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Abstract

Accountability has become an important concept in school-based mental health because students face many social and emotional issues that demand highly effective interventions (Repie, 2005). This study examined the data of a survey that was conducted with 147 members of the National Association of School Psychologists (NASP) regarding their counseling practices in the schools. The results indicated that a majority of NASP members only "sometimes" use pre and post measures with their counseling cases. A Stepwise Regression showed one significant predictor for the use of progress monitoring through pre and post measures in counseling – the more prepared for counseling a respondent felt, the more frequently the respondent used pre and post measures. In addition, the higher the respondent's educational degree level, the more prepared the respondent felt for providing counseling services.

CHAPTER ONE

Introduction

The federal government recently increased expectations and accountability standards for mental health programs in schools through the Individuals with Disabilities Education Act (1997, as cited in Schacht & Hanson, 1999), the No Child Left Behind Act of 2001 (US Department of Education, 2004), and the President's New Freedom Commission on Mental Health (2003). In response to these recent legislative initiatives, it is becoming increasingly important for school-based mental health programs to demonstrate effectiveness (Repie, 2005). School-based mental health professionals must find ways to analyze whether their programs and services are meeting the specific needs of students within their schools (Weist et al., 2000). They must also work to develop ongoing evaluation techniques and progress-monitoring strategies that lead to continued improvement of services for students with social and emotional difficulties (Weist, Lindsey, Moore, & Slade, 2006).

Terminology

The National Association of School Psychologists (NASP; 2003, p. 1) asserts that *school-based mental health services* are services that are provided within a school system that should focus on prevention and early intervention, and should be aimed at helping "students to overcome barriers to learning, many of which are the result of poverty, family difficulties, and/or emotional and social needs." NASP (2003) also indicates that school psychologists maintain an important role in the providing of these mental health services, as they are able to design mental health programs, use assessment tools, work with others in collaborative partnerships, and provide counseling and crisis intervention services.

School-based mental health professionals are defined in this study as those members of a student support team that are involved in the development and dissemination of mental health programs and services in schools. School psychologists and school counselors are the school's professionals most often referred to as school-based mental health professionals (Repie, 2005).

To build upon the concept of *school-based mental health services*, Weist (1997 as cited in Weist et al., 2005) defined *expanded school mental health* as a mental health program model that goes beyond traditional school-based mental health. It is based on collaboration between families, school professionals, and community agencies, and provides comprehensive, wrap-around services to students with mental health needs.

Best Practices refers to a specific set of guidelines put forth by Pluymert (2002) in her discussion of *Best Practices in developing exemplary mental health programs in schools*. These *Best Practices* are discussed further in Chapter Two and are congruent with the guidelines for exemplary mental health practice put forth by the National Association of School Psychologists (NASP; 2003) in its *Position Statement on Mental Health Services in the Schools*.

Present Study

This study will explore the extent to which school psychologists, as a group, are providing mental health services in their schools, and how many of them are using accountability practices with their daily caseloads. Due to the limited research on evidence-based practices in school-based mental health programming, it is hypothesized that few respondents will indicate that they use accountability practices to provide group and individual counseling services that are evidence based. In addition, it is hypothesized that school psychologists who spend the greatest number of hours providing counseling services per week and those who are relatively new to the field (practicing for less than six years) are the professionals who will more frequently use pre

and post measures to monitor progress. Finally, it is hypothesized that a school psychologist's level of education will impact the frequency of pre and post measure use.

In order to examine the relationship between demographic characteristics and school psychologists' mental health practices, a random sample of school psychologists provided demographic information, the number of hours per week they spend providing counseling services in their school, and information regarding their current counseling orientation and practices. Of particular interest to this study are the respondents' answers to the frequency with which they use pre and post measures to monitor the effectiveness of their counseling services for their individual and group counseling cases.

CHAPTER TWO

Background

In 2006, Ysseldyke et al. reported that "children's mental health needs have become a critical public health issue" (Ysseldyke et al., 2006, p. 9). Students facing mental health problems are less able to focus on academic tasks, thus have greater difficulty with learning. They also have lower levels of resiliency compared with peers, and without help, are less likely to have positive outcomes as adults (Ysseldyke et al., 2006). Impaired self-esteem has also been cited as one of the most serious mental health concerns for children and adolescents, overall (Repie, 2005). In addition, behaviors associated with attention deficits and hyperactivity, difficulties arising from peer relationship problems, suicidal thoughts and behaviors, inappropriate sexual activity, and drug and alcohol abuse are current issues faced by children and adolescents (Repie).

There are a number of barriers that make community mental health services difficult for children and adolescents to obtain (Weist et al., 2000). These barriers are especially profound for urban and rural youth, and may include transportation problems, limited funding and insurance coverage, poor knowledge of the services that are available, perceived stigma attached to obtaining mental health services, and lack of faith in the effectiveness of these services. Providing mental health services in schools minimizes many of these barriers, as students already attend school daily and transportation is provided (Weist et al., 2000). Ultimately, schools provide students who have social and emotional difficulties greater access to the mental health services they need (Ysseldyke et al., 2006).

Although schools are ideal places to provide mental health services, school-based mental health professionals must work in settings that include diverse organizational structures (Weist &

Evans, 2005). Because schools maintain their primary purpose of educating students, the school-based mental health services available in a specific school building often depend upon the culture of the school and its surrounding community, and the resources that are made available to the mental health team (Weist & Evans). This environmental context also influences how students respond to school-based mental health programs and services (Kazdin & Weisz, 2003).

Issues Faced by School Mental Health Professionals

Student mental health issues appear to be universal; however, Repie (2005) found that their importance varies depending on the age of the student population needing the services and the geographic location of a school. Repie surveyed 413 randomly selected school psychologists, school counselors, and regular and special education teachers. His survey was an expanded version of a survey developed by Weist, Myers, Danforth, and McNeil (as cited in Repie, 2005). Repie found that high school mental health professionals rated the issues of depression and suicidal thoughts and behaviors as more serious to their student population than elementary school professionals. High school and secondary school professionals also rated the issues of inappropriate sexual activity and drug and alcohol use as more serious for their students than elementary school professionals. Similarly, Weist et al. (2000), who surveyed school administrators to determine mental health needs in schools, found that high school and middle school students experience behavioral problems, depression, anxiety, and drug use at a higher rate than elementary school students.

With regard to geographic location, school-based mental health professionals, and general and special education teachers in urban schools rated impulsive and dangerous behavior and classroom disruptiveness as more serious for their students than mental health professionals and teachers in suburban or rural schools (Repie, 2005). School administrators also rated urban

youth as experiencing more problems with stress, anxiety, depression, and low self-esteem than

suburban or rural youth (Weist et al., 2000).

Guidelines, Best Practices, and Revised Principles for Mental Health Services in the Schools

The National Association of School Psychologists (NASP; 2007) published information

on its website about the role of school psychologists in providing mental health services in

schools. NASP (2007) affirms that because school psychologists are trained to connect mental

health difficulties with learning in educational settings, they are in a unique position to provide

appropriate mental health services that will directly help students be successful in school. In

addition, NASP (2007) affirms that school psychologists have been trained to focus both on

individual student needs and the needs of the school community, so they are also in a unique

position to be able to create individualized treatment plans and building or district-wide

programs. Finally, NASP (2007) affirms that school psychologists have unique training in the

use of assessment tools that can help evaluate social and emotional development, and monitor

the effectiveness of interventions. Not only is this training in the use of norm-referenced,

standardized tests, but it is also in the use of Functional Behavior Assessments and Curriculum-

Based Measurement.

A number of sources have discussed Best Practices or provided guidelines for school

psychologists and mental health teams providing mental health services to students in schools.

In 1998, NASP developed a *Position Statement on Mental Health Services in the Schools.* This

statement was later revised in April 2003. It affirms the importance of comprehensive mental

health programs in schools, and asserts that school mental health services can eliminate barriers

to student learning that are caused by behavioral, social, and emotional difficulties.   In this

statement, NASP (2003) also provides guidelines for exemplary mental health programs. These

guidelines are echoed in a discussion of *Best Practices in developing exemplary mental health programs in schools* (Pluymert, 2002).

In an effort to improve the overall quality of Expanded School Mental Health (ESMH), Weist et al. (2005) conducted a survey to evaluate the importance of 10 principles of *Best Practice in ESMH*. These principles were originally developed through a review of literature on school-based mental health programs, and through consultation with experts in the field. The original 10 principles were evaluated on a Likert scale ranging from clearly unimportant to clearly important by 428 individuals involved in school-based mental health. Using feedback from this survey, the principles were revised, and sent to an additional 86 mental health professionals for review. With the final results of surveys, Weist et al. (2005) developed a *Revised Principles for Best Practice in Expanded School Mental Health* (see Appendix A). They found that the principles of *Best Practice* are important to a diverse group of mental health professionals – including those with varying years of practice, those working with different age levels of students, those with different positions within the school-based mental health team, and those practicing in diverse geographic locations (Weist et al., 2005).

In combination, the guidelines, *Best Practices*, and *Revised Principles* indicate that mental health programs in schools must follow a continuum of services (NASP, 2003; Pluymert, 2002; Weist et al., 2005). Nastasi et al. (1997 as cited in Pluymert) described the continuum as including four levels of service. The first level should include Prevention efforts targeted toward the general school population. The Prevention efforts should work to create a positive social climate, and should help all students maintain healthy social and emotional development. The second level of service should include Risk Reduction for those students who are at-risk for social or emotional difficulties. These services can be delivered in a small group setting by a

school psychologist or school counselor. The third level of service should include Early

Interventions for those students who are already experiencing mild problems, and who are at-risk

for developing more serious social or emotional problems. Again, these services can be

delivered in a small group; however, individual counseling or programming may be necessary.

The fourth level of service should include Treatment targeted toward students with moderate to

high social or emotional problems. This fourth level of service is most often provided by school

mental health professionals in individual settings. Overall, the guidelines and *Best Practices*

state that school-based mental health programs should be cost-effective, and the funding for

these services should be provided by both government and private agencies (NASP, 2003;

Pluymert).

The combined practice guidelines emphasize that school-based mental health programs

should include teams of mental health professionals, educators, community agencies, and

families working in culturally sensitive, respectful collaboration (NASP, 2003). Weist,

Proescher, Prodente, Ambrose, and Waxman (2001) refer to this team-approach as Expanded

School Mental Health (ESMH). They state that school-based mental health professionals must

work with community agencies in order to discover what areas of need are especially apparent in

the area, and what services are available outside of the school to already work on these issues

(Pluymert, 2002; Weist et al., 2001). In addition, Weist et al. (2001) believe that school-based

mental health professionals must work with school health staff because some medical difficulties

are related to social and emotional difficulties. For example, asthma is a medical issue that is

positively correlated with stress, an emotional difficulty (Weist et. al., 2001).

While considering a team-based approach, Weist et al. (2001) state that because

educators are often not aware of the function of school-based mental health professionals in their

schools, mental health professionals must be clear about expectations. Educators may not know how or where to locate the school-based mental health team, and may see them more as disciplinarians than service providers. School-based mental health professionals also must stress the importance of student confidentiality when working with educators, and must assert that student information is not to be shared freely among colleagues (Weist et al., 2001).

Finally, the guidelines, *Best Practices*, and *Revised Principles* state that school-based mental health professionals should use evidence-based practices, and demonstrate the efficacy of these practices (NASP, 2003; Pluymert, 2002; Weist et al., 2005). Pluymert (2002) explains that it is important for school psychologists to incorporate research-based practices when providing services, but that it is also important for practitioners to evaluate the effectiveness of these practices within their own school environment. Hoagwood, Burns, Kiser, Ringeisen, and Schoenwald (2001) offer cautionary guidelines when using evidence-based practices with students in schools. First, they state that school psychologists must provide mental health services in developmentally appropriate ways – differentiating the content and approaches that are taken when working with children versus when working with adolescents (Hoagwood et al., 2001). Mental health professionals who work with students of multiple ages may need to research practices that are effective for the same difficulty at different age levels, and must realize that treatments proven effective for adults may not be appropriate for use with the school-age population. Second, they explain that school psychologists must consider the student within a family and a cultural context (Hoagwood et al.). A specific practice that is proven effective for some students may prove ineffective for others due to cultural differences.

Laws and Government Actions Regarding Accountability and School Mental Health

The Individuals with Disabilities Education Act, reauthorized in 2004 (IDEA; US Department of Education, Office of Special Education Programs, 2007), is a federal law that requires all students with disabilities to have an Individualized Education Plan (IEP), reviewed annually, through which they can receive free and appropriate public education. IDEA insists that students with disabilities be included, to the highest degree possible, in general education settings with a group of their peers. Further, IDEA insists that quality teachers and administrators provide quality education to students with disabilities, and that these students must participate in regular state and local assessments. It also affirms that parents are an important part of the Special Education process, and that they are entitled to regularly scheduled reports that detail the progress that their student is making toward previously determined goals.

Not only does IDEA impact the academic aspect of schooling, it also influences how mental health services are provided and documented in schools. This is especially important as mental health professionals in schools determine whether a student with a mental health issue is entitled to services under IDEA (Schact & Hanson, 1999). In order to receive mental health services under IDEA, students' behaviors related to social or emotional concerns must be impacting their school performance. Even when a student has a mental health diagnosis under the Diagnostic and Statistical Manual of Mental Disorder (DSM; American Psychiatric Association, 1994), this diagnosis does not guarantee that the student will receive mental health services in the school. The reverse also applies because the law states that the student does not need to have a DSM diagnosis to receive mental health services in school under IDEA (Schact & Hanson).

IDEA specifies that students may qualify for counseling services under the category of related services (US Department of Education, Office of Special Education Programs, 2007).

Related services help children with disabilities benefit from their special education programs.

When included in the student's Individualized Education Plan, counseling services must be

provided by qualified school personnel – including school psychologists.

The President's New Freedom Commission on Mental Health (2003) also discusses the

importance of providing mental health services to children and adolescents in schools. The

authors state that "early detection, assessment, and linkage with treatment and supports can

prevent mental health problems from compounding and poor life outcomes from accumulating"

(President's New Freedom Commission on Mental Health, 2003, p. 57). Because over 52

million students attend schools in the United States on any given day, schools represent an

effective setting for providing the greatest number of mental health services to the greatest

number of individuals (President's New Freedom Commission on Mental Health, 2003). The

Commission recommendations are that coordinated school-based mental health services be

explicitly stated in Individualized Education Plans for students, and that transition services for

adolescents be developed to include services for mental health issues.

The *No Child Left Behind Act of 2001* (NCLB) increases accountability for schools to

provide education to all students (US Department of Education, 2004; Weist et al., 2006).

NCLB relates to school-based mental health practices by discussing the need for prevention and

intervention efforts, and by maintaining government interest in school drop-out rates. NCLB

also calls for the removal barriers that get in the way of student success (President's New

Freedom Commission on Mental Health, 2003). Specifically, Section 5421 of NCLB discusses

the use of government funding for elementary and secondary school counseling programs (US

Department of Education). This section states that government funds may be used to support

school-based mental health programs that are comprehensive, that include families and

communities, and that consider aspects of child and adolescent development when planning programs and services. Section 5421 further states that programs receiving federal funding "shall evaluate … the effectiveness and outcomes of [their] counseling services and activities" (US Department of Education, 2004, p. 2). Ultimately, NCLB mandates that schools must use evidence-based practices, provided by well-qualified professionals, to provide services to students.

Accountability in Academics

In response to IDEA and to the *No Child Left Behind Act of 2001*, assessment tools have been developed to monitor student progress in various academic domains (Fuchs & Fuchs, 2004). Curriculum-based measurement (CBM) has become a particularly useful tool in this process. According to Deno (2003, p.185), "*curriculum-based measurement* refers to a specific set of standardized procedures" that sample a student's performance in order to compare that student's performance to the performance of others students at the same grade level. CBM can be easily taught to a variety of school professionals, and is time efficient because its procedures take only minutes to complete (Deno, 2003). CBM is also sensitive to small changes, over short periods of time. This is useful in that CBM allows for progress-monitoring data to be collected and evaluated regularly. Teachers can set end-of-year goals and physically graph a student's progress toward these goals (Fuchs & Fuchs).

Accountability is emphasized with progress-monitoring. From CBM, teachers obtain clear information about the quality and effectiveness of their instruction. On a weekly basis, they know whether their teaching strategies and interventions are working. When teachers find that students are not progressing toward previously determined goals, they modify their teaching strategies and interventions (Fuchs & Fuchs, 2004).

Accountability in School-Based Mental Health

With the federal government's rising expectations and focus on accountability for schools, it is becoming increasingly important for school-based programs to find ways to demonstrate effectiveness (Curtis, Walker, Hunley, & Baker, 1999; Repie, 2005; Studer, Oberman, & Womack, 2006). Educators are already doing this with curriculum-based measurement and a Response to Intervention model (Deno, 2003; Fuchs & Fuchs, 2004). In order to equally accomplish this goal, school-based mental health professionals must find ways to analyze whether their programs and services are effective at meeting the specific needs of students within their schools (Weist et al., 2000).

In 2006, NASP published *School Psychology: A Blueprint for Training and Practice III* to guide individuals in the field (*Blueprint III*; Ysseldyke et al., 2006). *Blueprint III* strongly enforces the previously discussed need for research-based practice and accountability. Specifically, *Blueprint III* states that school psychologists should be trained in methods leading to assessment and evaluation in order "to define problems and student needs and assets, to estimate current status, to link results to the development of effective interventions, and to evaluate outcomes and inform future intervention decisions" (Ysseldyke et al., 2006, p. 18).

School-based mental health professionals must work to develop ongoing evaluation processes and progress-monitoring strategies that lead to continued improvement of services for students with social and emotional difficulties (Weist et al., 2006). Ongoing, formative assessment allows school psychologists to make changes if a particular intervention or counseling technique is not helping a student reach a particular goal (Studer et al., 2006). School psychologists, as data-based problem solvers, must use evaluations of current interventions to inform the development of future interventions (Nastasi, 1998). Data collection for formative

assessments is often accomplished through the use of observations, interviews, self-report

measures, rating scales, anecdotal records, or standardized tests (Nastasi, Varjas, Bernstein, &

Pluymert, 1998).

Studer et al. (2006) encourage the use of pre and post measures to gain information about

program effectiveness. This action-based, or applied, research methodology allows school

psychologists to formally collect data on a particular intervention, and the results of the pre and

post measures can be charted or graphed in order to present the information to those maintaining

an interest.

In a NASP-funded study of 87 exemplary mental health programs, less than half of the

programs had effectiveness data available for review in written form (Nastasi et al., 1998).

Professionals in these programs spent a majority of their time implementing mental health

programs, and significantly less time evaluating these programs. This lack of written data may

ultimately be harmful to the programs – as they are unable to use their evaluation information to

make positive changes in their mental health programs (Nastasi et al.).

Survey Research in School-Based Mental Health

After completing a review of the school-based mental health literature from 1985 to

1995, Hoagwood and Erwin (1997) reported that schools are providing a variety of mental health

services to students, but that the effectiveness of most of these services has not been

demonstrated. Specifically, they found that out of 228 evaluations of school-based mental health

programs, only 34% utilized empirical designs that included a comparison group and

standardized outcome measures (Hoagwood & Erwin, 1997). They also found that the method

of random assignment was rarely used even in these empirical designs. Hoagwood and Erwin

(1997) report that a lack of random assignment may lead to the possibility of inappropriate

conclusions about program effectiveness; however, the absence of this research technique may be due to the ethical issue researchers would face if only providing mental health services to a select group of students, while denying services to a control group. In order to be done ethically, researchers would have to use random assignment, while placing the control group on a waiting list so that these students may also benefit from the mental health services after the study was completed.

A number of surveys have been conducted with randomly selected members of NASP over the past 10 years (Bramlett et al., 2002; Curtis, Hunley, & Chesno Grier, 2002; Curtis et al., 1999; Hosp & Reschly, 2002; Jimerson, Graydon, Curtis, & Staskal, 2007). Much of this survey research has focused on the demographic and professional characteristics of school psychologists, the roles and responsibilities that school psychologists maintain, the ideal roles that school psychologists see for themselves in the field, barriers to the practice of school psychology, and research interests in the field.

For demographic and professional characteristics, survey results have shown that a majority of practicing school psychologists are female (Bramlett et al., 2002; Curtis et al., 1999; Jimerson et al., 2007), have received a Specialist level of training (Curtis et al., 1999; Hosp & Reschly, 2002), and have had varying number of years of experience (Bramlett et al.; Curtis et al., 1999; Jimerson et al.). Results have also shown that there is a large amount of variance in the average school psychologist to student ratio throughout the world (i.e. 1 to 47 in Italy versus 1 to 19,056 in Hong Kong; Jimerson et al.).

For roles and responsibilities, survey results have shown that school psychologists tend to spend most of their time in assessment and evaluation activities for special education placement (Bramlett et al., 2002; Curtis et al., 1999; Hosp & Reschly, 2002; Jimerson et al., 2007). School

psychologists also spend a significant amount of time in consultation with teachers and other school professionals (Bramlett et al.; Jimerson et al.). Survey results have also shown that school psychologists would like to spend more time in counseling, direct intervention, and prevention activities, and that counseling is a preferred job function for school psychologists (Curtis et al., 1999; Hosp & Reschly; Jimerson et al.). Survey research has also shown that school psychologists believe new research is vital to the field; however, they report not feeling as though they have time in their schedules to complete this research (Jimerson et al.).

Very few studies have been conducted on the topic of accountability in school-based mental health. One survey that did focus on accountability was conducted by Fairchild and Zins (1992). They surveyed 161 randomly selected school psychologists from NASP in order to discover the current accountability practices for these mental health professionals. Accountability practices in this study, however, were measured through three main types of data. These included enumerative data (the amount of time the school psychologist spent working on certain activities), process data (the personal characteristics and skills of the school psychologists), and outcome data (the changes seen in students as a result of the school psychologists' efforts). The school psychologists were first asked whether they collected any of these types of data, and were subsequently asked about specifics of the data collection and its use. Fairchild and Zins found that most respondents collected some form of accountability data – with a majority collecting enumerative data that they were able to share with their administration. Few respondents collected outcome data on the effectiveness of their interventions.

In addition, Repie (2005) surveyed selected school professionals on their perceptions of the effectiveness of school-based mental health services (i.e. evaluation of problems, individual

counseling, crisis intervention, group counseling, family counseling, and substance abuse services) in schools across the United States. Survey results showed that, in general, school psychologists, special education teachers, and general education teachers perceive their schools' mental health services to be more ineffective than effective (Repie). The survey indicated that only school counselors perceive their schools' mental health services as more effective than ineffective.

From the research, it remains unclear whether school psychologists, as school-based mental health professionals, are following guidelines for providing exemplary mental health programs and services in daily practice. Specifically, the extent to which school psychologists are monitoring the progress of their mental health interventions in order to be accountable for the effectiveness of these interventions remains unclear. The present data analysis of survey data that was collected in 2005 targets these questions, and provides insight into the current practice of school psychologists providing school-based mental health services to students with social and emotional difficulties.

There were four main hypotheses in this study. The first hypothesis was that school psychologists working with a high student to school psychologist ratio would participate in fewer hours of individual or group counseling than school psychologists with a low student to school psychologist ratio. This hypothesis is based on the limited time available to those professionals working with a larger student population.

The second hypothesis was that school psychologists who participate in a greater number of hours per week of counseling would be more likely to use progress monitoring techniques with their counseling cases than school psychologists who participate in fewer hours of counseling. School psychologists who maintain a focus on mental health may be more likely to

find importance in being accountable for their counseling interventions. They may also have more time to collect progress monitoring data in the area of mental health.

Another hypothesis was that school psychologists who had been working for a longer period of time in the field use progress monitoring to a lesser degree than school psychologists who have been working in the field for a shorter period of time. This hypothesis is based on the idea that school psychologists working in the field may have less of a connection to the new developments within the field that are thoroughly discussed in training programs.

The final hypothesis was that a school psychologist's level of training (Masters, Specialist, Doctoral, or ABD) would have an influence on the frequency of progress monitoring for mental health services. Different levels of training may influence how prepared the school psychologist feels in regards to counseling, and may influence whether the school psychologists feels it necessary to be accountable.

CHAPTER THREE

Method

Archival data used in this study was collected in 2005 by a School Psychology Graduate Student from the Rochester Institute of Technology. The archival survey data was not systematically entered into a data base, nor was it analyzed prior to the present study.

Participants

The archival data represents a total of 147 surveys. Survey respondents were randomly selected members of the National Association of School Psychologists in 2005. They were 72.8% female and 27.2% male. Surveys were returned from NASP members in the Northeast (42.5%), North Central (21.2%), Northwest (5.5%), Southwest (13.7%), and Southeast (17.1%) regions.

Most survey respondents were full-time practitioners (82.2%), working with multiple age levels (65.2%), and practicing in suburban settings (50.0%). At the time of the survey, 32.1% of the respondents had been practicing for up to 6 years, 40.7% had been practicing for 7 to 17 years, and 27.1% had been practicing for 18 years or more. A majority of the respondents had received Specialist degrees (43.7%), whereas some had been trained at the Masters level (29.6%) or the Doctoral or ABD level (26.8%). Only 44.3% of the respondents reported working within the NASP recommended student to school psychologist ratio (1000:1), whereas the remaining 55.7% were working beyond the recommended ratio.

Instrument

The survey used in this study was developed by Wacker (2005), School Psychology Graduate Student under the direction of her thesis advisor, to gather information regarding the mental health practices of school psychologists in the United States. The survey first requested

demographic information from the respondents, including: (a) sex; (b) number of years in practice; (c) geographic location of practice; (d) employment status; (e) highest degree earned; (f) psychologist-to-student ratio; (g) grade level of the student population served; (h) primary job setting; and (i) type of placement. In addition to demographic information, items requested information about: (a) the theoretical orientation of the respondent; (b) the respondent's training and perception of preparedness in counseling; (c) the number of hours per week the respondent provides counseling services; (d) the types of groups the respondent facilitates; (e) whether or not, and how frequently, the respondent keeps progress notes or counseling goals for individuals and groups; (f) the types and sources of progress monitoring information the respondent uses; and (g) the types of interaction the respondent has with parents (see Appendix B).

The survey was administered to a group of school psychology professors and graduate-level school psychology students at the Rochester Institute of Technology. Based on feedback from the pilot, the survey was edited and reformatted by Wacker (2005) to increase clarity.

Procedure

The following procedures were used to generate the archival data. The survey and study were approved during the Spring of 2005 by the Institutional Review Board at the Rochester Institute of Technology. Mailing labels for 500 randomly selected, current members of the National Association of School Psychologists (NASP) were purchased from INFOCUS Marketing. A cover letter, survey, and self-addressed, stamped envelope were sent to the NASP members. The self-addressed envelopes were numbered and matched with duplicate copies of the mailing labels in order to keep track of which surveys had been returned. When a survey was returned in its pre-numbered envelope, the duplicate copy of the original label was destroyed in order to ensure confidentiality.

The first mailing of the survey took place in October 2005, with a response rate of approximately 26% (n = 129). In order to increase the response rate, a second mailing of surveys was conducted in December 2005 to target those who had not yet responded. An additional 18 surveys were returned, increasing the overall response rate to approximately a 29%. This response rate is relatively low in comparison to other rates (45-74%) for surveys given to NASP members (Bramlett et al., 2002; Curtis et al., 1999; Fairchild & Zins, 1992; Hosp & Reschly, 2002; Jimerson et al., 2007; Nastasi et al., 1998). A possible explanation for this relatively low response rate is that unlike some other surveys, this research design did not provide a tangible reward opportunity for respondents to participate.

In order to obtain usable data and to run accurate analyses for the present study, survey responses were coded and entered into a database by the present researcher.

CHAPTER FOUR

Results

Counseling Characteristics of the Respondents

Table 1 shows the complete demographic profile of the respondents and the percentage of respondents in each category. Frequency counts were also conducted for questions related to counseling in order to better understand the survey respondents' experience with this aspect of the profession (See Table 2). Most respondents reported spending a total of 1.0 to 5.9 hours counseling individually and/or in groups (41.2%), and most reported that the child is their primary client (86.3%). In addition, most respondents reported using an eclectic approach to counseling (75.2%), with a cognitive behavioral approach (14.2%) as the next most frequently reported counseling orientation. Furthermore, 39.0% of the respondents reported feeling that their school psychology training program prepared them well or adequately to provide counseling services, whereas 61.0% reported feeling that their school psychology training program prepared them only somewhat or inadequately.

Survey respondents also reported the frequency with which they use pre and post measures with their counseling cases. Results indicate that the greatest number of respondents use pre and post measures "sometimes" (34.1%). Only 6.3% use pre and post measures "always" with their counseling cases. In addition, more than half of the survey respondents who participate in progress monitoring report that they use "informal notes/reports," and information obtained from students, teachers, parents, and their own observations. Standardized, self-made, and "other" measures are less frequently used.

One-way Analysis of Variance

A one-way analysis of variance (ANOVA) was conducted with School Psychologist to Student Ratio as the independent variable and Hours of Counseling per Week as the dependent variable (See Table 3). In order to perform the statistical analysis, these variables were recoded from the original survey responses. The reported School Psychologist to Student Ratio responses were grouped into two levels (1:1 to 1:1000 and 1:1001 to 1:8000) based on NASP recommendations for an appropriate School Psychologist to Student Ratio. The reported Hours of Counseling per Week were recoded into three levels (0 to 0.9 hours, 1.0 to 5.9 hours, and 6.0 to 35.0 hours) based on whether the school psychologists provided less than one hour of counseling per week, one hour to one full day of counseling per week, or more than one full day of counseling per week. The ANOVA was not significant, $F(1,114) = 1.362$, $p = 0.246$, showing that the school psychologist to student ratio does not have a significant effect on the number of hours of counseling the school psychologist provides.

Stepwise Regression to Predict Frequency of Pre and Post Measure Use

A stepwise regression analysis was conducted to determine the factors that led to the respondent's frequency of pre and post measure use. Highest Level of Education, recoded Hours of Counseling per Week, Feeling of Preparedness (recoded into Well to Adequately Prepared and Somewhat to Inadequately Prepared based on inadequate group sample sizes among the original four groups), and Years Working (recoded into 0-6 years, 7-17 years, and 18-40 years based on the recent increase in emphasis on accountability and based on group sample sizes) were entered as independent variables. Frequency of Pre and Post Measure Use was the dependent variable. Accounting for 3.9% of the variance in Frequency of Pre and Post Measure Use, Feeling of Preparedness was the only significant predictor, $F(1, 110) = 4.508$, $p = 0.036$. This suggests that the more prepared for counseling the respondent felt, the more frequently the respondent uses

progress monitoring for counseling cases. These results also indicate that education level, amount of counseling, and number of years as a school psychologist do not directly and significantly predict the frequency of progress monitoring in counseling.

A subsequent one-way analysis of variance (ANOVA) was conducted with Feeling of Preparedness (well to adequate and somewhat to inadequate) as the independent variable, and Frequency of Pre and Post Measure Use (always, often, sometimes, rarely, never) as the dependent variable. The ANOVA was significant, $F(1, 117) = 4.779$, $p = 0.031$, further supporting the result that when a school psychologist feels more prepared to conduct counseling, the school psychologist is more likely to use progress monitoring techniques (see Table 4).

Stepwise Regression to Predict Preparedness for Counseling

A stepwise regression analysis was conducted to determine the factors that led to the highest Feeling of Preparedness to provide counseling services, as rated by respondents. Highest Level of Education and Years of Practice were the independent variables and Feeling of Preparedness was the dependent variable. Accounting for 4.6% of the variance in Feeling of Preparedness, Highest Level of Education was the only significant predictor in the regression, $F(1, 130) = 6.300$, $p = 0.013$. This indicates that the higher their degree level, the more prepared respondents feel for providing counseling services. Years of Practice did not account for a significant portion of the variance in Feeling of Preparedness.

A subsequent one-way analysis of variance (ANOVA) was conducted with Level of Education (MS/MA/MEd, Specialist, and Doctorate/ABD) as the independent variable and Feeling of Preparedness (well to adequately and somewhat to inadequately) as the dependent variable. The ANOVA was significant, $F(2, 132) = 6.765$, $p = 0.002$, supporting the result that the school psychologist's level of education significantly influences his/her feelings of

preparedness for counseling (see Table 5). Adjusting for differing samples sizes between

groups, a Tukey B post hoc test further revealed that significant differences were found between

the MS/MA/MEd group and the Doctorate/ABD group, and between the Specialist group and the

Doctorate/ABD group. This shows that school psychologists trained at the Doctoral or ABD

level have greater Feelings of Preparedness for counseling than those trained at the Specialist or

Masters levels.

CHAPTER FIVE

Discussion

The purpose of this study was to examine the current accountability practices (use of pre and post measures) of school psychologists providing individual and group counseling services. The survey results indicate that a majority of school psychologists only sometimes use pre and post measures, and that consistent progress monitoring of counseling cases across school psychology professionals in the field is rare. Results also suggest that the school psychologist to student ratio in a school has no significant relationship with the number of hours the school psychologist provides group and individual counseling services. In addition, the results suggest that there is no significant relationship between the number of hours of counseling a school psychologist provides or the number of years the school psychologist has been in practice and the frequency with which that school psychologist uses progress monitoring for counseling cases. Finally, the results of the study suggest that the more prepared a school psychologist feels to provide counseling services, the more frequently that school psychologist will use accountability practices in the form of pre and post measures. Furthermore, a school psychologists' feeling of preparedness for counseling is influenced significantly by the highest level of education the school psychologist has completed – with Doctoral and ABD level professionals feeling more prepared to provide counseling services than Masters and Specialist level professionals.

The finding that no significant relationship exists between the school psychologist to student ratio and the number of hours the school psychologist spends providing group and individual counseling services is inconsistent with an initial hypothesis and published survey research in the area of mental health service delivery (Curtis et al., 2002). Traditionally, the

higher the school psychologist to student ratio, the more frequently the school psychologist is engaged in activities related to special education eligibility and placement. Lower ratios have traditionally been associated with more individual and group counseling activities (Curtis et al., 2002). The small sample size analyzed in this study may account for this inconsistency with published research.

The finding that no significant relationship exists between the number of hours the school psychologist provides group and individual counseling and the frequency with which the school psychologists uses pre and post measures for counseling cases is inconsistent with an initial hypothesis that school psychologists spending more hours providing counseling services would more frequently use pre and post measures to demonstrate accountability. As scientist-practitioners, or action-based researchers, it would be expected that school psychologists would value and consistently use evaluation tools to be sure that their daily practices are effective for the students with whom they work (Nastasi, 1998). The lack of a relationship in this study may reflect the potentially time-consuming and novel nature of data collection in this aspect of the field (Fairchild & Zins, 1992), or a lack of emphasis on the use of pre and post measures during training for counseling.

The finding that number of years working in the profession also did not account for significant changes in pre and post measure use is inconsistent with an initial hypothesis, and is surprising for two reasons. First, government legislation regarding accountability practices were put in place in 2001 with the *No Child Left Behind Act of 2001* (NCLB; US Department of Education, 2004). School psychologists trained before the institution of NCLB may not have been given as much instruction on the use of progress monitoring and accountability for academics and mental health service delivery as school psychologists trained after this law was

put into place. Second, Curtis et al. (2002) reported that experienced professionals tend to spend more time working in intervention and prevention activities than in other school psychology-related activities. These prevention and intervention activities are likely to include individual and group counseling. With more time spent in counseling, it seems unusual that these experienced school psychologists are not using pre and post measures more often.

The finding that the more prepared a school psychologist feels to provide counseling services, the more frequently that school psychologist will use accountability practices in the form of pre and post measures helps to clarify an initial research hypothesis that the school psychologists' feeling of preparedness for counseling would, in some way, influence the use of accountability practices. Surprisingly, however, feeling of preparedness was the only independent variable that showed a significant influence over frequency of pre and post measure use. Results suggest that the variables of highest level of education, hours of counseling per week, and years working did not directly account for changes in the school psychologists' use of pre and post measure.

The finding that feeling of preparedness for counseling was significantly influenced by the school psychologists' highest level of education – with Doctoral and ABD level professionals feeling more prepared to provide counseling services than Masters and Specialist level professionals – is consistent with results of a survey by Curtis et al. (2002) who found that there was a positive relationship between highest degree level earned and the frequency with which school psychologists served students through inservice programs. School psychologists with higher degree levels may have been given more coursework and supervised experience in counseling, thus helping them to feel more prepared for this aspect of the profession and to take on more students for counseling and mental health programs. Overall, however, less than one

half of the survey respondents felt that their school psychology training program prepared them well or adequately for providing counseling.

Because feeling of preparedness for counseling significantly influences frequency of pre and post measure use, and because a school psychologists' level of education significantly influences feeling of preparedness, feeling of preparedness appears to act as a mediating variable between level of education and frequency of pre and post measure use when providing counseling services (See Figure 1). By itself, however, the school psychologists' level of education does not have a direct, significant relationship with frequency of pre and post measure use. Using this information, training programs should focus on helping school psychologists to increase their feelings of preparedness for counseling. This, in turn, may help to increase the overall frequency of pre and post measure use in monitoring the effectiveness of counseling services in schools.

Limitations

An obvious limitation to this study is the use of a survey research design. The survey called upon respondents to retrospectively estimate the number of years they have worked as a school psychologist, as well as to estimate the number of hours per week they provide counseling services in group or individual settings. Due to the nature of the profession, however, number of hours in counseling per week may change due to unexpected events within the school. The survey also asked respondents to qualify how prepared they felt in counseling, according to a four item scale, and how frequently they use pre and post measures for counseling, according to a five item scale. While this was the most efficient way to collect this information, descriptive responses may have provided more accurate information regarding progress monitoring in counseling.

The use of NASP members for this survey also presents a limitation. Fagan (1994 as cited in Curtis et al., 1999) estimated that NASP members represent approximately 70% of the total number of practicing school psychologists. While this is a majority, the views of NASP members may be markedly different than the views of non-NASP members – giving support to the reasoning behind their membership in the professional organization.

The low response rate for this survey, as compared with other survey research done with NASP members, also represents a limitation to this study. Although two mailings of the survey were completed, the response rate was only 29%. Additional responses may have provided different information, potentially altering the results.

A final limitation comes with the use of a research design and survey that was developed and initially carried out by an alternate researcher. Although data entry and analysis was complete and double-checked for the 147 available surveys, it cannot be guaranteed that other surveys were not returned and lost or discarded by the initial researcher.

Recommendations

Because this survey data was collected in 2005, it is necessary to collect updated data on the use of progress monitoring for counseling. Emphasis on the use of research-based practice and accountability data has increased with the publication of *Blueprint III* in 2006 (Ysseldyke et al., 2006). Since 2005, school psychologists may have begun to integrate recommendations from these practice guidelines in their everyday practice, potentially increasing their use of progress monitoring for counseling.

Empirical studies with control and experimental groups should also be conducted within schools to help school psychologists show that their programs and services are helping students with social and emotional difficulties function with greater success in academics and within the

school environment (Repie, 2005). There is limited research with this type of design in assessing the effectiveness of school-based mental health programs, and much of the research that does exist is based on studies done outside of the school or community setting (Hoagwood & Erwin, 1997; Hoagwood et al., 2001). Variables such as the personalities and level of training of the school psychologists, the characteristics of the mental health programs, the characteristics of the student population, and the overall school climate all play into whether a program will be effective in a given setting. Research assessing student outcomes must be conducted within individual school settings to account for these variables (Schoenwald & Hoagwood, 2001 as cited in Hoagwood et al.).

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Appendix A

Revised Principles for Best Practice in Expanded School Mental Health

1. All youth and families are able to access appropriate care regardless of their ability to pay.

2. Programs are implemented to address needs and strengthen assets for students, families, schools, and communities.

3. Programs and services focus on reducing barriers to development and learning, are student and family friendly, and are based on evidence of positive impact.

4. Students, families, teachers, and other important groups are actively involved in the program's development, oversight, evaluation and continuous improvement.

5. Quality assessment and improvement activities continually guide and provide feedback to the program.

6. A continuum of care is provided, including school-wide mental health promotion, early intervention, and treatment.

7. Staff hold to highly ethical standards, are committed to children, adolescents, and families, and display an energetic, flexible, responsive, and proactive style in delivering services.

8. Staff are respectful of, and competently address developmental, cultural, and personal differences among students, families, and staff.

9. Staff build and maintain strong relationships with other mental health and health providers and educators in the school, and a theme of interdisciplinary collaboration characterizes all efforts.

10. Mental health programs in the school are coordinated with related programs in other community settings.

Note. From "Developing Principles for Best Practice in Expanded School Mental Health," by M. D. Weist et al., 2005, *Journal of Youth and Adolescence*, *34*(1), p. 9. Copyright 2005 by Springer Science + Business Media, Inc.

Appendix B

Copy of Survey

I. Background Information: Please respond to the following items.

Sex (check): Male_____   Female_____

Years of school psychology experience: _____

In which state do you practice? _____

Employment status (check): Full time _____   Part-time _____   Contract services_____

Highest level of graduate education in school psychology (check):

 MA/MS/M.Ed _____   Specialist _____   Doctorate _____   ABD _____

Other_____

What is the approximate ratio of school psychologist to students in your district?
        1 to_____

What population (s) do you serve? (check all that apply):

Birth to 3 _____   Preschool____   Elementary _____   Secondary_____

What is your primary job setting? (check):

Urban_____   Suburban_____   Rural_____

In what placement setting(s) do you work? (please check all that apply):
Regular Education_____   Resource_____
Self contained_____   Day treatment_____
Residential_____   Other _____

II. Please respond to the following questions regarding your counseling practices and your counseling training in school psychology.

1. **What is your theoretical orientation for providing counseling? (check all that apply):**

     Child Centered_____   Cognitive Behavioral_____
     Solution Focused_____   Rational Emotive Therapy___
     Choice Theory_____   Adlerian_____

Psychodynamic_____   Systems_____
Psychoeducation (Structured Curriculum) _____
Other _____

2. **What is the extent of your training in counseling?**

Number of Graduate Courses_____   Number of Inservices_____
Number of Work Shops_____   Other_____

3. **How well did your school psychology training program prepare you to provide counseling services? (circle one):**

Well Prepared   Adequately Prepared   Somewhat Prepared   Inadequately Prepared

4. **Please indicate the type(s) of training you have received and in what setting: (check all that apply):**

	University	Workshop	No Training	Self Study
Response to Treatment Intervention (RTI)	☐	☐	☐	☐
Positive Behavior Interventions and Supports (PBIS)	☐	☐	☐	☐
Cognitive Behavioral Therapy	☐	☐	☐	☐
Crisis Intervention	☐	☐	☐	☐
Parent Training	☐	☐	☐	☐
Behavior Management at home	☐	☐	☐	☐
Behavior Management in school	☐	☐	☐	☐
Applied Behavior Analysis	☐	☐	☐	☐
Social Skills Training	☐	☐	☐	☐
Early Intervention	☐	☐	☐	☐
Consultation	☐	☐	☐	☐
Classroom Management	☐	☐	☐	☐

5. **Have you used any of the following modalities? (check all that apply):**

Sand Tray_____
Play Therapy_____
Eye Movement Desensitization and Reprocessing (EMDR)_____

6. **Estimate how many hours (total) per week you provide counseling services:**
_____. **Of this time how many hours are devoted to the following:**

IEP Mandated	Non Mandated
Individual counseling_____	Individual counseling_____
Group counseling_____	Group counseling_____

7. What do you believe is the most effective way to deliver counseling services?

Group _____   Individual _____   Drop by _____   Crisis _____

8. What do you typically do in your first counseling session? (check all the apply):

Discuss confidentiality_____   Focus on building rapport_____
Develop goals_____   Discuss what counseling is_____
Discuss rules/expectations____   Other_____

9. What types of groups do you run? Please indicate if these groups are run in a class or in a separate location? (check all that apply):

	<u>Location</u>	
	In Class	Separate Location
Social Skills	☐	☐
Anger Management	☐	☐
Death and Dying	☐	☐
Divorce Groups	☐	☐
Drug and Alcohol	☐	☐
Sexuality	☐	☐
Lunch Bunch	☐	☐
Parenting	☐	☐
Staff Training	☐	☐
Siblings Disability	☐	☐
Other	☐	☐

10. Do you document counseling goals and / or progress notes for your counseling cases or groups?

IEP Mandated:	Groups	Individuals
Counseling Goals	☐	☐
Progress Notes	☐	☐
Other	☐	☐

Non-Mandated:	Groups	Individuals
Counseling Goals	☐	☐
Progress Notes	☐	☐
Other	☐	☐

11. How often do you use pre/post measures to monitor student progress? (circle one):

Always   Often   Sometimes   Rarely   Never

12. What type of progress monitoring do you use? (check):

Standardized (pre/post) measures_____
Self-Made (pre/post) measures _____
Informal notes/reports_____
Other _____

13. What source (reporter) do you use to monitor progress? (check):

Student _____
Teacher _____
Parent _____
Self _____
Other _____

14. How often do you assign counseling homework? (circle one):

Always   Often   Sometimes   Rarely   Never

15. Who do you considered to be your primary client? (check one):

Child _____   Parent _____   School _____   Teacher _____

16. How much contact do you have with parents regarding their child's counseling sessions?
Only when safety is an issue _____
Limited to informed consent _____
Frequent updates regarding progress _____
Other _____

17. What type of supervision do you receive for counseling cases or groups?
Team supervision _____
Peer supervision _____
Specialist supervision_____

Table 1

Demographic Characteristics (N = 147)

Characteristic	Percent	Characteristic	Percent
Sex		Population	
Male	27.2	Preschool	0.7
Female	72.8	Elementary	18.4
Region		Secondary	15.6
Northeast	42.5	Multiple levels	65.2
North Central	21.2	Placement	
Northwest	5.5	Continuum of Services[a]	95.1
Southwest	13.7	Most restrictive[b]	4.9
Southeast	17.1	Student to School Psych Ratio	
Employment Status		1-1000:1	44.3
Full time	82.2	1001-8000:1	55.7
Other	17.8	Setting	
Level		Urban	26.8
MA/MS/MEd	29.6	Suburban	50.0
Specialist	43.7	Rural	20.4
Doctorate or ABD	26.8	Multiple Settings	2.8
Years Worked			
0-6	32.1		
7-17	40.7		
18+	27.1		

[a]Continuum of services includes service in a combination of placements
[b]Most restrictive placement includes service in one of the following: Self-contained, Residential, or Day Treatment

Table 2

Counselor Characteristics (N = 147)

Characteristic	Percent	Characteristic	Percent
Theoretical Orientation		Uses Pre/Post Measures	
Eclectic	75.2	Always	6.3
Cognitive Behavioral	14.2	Often	25.4
Child Centered	4.3	Sometimes	34.1
Solution Focused	2.1	Rarely	19.8
Psychodynamic	1.4	Never	14.3
Psychoeducational	1.4	Assigns Counseling Homework	
Choice Theory	0.7	Always	2.5
Other	0.7	Often	15.8
Preparedness in Counseling		Sometimes	40.0
Well to Adequately Prepared	39.0	Rarely	25.0
Somewhat to Inadequately Prepared	61.0	Never	16.7
Hours of Counseling per Week			
0 to 0.9 hours	28.7		
1.0 to 5.9 hours	41.2		
6.0 to 35 hours	30.1		
Group Counseling: Session 1			
Includes goal setting	46.6		
Does not set goals	53.4		

Table 3

School Psychologist to Student Ratio Compared to Hours of Counseling per Week

School Psychologist to Student Ratio	n	Hours of Counseling	Standard Deviation
1:1 to 1:1000	51	2.12	0.77
1:1001 to 1:8000	65	1.95	0.74

Note. Respondents were asked to report the total number of hours per week that they provide counseling services. These total hours were later recoded into groups and given numeric values for statistical analysis (1 = *0-0.9 hours*, 2 = *1.0-5.9 hours*, 3 = *6.0-35.0 hours*).

Table 4

Feeling of Preparedness Compared to Frequency of Pre and Post Measure Use

Feeling of Preparedness	n	Mean Frequency of Pre and Post Measure Use	Standard Deviation
Well to Adequately	48	2.81	1.003
Somewhat to Inadequately	71	3.27	1.183

Note. Respondents were asked to rate their Frequency of Pre and Post Measure Use on a 5-point scale, which was later recoded into numeric values for statistical analysis (1 = *Always*, 2 = *Often*, 3 = *Sometimes*, 4 = *Rarely*, 5 = *Never*).

Table 5

Level of Education Compared to Feeling of Preparedness

Level of Education	n	Mean Feeling of Preparedness	Standard Deviation
MA/MS/MEd	42	1.67	0.477
Specialist	59	1.71	0.457
Doctorate/ABD	34	1.35	0.485

Note. Respondents were asked to rate their Feeling of Preparedness on a 4-point scale (*Well Prepared*, *Adequately Prepared*, *Somewhat Prepared*, *Inadequately Prepared*). Responses were recoded into two groups and given numeric values for statistical analysis (1 = *Well to Adequately Prepared*, 2 = *Somewhat to Inadequately Prepared*).

Figure 1. Significant and Mediating Relationships Between Variables

Feeling of Preparedness for
Counseling

Level of Education

Frequency of
Pre/Post Measure
Use
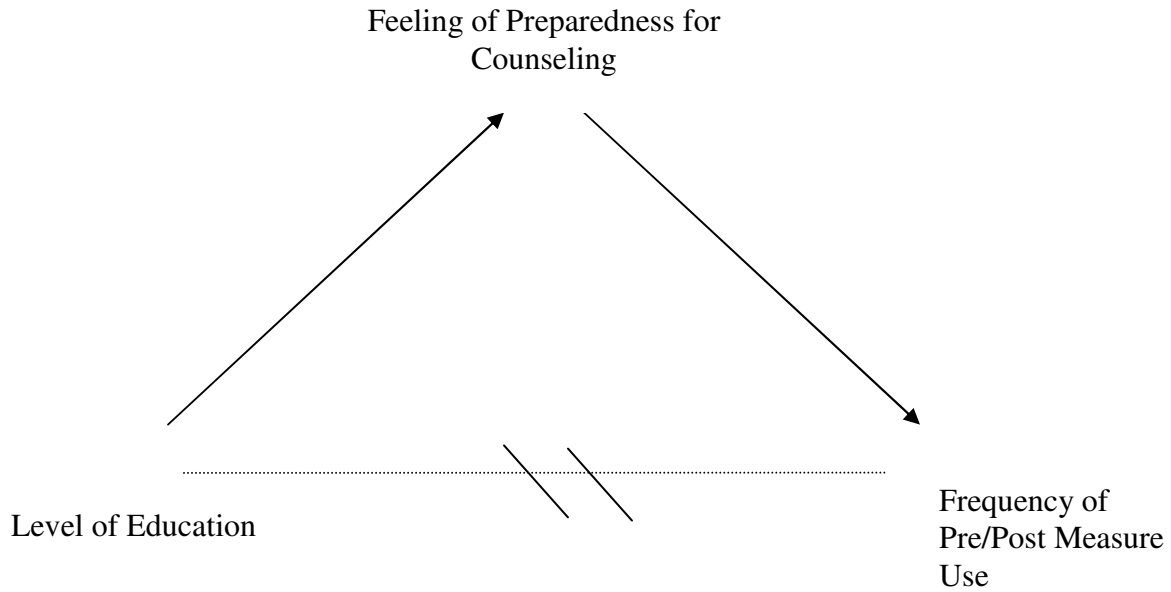
Note. Feeling of preparedness for counseling acts as the mediating variable between level of education and frequency of pre and post measure use. Level of education does not have a direct significant relationship with frequency of pre and post measure use.