents that don't care and that don't know what's going on, and they don't remember when they talked to you. They are so checked out. Because, if you really need the parents support or their input or there's a family issue, and

> you need them to come in so you can talk about it, and they just don't return your phone calls or don't talk about anything. It's hard to really get that care, sometimes proper care.

Participant 5, a SBMH therapist, also went on to discuss non-supportive parents:

> They(parents) kind of are like, "You deal with them, and make them great, and everything will be merry." And it just doesn't work like that.

Parents being supportive. Even though all of the SBMH professionals (10/10) admitted that unsupportive parents are a part of their experiences with parents, all of the SBMH professionals (10/10) discussed the supportive nature of most parents when approached about diagnosing, treating, and serving their children inside 9-12 high schools in Arkansas. Their experiences and perceptions of the positive support from parents is outlined through many comments from participants in this study. For example, Participant 4, a SBMH therapist, said "Some parents, meet and they're great, and they're involved. They know what's going on, and they will do whatever their kid needs to get help. So, they're amazing." Participant 6, a high school counselor, stated: "In our community, parents are typically a big help. I mean there's always going to be exceptions to everything, but those are very few and far between. Our parents are just good. We have good parents."

In the mind-set of having supportive parents, sometimes parents are overly involved with their high school students. Developmentally, high school students should be able to make simple decisions, and discuss these decisions with their parents. However, three of the five high school counselors in this study observed parents who

were overly involved in their high school students' lives inside of their high schools. For example, Participant 8, a high school counselor, discussed how overly-involved parents were harmful to secondary students:

> The other thing we see is, they talk about the helicopter parent, we have bulldozer parents. That's a new term, and I have seen it. That parent that doesn't want their child to have any obstacle in front of them, and they run in front of them, clearing it all away. And that's tough, because they may clear it, but then we have children who can't function and deal with things as they come up. And the child, they're always anxious, because they've had everything taken care of for them. So, anything that's a bump, they're too anxious to handle it.

Participant 3, a high school counselor, also discussed parents that are too involved with their student's lives:

> Sometimes, they will want to sit on the phone with you for an hour about something, rather than, their kid can stop in and, and visit with us, learn to be more independent in that sense, or if you don't get right on top of it, they're blowing up your email or calling somebody above you to complain about it, and that eats up your time, because then you sit there, and you have to address this problem.

Participant 7, a high school counselor, further reiterated the need for parents to let secondary students be more independent: "I mean parents that are some helicopters that you know won't let them grow up and let go. And teach them to do."

Serving and treating students. Serving and treating students was an important part of understanding the aspects of SBMH therapists and high school counselors' experiences and perceptions. There were several issues that these SBMH professionals addressed. Both types of SMBH professionals in this study discussed the most difficult and the least challenging issues that they addressed in treating high school students. These are discussed below.

The most difficult issues to treat. Within their experiences and perceptions, all SBMH professionals in this study (10/10) consistently identified suicide, suicidal students, and trauma-based issues (e.g., sexual assault, sexual abuse, physical abuse) as the most difficult issues to treat with secondary students. Participant 1, a SBMH therapist, emphasized why suicide was so challenging to treat with his secondary students:

> Probably the suicidal students. Typically, you know, there's more issues with that. There's depression or there's other things that they're dealing with that you have to work with, but I that's the most difficult, because like I said, that's ones that are hard to leave at school. And, thankfully this year so far, I've only had one. Now, it's probably been five, six years ago. I was working junior high and high school at that time, and that year I had 43 kids suicidal. And, I just worry when you get that many that someone's going to do it. The second most difficult I think are sexual issues like sexual assault.

Participant 4, a SBMH therapist, encapsulated and discussed why the treatment trauma in SBMH was so difficult:

> You know, if you have a set period that you can talk to them. Well, in 30 minutes you can't really, it's really hard to process a whole lot of trauma. To bring it up, to process it, and then I don't think it's fair sometimes to say, I know we just talked about this huge trauma in your life, and you're upset and you're crying, but I need you to leave because you've got to go to math. So, that's a really hard subject to bring up. And so, you have to, it's a lot longer term because you can't do as much in one time. You know, it's just not fair.

Participant 6, a high school counselor, again echoed SBMH therapists' views on why abusive situations were so difficult to treat in school setting:

> The most difficult thing is when you have students who are in abusive situations. That's those situations are absolutely heartbreaking. Those are the things you take home with you. You know to break down, to get in, to let them know that this is a safe place because about this age kids are conditioned, you don't tell what goes on at home. And, I know if they are coming in, and they are finally breaking down and telling somebody about abuse that's been ongoing for years that its-heartbreaking. Absolutely heartbreaking because they are at a point where they're at their ropes end, and a lot of times when I see them, when they get to that point, they are suicidal.

Participant 9, a SBMH therapist, explained why a SBMH therapist should be in secondary schools when dealing with suicide or crisis issues:

> I think the benefit to having them in an educational setting is the ability to address the crisis situation right now. The ability to have somebody who is already

established with rapport, with students, if they have a meltdown, if there's a problem, they're able to come in and, and address those issues right now.

The least challenging issues to address. Although the SBMH professionals in this study dealt with a great deal of challenging issues inside of secondary schools, they also discussed engaging students in less challenging issues. All SBMH therapists (5/5) described working with students with mild anxiety and educational issues such as academic and friend issues. The least challenging issues reported by the high school counselors (5/5) in this study were similar—class changes, schedule changes, and minor issues with friends and family.

Participant 2, a high school counselor, reiterated what the easiest issues were to treat and why:

> I would say talking to students about their schedules for next semester. Those are always easy times, and kind of fun. We get to turn that into some chitchat about what did you do over the weekend and a few minutes of just talking about nothing really important but getting to know the student a little bit better, building relationships would be.

Participant 4, a SBMH therapist, also elaborated about the least challenging issue: "Grades and educational issues like why they are not getting their work done, organizational skills.

One-on-one direct student services. In their experiences in serving and treating their students inside of 9-12 high schools, all (10/10) SBMH therapists and counselors interviewed said that they did 95% individual direct one-on-one services with students in

high school given their ages and issues. The high school counselors did some group sessions with students, when they did class scheduling with students or discussed career and academic needs with students. Both SBMH therapists and counselors (10/10) said they did a few group sessions, but when they treated or dealt with students that it was mostly one-on-one direct services. Participant 5, a SBMH therapist, discussed why one-on-one direct services worked best:

> I mean, I definitely, I do one-on-one, especially for high school. I would love to do some more group stuff. But I don't know how that would work with, and usually, a high school level, it's kind hard for them to do group. I think once they got used to it and exposed to it, they might come around, but they're a little bit more standoffish, you know. Other people have stuff going on like I do. You know, they might they're not alone. But far as for me, I just do individual for those at the high school.

Participant 6 discussed what high school counselors observed with boys and girls:

> We do one-on-one. There might be one-on-one, every now and then we'll do a small group because I'll have a group of girls especially or once a visit. Boys don't want to visit in groups. Girls want to come in-in groups, and they want to visit, and they have friends that they are concerned about so, it's usually one-on-one, but girls in small groups.

Research question one summary. Research question one explored SBMH professionals' perceptions and experiences as they diagnose, treat, and serve their students in grades 9-12 in Arkansas. There were six major themes that emerged from the

data for this research question. First, time is important to both SBMH mental health therapists and high school counselors, and both types of professionals need time to be successful with their students. Students also need the time with these professionals to work through the issues and problems that these students encounter inside of secondary schools. Second, after reflecting on their perceptions and experiences, SBMH professionals in this study were satisfied with their job and enjoyed working with secondary students, who they felt needed SBMH services because of the "developmental stage" of 9-12 grade students. Third, there were several suggestions from the SBMH professionals in this study for improvements in their jobs. These professionals suggested the following: more counselors and therapists in schools, more access to students, more professional development for teachers, implementing SEL programs, being in a consultant role, having more options for students, informing parents about social media and technology, and taking away administrative duties. Fourth, SBMH professionals in this study discussed changes in their job roles in the past few decades; most notably, participants identified that the number of students' mental health issues had increased, school demographics have changed, poverty issues were present in secondary schools, and threat assessments for violent students were a part of high schools now too. The fifth theme that emerged from the data for this research question was that all SBMH professionals in this study had experiences and interactions with parents and went into great detail about how most parents are supportive; they also mentioned there were parents who were not supportive of their work in schools. Finally, the sixth theme from the data for RQ1 was related to serving and treating students. SBMH professionals in this study noted that the easiest issues to treat were mild anxiety, class changes, and minor

issues with friends and family. The most challenging issues to treat for participants in this study were suicide, suicidal students and trauma-based issues.

RQ 2: What do SBMH professionals perceive as barriers for the delivery of mental health services to Arkansas secondary students in grades 9-12?

SBMH professionals perceived several barriers in their delivery of SBMH services. Some of those perceived barriers were specific to SBMH therapists, and some were specific to high school counselors. Some of the barriers they shared together. The interview questions that related to research question two were questions 2, 3, 6,7,12, 13, 14, and 15. The themes that emerged to support research question two were: issues preventing quality services for students and perceived barriers to getting students SBMH services. (see Table 7).

Table 7

Research Question 2 Themes and Subthemes

Themes	Subthemes
Issues preventing quality services for students	SBMH therapist-specific barriers: --"Efficiency" and "Confidentiality" SBMH professionals shared barriers: --"Administrative duties & paperwork" --"Communication" --"Student numbers" --Emotional toll
Perceived barriers to getting students SBMH services	"Access" "Stigma"

Financial

Note: Quotation marks represent in vivo codes

Issues preventing quality services for students. According to the participants in this study, several things impeded them from delivering quality services for students. SBMH therapists (3/5) had the specific perceived barriers of "efficiency and confidentiality." There were two SBMH therapists who were housed on the campuses with the students, so they did not experience the same problems with efficiency or confidentiality that the other three SBMH therapists did. Both high school counselors and SBMH therapists shared the following perceived barriers: "communication", "administrative duties and paperwork", "student numbers" and "emotional toll". These specifics in barriers are outlined in Table 8 and discussed in further detail below.

Table 8

SBMH Therapists' Individual Barriers and Shared Barriers between SBMH Professionals

SBMH therapist-specific barriers	SBMH Shared Barriers
"Efficiency" 3/5	"Communication" 10/10
"Confidentiality" 3/5	"Administrative duties" & "Paperwork" 7/10
	"Student numbers" 7/10
	Emotional toll 10/10

Note: Quotation marks represent in vivo codes

SBMH therapists' specific barriers: Efficiency and confidentiality. In this study**,** SBMH therapists discussed perceived barriers in depth in their detailed comments about efficiency and confidentiality. Also, several of the SBMH therapists (3/5) stated that, because of the students' schedules, actually getting time with students was not

always an efficient or productive process. Getting the students out of classes and scheduling them also conflicted with time in other mandated therapies (such as OT and/or PT). Even though a high school student may need SBMH services, it is not a mandated service, so the other therapies took precedence over SBMH services and left SBMH therapists a shorter amount of time to treat students' mental health needs. For example, Participant 5, a SBMH therapist, discussed efficiency: "One is scheduling. So, I have to work around academics. I have to work around OT, PT, speech any other kind of pull outs they have their lunch, in their activities, and so that's probably the main [barrier]."

Some SBMH therapists (3/5) also mentioned confidentiality as a perceived barrier for the delivery of mental health services because therapists had to have a private office to protect the confidentiality of the high school students. Most of the SBMH therapists were not housed on the actual high school campus, so they did not have a permanent private space to visit with students. For example, Participant 4, a SBMH therapist, discussed the details of specific constraints on confidentiality:

> And, there've been schools that I've gone to that, it's somewhere different every time, or it's a broom closet, or stage. And so, it's not really confidential so that kind of puts an issue on what you feel like you're able to talk about with students.

However, two of the SBMH therapists did have a permanent office on a campus or directly on the campus of the high school.

SBMH therapists and high school counselors' shared barriers: Administrative duties and/or paperwork. All counselors and SBMH therapists in this study (10/10 participants) shared the responsibilities of administrative duties and/or paperwork as a part of their jobs. Because they deal with students' mental health issues

and the various programs that assist them with those issues, both types of SBMH professionals (10/10) must have documentation as part of their jobs to ensure that certain functions for students were documented and handled. For high school counselors specifically, some administrative duties included scheduling classes, handling parent consent paperwork for class changes, documenting failing students' grades, and determining students who could not graduate because of lack of credits. Participant 8 discussed in his/her district counselors have "more administrative duties than has had in the past."

Testing was also a part of what counselors did inside of schools, as counselors were also responsible for delivering the tests to students, managing test scores when those tests come back from the testing company, and sharing those test results with parents and students as well. The paperwork associated with testing took hours and days to complete. Participant 6, another high school counselor, mentioned that she had "more testing duties that could add up to 10 days per test" and felt "this is significantly higher than in the past."

Counselors also helped with 504 Plan paperwork, which protects a student's access to curriculum in Arkansas' 9-12 schools if that student was suffering from a medical issue or disability that kept them from accessing the curriculum. Participant 2, a high school counselor stated: "just different administrative duties that we are assigned, whether its testing, 504 conferences, 504 paperwork, um, special ed paperwork. There is just a whole lot of paperwork that we are required to do that keeps us from spending the time that we need to with one-on-one interaction with the students." A 504 Plan document requires a meeting with teachers, administrators, parents, and sometimes

students to build a plan to help that student be successful in school. This plan also requires paperwork with signatures and minutes of the meeting that was held to protect the student and make sure the student's accommodations were being met inside the high school. This documentation could be used in a court of law if the school were to be sued about an issue dealing with the student. SBMH therapists may also be a part of this process, as a 504 student may have mental health services added to their 504 Plan, but they were not typically involved in the actual meeting or documenting the meeting or accommodations for the students. The same process for paperwork also goes for Individualized Educational Plans (IEP) for students with disabilities. IEP meetings, much like 504 Plan meetings, entailed paperwork, discussions about any issues the students may be having, medications that the students were on, previous issues and problems that those students may have encountered, and how teachers could help students be successful in high school. IEP documentation can also be used in a court of law if the school were to be sued about an issue related to a student with a disability.

Unlike counselors, SBMH therapists dealt with financial paperwork and were required to document how much time they spent with the student, how they spent that time, and what they did while they were with the students treating them for a mental health issue. The documentation included how the mental health issue was addressed, progress or lack of progress with the student, and a plan as to how to help that student be successful and deal with their mental health diagnosis. Participant 5, a SBMH therapist, stated: "I mean the paperwork process has changed just because insurance companies are always changing requirements and different things."

If a student went into a crisis situation, both counselors and SBMH therapists (10/10) were involved in the treatment and documentation process. The counselors and/or SBMH therapists filled out paperwork for parental consent, which was required for SBMH therapists to diagnose, treat, or serve a student in Arkansas' 9-12 schools. SMBH therapists would work on a plan to address this crisis situation. Inside high schools, most situations dealt with suicidal students or students who had suicidal thoughts. In dealing with a suicidal student, addressing and documenting the issue would take hours for both SBMH therapists and high school counselors.

All of the high school counselors (5/5) in this study said that if a student went into crisis, all of the administrative duties they were expected to finish, such as "testing, scheduling, paperwork has to wait." Counselors felt that leaving the administrative duties to address a student's mental health crisis put pressure on them and made them (the counselors) feel like they would not be able spend the amount of time they needed with the students who were struggling with a mental health issue. Counselors also said "administrative duties prevented them from addressing academic issues, home issues, or peer-pressures that all students struggled to handle in high school."

Most SBMH therapists (3/5) also mentioned paperwork as a difficult part of their job. Participant 5, a SBMH therapist, stated: "You know, my paperwork part hinders me, because it does take a huge chunk of time." Participant 2, a high school counselor, outlined the constraints too:

> There were several constraints. One of them is different administrative duties that we are assigned, whether its testing, 504 conferences, 504 paperwork, special ed. paperwork. There is just a whole lot of paperwork that we are required to do that

keeps us from spending the time that we need to with one-on-one interaction with the students.

Participant 3, who was also a high school counselor, discussed more administrative duties as a barrier:

> We have a lot of different roles and responsibilities aside from getting to spend time with kids. Paperwork is a big one in high school. We have testing, that's a big thing that comes in the way of being able to deliver services for mental health with students. Honestly, the main thing is just the paperwork. The scheduling and testing are the biggest ones that affect the time we can. Also, schedule changes, that's a lot of paperwork. There's a lot of paperwork that goes with that as well. Even though a majority of things are on the computer, it has to get into the computer.

Participant 8, also a high school counselor, expressed a similar sentiment:

> The most difficult time wise is the amount of administrative duties. The most difficult thing I deal with as a counselor, is when you have a child in need that you can't find a way to help. That is the stuff you take home. And then, you're restrained sometimes in your time to spend as much time as you want to help them. And that's very stressful.

SBMH therapists and high school counselors' shared barriers:

Communication. For SBMH therapists and high school counselors in this study, communication was essential to treating and serving high school students. However, both types of SBMH professionals (10/10) in this study discussed communication as one of the barriers to doing their job and being effective in their work with students. All

SBMH professionals (10/10) in this study have had issues with communication, and this included the lack of communication, and how it added to the misunderstandings and confusion of their roles inside of 9-12 high schools in Arkansas. Participant 3, a high school counselor, clearly emphasized this issue:

> I guess maybe one of the barriers is just the importance of what we do, and people understanding exactly what we do, and like I said earlier, you can't really put that down on paper. What school counselors used to be, and what they are now are very different. You know, you ask any generation from 50 years ago, their guidance counselor wasn't what they are now. I think the biggest barrier, just people understanding what we're really there- are here for and what we do. Most kids just need somebody to vent to. There are some that need further help and we are not an LPC counselor. It's harder when, when they're at school. They can't come see us every day, but they're really need to be here in class, if possible. So, we want to see kids, but we do have to do it in a smart way to make sure they're learning what they need to learn. Being with you guys and also the educational requirements that you're also responsible for, the credits and because we have to keep that in mind. Whereas a counselor that they see outside of school or comes to see them, they're not really worried necessarily if they're passing everything, or they don't have to hear from their teacher. I have a lot of kids who want to come see me like I'm their everyday counselor, and you have to create that boundary with them so they understand that, and they don't always understand it, and you hope that their parents will get them the help they need outside of school where they are regularly seen in that way.

Another SBMH therapist mentioned all the people that they had to contact and communicate with and all the documentation that went with the job. Participant 10, a SBMH therapist, elaborated on the time-consuming nature of paperwork and communication:

> I think being able to provide good documentation-as strange as that is, you know, when we're working with kids with mental health, documentation is so important-that it also, in order to be really thorough, to document all contacts we have with teachers, with parents with kids, of course and it is very time consuming. I think sometimes things like small encounters with like phone conversations with a parent or something may get missed, and putting that stuff in, because we're so busy actually trying to see the kids and trying to do that. I think maybe documentation or communication as a whole. With school-based mental health, there's a lot of, um, different people you have to communicate with, and so it's then trying to go back and make sure your documentation is thorough for every single one of those, it's just a lot of time.

Specifically, SBMH professionals in this study emphasized three main areas of communication that were sometimes a barrier for them: communication with parents and families, communication with school faculty and staff, and communication with administrators.

Communication with parents and families. Another perceived barrier that high school counselors and SBMH therapists dealt with was when parents did not understand what they did in their work inside of schools with high school students. Participant 4, a

SBMH therapist, specifically discussed parents, and the lack of communication that they had about how SBMH therapists treated their child inside of high schools:

> A barrier of having us in the school would be that sometimes we'll be seeing a kid for a while and then they'll go, all of a sudden, their parent will be like, "Oh we're, we're." You know, you'll be in an IP meeting and they're like, "Oh, well they're getting their medicine over here and they're going to counseling." And I'll be like, what? They just confuse you with the school counselor. And even though when you introduce yourself as a therapist, your licensed, you know. And you explain the difference, they just still think that you're the school, and you're not the same as a counselor at an outpatient clinic. Then you're like, wait a minute, you can't be going to two different services, so I think that may be a barrier. Maybe they just don't understand that, just because we're in school, we're completely the same being as going and paying, you know, $140 dollars an hour to see somebody. Sometimes the hard thing was maybe because you are kind of like a behind the scenes person and maybe just because I was contracted, not really like, a regular teacher.

The misunderstandings in communication also impacted parents as well. SBMH therapists said that parents did not understand that they had the same college degrees and could treat their children just like a private therapist that worked outside of the school district could. Some of those SBMH therapists also did private work with other clients too outside of their district, and the only difference was the pay that they received for that work. Participant 9, a SBMH therapist, discussed some of the perceived mental health misunderstandings that miscommunication fostered:

> I think one of the things that we still battle, although I think it's getting better, is that there is still a misunderstanding about sort of the culture of mental health services. With educators not really understanding how that impacts educational outcomes, and them feeling like that's stuff that needs to be down outside of school. So, sometimes that's very difficult, although I will say that's getting better.

An additional communication barrier for Participant 7, a high school counselor, was that communication was difficult with the families that they dealt with in their community due to a language barrier. When they had a student, who was struggling with a mental health issue, communication with the students' family was slow and took a great deal of time out of the school day to get the student the help they needed. Participant 7 reflected: "If a student is in crisis, we need permissions from parents, and we have a big issue getting in touch with the parents and communicating with them because of the language barrier."

Communication with faculty and staff. Both SBMH therapists and counselors (10/10) also discussed the perceptions of the misunderstandings that lack of communication that surrounded their jobs inside of secondary schools lead to the lack of clarity of their roles. All SBMH therapists and counselors (10/10) in this study often felt that teachers and staff did not know what they did or how they did their jobs.

Participants in this study felt that traditionally, high school teachers were content-oriented and were preparing students for the world beyond high school with content for college and careers in their adult lives. In saying this, teachers may not even be aware of students that were struggling with a mental health disorder, if they were not outwardly

showing signs in the classroom. Teachers may not even be aware that a student was struggling because of the rules and regulations surrounding what a SBMH professional would be able to disclose to teachers. Most high school teachers would understand and have had training on how to direct students to a professional that had more experience in dealing with mental health issues, which begins with the high school counselor. The counselors would help with the mental health issue or would bring in a SBMH therapists to assist in helping the student, if the mental health issue warranted this kind of assistance But, even with training and direction that teachers had in high schools, SBMH professionals felt that teachers still misunderstand their roles and had a lack of clarity as to what they did with students with SBMH issues and lack of communication exasperated the problems.

Participant 9, a SBMH therapist, discussed the lack of communication of just how what they do with students "impacts educational outcomes of the students' that need SBMH services":

> It is about the culture of mental health services-and, with educators, not really understanding how that impacts educational outcomes-and them feeling like that's stuff that needs to be down outside of school. So sometimes that's very difficult, although I will say that's, that's getting better. If they don't suffer from a mental health issue, they have a hard time understanding how can that affect their learning, or how can this impact me, or if they're not overtly systematic? I think the other thing is that, and this is going to sound terrible, but there are teachers who are older-who did not have any sort of exposure-to what mental health might look like in the classroom as they went through school. So now,

> trying to come in and say this is important too, I think sometimes is difficult for them to make that shift. I don't think it's a malicious thing, I think that we're comfortable with the way we learn things-I think sometimes that's just very difficult. One of the things that I tell my staff is, "You know, guys, I get it. You think that the most important thing that these students are going to do all day is that they're sitting with you.

Participant 1, a SBMH therapist, also discussed the barrier of communication with faculty and staff:

> One thing is just educating faculty and staff is to what you're trying to do, and how you're trying to do it and that you're respecting their classrooms too as much as you can. Not as a group, sometimes individually, I may visit with a- a teacher and just let them know what's going on with a student and what to look for if they- if they see something different. And, maybe when a student has either started meds or ... I guess, back- back to several questions ago about parents. Many times, parents would just either take their kids off meds or not get them filled. But if I know a student is coming off medication just let the- the teacher knows, 'Hey, you may see some changes, and just let me know if I can help.'

Participant 4, a SBMH therapist, also discussed the need for communication with other staff members:

> You know, so we kind of do like a mini staffing of just checking in and they let me know, hey, this has happened with these kids, or if I let them know that there's something going on that they need to maybe be concerned with or watch. Just working more closely with them. I definitely don't want to keep them out of it, but

just letting them know that like hey, this is who we're seeing. These support services and just trying to, trying to be absorbed into system. But maybe have like your records and stuff still not combined with like their main records.

Communication with administrators. Communication with administrators was also mentioned as a perceived barrier with SBMH professionals. SBMH professionals (10/10) had the perception that high school administrators weren't clear about their jobs and/or misunderstood what exactly they did inside of high schools. The roles of counselors and SBMH therapists, unless clearly communicated, can be confusing, not only to parents and teachers, but also, to administrators. High school counselors were considered a part of the administrative staff inside of high schools. They work closely with the administration because of the amount of contact that they have with the "master schedule, scheduling students, testing information, helping to get students graduated from high schools." High school counselors worked hard to help with all of the paperwork that goes along with special education students, IEP's, 504's, scholarships and building relationships with parents as well. Due to the lack of communication and contact, administrators are also guilty of not understanding exactly what counselors do and that lack of communication of roles also goes for SBMH therapists too. SBMH therapists, on the other hand, were not usually housed on the high school campus like high school counselors, but for this study, two of the SBMH therapists were on the campus. So, three out of the five SBMH therapists in this study came on and off campus throughout the year, and they came to work with high school students directly. Only when there is a crisis situation, an administrator would be called to interact with the SBMH therapist. Those crisis situations would be like helping a suicidal student, a severe behavior issue of

a student being treated by a SBMH professional already, or an abuse case like that of a parent abusing a student. So, the lack of communication about the roles of SBMH professionals, not only pertained to parents and teachers, but also, for administrators too.

Participant 7, a high school counselor, went on and discussed the lack of communication that surround their role as it related to administrators:

> The students wouldn't have schedules. They wouldn't know how to get them graduated. They wouldn't know if there's a crisis they wouldn't know how to manage it. I mean literally-I think we're the best kept secret in the world. People have no clue what I mean it just hacks me off whenever we don't get any recognition from a principal, and you've been working your butt of for the schedules. My current principal's not like this. You know before school starts and we are just busting our tail and you're like you know what, if you didn't have us nobody would be in any class in any seat. People would not, school would not be going on. I think because we provide all these frameworks and skeletons. And then we are just the middleman liaison for all that. You know, trying to facilitate relationships and we put that together with the teacher or the parent, or you know we get to be the glue too. We're not the bad guy and you're not in trouble when you come to us, but we try to help you keep out of trouble.

Participant 8, another high school counselor, discussed why there was very little communication about their jobs as high school counselors, and how that impacted their jobs:

> And, we all try to pull that load, but I don't know, I guess I just wish it was a little more appreciated for as many places that counselors get pulled every day. A little

more, uh, rec- not that I need a pat on the back, just recognition that somebody says, "Thank you." And I think in this building, you all do. They have no clue. That this one's in, I'm getting an email from mom, I've got a phone call over here, and I've got this from, uh, my superintendent I've got to get done. The Principal of the school is needing me to pull something for a grant he's writing. All these questions, and at the same time, we're dragging kids in here. Those kids going to say they're going to kill themselves. And, I've got teachers saying, "Look he's the, the, this one cheated, and I've called his mom, and he's in trouble." And he didn't even cheat. Next, somebody failed a class, and we've got to get him out of that class, and what are we going to do about that? Sometimes that's, that's overwhelming.

Student numbers. With regard to issues preventing quality services to students, all (5/5) of the high school counselors in this study mentioned the number of students they have assigned to them was too many for them to feel like they were reaching all those students and meeting their needs effectively. This problem also impacted SBMH therapists (2/5), because they also had a limit on how many students they could have added to their caseload. Both spoke about this perceived barrier inside their high schools. For example, Participant 9, a SBMH therapist, discussed student case load sizes:

> Caseload sizes matter, if you don't have enough therapy staff, you have to limit caseload sizes, and then there's a waiting list. So, we have to be mindful. We can't give one person 65 kids and expect them to be effective with those students. You know, we have to be mindful of that.

High school counselors (5/5) went on to discuss student numbers, and the sheer "volume" of students that they have to treat in secondary schools. All of the high school counselors spoke about how many students they had to serve and how this prevented quality services for students. Participant 2 said, "We probably have 450 students per counselor." Participant 3, also a high school counselor, elaborated the problem with having so many students: "I have over 300 students and making sure you are touching every single student; it is probably not going to happen." Participant 6, also a high school counselor, said that he/she is responsible for "296 ninth graders and 120 special education students." Participant 7, a high school counselor, stated: "We have 2200 students and nearly 460 in the building. It is the volume and the variety of things we do." Participant 8, a high school counselor, said that "three counselors with 1100 kids is just not enough to the level you need to be with kids, with those numbers. It needs to be lower."

The emotional toll. All of the participants (10/10) in this study mentioned one of the most difficult parts of their job and an issue that prevented quality services was "hearing and dealing with such situations that students were involved in, in their lives," and knowing that "personally, they would not be able to help the student in certain situations." Part of the counselors and SBMH therapists' job was to listen to students' real daily life problems and issues. These professionals experienced, along with their students, the raw emotions-- sometimes heartbreaking stories and deep pain the students felt for weeks and even years as a result of emotional, physical, and sexual abuse. SBMH professionals treated students and worked closely with these students for days, weeks, and sometimes, years. This type of work was a perceived as a stressor to delivering

quality services to students. For example, Participant 4, a SBMH therapist, discussed the emotional toll that this job takes on these professionals:

> You know, and I think that's just a hard. Part is maybe hearing some of their stories and having to, to go home and you worry about them. You want to make sure that they're okay and they're safe and trying to figure out what you can do.

Participant 6, a high school counselor, wanted to help all students and felt helpless when that wasn't possible:

> When you're talking to a student, and they're in a horrible situation and knowing that there's absolutely nothing that you could do or say except maybe to give them some coping skills because you can't change the situation that they are in.

Perceived barriers to getting students SBMH services. SBMH professionals in this study discussed several perceived barriers to serving the high school students with whom they worked. SBMH professionals elaborated on three perceived barriers to getting students SBMH services: "access", "stigma," and the "financial" aspects of serving students.

Access. All of the SBMH professionals (10/10) discussed "access" and agreed that all students deserved to be able to obtain the services they need for SBMH. Access has a few different meanings as it relates to SBMH professionals and treating high school students. Access can mean being able to be with students all day, every day or having direct access to the students. Access can also mean students being able to receive the mental health services that they need, while they were in school. This definition included access for all students even if students were not being served under a 504 Plan or an Individualized Educational Plan (IEP). Also, SBMH professionals felt that "students in 9-

12 high schools had fewer facilities and/or professionals that wanted to work with this age group." Even in long-term treatment center, SBMH professionals mentioned that there were "less options for high school students."

Participant 1 a SBMH therapist stated:

> I'm just blessed to be at a school that when our grant ran out, recognizes hopefully the need and the impact that school-based mental health has on the students, that they were willing to go ahead and bite the bullet and- and you'll take care of the salary without having income. I guess one way they explained it to me is there's probably a substantial number of the students I see that would be potential drop-outs, if they didn't have supports. And so, I guess in a way they kind of get their money back there. Participant 4 discussed access to mental health as a limiting factor: "Yes, especially kids with a lower socio economic. They might not always have like the means or the funds or the transportation to get to a clinic somewhere."

Participant 4 goes into what more access to all students would look like.

> You may have access to some other kids that, if they're, they're homeless, their parents are fighting, going through divorce, and it's really causing a hard time. You'd be able to talk to those kids. Then, maybe short term. Some of those would be short term. It's not a long-term thing. It doesn't have to be just kids with a 504 and IEP or anything like that.

Participant 8, a high school counselor, also addressed the limiting part of SBMH in access for secondary students and why it was a significant barrier in treatment for them:

> I'd say access for kids of our students age, for things they need. Such as facilities and stuff, and counseling opportunities outside of school. That's hard. Not everybody counsels or works with teenagers, and there's a limitation on beds, and options for them.

Stigma. Generally speaking, all of the SBMH professionals (10/10) in this study discussed stigma in their profession as they treated high school students. They know and work on combating this issue every single day because they wanted students to come see them if they (the students) feel that they are suffering from a mental illness or struggling with an issue that impacts their lives and/or choices. According to SBMH professionals (10/10) in this study, stigma had always been a part of SBMH services and was still an issue inside of secondary schools, but this barrier seemed to be getting better for SBMH therapist and counselors. Participant 1, a SBMH therapist, discussed the positive side of the way stigma was impacting secondary students: "the stigmas and prejudice and stereotypes of- of mental health. I feel like that's getting better." Participant 4, another SBMH therapist, felt that having SBMH therapists' in schools was important to address stigma: "We are boots on the ground; you know. I think it's just been a good service to. And also, just helping change the stigma of what mental health is and getting the understanding out there."

Financial. Both the high school counselors (2/5) and SBMH therapists (5/5) in this study mentioned the financial aspects of "meeting the mental health needs of the students and getting the students the help, they needed." All of the SBMH professionals in this study felt that "all students deserved access to services regardless of whether the students have no insurance, private insurance, or Medicare." A few of the high school

counselors (2/5) mentioned the issues about the financial aspects of SBMH services, but all (5/5) of the SBMH therapists wanted to discuss this as a perceived barrier to students getting the mental health services they needed in high school. SBMH therapists are all paid through either private insurance, Medicare, or the school district they work for (or offer their services pro-bono or for free). Generally speaking, most SBMH therapists are employed by agencies outside of the district and actually work as contracted employees through these agencies. In this study, 3/5 therapists were contracted employees that came to the high schools to service students. SBMH therapists also all discussed doing pro-bono services or treating students for free for students who cannot afford private insurance and don't qualify for Medicare either.

Participant 5 discussed the financial services part of the SBMH therapists as a barrier.

> So, with the financial, I know you and I talked about it before, and I guess we talked about it today some, but we bill insurance, and I do pro bono services, so many as compared to how many kids I have. I mean, typically they have some kind of insurance on them. But if not, we'll pro bono services, so sometimes I think that is a barrier for the families. I mean, you may not know that because they don't want to tell you- But they may never mention that for their kid just because they feel like that could be a problem. They're going to have to dish this money, and they don't have it, and they don't want to say I don't have it, because they don't want anyone thinking they don't care about their kid. But there again, you can't tell a thousand students that, "Hey, you can sign up for free therapy," um, and get, you know, 200 kids out of that because then you don't, you know, you couldn't keep your doors open. So, it's kind of a, kind of a catch 22. But we

don't really run into a whole lot of that. I mean the ones that we've need to accommodate; we've done that with pro bono.

Participant 9, a SBMH therapist, goes on to discuss the financial aspect of SBMH therapists' problems:

> And I hate to keep going back to funding, but with private insurance policies-we have had to be very creative sometimes in how those policies are accessed. Private insurances tend to fight against reimbursing anything that happens in a school-so there has to be a clinic within the school, you know, so you have to, you have to do some, sort of administrative things so that you're just not saying hey, this was provided at a school they are backing down on some of that, but students who have private insurance should have the same access to services at school that students with our kids have-so that sometimes is a barrier that we have to work through. We've used interns, we've even used interns in situations where private insurance policies just say we're just not going to do it, we're just not going to do it. We'll pull in an intern to provide some pro bono services-because we feel, the services are important, the student needs the services, and the insurance company makes it very difficult.

Participant 1, a SBMH therapist, discussed the financial in great detail and the discrepancies and the possible reasons for the confusion surrounding this element of helping students in secondary schools. He is paid by his school district. He stated:

> I see students who don't have a payer source. And like I said, the school just pays me. But what Medicaid paid versus what the school would receive if they saw some of our- like some of our school employees, therapists, they do file Medicaid.

But anyway, it was a big discrepancy on what was paid to the school and what was paid, I call it private practice. And I do some private practice too. I'd ask them, you know, explain to me if I'm. And I- I don't remember the figures. But explain to me if I'm working here at the school and I'm seeing a student that has Medicaid and I get paid, you know, $17.50, and I do that all morning, but afternoon I could go across the street and in my in my private practice see someone, or in a community agency or whatever, and file the very same thing across the street and, you know, get paid $120. I said, "Explain that to me. "I mean, I have the same license of the afternoon I had of the morning. I'm doing the same therapy I was doing of the morning. They never could really explain it. So, you know, finally it has increased what the schools are reimbursed on Medicaid.

SBMH therapists (3/5) also discussed the recent changes in the Medicare payment system for SBMH services. These changes had made it increasingly difficult for parents to help their children get SBMH services and/or pay for them. Participant 9, a SBMH therapist, discusses those changes:

Going back kind of to the Medicaid stuff with the PASS. If the parents don't comply with those independent assessments, it really restricts the services that a student's going to qualify for. If a parent does not comply with those care coordination services through the PASS, they can actually lose their access to mental health services through the PASS. So, I mean there's a lot of responsibility on the parent to be able to make this happen, and then to be able to keep that going. And, some parents are responsible, but some parents are not responsible, not only are they not responsible, but a lot of parents don't have the skills. A lot of

parents don't understand. I mean there's a lot of professionals right now that are still very confused by what all the requirements are. It is very difficult and confusing.

Research question two summary. Research question two explored the perceived barriers for the delivery of SBMH services to Arkansas secondary students in grades 9-12. There were two major themes that emerged from the data for this research question. The first theme to emerge from the data was "Issues preventing quality services for students." Several things impeded them from delivering quality services for students. First, SBMH therapists discussed efficiency and confidentiality. They had a hard time getting students out of class, and it is a time-consuming process. SBMH therapists also discussed the issue of confidentiality because they didn't have a private place on campuses to see students once they do get them from their classes for treatment.

Second, both high school counselors and SBMH therapists shared the following perceived barriers: "communication", "administrative duties and paperwork", "student numbers" and "emotional toll". Both high school counselors and SBMH therapists had five shared barriers: "communication", "administrative duties and paperwork", "student numbers", and the "emotional toll" of the job. Even though paperwork and administrative duties have always been a part of high school counselors and SBMH therapists' jobs, all of the SBMH professionals agreed that administrative duties and paperwork had increased. SBMH professionals also agreed that communication was a big part of the misunderstandings surrounding their jobs. Clearly, their roles, activities and interactions with staff, teachers, parents and administration should be better and more beneficial for students, and more communication would assist in helping with the clarity

of their roles and lessen the confusion that was perceived by staff, teachers, parents and administration in their interactions with SBMH professionals ,and the work they in their jobs. Both SBMH professionals also discussed student numbers, and how many students they see has increased and impacted their ability to feel that they could be effective with so many students in their caseloads.

All SBMH professionals spoke about the perceived emotional toll of the job took on them as treated high school students. High school counselors mentioned that they felt like they had more students in their caseload than they could successfully meet their needs. SBMH therapists also discussed their caseload because they have a limit of how many kids they can have on their caseload as well. All SBMH professionals also discussed barriers to services for students.

The next theme that emerged from question two was perceived barriers to getting students SBMH services. SBMH professionals perceived three central barriers to getting students SBMH services: access, stigma and the financial aspects to serving students. First, all students deserve access to SBMH services; SBMH professionals need direct access to students. Second, stigma still impacts their jobs because high school students do worry what their peers will think of them or that they might be perceived as crazy. SBMH professionals felt that although that stigma is still a problem, but it is getting better inside of Arkansas 9-12 high schools. The last issue that was a perceived barrier to students getting SBMH services was the financial barrier. All SBMH professionals felt that students deserve to receive SBMH services "regardless of whether students had no insurance, private insurance or Medicare." SBMH professionals felt that getting financial services for students has become more challenging and difficult. This put an additional

strain on SBMH therapists because they felt that they did even more pro-bono services and this caused them because it increases their caseloads.

Chapter Summary

Chapter 4 was outlined using demographic information about who the participants were, their experience and background information. Interviews were also collected as data and were used to answer two research questions:

1) What are the SBMH professionals' perceptions and experiences as these professionals diagnose, treat and serve their students in grades 9-12 in Arkansas?

2) What do SBMH professionals perceive as barriers for the delivery of mental health services to Arkansas secondary students in grades 9-12?

For research question one, there were six themes that emerged from the data surrounding the perceptions and experiences as SBMH professionals diagnosed, treated and served students in grades 9-12 in Arkansas. Those six themes are discussed in the paragraphs systematically: (a)time is important, (b) perceptions and experiences about the job and assisting secondary students, (c) suggestions for improvements in SBMH professionals' jobs, (d) changes in job roles, (e) experiences and interactions with parents, while treating and serving students and (f)serving and treating students. Both SBMH mental health therapists and high school counselors (10/10) felt time was important, and both professionals need time to be successful with their students. All SBMH professionals (10/10) had high job satisfaction and enjoyed working with students, and were satisfied with working specifically with 9-12 students. All SBMH professionals (10/10) participating in this study agreed that secondary students also need

SBMH services because of their developmental stage, and the many issues and stressors students encountered in high school.

Additionally, there were several suggestions from the SBMH therapists for improvements in SBMH their jobs. Each SBMH therapist and counselor had an individualized idea of what those improvements needed to be. These SBMH therapists suggested more therapists in schools, more access to students, more professional development for teachers, implementing SEL programs, or being in a consultant role. High school counselors suggested more counselors in school, having more options for students, informing parents about social media and technology, and taking away administrative duties. There were also changes in job roles that had occurred in SBMH professional's jobs and were noted: the number of students' mental health issues had increased; school demographics, stress and poverty were real issues present inside of secondary schools, and threat assessments for violent students were a part of high schools, specifically in Arkansas' 9-12 high schools.

Furthermore, all SBMH professionals (10/10) had experiences and interactions with parents and went into great detail about how most parents are supportive, and they also mentioned that there were parents who were not supportive inside of 9-12 high schools in Arkansas. Also, SBMH professionals discussed the easiest issues to treat which were mild anxiety, class changes and minor issues with friends and family. All SBMH professionals (10/10) discussed the most challenging issues to treat: suicide, suicidal students and trauma-based issues. They also spoke about the type of student services that were delivered inside of high schools. All of the SBMH professionals

(10/10) stated that 95% of the services that they delivered were one-on-one direct services with 9-12 high school students in Arkansas.

For research question two, there were two themes that emerged from the data surrounding what SBMH professionals perceived as barriers as they deliver SBMH services to students in 9-12 Arkansas schools. The first theme was issues preventing quality services for students. The second theme was perceived barriers to getting students SBMH services.

There were several barriers that prevent quality services for students. Several SBMH therapists (3/5) discussed efficiency and confidentiality. They discussed efficiency because of scheduling, and they had a hard time getting students out of class. SBMH therapists also discussed the issue of confidentiality because they didn't have a private place on campuses to see students once they do get them from their classes.

Both high school counselors and SBMH therapists had some shared barriers: "communication", "administrative duties and paperwork", "student numbers" and the "emotional toll" of the job. Even though paperwork and administrative duties have always been a part of high school counselors and SBMH therapists' jobs, all of the SBMH professionals (7/10) agreed that administrative duties and paperwork had increased. They (10/10) also agreed that communication was a big part of the misunderstandings surrounding their jobs. Clearly, their roles, activities and interactions with staff, parents and administration should be better and more beneficial for students, and more communication would assist in helping with the clarity of their roles and lessen the confusion that SBMH professionals perceived about their jobs.

Both SBMH professionals (7/10) also discussed student numbers. All SBMH professionals (10/10) spoke about the emotional toll of the job. High school counselors (5/5) mentioned that they felt like they had more students in their caseload than they could successfully meet their needs. SBMH therapists (3/5) also discussed their caseload because they have a limit of how many kids they can have on their caseload as well.

All SBMH professionals (10/10) also discussed perceived barriers to getting students SBMH services. SBMH professionals perceived three central barriers to getting students SBMH services: access, stigma and the financial aspects to serving students. Access was a barrier to SBMH services because these professionals felt that all students deserve access to SBMH services. Additionally, stigma is still a perceived barrier by all SBMH professionals (10/10) because students are very aware of how other students view them and didn't want to be chastised for seeking help for their mental health issues, but SBMH therapists felt that the stigma is "getting better."

Financial was also a perceived barrier for (2/5) high school counselors and (5/5) SBMH therapists. SBMH professionals felt all students regardless of their type of insurance should have a way to be able to get SBMH services. This can be a difficult process for SBMH therapists.

CHAPTER 5: DISCUSSIONS

SBMH professionals treat, diagnose and guide students in the educational setting and are an important part of schools today (NASP, 2019). However, little is known about their experiences in serving students inside of Arkansas 9-12 6A and 7A high schools. This qualitative, phenomenological study examined the important perceptions and experiences from Arkansas' SBMH professionals while they diagnosed, treated and served students in grades 9-12. The results from this study uncovered barriers for these mental health professionals as they delivered services to Arkansas' larger 6A and 7A schools with secondary students in grades 9-12.

The study incorporated a demographic survey and face-to-face interviews to reveal the experiences and perceptions of these SBMH professionals. The participants in this study were five counselors and five school-based therapists (N=10) that served Arkansas' 9-12 grade students in 6A and 7A schools as they are defined by the Arkansas Activity Association. Out of the participants, nine were females and one was male; further, nine were Caucasian and one was Hispanic. Seven belonged to a professional organization in their field, and three did not. All 10 participants had counseling and/or SBMH therapy experience in grades 9-12 in 6A and 7A schools in Arkansas. In terms of experience in counseling and SBMH therapy, participants ranged from two to 24 years. Seven participants had experience in rural schools, and three had experience in suburban schools. Four participants had worked in Title 1 schools, which indicated a high poverty rate inside of those schools.

Two research questions guided this study:

1. What are the SBMH professionals' perceptions and experiences as these professionals diagnose, treat and serve their students in grades 9-12?
2. What do school-based mental health professionals perceive as barriers for the delivery of mental health services to Arkansas secondary students in grades 9-12?

Summary of Findings

This qualitative, phenomenological study examined the important perceptions and experiences from Arkansas' SBMH professionals while they diagnosed, treated and served students in grades 9-12. The results from this study uncovered barriers for these mental health professionals as they delivered services to Arkansas' larger 6A and 7A schools with secondary students in grades 9-12. The 10 SBMH professionals shared their perceptions and experiences from working inside of Arkansas 9-12 high schools with high school students, and this revealed the lack of resources for these professionals. Through the 15 interview questions and demographic survey questions, data was gathered and shared in this summary.

Research question one explored the perceptions and experiences of SBMH professionals as they diagnosed, treated and served their students in grades 9-12. Based on question one, there were six themes identified: (a) time is important, (b) perceptions and experiences about the job and assisting secondary students, (c) suggestions for improvement of SBMH professionals' jobs, (d) changes in job roles, (e) experiences and interactions with parents, while treating and serving students, and (f) serving and treating students.

The overall findings from the study discussed in the previous section. SBMH professionals believed they needed more time with their students, and time was valuable. This was evident in the findings. Based on the results of the study, 95% of SBMH services are one-on-one direct services with students. Additionally, SBMH professionals reported high job satisfaction while they treated, diagnosed and served students in Arkansas 9-12 high schools. Moreover, SBMH professionals also identified SBMH services as a significant need for high school students. Based on the findings of this study, SBMH professionals believed that services were necessary, because high school students had significant stressors like violence, trauma, poverty, anxiety, depression, suicide, and suicidal thoughts. SBMH professionals needed more access to students, development of SEL programs K-12, and strategies to deal with social media and technology issues for students.

Research question two explored the perceived barriers that SBMH professionals as they delivered SBMH services to 9-12 high school students. Based on question two, there were two themes identified: (a) preventing quality services for students (b) perceived barriers to getting students SBMH services.

Findings from research question two: SBMH professionals discussed several perceived barriers for the delivery of SBMH services to Arkansas 9-12 students. SBMH therapists discussed efficiency and confidentiality. In regard to efficiency, SBMH therapists identified time out of class as a barrier. Additionally, SBMH therapists described the complexity of therapy sessions and highlighted the issues involving privacy needed for treatment and confidentiality. All of the SBMH professionals shared perceived barriers as well. The lack of communication with all stakeholders created an atmosphere

of confusion and a lack of clarity on what their jobs entailed inside of high schools. They felt that they were more effective in their jobs with better and more efficient communication with parents, teachers, and administrators. Because SBMH professionals had an increased number of students to serve and more paperwork and administrative duties, they felt overwhelmed and stressed. Based on the increase in stress, SBMH professionals discussed the emotional toll this took on them and their students.

SBMH professionals also felt that there were three central barriers to getting students the SBMH services students needed inside 9-12 grade Arkansas schools: access, financial and stigma. Access was an essential word with SBMH professionals because they felt that all students 9-12 should have access to SBMH services, regardless, of their placement in schools (IEP, 504), socio-economic status, or were identified with a severe mental illness or had a minor issue to work through. In addition, the access that they spoke about was having direct access to students, and they needed more time with students.

Stigma, in SBMH services, was addressed as the third barrier for SBMH professionals. The stigma that surrounds mental health services is a well-known and documented problem inside of high schools. Because of the developmental age of the students, and how they felt about being treated for a mental illness, students were very aware of how other students would view them and not want to be around them because they were mentally ill or labeled as crazy. SBMH professionals felt that this was a real and distinct issue that SBMH professionals dealt with every day with teenagers. Although stigma was evident, all SBMH professionals believed that the stigma was improving.

Lastly, a majority of SBMH professionals discussed the financial concerns of SBMH services. They felt Medicare has become even more difficult to work with to obtain mental health services for students. Additionally, private insurance companies made it difficult for them to pay SBMH therapists. Students who had no insurance found that mental health services were too expensive for most students to be able to afford outside of school, so SBMH professionals added even more pro-bono services, which creates more stress for them.

Discussion and Conclusions

Clearly, the need for adolescents to receive mental health services from SBMH professionals inside of schools is well-documented in the literature (Fertman & Ross, 2003; Bowers et al., 2013; NASP, 2019; Walker, 2019). Therefore, it is important to discuss and understand SBMH professionals' experiences and perceptions as 75% of students receive SBMH services inside of schools (NASP, 2019; Kann et al., 2017). SBMH professionals treated, diagnosed and guided students in the educational setting and are an important part of schools today (NASP, 2019).

The findings in this study are important because serving students inside of high schools are what SBMH professionals do every day inside of Arkansas' high schools. This study reflected what the SBMH professionals' perceptions and experiences were and the exploration of resources that these professionals have or do not have, and this information may inform mental health services and/or help students that are served, diagnosed and treated in these school systems. Also, by knowing and discovering the SBMH professionals' perceived barriers, mental health services for students may be improved and/or help students by understanding what was preventing the students from

getting the treatment they needed inside 9-12 high schools in Arkansas. Key findings in this study are: (a) Increase in the number of severe mental health issues and SBMH professional's caseload has increased; (b) Parents are important; (c) Administrative paperwork has changed; (d) Bronfenbrenner's Ecological Systems Theory is connected to what SBMH professionals do in high schools.

Increase in the Number of Severe Mental Health Issues and SBMH Professionals' Caseloads

The literature reports that suicide was the second leading cause of death in the United States for adolescents from ages 10-15 in 2019 (Udoetuk et al., 2019). SBMH professionals confirmed that suicides and suicidal ideation were mental health issues that they dealt with every day. SBMH professionals in this study also reported that cases were so severe who required hospitalization and long-term treatment. Suicide and suicidal ideation took a great deal of time to treat, diagnose, and document, and it increased SBMH professionals' time, a valuable resource, away from other students who were struggling with other mental health issues.

Also, in the literature, SBMH professionals treated mental health issues which included trauma such as sexual abuse, physical abuse, neglect, violence, parental addiction, and parental mental illness (Spinazzola et al., 2016). SBMH professionals in this study stated there were more severe trauma cases with high school students--so many they could not treat them all. Students needed more services, and there was not enough time for these SBMH professionals to do the work that they needed to do because of the size of their caseload. This is also supported in the review of the literature. Many schools want to address student mental health issues but struggle to meet the demands as they do

not have adequate student support services staff (e.g., counselors, social workers, school psychologists) to provide the level of support needed for many students (Crepeau-Hobson et al., 2005; Walker, 2019). Again, supporting the lack of resources that SBMH professionals lack.

With the addition of social media and technology and the issues with depression and anxiety these technology programs brought with them, SBMH professionals felt like social media and technology increased their caseload significantly. With an increase in caseload sizes, SBMH therapists have more students to serve and less time to do it. The Arkansas Department of Education (ADE, 2018) recommends a ratio of 450 students to one counselor. The Arkansas School Counseling Association (2019) recommends 250 students per counselor. The National Association of Secondary School Principals (2019) reflected the widening gap of services for students when the data in the study they conducted in 2019 reflected that each counselor was expected to serve 482 students. These statements support that the current numbers are unacceptable and also too high. For SBMH therapists, ADE (2012) recommended for every 500 students the schools should have one SBMH therapist with a caseload of 20-30 students. Although these numbers were suggested, schools are allowed to create a plan of how to deal with the number of students and counselors that they managed (ADE, 2012).

Parents are Important

In this study, SBMH professionals felt that parental support and lack of parental support both influenced the success or failure of 9-12 high school students in Arkansas. This was important to note from the study because of the increase in SBMH issues that are happening in high schools. To make gains with a student and help them become

successful, SBMH professionals believed that parents needed to be involved in the treatment of students. The reasons for lack of parental support could be considered emotional and educational neglect. In addition, emotionally disturbing events can be of an interpersonal nature (e.g., sexual or physical abuse, emotional abuse, verbal abuse, neglect, war, community violence, loss of a parent/caregiver; parental addiction, parental mental illness; Spinazzola et al., 2016). These exposures often happen inside the child's caregiving system and may incorporate educational neglect as well as emotional and physical neglect (Spinazzola et al., 2016). In fact, interpersonal victimization is the most prevalent form of trauma exposure with most of these experiences for children coming from the home environment (Spinazzola et al., 2016). So, when parents were not supportive (or too involved), students did not progress as quickly. Lack of parent support included: parents not signing SBMH services documents to help their child obtain services, help the student secure funding for that treatment, or being absent and un-involved in the student's life. Lack of parental involvement directly impacted students who were suicidal or had suicidal thoughts. SMBH professionals also indicated an increase in suicide and/or suicidal thoughts inside of high schools.

SBMH professionals felt most parents were very supportive and responsive to getting their student the mental health services that they needed. There was some discussion of parents that were actually too involved with their students too. Overly involved parents may cause anxiety to students. Specifically, anxiety is associated with events that may not allow optimal growth and development in children (McGuinness, 2016). It is also to note that approximately 25-50% of youth with depression also suffer from anxiety too (Axelson & Birmaher, 2001; Huberty, 2019a). SBMH professionals

suggested when these students did encounter any kind of adversity, they wouldn't be able to deal with the adversity they encountered in high school. High school students must become independent; therefore, SBMH professionals foster independence with students who struggled in this area.

Administrative Duties and Paperwork Have Changed

A major finding in this study was the increase in administrative duties and paperwork that negatively affected SBMH therapists and high school counselors as they worked in high schools in Arkansas. Administrative duties and paperwork have always been a part of the SBMH professionals' jobs. Although counselors have administrative duties and other job assignments in schools like giving state student assessments, student scheduling, checking students' grades, and verifying grade point averages for students, these duties can take up a great deal of their time inside the school day, leaving no time for long-term counseling with students (American School Counselor Association, 2012). Similarly, SBMH therapists complete paper work that includes risk assessments for suicidal or homicidal issues, support services for parents and teachers, collaboration with other community provider and also linkage to additional community resources (NASP, 2019).

Even though these SBMH professionals have paperwork and administrative duties, due to the number of students that have mental health issues in high schools increasing, the administrative duties and paperwork have increased significantly as well. High school counselors in this study felt the increase was because of academic accountability with testing, more 504 plans, and IEP paperwork along with scheduling, parent-consent, and documenting failing grades. SBMH therapists felt as though the

paper load had become overwhelming because of the increased workload they were experiencing and severity of issues they were dealing with too. Based on the review of the literature, the National Association of School Principals (2019) acknowledged that the increased caseload for those who remain in schools is overwhelming and limits access for students who need this support in their lives. Also, the growing threat of violence inside of schools and violent students has increased that number of students with these issues inside of high schools. The research shows there is a real and direct connection between secondary school safety and school-based mental health services (Lenhardt et al., 2010). SBMH therapists and counselors treated and served many of these angry, violent students with severe behavior issues inside of Arkansas' 9-12 schools. Threat assessments were also included inside of SBMH professionals' roles too, adding to their paperwork and caseload.

The financial aspect of SBMH services was another part of SBMH therapists' jobs. Although high school counselors were aware of the cost of SBMH treatment, few dealt with the directly securing the payment for the treatment for students. In addition, where Medicaid is concerned, billing for services can be complicated and costly, and some school districts do not have the staff to handle this complex pursuit (Lear, 2007). SBMH therapists discussed changes in the recent Medicare system, and the fact that, private insurance companies are making it increasingly difficult to get students' mental health services covered. This fact is an important contribution to the literature because those recent Medicaid changes are impacting SBMH treatment of students' mental health concerns and has not been discussed in the literature. Again, supporting that the lack of resources contributed to students not getting the care that they need.

Bronfenbrenner's Ecological Systems Theory

The results of this study on the perceptions and experiences of SBMH professionals in Arkansas' high schools demonstrated how Bronfenbrenner's Ecological Systems Theory brought all of the data full circle. Because of the direct connection between the child, home, and school, Bronfenbrenner's Ecological Systems Theory has moved to the forefront in the world of child development and into the school because it defines and explains a great deal of how the surrounding world impacts children, and their development inside and outside of schools (Berk, 2013). In this theory, SBMH services is a connecting factor for the "bidirectional" relationship that Bronfenbrenner's ecological theory creates and embodies (Berk, 2013).

The data in this study supported the reasons students needed to be mentally healthy inside of schools. SBMH professionals needed to treat and/or address students' mental health issues because mental health issues directly impacted the students' life inside and outside of school. Those connections were never more apparent as SBMH professionals diagnosed and treated issues such as poverty, stigma, access, trauma, violence, and the stressors from the school, home and communities—all of which impacted student's mental health. SBMH professionals are intertwined in their interactions with students, parents, teachers, administrators, and the community. As suggested by Bronfenbrenner's Ecological Systems Theory, as mental health issues increase in schools, they will impact all of the stakeholders inside and outside of schools (Bronfenbrenner, 1986).

Implications and Future Research

The findings in this research revealed what the SBMH professionals' perceptions and experiences were. Additionally, these data can be used to improve mental health services and/or help students that are diagnosed, treated, and served in these school systems and revealed the lack of resources SBMH professionals had. Also, by knowing and discovering the SBMH professionals' perceived barriers that revealed some specific lack of resources, mental health services for students may be improved and/or help students by understanding what is preventing the students from getting the treatment they need. Finally, in a broader sense, the results of this study may also be transferable to students, and SBMH professionals outside of Arkansas by knowing the resources SBMH professionals were lacking or already have. Specific implications are discussed below.

Implications for Practice

The findings from this study suggested implications for practice in six areas: (a) for policy (make mental health services mandated); (b) implement K-12 SEL programs throughout schools;(c) increase the number of SBMH professionals in the State of Arkansas; (d) For schools, improve communication between teachers and administrators regarding what SBMH professionals do and why; (e)for SBMH professionals, dealing with the emotional toll of the job, and (f)for parents educating themselves about what SBMH professionals do and how important their (parents') role is in getting students treatment.

For policy, mental health services should be mandated

Currently, students with special needs are already protected through federal laws and civil rights laws, which guarantees SBMH services (Lear, 2007). However, not all students who need SBMH services have this kind of access to SBMH services. Because

funding for school health programs typically come from the entire school's budget, and not from the public health budget, school health programs tend to compete with academic agendas and federal regulations like No Child Left Behind (Lear, 2007). The way SBMH programs are funded makes it hard to secure the funding needed for mandated SBMH services for all students. However, mandating mental health services for all students is needed, this way SBMH professionals will not compete for time with their students over these other mandated services. This would ensure that SBMH professionals had the access and time they need to successfully treat all students in high school.

Implement K-12 Social Emotional Learning (SEL) programs throughout schools

There needs to be an increase social emotional learning (SEL)programs K-12 similar to the way physical educational (PE) classes are required, so by the time students entered high school, the benefits of the social and emotional training students would receive would be apparent. SBMH professionals also dealt with social and emotional-learning programs to help students in schools. Social and emotional learning programs (SEL) are designed to address student mental health issues and have been developing and researched for well-over 40 years (Dix et al., 2012). Some studies reflected that these social and emotional programs offer benefits to students both socio-emotionally and academically, if the programs are well-planned and implemented inside of schools (Dix et al., 2012). Based on the findings of this study, SBMH therapists and counselors believed that SEL programs may help with all of the stressors and issues that high school students are dealing with in9-12 high schools. Having these SEL programs would help students identify and understand their feelings, and who to seek out for help and get the help they need before those issues become more severe.

Increase number of SBMH professionals in the State of Arkansas

The State of Arkansas regulated the ratio of the number of students that each counselor and/or therapist could have; however, the number of students each counselor and/or SBMH therapist is currently too high for high school counselors and SBMH therapists to be effective. In the literature, the Arkansas Department of Education (ADE, 2018) recommended for every counselor that counselor is allowed to have 450 students. The Arkansas School Counseling Association (2012) recommends 250 students per counselor. The National Association of Secondary School Principals (2019) reflected the widening gap of services for students when the data reflected that each counselor was expected to serve 482 students. For SBMH therapists, ADE (2012) recommended for every 500 students the schools should have one SBMH therapists with a caseload of 20-30 students. Although this number was suggested, schools do not have to go exactly by these guidelines for SBMH therapists, as schools could have a plan of how to deal with the number of students and counselors that they managed over the suggested guidelines (ADE, 2012). Currently, SBMH therapists and counselors may have a higher number of students in their caseloads than even the recommended amount.

In Arkansas specifically, Asa Hutchinson, Arkansas' current Governor, enacted Act 190, School Counselor Improvement Act, 2019. Based on this legislation, school counselors must spend 90% of their time with students and have direct contact with students. Further, according to this law, in their time with students, counselors should be providing direct and indirect services to students, leaving about 10% for administrative activities during student contact days (ACT 190, 2019). This does help SBMH professionals be able to treat more students and be more effective in their jobs. However,

there also needs to be more SBMH professionals to meet the increased need that SBMH professionals are currently seeing, and the increased severity and number of stressors and issues that high school students have in schools today. An increase in SBMH professionals would also reduce the amount of administrative duties these professionals had as well. This would be creating more resources for SBMH professionals.

For schools, improving communication between teachers and administrators about what SBMH professionals do and why

The lack of communication was a shared perceived barrier for SBMH professionals because it impacted their ability to be effective in the work they did for students. The data in this study indicated SBMH professionals wanted to increase communication with teachers and administrators, but worried about the amount of time that would take for everyone involved. Time was one of the most valuable resources that these SBMH professionals had. SBMH professionals found that effective communication helped teachers and administrators understand the mental health issues going on with a student more clearly. In the literature, SBMH professionals found if the interventions lasted up to one year and were targeted, intensive, and included teachers, students, and parents, the interventions would more likely have positive impact on academic success as well as student's mental health (Burnett-Zeigler & Lyons, 2011). Also, there is a lack of communication on what exactly SBMH professionals did inside their jobs, and this created some confusion on what SBMH professionals' roles were. Clarification on what high school counselors do inside of high schools, and what SBMH therapists do in high schools, and communicating that information to teachers and administrators would be beneficial for these mental health professionals, and the students they serve.

For parents, educating themselves about what SBMH professionals' roles and responsibilities and the importance of parents' roles and responsibilities their (parents') role is in acquiring treatment for students

SBMH professionals can assist parents with service providers, address minor/ major mental health issues, and serve as a school/student liaison (Zirkelback & Reese, 2010). SBMH professionals can be a great resource for parents, but parents need to know how to help their students get the mental health services they need as well. Parents play a pivotal role in assisting SBMH therapists and counselors in treating their child. Additionally, involving parents is essential students' success when addressing mental health issues. Based on both the findings in the literature review and the results of this study, parents need to know that if left untreated, some of the effects of mental illness in adolescents could exasperate problems like not being able to keep and maintain a job, continued untreated depression and other disorders, not being entirely engaged in society as adults, and possibly even lead to suicide (Fergusson & Woodward, 2002; U.S. Department of Health and Human Services, 2000; Merikangas et al., 2010; Kann et al., 2017). Early treatment is critical for students, and parents must be involved in this treatment and understand their roles and responsibilities as well as those of SBMH professionals.

For SBMH professionals, dealing with the emotional toll of the job

All of the SBMH professionals in this study discussed the emotional toll that listening to students can have on them. They feel anger, frustration, and listen to the horrifying and heartbreaking stories students have dealt with in their lives. SBMH professionals have had specialized training to assist with mental health issues and

problems that students have. However, having too many other administrative duties and paperwork can wear on SBMH professionals and take away valuable time that they need to process and deal with the emotional toll that this specialized job takes on them as individuals and professionals. Taking some of those administrative assignments and paperwork away and giving these SBMH professionals time to work together and focus on SBMH services work and concentrate on serving students may offer a great deal of support for them. Additionally, it would also help students by allowing SBMH professional to serve their mental health needs. This change would also allow SBMH professionals the time they need to spend with SBMH.

Implications for Future Research

This study found three distinct implications for future research: (a) Expanding the scope of the study, (b) Adding more research on SEL programs, and how they influence student mental health outcomes, (c) Adding more research on parents' roles and responsibilities with SBMH professionals.

Extend the scope of the study

By replicating the study and expanding the number of participants with various locations around the state (and perhaps even the U.S.) and by looking at the resources these professionals need or already have, the information gathered might lead to how other counselors and SBMH therapists' felt about their experiences and perceptions about working with 9-12 high school students inside larger high schools. Also, exploration regarding the perceived barriers that keep students from getting the services they need would be also necessary. This could also increase the understanding of what SBMH professionals see at this age level as the students enter high schools. Additionally, another

way to expand the scope of the study might be to study parents' perceptions of mental health services inside of high schools. All of these possibilities this could increase transferability of this study.

Adding more research on SEL programs and how they influence student mental health outcomes

SBMH professionals also deal with social and emotional-learning (SEL) programs to help students in schools. SEL programs are designed to address student mental health issues and have been developed and researched for well-over 40 years (Dix et al., 2012). The pursuit of understanding SEL programs should be continued inside of high schools as a way to help high school students deal with the increase in mental health issues high schools face today and help SBMH professionals manage valuable resources that they have.

Adding more research on parents' roles and responsibilities with SBMH professionals

There should be more research about what parents think their role is in their child's mental health needs inside of schools and dealing with SBMH professionals. This would increase the understanding of why parents may be supportive or not supportive with SBMH professionals. This may increase the possibility of all parents being supportive as they work with SBMH professionals, and it may also increase the number of students that will get the mental health services that they need in the future and contribute to building more resources for SBMH professionals.

Chapter Summary

SBMH professionals who treat, diagnose, and guide students in the educational setting are an important part of schools today (NASP, 2019). However, little is known

about their experiences and perceptions in serving students inside of Arkansas 9-12 6A and 7A high schools. This qualitative, phenomenological study examined the important perceptions and experiences from Arkansas' SBMH professionals and uncovered the lack of resources these professionals had while they diagnosed, treated and served students in grades 9-12. While studying these professionals, barriers were uncovered and delineated for these mental health professionals as they delivered services to Arkansas' larger 6A and 7A schools with secondary students in grades 9-12.

Key findings were thoroughly outlined and discussed in this chapter. The findings in this study are as follows: (a) Increase in the number of severe mental health issues and SBMH professional's caseload has increased; (b) Parents are important; (c) Administrative paperwork has changed; (d) Bronfenbrenner's Ecological Systems Theory is connected to what SBMH professionals do in high schools. This chapter concluded with an explanation for implications for practice and future research. Three implications for practice: (a) expanding the scope of the study, (b) adding more research on SEL programs and how they influence student mental health outcomes, (c) re-evaluating minimum and maximum numbers for SBMH professionals. Finally, there were three implications for future research (a) expanding the scope of the study, (b) adding more research on SEL programs and how they influence student mental health outcomes, (c) adding more research on parents' roles and responsibilities with SBMH professionals.

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Appendix A

Demographics Survey

PLEASE DO NOT PUT YOUR NAME ANYWHERE ON THIS SHEET

1. What is your age? *_____

2. What is your gender? * _____

3. What is your Race and/or Ethnicity? * _____

4. Please indicate the highest level of your Educational Training: *

Masters Level Specialist in Education Level Doctoral Level

5. How long have you been employed as a School Counselor/School Therapist/Psychologist? * _____

6. How many years of total counseling experience do you have? *

_____

7. What best describes the locations of the schools where you worked/supervised? *

Urban Rural Suburban

8. Were any of the schools you worked or supervised interns identified as a Title 1 Schools? *

9. Do you have experience working as a Mental Health Counselor/School Therapist/Psychologist? *

Yes No

10. Do you have experience working as a Substance Abuse Counselor/School Therapist/Psychologist? *

Yes No

11. Are you a Nationally Certified Counselor (NCC) through NBCC or certified therapist or psychologist through NCSP? *

Yes No

12. Are you a Nationally Certified School Counselor (NCSC) through NBCC or NCSP? *

Yes No

13. Are you licensed as a counselor, therapist, or psychologist in your state? *

Yes No

14. What national counseling or psychologist association(s) are you a member of? *

15. What age group of students have you worked with inside of schools, and how long did you work with those students? *

Questions with asterisks were adapted from Cothrell, K. (2014). The role of mental health counselors in public schools. Doctoral Dissertation, Georgia State University. Retrieved from https://scholarworks.gsu.edu/cps_diss/107

Appendix B

IRB Approval Letter

Office of Sponsored Programs and University Initiatives
Administration Building, Room 207
1509 North Boulder Avenue
Russellville, Arkansas 72801

Office: 479-880-4327
www.atu.edu

November 5, 2019

To Whom It May Concern:

The Arkansas Tech University Institutional Review Board has approved the IRB application for Teri Morris's proposed research, entitled "School-Based Mental Health Professionals' Perceptions and Experiences Working with 9-12 Grade Students in Arkansas."

This approval is valid until November 4, 2021, at which time the research may apply for an extension if the data collection process for this research project is not yet completed.

The IRB approval code for this study is Morris_110519.

Sincerely,

Gabriel L. Adkins, Ph.D.
Institutional Review Board Chair
Arkansas Tech University