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The Influences of School Counselors' Professional Development on Their Comfort Levels Addressing Mental Health and Substance Use

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This is to certify that the doctoral dissertation by

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2020

Abstract

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MS, Walden University, 2011

BA, George Mason University, 1997

Dissertation Submitted in Partial Fulfillment

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Abstract

This study was an investigation of the comfort levels of school counselors to address PK-12 students' mental health and substance use concerns. While incidents of bullying and school shootings rise it is unclear how school counselors' professional development has influenced their level of comfort identifying and addressing PK-12 students' mental health and substance use concerns. Accordingly, this quantitative descriptive survey examined school counselors' recognition of mental health and substance use symptoms, frequency of encounter, and whether their developmental stages influenced their comfort levels in addressing students' mental health and substance use concerns. Rønnestad and Skovholt's counselor development model was the theoretical lens used. An online survey was used to contact 3,309 school counselors, 550 responded and 390 completed the survey. Analysis of variance (ANOVA) was used to analyze how school counselors' stage of development influenced their level of comfort addressing PK-12 students mental health and substance use concerns. All 15 disorders identified in the survey met the assumptions of ANOVA. No significant differences were found in school counselors' comfort levels as counselors progressed across the novice, experienced, and senior professional phases of development. The results identified school counselors in need of additional training to improve their level of comfort. This study promotes social change through supportive efforts in preparing school counselors to meet the mental health and substance use needs of PK-12 students.

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Dedication

I dedicate this dissertation to my Mom and Dad who have consistently expressed their love, support, and encouragement throughout my entire life and in all of my academic endeavors. Thank you for instilling in me at a very young age a desire to learn and the importance of pursuing an education. Your never-ending love and support have made this dream of a Ph.D. possible. Thank you Mom and Dad!

In addition, I would like to thank both of my sisters Erin and Kelly for their ongoing support throughout this process. May this dissertation act as an inspiration to my nieces Sophie, Maddie, and Annie and my nephew Gabe that they too can pursue and accomplish anything they put their heart and mind too.

An additional thank you goes to my dear friend Misty who walked this dissertation journey with me and brought perspective, insight, and laughter to an otherwise, stressful time.

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Chapter 1: Introduction to the Study

School counselors are at the forefront of addressing the mental health and substance use of PK-12 students in schools (Carlson & Kees, 2013) making it necessary for them to have an understanding in how to identify students exhibiting mental health and/or substance use symptoms. This continues to be an important area of focus and concern in school systems due to the growing number of students presenting with mental health and/or substance use needs (Bor, Dean, Najman, & Hayatbaksh, 2014) and the association between students' mental health and substance use issues and the increase in school shootings in the United States.

Students' mental health and substance use are prominent concerns among school counselors, educators, administrators, students, parents, and local, state, and federal agencies in regard to school safety. There continues to be a rise in school shootings in elementary, middle, and high schools throughout the United States. The Pew Research Center conducted a study of 473 teens (12 to 17 years of age) in which 57% of the teens reported feeling worried a school shooting would occur at their school (Graf, 2018). The frequency of school shootings has created a national concern and discussions on how to keep students safe at school.

There have been over 180 school shootings with injuries and deaths in elementary, middle, and high schools since the school shooting on December 14, 2012, at Sandy Hook Elementary School in Newtown, Connecticut (Krishnakumar, 2018). These totals do not include additional school shootings at college and university campuses. School safety continues to be of utmost concern due to the increasing number of school

shootings, which are averaging one per week (Krishnakumar, 2018). As school safety continues to be explored, there is research emphasizing connections between school shooters and the presence of mental health symptoms.

Vossekuil et al. (2002) conducted a study of 41 offenders who were involved in school-based attacks/shootings and identified that 78% had attempted suicide or had suicidal thoughts, and 61% had a history of depression prior to the school attack/shooting. Two prominent causes of school shootings are (a) bullying (78%), and (b) noncompliance and/or side effects of psychiatric medication (12%; Paolini, 2015; Lee, 2013). Additional factors common among school shooters are social isolation, loneliness, rejection, anger, and a history of abuse (Duplechain & Morris, 2014; Baird, Roellke, and Zeifman, 2017). Baird et al. 2017 identified additional factors as "nearly all perpetrators are male and have a history of mental illness and/or familial instability" (p. 262). School shootings are not random or impulsive acts and tend to be carefully planned by the shooter (Gerard, Whitfield, Porter, & Browne, 2015). The analysis of the Marjory Stoneman Douglas High School shooting in Parkland, Florida, identified mental health as a "primary solution-and as a cause" (Vatz, 2018).

The continuing rise in school shootings and the concern for student safety has created public discussions about the role of school counselors' readiness to address PK-12 students' mental health and substance use concerns. An example of this is that on July 1, 2017, Senate Bill 1117 passed that prospective school counselors in Virginia who are "seeking initial licensure or renewal in the recognition of mental health disorder and behavioral distress, including depression, trauma, violence, youth suicide, and substance

use" (VA Code §22.1-298.1, 2018). The implementation of Senate Bill 1117 indicated a public acknowledgement of the need for training Virginia school counselors to be comfortable in recognizing mental health/substance use disorders, depression, behavioral distress, trauma, violence, and youth suicide. This research study examined (a) the frequency in which Virginia school counselors report seeing students displaying symptoms of mental health problems and substance use, (b) Virginia school counselors' current level of comfort in addressing mental health and substance use, and (c) the training Virginia school counselors indicate they need to address students' mental health and substance use concerns.

Counselor development continues after their initial formal educational training; however, little is known about how school counselors' development influences their abilities to identify mental health problems and substance use among PK-12 students. This study employed Rønnestad and Skovholt's (2003) counselor development model. This development model can be used to examine the development of school counselors from their initial educational training to their retirement from the profession. I used Rønnestad and Skovholt's (2003) development theory to examine whether school counselors' development influences their level of comfort in addressing PK-12 students' mental health and substance use concerns in schools. This study promotes social change by promoting early recognition of symptoms of mental health and substance use concerns in schoolchildren and furthering school safety. This study informs both public and legislative dialogue about what Virginia school counselors need to address regarding PK-12 students' mental health and substance use concerns. The study focused on Virginia as

a state having (a) both urban and rural areas, and (b) recently passed legislation focusing on training school counselors to recognize students demonstrating mental health and/or substance use concerns. This study yielded a better understanding of how school counselor development influenced their level of comfort with and the training they need to address students' mental health and substance use concerns to further school safety.

In this chapter, I discuss (a) PK-12 students' mental health and substance use concerns, (b) the need for mental health and substance use support in schools, and (c) Rønnestad and Skovholt's development model in regard to the development of school counselors. I examine the literature related to this research topic while identifying current gaps in the professional literature regarding the subject. For this study I identified several research questions, conducted a survey, and used the results to answer the initial research questions while simultaneously enhancing the body of knowledge around how school counselors' development affects their level of comfort in addressing PK-12 students' mental health and substance use concerns.

Background

The professional literature (Bor et al., 2014; Tegethoff et al., 2014; U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration [SAMHSA], 2017) provided support for the assertion that students in grades PK-12 are increasingly presenting with mental health and substance use concerns. School counselors' level of comfort addressing students' mental health and substance use begins with their formal training. Counselor development continues after professional

training, and yet little is known about the abilities of school counselors as professionals to identify and address the mental health and substance use of PK-12 students.

School Counselor Development

School counselors begin their professional development by attending, completing, and graduating from a master's degree program in school counseling and meeting all of a state's certification or licensure standards (O'Connor, 2018). School counselors are responsible for the delivery of a variety of services to the student population. School counselors address three specific domains when working with students: (a) career and college development, (b) academic development, and (c) social and emotional development (American School Counselor Association [ASCA], 2014). Career and college development refers to school counselors helping students transition to college or careers as postsecondary planning. Academic development refers to school counselors' active role working with individual student planning as a means to enhance academic growth. The social and emotional development refers to school counselors responding to students' who are experiencing personal challenges and helping them to obtain the appropriate support and services at school or within the community (O'Connor, 2018).

School counselors are at the forefront of PK-12 mental health and substance use concerns in elementary, middle, and high schools in the United States. Traditionally, school counselors have been the only professionals in schools who have advanced training in mental health (Bickmore & Curry, 2013). Due to their advanced training in mental health they are called upon to assist students with mental health and substance use more frequently than other staff members in a traditional school setting.

Mental Health of PK-12 Students

Suicide is the second leading cause of death for adolescents ages 12 to 17 years old (Centers for Disease Control and Prevention [CDC], 2016). The 2016 Child Mind Institute Children's Mental Health Report identified a total of 80% of all chronic mental health disorders begin during childhood. A total of 50% of all mental health disorders begin before the age of 14 (Child Mind Institute, 2016). This report identified: (a) 75% of attention-deficit hyperactivity disorders start by the age of 8, (b) 75% of separation anxiety begins by age 10, (c) 75% of all oppositional defiant disorders begin by age 14, and (d) 75% of all social phobia starts by age 15. A total of 2.7% of adolescents ages 13 to 18 years old have an eating disorder, while 5% of adolescents in this age range meet criteria for posttraumatic stress disorder (Merikangas et al., 2010; Hamblen & Barnett, 2016). Mood disorders such as depression, anxiety, and bipolar disorder as well as attention-deficit hyperactivity disorder are the most prominent mental health diagnoses for children and adolescents (Pfuntner, Wier, & Stocks, 2013). A total of 75% of students struggling with mental health challenges do not receive mental health services (Child Mind Institute, 2016).

Substance Use of PK-12 Students

In their article Keeping Youth Drug Free, the Center for Substance Use in collaboration with SAMHSA identified in 2016 a total of 1.9 million children ages 12 to 17 years old who used illicit drugs, with 2.3 million children in this same age group who used alcohol within the previous month and more than half who reported binge drinking

(SAMHSA, 2017). A total of 3,300 children each day are trying marijuana for the first time, and 6,300 children each day are trying alcohol for the first time (SAMHSA, 2017).

The National Center on Addiction and Substance Abuse at Columbia University (2012) conducted a national survey that included 1,003 adolescents between 12 and 17 years old. A total of 60% or more of the adolescents surveyed identified their high school as drug infested, meaning that drugs were used, stored, and sold at their school. One in five of the students (17%) identified knowing other students drugging, drinking, and smoking during the day. A total of 44% of the 12 to 17-year-olds surveyed identified knowing a student at school who sells drugs, 91% knew of someone selling marijuana, 24% knew someone selling prescription drugs, one out of nine knew someone selling cocaine, and 7% knew someone selling ecstasy. Of the 12 to 17-year-olds surveyed, 97% of all students knew other students who either drank (47%), used drugs (40%), or smoke (30%).

The Need for Mental Health and Substance Use Support in Schools

Bor et al. (2014) indicated one in five adolescents suffer from mental health problems. A total of 75% of students struggling with mental health issues are not receiving the necessary mental health services (Paolini, 2015; Stagman & Cooper, 2010). Atkins, Cappella, Shernoff, Mehta, and Gustafson (2017) suggested that schools have been the primary location for providing mental health services to children and adolescents even though the necessary resources and expertise are not present. They noted how little is known as to either the types of mental health services available in schools or the quality of these services. Tegethoff, Stalujanis, Belardi, and Meinischmidt

(2014) emphasized how schools are the primary resources for children and adolescents to access necessary resources such as mental health services.

Hill, Ohmstede, and Mims (2012) examined the current mental health services offered in Nebraskan schools and whether these current services met the mental health needs of students. This study examined 240 principals, school psychologists, and school counselors in Nebraska who responded to an online survey. The results of this study indicated that principals, school psychologists, and school counselors identified the current mental health services did not meet the overall mental health needs in the Nebraska schools and more mental health services in their schools was needed. The authors identified the untreated mental health needs significantly contributed to (a) a decline in school attendance; (b) poor academic performance; (c) difficulty in overall physical, emotional, and mental development; and (d) the likelihood of mental health problems persisting into adulthood.

Carlson and Kees' (2013) descriptive survey of 120 school counselors found school counselors were most comfortable with the following skills: (a) consultation with parents, teachers, and administrators; (b) collaboration and teamwork; and (c) ethical practice. The study indicated school counselors were least comfortable with the following skills: (a) using the Diagnostic and Statistical Manual of Mental Disorders 5th edition, (DSM) for diagnosing issues, (b) family counseling, and (c) treatment planning.

In this study, I examined school counselors' level of comfort identifying and working with PK-12 students with mental health problems and/or substance use. The

school counselors' level of comfort was examined through the theoretical lens of Rønnestad and Skovholt's (1992, 2003) developmental model.

Rønnestad and Skovholt's Development Model

Rønnestad and Skovholt's (1992, 2003) provided a theory of counselor development across six phases. The first three emphasize educational training and end with graduation from a training program. The last three phases encompass the working life of counselors from the beginning of their professional experiences to ending with retirement (Rønnestad and Skovholt, 1992, 2003). This theory provided a lens for examining if school counselors' level of comfort in addressing mental health and substance use symptoms is influenced by their stages of development.

School counselors enter their professional work with specific levels of formal training, and yet little is understood regarding how counselor development across their professional careers influences on-the-job performance. No current research examines how school counselor development influences school counselors' level of comfort addressing PK-12 students' mental health and substance use. This study addressed the current gap in the research literature.

Problem Statement

There are an increasing number of school shootings in the United States, which have been liked to PK-12 students presenting with a variety of mental health and substance use concerns. Data from the 2015 National Survey on Drug Use and Health conducted by the Substance Abuse and Mental Health Services Administration (SAMSHA; 2017) identified children 17 years of age and younger have a variety of

mental health and substance use disorders. This survey identified that 12.5% (3 million) adolescents 12 to 17 years of age experienced a major depressive episode (MDE) in the past year, and 8.8% (2.1 million) experienced an MDE with severe impairment in the preceding year. Those who experienced an MDE with severe impairment in the past year made up 70.7% of children who experienced an MDE, with 1.4% (350,000) having comorbid substance use disorders. Substance use includes (a) alcohol use, 9.6% (2.4 million); (b) marijuana use, 7.0% (1.8 million); and (c) other illicit drug use, 8.8% (2.2 million). If not addressed during childhood and if left untreated, these mental health and substance use symptoms can manifest in significantly worse problems in adulthood.

Due to the increased need to address the mental health and substance use of students, school counselors are transitioning from a traditional academic guidance role to providing mental health support to PK-12 students. The ASCA national model recommends school counselors spend 80% or more of their time with direct or indirect services to students (ASCA, 2012). School counselors need to have the necessary skills to recognize and address the growing number of PK-12 students who exhibit mental health and/or substance use symptoms; however, it is not clear they are prepared by either their educational programs or requirements for state certification or licensure to address the mental health and substance use of students.

Ball et al. (2016) proposed that with the increasing rise in mental health conditions among PK-12 students in the United States, the role and responsibilities of school counselors requires them to step up in a more direct way to meet these needs. This study examined school counselors' level of comfort in addressing this rise in mental

health and/or substance use concerns among students. School counselors have been at the frontline in addressing mental health within the school systems even though the traditional role of school counselors has been to help students in the selection of classes. The ASCA developed the National Standards for Students to address the emotional, physical, social, and economic barriers to students' academic success (ASCA, 2004). This transformation in the role of school counselors emerges from the need to address the growing mental health and substance use concerns of PK-12 students. School counselors have been primarily academic and career focused advisors, but now addressing a variety of social and environmental stressors in students' lives has become a necessary focus.

As school shootings and bullying continue to rise, mental health and substance use symptoms and diagnoses continue to rise among PK-12 students (Duplechain & Morris, 2014). It is currently unclear as to how school counselors' professional development influences their level of comfort identifying and addressing PK-12 students' mental health and substance use symptoms.

Purpose of the Study

Mental health functioning is crucial to the overall learning and academic success of PK-12 students (Atkins et al., 2017). Traditionally, school counselors have helped with academic and career development and are now on the frontline in identifying and addressing mental health and substance use in schools. The purpose of this quantitative descriptive survey study was to identify (a) the frequency with which school counselors are encountering students displaying mental health and substance use problems, (b) school counselors' level of comfort in recognizing mental health and substance use

problems, and (c) if school counselors' developmental phases influence their comfort levels in addressing mental health and substance use problems. The independent variables were Rønnestad and Skovholt's (2003) developmental phases and the dependent variable was school counselors' level of comfort. This descriptive research study surveyed school counselors throughout the state of Virginia.

Research Questions

The important variables for this research study were (a) school counselors' report of the frequency of PK-12 students displaying mental health and substance use symptoms, (b) their developmental stage, and (c) their comfort levels in addressing mental health and substance use symptoms.

RQ1: How frequently do school counselors report interacting with PK-12 students who exhibit mental health or substance use symptoms?

RQ2: What are school counselors' comfort levels in addressing challenges associated with mental health and/or substance use among PK-12 students?

RQ3: How does school counselors' stage of development influence their level of comfort in addressing PK-12 students' mental health and/or substance use?

RQ4: What additional training do school counselors report as being needed to increase their comfort in addressing mental health and/or substance use concerns among PK-12 students?

Theoretical Framework for the Study

Rønnestad and Skovholt's (2003) theory examines counselor development through six phases of development: "(a) lay helper, (b) the beginning student, (c) the

advanced student, (d) the novice professional, (e) the experienced professional, and (f) the senior professional" (p. 10). According to Rønnestad and Skovholt (2003), the concept of development (a) implies change, (b) is organized and systematic, and (c) occurs over time.

1. The first phase is the lay helper phase, a pretraining period where the individual helps, projects solutions, and gives personal advice.
2. The second phase is the beginning student phase where professional training begins with introductions to theories/research, peers/supervisors, and clients. During this phase, counselors learn basic and straightforward counseling methods with clients.
3. The third phase is the advanced student phase where counselors are working in practicum, internship, and field placement settings as well as seeking opportunities to watch and learn from senior counselors and supervisors.
4. The fourth phase is the novice professional phase, which are the first several years after graduation. During this phase, counselors begin experiencing a sense of being on their own. Three significant experiences occur during this phase: (a) counselors examine and question the validity of their professional training; (b) when confronted with professional challenges, counselors experience moments of disillusionment concerning their professional training and abilities; and (c) counselors experience more intense exploration into their ongoing professional development and environments.

5. The fifth phase is the experienced professional phase where counselors have been working in a professional role with clients for numerous years and continue to develop specific approaches for meeting clients' needs.
6. The sixth phase is the senior professional phase in which the counselor has been practicing in the counseling profession for 20 or more years, is beginning to disengage from the profession, and is approaching retirement.

Rønnestad and Skovholt (1992) suggested counselor development occurs over the lifespan of counselors' careers. This theoretical framework demonstrates a continuum in which counselors initially extend their reliance on external influences and authorities separate from themselves to a reliance on internal influences and authorities. In this research study, Rønnestad and Skovholt's (1992) development model was applied to the professional development of school counselors and how their movement through the fourth, fifth, and six phases of this development model influences their level of comfort in identifying mental health and/or substance use concerns.

Nature of the Study

This study examined Virginia school counselors' development stages, PK-12 students reported mental health and/or substance use symptoms, counselors' level of comfort addressing PK-12 students' mental health and/or substance use symptoms, and areas school counselors identify where further training is needed. This descriptive research study collected data by using an online survey research methodology to examine school counselors in the State of Virginia. These school counselors were contacted by e-mail by creating a list of current school counselors working in PK-12 schools throughout

the State of Virginia. The data from over 350 licensed Virginia school counselors was collected from the online survey. A total of 350 desired responses were needed for the survey based on an estimated 3,500 Virginia school counselors (Virginia Department of Education, 2018) with a 95% confidence level and 5% margin of error. This study focused on Virginia school counselors due to the recent passing of Senate Bill 1117 requiring additional training in mental health and substance use disorders, depression, behavioral distress, trauma, violence, and youth suicide (VA Code §22.1-298.1, 2018) in order to gain an understanding of Virginia school counselors current level of comfort addressing students' mental health and substance use. This survey provided a unique opportunity to examine how Virginia school counselors' current phases of development influences their current level of comfort in addressing students' mental health and substance use. The survey instruments were based on Carlson and Kees' (2013) survey and modified to capture school counselors' developmental stage based on the theoretical development model developed by Rønnestad and Skovholt (1992, 2003). The data was analyzed using analysis of variance (ANOVA) as well as reported in frequencies, percentages, and other basic descriptive statistics.

Definitions

The following list of definitions are terms used throughout the study.

Mental health: The emotional, psychological and social well-being of an individual that impacts how an individual thinks, feels, and acts. It influences how individuals manage stress, relate to others, and make choices. Contributing factors are: (a) biological factors such as brain chemistry, (b) life experiences such as trauma or

abuse, and (c) family history of mental health problems (U. S. Department of Health and Human Services, 2017).

Substance use: The recurrent use of alcohol and/or substance use with clinically and functionally significant impairment such as health problems and failure to meet specific responsibilities such as school, work, and home (SAMHSA, 2015).

Assumptions

There are assumptions in this research study that were taken for granted to support the research study. They include the following:

1. Individuals who had participated in this survey study were current school counselors in the State of Virginia who received e-mails inviting them to participate in the survey.
2. School counselors who participated in the survey study were comfortable answering online survey items being used to collect data.
3. School counselors gain experience as they move through the six phases of Rønnestad and Skovholt's (1992, 2003) development model.
4. School counselors do have opportunities to observe if PK-12 students are displaying mental health and/or substance use concerns.

Scope and Delimitations

The focus of this research study was the developmental phases of school counselors and their comfort levels addressing the mental health and substance use disorders experienced by PK-12 students. Research studies that address these types of concerns will help school administrators understand how the mental health and substance

use disorders of PK-12 students are currently being addressed by school counselors. Delimitations are areas of the research study where the scope of the research was narrowed or limited, whereas limitations are potential weaknesses in the study which are out of the researcher's control (Simon & Goes, 2013).

Delimitations for this research study included the following:

1. This study does not include the actual experiences Virginia school counselors have in addressing students' mental health and/or substance use concerns.
2. This study is an examination of Virginia school counselors comfort level with specific mental health yet does not address whether they have ever actually dealt with specific mental health or substance use concerns.
3. This study does not include what actions Virginia school counselors take when they identify students with mental health and/or substance use concerns.

Limitations

Limitations in this research study included the following:

1. This study was limited to the population of Virginia school counselors.
2. This study was limited to the Virginia School Counselors Association (VSCA) and ASCA directories.
3. This study was limited to a voluntary online survey.
4. The study was conducted through an online survey, and various spam filters may have blocked participation.
5. School counselors participating in the online survey needed access to a computer to participate and complete the survey.

Significance

This quantitative descriptive research study promotes social change by providing information regarding the degree to which school counselors are comfortable addressing students' mental health and/or substance use concerns. In addition, in this survey I examined school counselors' responses on what further training in mental health and/or substance use would be desired and identified as needed for them in their work with PK-12 students.

Summary

In this quantitative, descriptive study I examined school counselors' level of comfort with PK-12 students' mental health and substance use concerns. I explored the challenges facing school counselors and how they are currently addressing the mental health and substance use concerns of PK-12 students. The results of this study help to identify where school counselors are in need of additional training, and the study promotes social change through supportive efforts in preparing school counselors to better meet the mental health and substance use needs of the PK-12 students they serve.

Chapter 2: Literature Review

Introduction

In this literature review, I present the argument that the professional identity of school counselors has changed and has adapted historically to meet various social circumstances. As the profession has grown, various influences have been exerted upon it by (a) local communities, (b) state school boards, (c) accrediting bodies, and (d) its own professional association. These influences have not always aligned in the roles school counselors assume in schools. The school counselor profession includes individual school counselors who, through education and experience, have professionally developed across the span of their careers. Emergent social challenges such as the currently increasing need of school children for mental health and substance use services may become stress factors for school counselors and alter their professional identity as addressing these concerns has not been clearly delineated and may be at odds with other roles they are expected to perform. Further, the stage of school counselors' professional development may reflect their estimates of their abilities and desires to be the first to recognize serious mental health and substance use concerns in PK-12 students and to provide mental health and substance use counseling in the schools.

In this chapter, I discuss school counselors as certified/licensed professionals qualified to assist and address the academic, career, and social/emotional development needs of PK-12 students (ASCA, 2017). These are professionals who hold a master's degree or related degree in school counseling.

This chapter presents Rønnestad and Skovholt's (2003) six phase counselor development model as the theoretical framework for this research study. In this chapter, I also examine the history and role of school counselors and consider how the roles and professional identity of school counselors has evolved in the schools in response to societal needs.

Following an examination of the historical development of the school counseling profession, I review the educational standards necessary to become a school counselor, the Council for Accreditation of Counseling and Related Education Programs (CACREP) standards for school counseling educational programs, and the state educational agencies' specific state requirements for becoming licensed/certified school counselors. In this chapter, I examine the professional identity of school counselors and how their identity is influenced by societal needs. This literature review covers how PK-12 students are affected by mental health concerns. Students affected by a mental health condition are more likely to experience suspension, expulsion, and/or credit deficiencies than students who do not experience a mental health condition (SAMSHA, 2017). A total of one third of students affected by a mental health condition do not pursue a postsecondary education (SAMSHA, 2017). This chapter concludes with an examination of three studies specific to school counselors working with PK-12 students with mental health conditions. Each of these specific areas is significant for understanding the role of school counselors and how these areas contribute to school counselors' level of comfort addressing PK-12 students with mental health and substance use conditions.

Literature Search Strategy

The comprehensive review of literature for this research included a systematic search for pertinent peer-reviewed articles written from 2012 to 2017 using the EBSCOhost databases of PsycINFO, Eric, and Medline. Additional resources were obtained from CACREP and SAMHSA. I used the internet to access professional organizations' websites such as the ASCA and VSCA and Virginia Department of Education (VDOE). The key terms I used in my search included *mental health, substance use, school counselors, PK-12 students, Rønnestad and Skovholt's development model, school shootings,* and *bullying.*

This examination of the professional literature yielded a variety of articles on the mental health and substance use issues of PK-12 students with a majority of articles emphasizing the challenges of adolescents. Some of these articles looked at how school counselors are addressing the needs of PK-12 students and their comfort level in working with students with mental health or substance use concerns. None have looked specifically at how Virginia school counselors' development impacts their level of comfort in addressing PK-12 students' mental health and substance use.

Rønnestad and Skovholt's Development Model

Rønnestad and Skovholt (2003) created a development model examining the phases of counselor development across the career of the counselor. Rønnestad and Skovholt (2003) emphasized the education, professional training, and lived experiences as components of school counselors' professional development. The development model included the following six phases: "(a) Lay Helper, (b) Beginning Student, (c) Advanced

Student, (d) Novice Professional, (e) Experienced Professional, and the (f) Senior Professional Phase" (Rønnestad & Skovholt, 2003, p. 10). These phases address counselors' mental states and development of professionalism from the beginnings to the ends of their careers. They suggested the expertise and confidence levels that counselors reflect would be a function of their career longevity.

The first two phases address the graduate school experiences of counselors in training from entry to when they start working in supervised internships. The first phase, lay helper, refers to individuals initially entering the professional training with previous experiences helping others. The second phase, beginning student, is the movement of lay helpers into the beginning of their professional training where education on theories, research, clients, and an understanding of multicultural perspectives are the prominent focus. Counselors' initial meetings with clients during this stage often evoke the beginning counselors' anxiety and apprehension. During this phase, supervisors must provide extensive feedback and encouragement to the new counselors. In the first two phases of Rønnestad and Skovholt's (2003) development model, trainee counselors are developing an understanding of their role based on CACREP standards, which emphasize the role of school counselors as counselors versus school administrative personnel.

The third phase, known as the Advanced Student phase, is when counseling students begin working at internship sites and further develop their counseling skills. It is during this phase that clinical supervisors provide guidance and feedback and model professionalism to the supervisee or counseling student. During this third phase, school

counselors begin to experience their roles in a school setting and realize how they may vary from their educational experiences.

The fourth and fifth phases are when school counselors start working in school settings as professionals. They compare their educational and their work experiences and begin evolving as school counselors as a result of their professional experiences. The fourth phase is the novice professional phase occurring in the first several years after graduation. It is during this phase that novice professionals experience being on their own, questioning what was taught in graduate school, and comparing it to the actual experiences in their job with their roles as counselors. Novice professionals typically seek additional supervision from colleagues at work to provide further support and guidance. It is during this time that counselors begin to see (a) the complexities of their roles as counselors, (b) the importance of the therapeutic relationship, (c) the need to develop therapeutic strategies, and (d) the need to maintain healthy boundaries.

The fifth Experienced Professional phase is when counselors have been working in the field for many years and have developed experience as a counselor. It is in this phase that counselors expand professional boundaries and further fine-tune their professional perspectives and voices so that their work is guided by intention, knowledge, and experience. In the latter part of this phase counselors start to remove themselves from opportunities to further develop or learn new skills. Counselors are established in their skills set and do not view additional information or development is needed.

The sixth Senior Professional phase is identified as the point when a counselor is in the field for 20 or more years and approaches retirement. Counselors are experiencing

the ending of their careers, the loss of colleagues, a loss of connections, and a decline in mood.

Moss, Gibson, and Dollarhide's (2014) Study

Moss, Gibson, and Dollarhide's study (2014) conducted a qualitative study to examine the professional identity of counselors by collecting information from a total of 26 participants who were either school counselors or licensed professional counselors. The findings of this research study concluded that Rønnestad and Skovholt's (2003) counselor development model accurately depicted counselor development throughout the six phases of development. This study supported the impact of ongoing counselor supervision to further foster counselor development and growth while at the same time recognizing the successes and failures in working with clients being a major impact on counselors' professional identities.

Rønnestad and Skovholt's (2003) development model is significant because of its emphasis on the collective lived experiences of counselors. It speaks to how the education and training of counselors both prepares them for their roles in schools and instills a professional identity that evolves over the course of their careers in schools. The theoretical framework is equally important when examining what school counselors perceive as their roles in supporting students' mental health needs in schools and how the different phases of their professional development influences those perceptions. In this study I used the phases of development to better understand school counselors' comfort level identifying when PK-12 students exhibit mental health or substance use concerns.

PK-12 Students with Mental Health and/or Substance Use

Mental Health and Substance Use Disorders

It has been well established in the professional literature that the number of children and adolescents experiencing symptoms of mental health disorders is increasing. Bor et al. (2014) reported one in five children under the age of 18 years old suffered from a mental health condition. Most (80%) of all chronic mental disorders originate in childhood with half beginning prior to the age of 14 years old (Child Mind Institute, 2017). DeKruf (2013) reported half of students who drop out of school had identifiable and diagnosable mental disorders and 70% of all youth in the juvenile justice system were challenged with mental health concerns. He indicated that more than 75% of children who needed mental health support and services did not receive any Tegethoff et al. (2014) indicated that frequently children and adolescents in need of mental health services do not receive actual treatment until almost a decade after initial symptoms start to emerge.

The 2016 National Survey on Drug Use and Health conducted by the Substance Abuse and Mental Health Services Administration (SAMSHA) found children 17 years of age and younger, have various mental health and substance use disorders (SAMSHA, 2017). This survey identified in the preceding year, 70.7% of children experienced a major depressive disorder with 1.4% (333,000) having co-morbid substance use disorders. Substances used include (a) alcohol use, 9.2% (2.3 million), (b) marijuana use 6.5% (1.6 million), and (c) other illicit drug use 7.9% (2.0 million).

A total of 12.8% (3.1 million adolescents) of adolescents 12 to 17 years old have experienced a major depressive episode with 9.0% (2.2 million adolescents) having a major depressive episode with severe impairment. A total of 333,000 adolescents between 12 to 17 years old have had a major depressive disorder and a substance use disorder (SAMSHA, 2017). Three quarters (75%) of specific mental illnesses are diagnosed in childhood: (a) attention deficit hyperactivity disorder before age 8, (b) separation anxiety before age 10, (c) oppositional defiance disorder before age 14, and (d) social phobias before age 15 (Child Mind Institute, 2017).

Suicides

Suicide is the second leading cause of death among adolescents 12 to 17 years old. Suicide rates continue to rise among children and adolescents in the United States. The CDC conducted a 17-year long survey from 1999 to 2015 and identified more than 1,300 children between the ages of 5 and 12 years old who took their life by suicide (CDC, 2016). During the 17-year timeframe from 1999 to 2015, children 12 years old or younger died by suicide at the rate of one every 5 days (CDC, 2016).

The National Violent Death Reporting System (NVDRS) conducted a study from 2003 to 2012 which included 17 states and found mental health conditions were prevalent among children and adolescents attempting or committing suicide. Children aged 5 to 11 years old were more likely to have a diagnosis of attention-deficit disorder while adolescents ages 12 to 14 years old were more likely to have a diagnosis of depression (Knopf, 2016; Shetall et al., 2016).

School Problems Linked to Mental Health and Substance Use

School Shootings

The prevalence and continuing rise of school shootings has become a major safety concern for schools in the United States. Since 1982, there have been a total of 66 school shootings with fatalities in elementary, middle, and high schools in the United States (CNN, 2017). Madfis (2016) reported that research on school shootings demonstrates shooters tend to have a history of suicidal thoughts and depression coupled with challenges in interpersonal relationships. Gerard et al. (2015) noted that school shooters demonstrate anger management issues and interest in violence yet do not exhibit a history of violent behaviors or any type of criminal background. Goral (2016) examined Forensic Psychologist J. Reid Maloy's position on school shooters. He proposed school shooters are not impulsive, but rather calculated, planning for months prior to the actual school shooting.

Bullying is one of the most prominent risk factors among mass school shooters (Duplechain & Morris, 2014). Several prominent qualities of school shooters are: feelings of social isolation, loneliness, exclusion, rejection, abuse from peers, anger, depression, and suicidal ideations (Baird et al., 2017). Additional identifiers common among mass school shooters are "nearly all perpetrators are male and have a history of mental illness and/or familial instability" (Baird et al., 2017, p. 12).

Bullying/Peer Victimization

Bullying/peer victimization occurs when one individual exhibits aggressive actions toward another individual with the intention to physically or psychologically

harm the individual (Rasalingam et al., 2017; Baraccia et al., 2017). Hertz et al. (2013) identified 20% to 56% of PK-12 students are involved in bullying which means in a classroom of 30 there are a total of 6 to 17 students involved in bullying. Sixty percent of gay youth report being victims of bullying more compared to 28.8% of heterosexual youth (Hertz, 2013). These acts can be physical, verbal, emotional, and/or relational having substantial impact on a child's cognitive, emotional, social and behavioral development (Baraccia et al., 2017; Turner et al., 2015). Bullying/peer victimization can occur face-to-face, over the phone, and/or through social media. Frequent bullying/peer victimization results in the development of various mental health symptoms such as depression, anxiety, and suicidal ideations (Rasalingam et al., 2017; Winsper et al., 2012; You & Bellmore, 2012). Additional problems occurring over time are disruptiveness, aggression, antisocial behaviors, and school avoidance (Rasalingam et al., 2017). Bullying/peer victimization is one significant way individuals are isolated from their peers, experience loneliness and anger coupled with caring less about life and future events (Gerard et al., 2015).

The professional literature cited here has indicated that over the course of the last 5 years there has been increases in the number of children and adolescents who display symptoms of mental health concerns. Incidents which lead to psychological distress, such as school shootings and bullying in schools, have also increased. Given this increasing rise in mental health and substance use disorders within schools it is important to note how these mental health and substance use are being addressed within school systems. Atkins et al. (2017) noted schools are the primary location where counseling services are

administered to children and adolescents even though the necessary resources are not easily accessible. School counselors are the frontline within school settings for understanding how best to address these concerns. However, there is little current professional literature addressing school counselors' readiness to identify mental health disorders in children and adolescents.

History of School Counselors

The role of school counselors has evolved over time to meet the needs most prominent among PK-12 students. Other academic professionals such as teachers and school administrators have had less marked changes throughout their professional history. The school counseling profession continues to be at the forefront of addressing the needs of students and continues to change as the needs of students' change. Herr (2001) noted the expectations upon school counselors and the types of concerns they address are a result of the historical movements of the nation and the perceived needs of that particular time. While the history of school counseling is rooted in vocational guidance, the development of the profession has come to place greater focus on the mental health concerns of children in schools.

Progressive Movement

During 1890 and 1919, vocational guidance emerged in response to tremendous societal upheavals and job losses as communities began shifting from an agricultural to an industrial economy during the Industrial Revolution (Pope, 2000). Baker (2009) discussed that larger industrial cities such as New York, Chicago, Boston, and Philadelphia had immigrants from all over the world seeking a better life. Not knowing

the culture or the language, immigrants were susceptible to the poor societal condition in these industrial communities.

The Progressive Movement emerged out of the Industrial Revolution to address the negative social conditions during this time frame. The Progressive Movement worked to resolve negative societal conditions by initiating social protest and reform (Gysbers & Henderson, 2001). The first guidance programs in schools began in the late 1800s and promoted vocational guidance programs focused on (a) character development, (b) appropriate social behaviors, and (c) vocational planning. Incorporating guidance and counseling into the schools in the early 20th century involved having teachers placed in the role of vocational counselors with a separate set of responsibilities in addition to their responsibilities as teachers (Gysbers & Henderson, 2001).

The first systematized guidance programs in public schools were created by Jesse B. Davis (Gysbers & Henderson, 2001). The main focus of vocational guidance in schools was to prepare children for the world of work and determine what specific type of work that would entail based upon observation of the children (Gysbers & Henderson, 2001; Paisley & Borders, 1995). During the early 20th century, there were 15 basic responsibilities of vocational guidance professionals which consisted of specific tasks such as (a) meeting with children who were failing and finding solutions, (b) encouraging students to stay in school, (c) suggesting teachers relate education to employment, and (d) helping students get a work card if they were leaving school (Gysbers & Henderson, 1997).

As guidance programs in schools gained and were used to educate and train individuals in a vocation. World War 1 was influential in the evolution of vocational guidance due to the mental testing movement and use of psychometric testing to help soldiers returning from war. This form of mental testing was utilized to classify and determine what type of vocational guidance was needed for students. This brought about the use of testing and the use of assessment tools in schools by vocational guidance professionals.

Sputnik

With the launching of Sputnik in 1957, the United States became increasingly more concerned about math and science and properly training and encouraging youth to pursue careers in those fields (Cox, 1999; Herr, 2001). The National Defense Education Act (NDEA) was created to help school counselors identify students who exhibited interests, knowledge, capabilities in math and science to be identified (Herr, 2001). Federal funding was allocated to develop vocational guidance professionals in schools to ensure they had the necessary formal training to test and identify students with special interests and skills in science.

Civil Rights

The Civil Rights Movement is another example of how major social change influenced the role of school counselors in school systems. The Civil Rights Movement of the 1960s brought about educational changes creating a place where social inequalities were challenged (Ravitch, 2000). One of the major challenges during the 1960s and 1970s was the nature and role of school counseling and what it actually entailed (ASCA,

2012). It was during this time period that a comprehensive program specific to school counseling became a major focus within the profession.

During the 1980s and 1990s states began to develop models to initiate comprehensive program approaches for the school counseling profession (ASCA, 2012). The predominate roles of school counselors at this time consisted of coordinating, counseling, and consulting. Questions began to surface around what this profession should be called and how the professionals who offer these skills should be considered. Terms such as "guidance," "guidance and counseling," and "school counseling" were adopted at this time.

21st Century

The 21st century brought about the formation of the American School Counselors Association (ASCA) National Model focused on the types of help and services school counselors should be offering in schools such as (a) educational (academic), (b) vocational (career) and (c) social/emotional (mental health) supportive services. The third edition of the ASCA National Model was released in 2012 and outlined components for a comprehensive school counseling program focusing on four main components: (a) foundation, (b) management, (c) delivery, and (d) accountability (ASCA, 2012). Within this national model area such as program focus, student standards, and professional competencies are discussed in detail. Not all school counseling programs adhere to the national model proposed by ASCA National Model. These standards provided a model outlining expectations by ASCA as to what school counseling programs could include.

The delivery system within this national model proposes school counselors are to provide individual counseling or small-group counseling to assist students in addressing challenges impacting their abilities to academically achieve (ASCA, 2012). ASCA defines individual counseling as a short-term goal focused strategy provided by school counselors is distinguished from therapy and long-term counseling. The ASCA defines "therapy and long-term counseling" as an approach used to address psychological disorders not within the school counselors' scope, yet within the school setting (ASCA, 2012). However, the ASCA National Model does suggest school counselors are able to recognize student mental health crises, the needs of students during crises, as well as ways to address these challenges with the use of education, prevention, and short-term interventions until referrals can be made for connecting students to community resources (ASCA, 2012).

Understanding the historical development of school counseling profession is important for understanding the professional development of school counselors and their professional identity because it provides an overall context as to the role changes of school counselors throughout the profession's development. Much in the same way as school counselors go through the six phases of Rønnestad and Skovholt's (2003) development model so too has the school counseling profession as a whole gone through various phases in its own development to best meet the needs of the students.

Education and State Certification/Licensure for School Counselors

Rønnestad and Skovholt's (2003) development model identifies the education and training of school counselors as the second phase, beginning student, and the third phase,

advanced student. It is during these two phases where school counselors learn: (a) the professional scope of the school counseling profession, (b) learn theories and techniques, and (c) how to apply this knowledge and training within school environments. The education and state certification/licensure of school counselors is very specific and contributes to the development of school counselors and provides context for understanding how school counselors identify and address the mental health needs of students.

Critical to the first three phases of Rønnestad and Skovholt's (2003) model are educational aspects of counselors which include supervision during internship in schools prior to graduation. The educational experiences of school counselors are influenced by (a) standards set by CACREP, (b) state standard for school counselor licensure and certification and (c) continuing education requirements for maintaining licensure or certification. It is during the second and third phases of Rønnestad and Skovholt's (2003) developmental model when school counselors begin learning about the significance of the CACREP standards in relation to their educational development into becoming school counselors. During this time, school counselors are learning the importance of their educational training and the specificity of the classes in formulating their development as school counselors and creating a foundation for their continuing growth and professional development. The structure of the educational curriculum of school counselors as provided in the CACREP standards is at the core of their professional development during the second and third phases of Rønnestad and Skovholt's (2003) counselor development model.

Council for Accreditation of Counseling and Related Education Programs (CACREP)

CACREP is the national accreditation organization which outlines the educational training and foundation school counselors need prior to becoming a certified school counselor. CACREP grants national accreditation to counseling programs in the United States. CACREP has a set of nationally accepted educational standards specific to school counselors that is recognized by state school certification authority boards. CACREP approved school counseling programs have all of the educational requirements necessary for graduates to become certified school counselors.

A school counseling program needs to demonstrate the following CACREP standards. Section 2: Professional Counseling Identity and Section 5: Entry-Level Specialty Areas-School Counseling in order to be CACREP-approved. School counseling programs are required to meet Section 2: Professional Counseling Identity. This section identifies foundation and counseling curriculum as the two main areas of this section. The Counseling Curriculum portion within this section identifies eight main areas of focus: (a) Professional Counseling Orientation and Ethical Practice, (b) Social and Cultural Diversity, (c) Human Growth and Development, (d) Career Development, (e) Counseling and Helping Relationships, (f) Group Counseling and Social Work, (g) Assessment and Testing, and (h) Research and Program (CACREP, 2017).

Section 5 of the CACREP (2017) standards is divided into sections for (a) school counselors, (b) clinical mental health counselors, (c) addiction counseling, (d) clinical rehabilitation counseling, (e) marriage, couple, and family counseling, (f) rehabilitation

counseling, and (g) college counseling and student affairs. It is in this section, CACREP standards specify the differences between the school counseling program and other CACREP counseling programs.

In Section 5 of the CACREP (2017) standards, school counselors' educational programs include: foundations, contextual dimensions, and practice. The foundation portion refers (a) to the history and development of school counseling, (b) models of school counseling programs, (c) models of career development, (d) school-based collaboration and consultation and (e) assessment tools specific to educational environments. The contextual dimensions refer to the roles of school counselors as teachers, advocates, consultants for families, community agencies, and system change agents. This section also identifies school counselors' roles and responsibilities in school emergency management plans, crises, disasters, and trauma.

This standard refers to the practice of school counselors and emphasizes the importance of developing (a) school counseling programs, (b) career counseling interventions and strategies, (c) plans for postsecondary transition, (d) strategies for implementing peer intervention programs, and the (e) skills for examining the connection between social, emotional, and behavioral problems and the connection and influence these have on academic achievement (CACREP, 2017). Additionally, CACREP suggests school counselors have an educational background and understanding of "characteristics, risk factors, and warning signs of students at risk for mental health and behavioral disorders" as well as "signs and symptoms of substance abuse in children and adolescents as well as the signs and symptoms of living in a home where substance use occurs

(CACREP, 2017, p. 33). However, CACREP standards for school counseling do not include any specifics in relation to identifying or knowing mental health disorders or developing a familiarity with the DSM, which outlines symptoms of mental health disorders.

State Certification/Licensure for School Counselors

Each state has its own specific guidelines for becoming a certified/licensed school counselor. State certification requirements are determined and often governed by the Department of Education. Each state has its own specific requirements necessary for becoming a certified school counselor. According to the American Association of School Counselors (ASCA, 2017). A majority of states have the following education requirements:

1. Educational Requirements: (a) a master's degree from an accredited counselor education program or (b) earned a master's degree from an accredited college or university from an approved counselor education program and an (c) internship to demonstrate an individual has completed the necessary course work and clinical experience to meet state's necessary competencies.
2. Experiential Requirements: In addition, to these educational requirements there may be 2 years of full-time experience in guidance counseling, or 2 years of full-time guidance counseling with provisional license. Once, all requirements have been met and approved by the state's Department of Education a certification in school counseling is granted.

Continuing Education

According to ASCA (2016), each state has its own specific requirements for the time period when school counselor certification renewals are due and how many continuing education units (CEU) must be earned within that timeframe. While a majority of states require certification renewal every 5 years there are several states where school counselors may renew their certification at 3, 5, and 10 years. Missouri is the only state requiring school counselors have the option to renew their certification on a yearly basis.

CEU credits are necessary at the time period when school counselor certification renewals are due. CEUs are obtained via various types of education experiences such as attending state and nation school counselor conferences, attending educational or training seminars, taking educational coursework on-line, or reading journal articles and participating in the accompanying quiz (ASCA, 2016). CEUs provide counselors with an opportunity to learn more about specific topics which are pertinent to their schools and communities.

The American School Counselors Association (ASCA) offers additional training for school counselors providing certificates acknowledging specialization in various areas such as: (a) mental health, (b) anxiety, (c) stress management, (d) bullying prevention, (e) trauma and crisis, (f) grief and loss, and (f) cultural competency (ASCA, 2016). Obtaining specialized training is completely at the discretion of the school counselor. The fact that ASCA offers specialist trainings emphasizes the importance of these subjects in schools.

Rønnestad and Skovholt's (2003) development model identifies education and training is a critical element in school counselors' development of a professional identity. Reviewing CACREP standards reveals school counselors are expected to have some level of ability to recognize how mental health issues may impact on students' education progress, however, it is clear there is no specified level of training in recognizing mental health issues required either by CACREP or in state requirements for employment as school counselors. The next question becomes if within their professional identity school counselors embrace the role of recognizing when PK-12 students are presenting mental health symptoms.

School Counselor Professional Identity

Professional Identity

Since the profession's inception the professional identity of school counselors has been defined by the social, economic, political, and cultural impacts of society. School counselors straddle both the field of education and the field of counseling. School counseling education programs and their professional associations such as ASCA, promote professional identity in school counselors. However, Cinotti (2014) noted that school counselors are challenged to develop and maintain a professional identity when school administrations expect them to perform multiple roles outside of their identity.

Gruman et al. (2013) suggested that school counselors oftentimes are prohibited from using counseling skills to their fullest abilities due to the other role demands placed on them by the school administration such as test duties, tracking student credits, and fulfilling a variety of administrative and clerical tasks. He noted these additional non-

counseling activities can divert school counselors from their primary responsibilities with students, not allowing them to take the time in providing direct services to students.

School counselors have a unique role within the field of education and the field of counseling. Typically, the counseling skills are what set school counselors apart from other professionals in schools (Shallcross, 2013). However, counseling skills, and other skills sets, such as consulting, guiding, and advising can become overshadowed by the expectations and job duties by the school administration. School counselors work with 470 students as an average caseload (Patterson, 2015; Bardhoshi et al., 2014). This number far exceeds ASCA (2016) recommended caseload of 250 students per school counselor. These counseling skills and other skills sets such as consulting, guiding, and advising learned in school can become overshadowed by the expectations and job duties required by the school administration. It is these expectations which have placed school counselors in competing professional identities with one foot heavily grounded in education and the other heavily grounded in counseling. School counselors are challenged with how to develop and maintain a professional identity when challenged with multiple roles and expectations from both the ASCA and school administrations (Cinotti, 2014).

School counselors are expected to meet the specific requirements and standards required by their school administration. School counselors are placed in a precarious position and expected to maintain a healthy professional balance between the requirements of the ASCA National Model and their school administration. The expectations of the ASCA National Model and the expectations of the school

administration can differ significantly from one another placing school counselors in a position where professional expectations and professional identity become unclear. According to the ASCA National Model (2012), school counselors are expected to spend 80% of their time in the delivery of direct and indirect services. The additional tasks placed on school counselors by the school administration can decrease the delivery significantly. The role of school counselors is often blurred and unclear due to the differing expectations of the ASCA, CACREP, Board of Education, and school administration. These differing expectations blur the professional identity of school counselors due to the significant differences required by each organization, pulling school counselors in multiple directions. School counselors are expected to meet the requirements and standards of school administrators. These differing expectations blur the professional identity of school counselors due to the significant differences required by each organization, pulling school counselors in multiple directions.

Direct Services

School counselors have an extensive list of responsibilities within the school where they work. One of these responsibilities is their work with students. Goodman-Scott (2015) indicated that school counselors are expected to meet academic, career, social, and individual needs and challenges of students. Carlson and Kees (2013) indicated that over the years, the ASCA has been advocating to have non-counseling activities such as administrative and clerical activities removed from the professional responsibilities of school counselors.

Direct services are (a) core lessons, (b) individual student planning, and (c) responsive services, such as individual and group counseling (ASCA, 2016; Kaffenberger & O'Rorke-Trigiani, 2013).

It is clear school counselors, both by education and training and by professional association, have within their professional identity the ability to treat mental health concerns. These mental health concerns range from specific mental health and substance use diagnoses to other school problems linked to mental health and/or substance use problems. Additional school problems are linked to PK-12 students experiencing mental health and substance use problems which have been left unidentified and untreated. In order to understand the role of school counselors in addressing the mental health and substance use problems of PK-12 students it is first necessary to understand the most prominent challenges students face.

Studies Related to School Counselors and Addressing Mental Health in Schools

Carlson and Kees' Study

Carlson and Kees (2013) conducted a study to examine the comfort level of school counselors in (a) addressing specific student issues, (b) applying DSM diagnoses, and (c) utilizing professional skills. The results of the study for specific student issues indicated school counselors are most comfortable with addressing (a) academic concerns, (b) relationship concerns, and (c) stress management. School counselors had the least amount of comfort in addressing (a) immigration concerns, (b) addiction/substance use, and (c) spirituality.

Carlson and Kees (2013) found that for the DSM diagnoses that school counselors are most confident working with students who have (a) anxiety disorders, (b) disorders primarily diagnosed in children, and (c) cognitive disorders. School counselors identified the least amount of confidence in: (a) factitious disorders, (b) sleep disorders, and (c) schizophrenia and other psychotic disorders.

Additionally, school counselors identified (a) consultation with parents, teachers, and administrators, (b) collaboration and teamwork, and (c) ethical practice as the three professional skills school counselors are least comfortable with are: (a) using the DSM-5 to diagnose client issues, (b) family counseling, and (c) treatment planning. Even though school counselors who participated in the study identified confidence in the areas of counseling skills and student issues a significant discomfort in working with students who have a mental health diagnosis.

Moon, Williford, and Mendenhall's Study

Moon, Williford, and Mendenhall (2017) stated only one half of children who have mental health concerns receive the help needed. Schools, as the place where children spend a majority of their time, are ideal for PK-12 students to receive help with mental health conditions. Moon et al. (2017) study used an online survey to examine 786 educators' perspectives on how mental health is addressed in schools. The purpose of this study was to: (a) replicate previous studies by examining the mental health needs in schools, (b) identify educators level of confidence in addressing mental health needs, and (c) identify resources needed to address the needs, (d) examine mental health training needs, (e) compare responses from rural and urban schools located in the same

geographic region in a Midwestern state, and (f) examine the similarities/differences in mental health support in schools and the school personnel actively involved.

Moon et al. (2017) found that more than 96% of the educators (n = 703) identified that they were likely to encounter students with mental health needs, with 93% (n = 679) feeling moderately to severely concerned about students' mental health issues. In this study, a total of 97% of educators agreed or strongly agreed that it is important for school personnel to understand the mental health concerns encountered by students. Close to half of the participants (n = 341) in the study *disagreed* or *strongly disagreed* that they received "adequate mental health training, and 85% expressed a desire to receive additional training in mental health issues" (Moon et al., 2017, p. 387). The respondents in the study specifically identified the following areas where more training and knowledge was needed: (a) mental health disorders (58%), (b) behavioral management techniques (57%), specialized skill training (e.g. social skills and anger management skills) (52%), positive behavioral supports training (50%), and understanding trauma (45%; Moon et al., 2017).

Conclusion/Summary

School counselors have continuously adapted to changing social conditions faced by PK-12 students, evolving in their professional roles. Rønnestad and Skovholt (2003) proposed a model for the school counselors' professional development over the course of their careers. This model suggested that counselors who have more experience would be more likely than younger counselors to have confidence in their expertise and a better developed sense of professional identity. While the training standard for counselors

recognize school counselors should be able to address students' mental health and substance use issues, they do not specify the degree to which school counselors should have expert skills by which this can be accomplished. Students are displaying increased frequencies of mental health and substance use symptoms and are experiencing incidents in school which foster psychological distress. The current professional literature indicates that school counselors do not feel sufficiently trained to address all the mental health and substance use issues they are currently facing in their schools. This study advances the current body of knowledge by considering how school counselors' development influences their expertise in recognizing symptoms of mental health and substance use displayed by PK-12 students.

Chapter 3: Research Method

Introduction

There is substantial evidence from both national media and the professional literature (Bor et al., 2014; Carlson & Kees, 2013; Child Mind Institute, 2016; Graf, 2018; Krishnakumar, 2018; SAMHSA, 2017; Tegethoff et al., 2014) suggesting school counselors need to identify mental health and substance use among students, and yet little is known about school counselors' level of comfort when addressing these issues. This research study surveyed school counselors to examine if their stage of development, as theorized by Rønnestad and Skovholt (2003), influences their level of comfort in addressing PK-12 students' mental health and/or substance use disorders.

This research study used a survey to answer questions regarding (a) the frequency of school counselors interacting with PK-12 students exhibiting mental health and/or substance use symptoms, (b) the comfort level of school counselors' addressing PK-12 students' mental health and/or substance use disorders, (c) whether school counselors stage of development influences their level of comfort addressing PK-12 students' mental health and/or substance use disorders, and (d) training that school counselors identify as needing to increase their comfort level in addressing PK-12 students' mental health and/or substance use disorders. This research study surveyed school counselors at elementary, middle, and high schools throughout the State of Virginia. Carlson and Kees' (2013) *School-Based Mental Health Services Survey* and additional survey questions specific to Virginia school counselors were the measuring instruments for this study. I modified the survey instrument and used a pilot study to test the feasibility of the

recruitment, administration, and data collection for conducting this survey. This chapter describes the population of interest, sampling strategy, data collection, and data analysis for this study.

Research Design and Rationale

On July 1, 2017, Senate Bill 1117 passed requiring individuals in Virginia who are "seeking initial licensure or renewal of a license with an endorsement as a school counselor shall complete training in the recognition of mental health disorder and behavioral distress, including depression, trauma, violence, youth suicide, and substance abuse" (VA Code §22.1-298.1, 2018). The implementation of Senate Bill 1117 suggests additional support for Virginia school counselors in recognizing mental health and substance use disorders, depression, behavioral distress, trauma, violence, and youth suicide. This research study examined Virginia school counselors' current level of comfort in addressing mental health and substance use issues.

There have been previous studies examining school counselors' appraisal of the need for mental health services in the school and their abilities to address these challenges; however, none of the studies are specific to Virginia. Social change inherently starts at the local level. This study provided specific information pertinent to Virginia school counselors and PK-12 students' mental health and substance use. The data from the survey are pertinent for affecting social change in Virginia as it is necessary to understand the current status of Virginia school counselors' level of comfort in addressing PK-12 students' mental health and substance use concerns. The data collected from this study identified specific areas that could be improved in regard to Virginia

school counselors' level of comfort in identifying these challenges among PK-12 students.

This quantitative research study incorporated a cross-sectional survey research methodology for collecting data on Virginia school counselors and their work with PK-12 students with mental health and/or substance use. The variables in this research study included: (a) stages of school counselor development based on Rønnestad and Skovholt's (2003) development model, (b) the reported mental health and/or substance use of PK-12 students, and (c) school counselors' level of comfort in addressing these issues. The need for examining and evaluating these variables stems from the continuing nationwide increases in school shootings, suicide attempts, and mental health problems and substance use among PK-12 students.

This research study had minimal time and resource constraints. One possible time constraint for this research study was the academic school year. The online survey pulled contact information from the membership directories for the ASCA and the VSCA with a focus on members who were certified school counselors currently working in the State of Virginia. These directories include school counselors' e-mail addresses, which may be work related. It is important to have an accurate and current sampling frame to obtain a representative data collection. In order to conduct this survey, I assumed each of the school counselors had access to a computer and internet where they could view e-mails. It is important to have an accurate and current sampling frame to obtain a representative data collection.

I considered the use of a quantitative cross-sectional survey research methodology the best option to obtain data reflecting the current situation of school counselors in Virginia schools. This survey research design enables the collection of data from a sample to describe a specific population (Creswell, 2009). The use of a cross-sectional survey was most applicable due to my desire to take a sampling of all Virginia school counselors. The intended population was all Virginia school counselors. Given there are over 3,000 Virginia school counselors who were the intended population, the persons who contribute data to research studies are referred to as samples. The hope was that the data collected from the sample would be a representative of the intended population. Using a cross-sectional survey is a low-cost type of design in which data collection occurs one time (Creswell, 2009). This research design enabled me to collect more data than a qualitative research study would be able to collect. Previous research has examined the level of comfort of school counselors addressing mental health issues among students without any specificity given to any particular state or region in the United States. The sampling framework for this research study focused on the level of comfort and experiences of Virginia school counselors. The uniqueness of this research study is the focus on Virginia school counselors' level of comfort in the areas of mental health and substance use of PK-12 students.

This survey study can be used as an initial baseline for Virginia school counselors' level of comfort in addressing PK-12 students' mental health and substance use. A survey was the preferred research design for this study due to the amount of data that could be collected about the total population of Virginia school counselors and the

ability to collect data that reflects the current state of Virginia school counselors' comfort levels in recognizing and addressing students' mental health and substance use issues.

Research Methodology

Population

Virginia school counselors were examined due to a rise in PK-12 students' mental health and substance use concerns. Virginia school counselors were the target population due to a desire to have data specific to school counselors' level of comfort addressing the mental health and substance use of students in the State of Virginia.

Sampling and Sampling Procedures

The sampling frame was member lists from the ASCA and/or VSCA. The ASCA and VSCA directories provide a listing of members and contact information to enable communication with members. The sampling strategy was to e-mail an invitation to the survey to every school counselor in Virginia who was listed in either the VSCA or ASCA directories. I anticipated that persons providing the data would be school counselors working in elementary, middle, and high schools across Virginia who volunteered to participate in the online survey.

Power Analysis

The VSCA (2016) indicates there are over 3,000 school counselors in the State of Virginia. I conducted a G*power a priori analysis (see Buchner, Faul, & Erdfelder, n.d.) for an *F* test for a one-way analysis of variance to determine the needed sample size. I used a .05 alpha for the purposes of my research study. I used a power of 95% in order to decrease the chance of a false negative or Type II error (see Burkholder, 2012). Allowing

for a medium effect size, a sample of 350 will align with a 95% confidence level and a 5% margin of error.

Procedures for Recruitment, Participation, and Data Collection

Recruitment

The procedures I used to recruit participants for this online survey were drawn from the ASCA and the VSCA membership directory lists. I am a member of both ASCA and VSCA and able to access the membership directories and contact information for each member. The two directories were referenced and compared to ensure duplicate surveys were not sent out or filled out more than once by each of the survey participants.

Participation

The inclusion criteria are all participants in the online survey needed to be licensed Virginia school counselors working in elementary, middle, and high schools in Virginia. The first question of the online survey asked whether a participant is a licensed Virginia school counselor working in an elementary, middle, or high school in Virginia. The response could have been either yes or no. If the participant selected “yes” then the participant would continue with the rest of the questions in the survey. The exclusion criteria pertain to participants who are not currently licensed as Virginia school counselors working in an elementary, middle, or high school in Virginia. If a participant selected “no” on the first question of the survey, then the survey ended and thanked the participant for their participation.

Data Collection

Emails were sent to Virginia school counselors who are members of either ASCA and/or VSCA. The e-mail was sent from my Walden University e-mail address to all possible participants from each of the two membership directories. The invitation email provided information on the purpose of the study and how the school counselor was selected to be invited to participate in the study. It provided a copy of the informed consent form to be signed electronically including: (a) voluntary participation, (b) limits of confidentiality, and (c) potential risks to participants. The emailed invitation provided the Survey Monkey link to access the survey.

The emailed invitation included information for the participants seeking additional information, questions, or who wanted to reach out to the researcher regarding their participation in the survey. If participants desired a copy of the survey results once the study had been completed, they asked for a copy of the results emailed directly to them. All emailed invitations contained the same information: (a) introduction, (b) informed consent, (c) electronic link to the survey, (d) explanation of the promotional raffle for respondents, and (e) how to contact the researcher.

Exiting from the study occurred when participants completed the entire survey. A brief note thanking participants for their time and participation appeared at the end of the survey. No debriefing was necessary. A total of three follow-up emails were sent after the first, second, and third weeks of the initial email to non-responders to achieve as many responses as possible.

The invitation email provided information on the purpose of the study and how the school counselors were selected to be invited to participate in the study. It provided (a) voluntary participation, (b) limits of confidentiality, and (c) potential risks to participants. This email included information, questions, and how to reach out to the researcher regarding if participants desired a copy of the survey results once the study had been completed. Participants were able to reach out to the researcher by email and a copy of the results emailed directly to them. No debriefing was necessary.

Pilot Study

Prior to the initial email being sent to each Virginia school counselor, a pilot study was conducted in order to test the content validity and the feasibility of conducting this larger research study. This pilot study included: (a) demographic questions, (b) questions from Carlson and Kees' (2013) *School-Based Mental Health Services Survey*, and (c) additional questions specific to Virginia school counselors. This pilot study was reviewed prior to being distributed by my dissertation committee for question completeness and the relevancy of the questions in the study. The pilot study was administered to 15 participants which is typical for a proposed study (Andrews et al., 2003). The participants included in this pilot study were Virginia school counselors from elementary, middle, and high schools.

Instrumentation and Operationalization of Constructs

The instrument used for this survey is a web-based survey created by Laurie A. Carlson, Ph.D. entitled *The School-Based Mental Health Services Survey*. I received permission from the creator of this survey Laurie A. Carlson, Ph.D. on July 5, 2017, to

use her survey in my research study to further inform research on the topic of school counselors and their level of comfort identifying and working with PK-12 students exhibiting mental health and substance use symptoms.

The School-Based Mental Health Services Survey by Dr. Carlson consists of 17 questions with 5 of those questions containing multiple items to select from. Carlson and Kees (2013) reported the Cronbach's Alpha internal reliability for the three scales "(a) Skills Scale (.84), (b) Student Issues Scale (.93), and the (c) Diagnoses Scale (.95)" (p. 214).

Some of the demographic questions from The School-Based Mental Health Services Survey were removed since they were not applicable in this current study. Additional demographic and survey questions specific to Virginia school counselors were added to this survey. The first portion (questions 1-11) of the survey consists of demographic questions specific to the individual school counselor and (a) consisting of education, (b) length of time working in the profession, and (c) the frequency of school counselors working with PK-12 students with mental health and substance use concerns. The second portion (questions 12-51) of the survey consists of school counselors' confidence and level of comfort addressing PK-12 mental health and substance use, and DSM-5 diagnoses. The third portion (questions 52-68) of the survey consists of continuing education and questions specific Virginia school counselors.

In addition to *The School-Based Mental Health Services Survey* (Carlson, 2013), this researcher included additional questions in order to (a.) collect demographic information not previously collected, (b.) questions specific to Virginia school

counselors, (c.) years of experience as a school counselor to determine their stage of development per Rønnestad and Skovholt's (2003) development theory (d.) questions about additional mental health and substance use training for school counselors due to Virginia legislation passed on July 1, 2017. This legislation requires additional mental health training for Virginia school counselors to be obtained prior to receiving their initial license or at their license renewal if the school counselor did not graduate from a CACREP-approved school counseling program. In addition, each school counselors' years of professional experience provided necessary information to determine their current stage of development according to Rønnestad and Skovholt's (2003) development model.

Data Analysis Plan

A one-way variance ANOVA was used to analyze all data collected from the online surveys distributed to Virginia school counselors. The one-way ANOVA was conducted on the data collected from the survey in order to analyze any possible differences between any of the variables. SPSS was used to analyze the data. This data analysis was conducted in order to answer the original research questions:

RQ1: How frequently do school counselors report interacting with PK-12 students who exhibit mental health and/or substance use?

Data from the Student Scale within *The School-Based Mental Health Services Survey* (Carlson, 2013) related to this research question. This scale yields the frequency of school counselors' encounters with school children evidencing specific types of mental health issues such as depression or anxiety.

RQ2: What are school counselors' comfort levels in addressing challenges associated with mental health and/or substance use among PK-12 students?

RQ3: How does school counselors' stage of development influence their level of comfort in addressing PK-12 students' mental health and/or substance use?

Data from the survey distributed to Virginia school counselors responded to this research question. This survey yielded the level of comfort school counselors have in addressing PK-12 students' mental health and substance use disorders and the amount of counselors' years of experience and what professional stage of development each counselor is currently in.

RQ4: What additional training do school counselors report as being needed to increase their comfort in addressing mental health and/or substance use issues among PK-12 students?

A one-way analysis of variance (ANOVA) was used to determine whether school counselors' level of comfort in addressing mental health and/or substance use in PK-12 students differ based on their developmental stage. There is an appropriate statistical test because (a) the independent variable, stage of counselor development, is discrete, captured at the ordinal level, allowing grouping by stage; (b) the dependent variable, counselor comfort level, is continuous, captured at the internal level.

Threats to Validity

This research used survey research methodology and is not an experimental design, concerns about internal and external threats to validity are not germane. The greatest concern is whether or not the sample responding to the survey would be

considered to be representative to the population. It is possible by surveying all school counselors across the state, that some areas yielded disproportionate responses. Mitigating possibility by noting the numbers of school counselors in the various regions of Virginia as represented in the sampling frame and checking the demographic of the sample are aligned proportionally.

Ethical Procedures

This online survey gathered Virginia school counselors who were currently working as school counselors in the State of Virginia. Each school counselor notified was given the option to participate or not participate in the survey. Each of the voluntary participants were provided consent online prior to participating and completing the online survey. There is no expectation of harm regarding participants' involvement in completing the survey due to the content of the survey consisting of questions about education, training, and experiences working with PK-12 students in schools. A sampling of over 350 licensed Virginia school counselors participated in the online survey.

Once the Institutional Review Board granted approval for the study (approval number 06-27-19-0074044) I proceeded forward with sending survey invitations to the sampling frame. Ethical considerations pertinent to this study were addressed in the initial email contact sent to each individual in the sampling frame. This informed consent explained the voluntary nature of the survey and how none of the school counselors contacted were obligated to participate and their participation was completely voluntary and confidential.

Summary and Conclusions

A survey of Virginia school counselors was conducted from the emails collected from each Virginia schools' website as a sampling framework. This survey focused on the level of comfort Virginia school counselors have in identifying and working with PK-12 students who exhibit mental health and/or substance use issues. This survey was completely voluntary, and the results were used to develop a baseline of understanding as to how the current level of comfort Virginia school counselors experience working with PK-12 students with mental health and substance use concerns. The results of this survey could be used to inform legislators and the Virginia Board of Education with a potential to affect social change within school systems in the State of Virginia dependent upon the data results obtained from the survey conducted.

Chapter 4: Results

Introduction

The mental health functioning of PK-12 students is crucial for their overall learning and academic success (Atkins et al., 2017). School counselors are at the frontline in identifying and addressing mental health and substance use concerns among students. This study employed survey research methods and Rønnestad and Skovholt's (2003) six phase counselor development model as the theoretical framework to consider if counselors' stage of professional development influenced their readiness and level of comfort to address the mental health and substance use concerns of students.

The research questions were:

RQ1: How frequently do school counselors report interacting with PK-12 students who exhibit mental health and/or substance use?

RQ2: What are school counselors' comfort levels in addressing challenges associated with mental health and/or substance use among PK-12 students?

RQ3: How does school counselors' stage of development influence their level of comfort in addressing PK-12 students' mental health and/or substance use?

RQ4: What additional training do school counselors report as being needed to increase their comfort in addressing mental health and/or substance use issues among PK-12 students?

In this chapter I examine the (a) pilot study and survey instrument results, (b) data collection, (c) sample, (d) data analysis, and (e) interpretation of the data analysis to answer the research questions. I also include other interesting findings from the data.

Pilot Study

I conducted a pilot study over a 2-week timeframe. For the pilot study I requested Virginia school counselors' (a) participation and the completion of the survey, and (b) feedback. I also provided counselors the option to ask any questions. Of 100 potential respondents contacted, 15 Virginia school counselors completed the survey entirely providing usable data. A total of 10 females and 5 male school counselors participated in the survey with four elementary school, six middle school, and five high school counselors who participated; this yielded a 15% response rate. The survey consisted of 63 questions and the average time to complete the survey was 12 minutes.

Of the 15 school counselors who provided usable data, 10 (67%) reported encountering students with either mental health or substance use concerns within the last 30 days. On average, school counselors reported seeing seven students (SD = 8.6) with mental health concerns and two (SD = 2.6) with substance use in the last 30 days (see Appendix B, Table B1).

Virginia school counselors had the greatest level of comfort working with students diagnosed with (a) anxiety disorders (M = 81, SD = 24.2), (b) impulse-control disorders (M = 75.1, SD = 27.2), and (c) adjustment disorders (M = 73.5, SD = 26.8). School counselors' had the lowest level of comfort working with students diagnosed with (a) DSM diagnoses of schizophrenia and other psychotic disorders (M = 46.3, SD = 34.3), (b) factitious disorders (M = 60.6, SD = 25.8), and (c) sleep disorders (M = 64.5, SD = 27.6) (see Appendix B, Table B2).

School counselors' level of comfort in addressing PK-12 students' mental health and substance use was examined across their stages of development based on Rønnestad and Skovholt's (2003) theory using the statistical test of Fisher's analysis of variance (ANOVA). The assumption of homogeneity of variances was tested by using Levene's test for equality of variances. A total of nine disorders met the assumption except: (a) anxiety disorders, (b) eating disorders, (c) sleep disorders, (d) impulse-control disorders, (e) adjustment disorders, and (f) personality disorders, which were all significant. These disorders that did not meet the assumption of the homogeneity of variance were tested using the Welch robust test for equality of means. No significant differences were found in the counselors' comfort levels in dealing with mental health and/or substance use concerns across the theoretical stages of counselors' professional development.

I used a frequency table to determine what additional training school counselors indicated they needed to increase their level of comfort in addressing mental health and/or substance use concerns among PK-12 students. The 15 school counselors identified (a) youth suicide (n = 8, 27.6%), (b) trauma (n = 7, 24.1%), (c) mental health disorders (n = 6, 20.7%), (d) substance use (n = 5, 17.2%), and violence (n = 3, 10.3%) (see Appendix B, Table B3).

The pilot study demonstrated the data collection methodology of individual e-mails to Virginia school counselors was likely to yield a response rate of 15%. The pilot study confirmed the survey instrument was suitable to gather usable data to respond to the research questions, so no changes in the survey instrument were required.

Survey Instrument

The survey instrument used for this survey was a web-based survey created by L. A. Carlson, *The School-Based Mental Health Services Survey* (see Appendix A for a copy of the survey). Permission to use the survey was granted from the creator of this survey. Additional questions were added to the original survey to include questions specific to Virginia school counselors' experiences. A survey was the preferred research design for this study due to the amount of data that could be collected about the total population of Virginia school counselors' comfort levels in recognizing and addressing students' mental health and substance use issues. Virginia school counselors' comfort levels were measured by examining their level of comfort regarding (a) DSM-5 diagnoses, (b) common counseling issues, and (c) counseling skills. This survey research study was primarily a quantitative study; however, a qualitative component was added at the end of the survey to provide an opportunity for participants to comment on the additional training known as the Recognition of Mental Health Disorder and Behavioral Distress training required by the State of Virginia for Virginia school counselors in legislation passed July 1, 2017. The qualitative question at the end of the survey provided Virginia school counselors the opportunity to comment on whether there was additional information they wanted the required training to include.

The survey incorporated an examination of Rønnestad and Skovholt's counselor development model (2003). Rønnestad and Skovholt's (2003) development model examines counselor development over six phases: (a) lay helper, (b) beginning student, (c) advanced student, (d) novice professional, (e) experienced professional, and (f) senior

professional. This survey study specifically examined Virginia school counselors' phases of development after initial training, specifically: fourth phase, novice professional, fifth phase, experienced professional, and sixth phase, senior professional. Phase 4, novice professional, refers to school counselors who are in the first several years of their counseling careers after graduation. Phase 5, experienced professional, refers to school counselors who have been working for many years as school counselors. Phase 6, senior professional, refers to school counselors who have been working as school counselors for over 20 years. These phases were identified from the survey item asking participants to identify how long they had been actively working as school counselors. School counselors' responses to the survey were categorized in accordance with Rønnestad and Skovholt's (2003) development model with those working as school counselor for (a) 1-9 years in Phase 4 as novice professional, (b) 10-19 years in Phase 5 as experienced professional, and (c) 20 or more years in Phase 6 as senior professional.

Data Collection

I conducted the data collection for this descriptive survey research study over a 33-day timeframe from Tuesday, August 20, 2019, until Sunday, September 21, 2019. Virginia school counselors were the population of interest. The original research plan was to recruit participants for this online survey drawn from the VSCA membership directory list. Due to the privacy concerns, the VSCA did not allow for their membership directory to be used for the purpose of a research study. Consequently, contact information for school counselors was obtained by printing out a list of all public elementary, middle, and high schools from the Virginia Department of Education website. Once the list of

elementary, middle, and high schools in Virginia was obtained, the e-mail addresses for each of the school counselors was identified from the schools' websites. This confirmed that, aligning with the initial power analysis, there were over 3,000 school counselors in the State of Virginia, so 350 responses to obtain a 95% confidence level with a 9% margin of error for the sample responses were likely to represent the population of Virginia school counselors. I contacted each school counselor by e-mail. I sent an initial e-mail and then two additional e-mail reminders. Of the 3,309 potential respondents contacted, 550 Virginia school counselors responded to the survey and 390 of those Virginia school counselors completed the survey in its entirety.

Sample/Demographics

All usable data was included in the following analysis whether the 550 respondents completed the survey in its entirety or not. The table below identifies the demographics results of the survey, which included: (a) gender, (b) race, (c) age, (d) years licensed, (e) professional licenses/certification, and (f) phases based on Rønnestad and Skovholt's (2003) development model.

Table 1

Demographics of Virginia School Counselors

Gender	n	%	M	SD
Male	68	12.4		
Female	456	82.9		
Race				
White	416	75.6		
Asian/Pacific Islander	5	0.9		
Black/African American	90	16.4		
Hispanic or Latino	5	0.9		
Native American/American Indian	2	0.4		
Other*	5	0.9		
Age				
18-24 years old	4	0.7		
25-34 years old	142	25.8		
35-44 years old	69	30.7		
45-54 years old**	174	31.6		
65-74 years old	17	3.1		
Years licensed as a school counselor			11.87	8.47
Years actively working as a school counselor			11.30	8.01
Years licensed as a school counselor in Virginia			1.68	.75
Less than 1 year	12			
Between 1-10 years	257			
Between 11-20 years	189			
Between 21-30 years	82			
Between 31-40 years	10			
Professional certification/licenses				
Licensed school counselors	348	63.3		
Licensed social workers	1	0.2		
Licensed professional counselors	29	5.3		
Other	96	17.5		
No other license	143	26.0		
Licensed school psychologist	29	5.3		
Licensed family marriage and family therapist	0			
Listing of Various Licenses				
Development stage based on Rønnestad and Skovholt's development model (2003) ***				
***Novice professional	269	48.9		
***Experienced professional	172	31.3		
***Senior professional	92	17.6		

*Note: Race: the "other" responses included 1 Bi-racial, 1 European, 1 Half black half white, 1 Mixed with black, white, and American Indian, and 1 Palestinian.
**Note: Age: through researcher error, the age category of 55-64 years old was omitted by researcher;
***Note: Novice Professional included 1-9 years of experience as a school counselor. Experienced Professional included 10-19 years of experience as a school counselor. Senior Professional included 20+ years of experience as a school counselor.

Counselors' Levels of Training

Virginia school counselors who participated in the survey were asked whether they graduated from a program accredited by CACREP. The majority of Virginia school counselors who participated in the survey had to indicate either (a) *yes they graduated from a CACREP school* (*n* = 317, 80.5%) or (b) *no they did not graduate from a CACREP school* (*n* = 77, 19.5%). The school counselors who participated were asked what education was required for their current position.

Virginia school counselors were asked to identify educational courses taken during their training to become school counselors. The three courses selected the most by Virginia school counselors were: (a) counseling theories (*n* = 392, 71.3%), (b) group counseling (*n* = 382, 69.5%), and (c) ethics and professional practice (*n* = 375, 68.2%). The three courses selected the least by Virginia school counselors were: (a) advance skills group (*n* = 86, 15.6%), couples counseling (*n* = 37, 6.7%), and pharmacology (*n* = 31, 5.6%). (See Appendix C Table C5 for a complete list of education courses taken by school counselors).

Counselors' Employment Settings

Additional areas examined were (a) school level, (b) geographical setting, (c) school district and (d) how students are typically referred. Out of all of the usable data, Virginia school counselors reported the following work settings: (a) elementary schools (*n* = 225, 40.9%), (b) middle schools (*n* = 171, 31.1%), and (c) high schools (*n* = 157, 28.5%). The Virginia school counselors who participated identified being from the following geographical settings: (a) rural (*n* = 182, 33.1%), (b) suburban (*n* = 269,

48.9%), and (c) urban (*n* = 73, 13.3%). The Virginia school counselors who responded represented 111 school districts out of a possible 133 school districts in the State of Virginia. The larger cities/counties had a greater amount of responses than the smaller cities/counties and were proportionate to the size of the cities/counties (school districts). In the survey, the school districts represented with the greatest number of responses aligned with the most populous areas of Virginia were: Chesterfield County (*n* = 46), Fairfax County (*n* = 41), Prince William County (*n* = 41), Loudoun County (*n* = 26), and Norfolk County (*n* = 21). Based on this analysis, the survey data was deemed to be representative of the cities/counties (school districts) in Virginia. (See Appendix C, Table C6 for a complete listing of the representation of the school districts).

The Virginia school counselors who participated were asked to identify how students are primarily referred and given the option to select all that apply. The respondents indicated (d) referrals from student (*n* = 475, 85.8%), (e) peers (*n* = 291, 52.9%), (f) parent (*n* = 424, 77.1%), (g) teacher (*n* = 486, 88.4%), (h) principal (*n* = 359, 65.3%), (i) outside agency (*n* = 81, 14.7%), and (j) educational professionals (*n* = 141, 25.6%).

Research Questions

RQ1: How frequently do school counselors report interacting with PK-12 students who exhibit mental health and/or substance use?

Of the usable data 391 (71%) Virginia school counselors reported encountering students with mental health concerns and 397 (72%) reported encountering students with substance use concerns within the last 30 days. On average, Virginia school counselors

reported seeing 19 students (*SD* = 22.5) with mental health concerns and 4 students (*SD* = 13.9) with substance use concerns.

RQ2: What are school counselors' comfort levels in addressing challenges associated with mental health and/or substance use among PK-12 students?

Virginia school counselors had the greatest level of comfort working with students diagnosed with (a) anxiety disorders (*M* = 81, *SD* = 21.6), (b) disorders primarily diagnosed in children (*M* = 76, *SD* = 23.0), and (c) cognitive disorders (*M* = 72, *SD* = 23.7). Virginia school counselors' had the lowest level of comfort working with PK-12 students diagnosed with (a) factitious disorder (*M* = 46.8, *SD* = 32.1), (b) schizophrenia and other psychotic disorders (*M* = 49.6, *SD* = 30.3) and (c.) somatoform disorder (*M* = 51.6, *SD* = 33.0). (See Appendix C Table C3 for a complete listing of the 15 disorders and counselors' reported comfort levels).

RQ3: How does school counselors' stage of development influence their level of comfort in addressing PK-12 students' mental health and/or substance use?

Rønnestad and Skovholt's (2003) development model was the theoretical lens used to examine how the phases of novice professional, the experienced professional, and the senior professional influenced school counselors' level of comfort addressing students' mental health and/or substance use concerns. The statistical test of Fisher's Analysis of Variance (ANOVA) was used to determine how school counselors' stage of development influenced their level of comfort in addressing PK-12 students' mental health and/or substance use. The assumption of homogeneity of variances was tested by using Levene's test. All 15 disorders identified in the survey: met the assumption of

variance. No significant differences were found in the counselors' comfort levels in addressing mental health and/or substance use concerns across the theoretical stages of counselors' professional development.

RQ4: What additional training do school counselors report as being needed to increase their comfort in addressing mental health and/or substance use concerns among PK-12 students?

Participants were able to select more than one possible additional trainings listed. All usable data was considered and identified (a) trauma (n = 276, 50.2%), (b) mental health disorders (n = 241, 43.8%), (c) substance use (n = 219, 39.8%), (d) youth suicide (n = 211, 38.4%), and (e) violence (n = 178, 32.4%) as the most frequent areas where counselors need more training.

During the course of conducting the research for this study additional findings were derived from survey items addressing (a) counselors' level of comfort addressing DSM-5 diagnoses, (b) counselors' self-assessment of their counseling skills, (c) counselors' assessment of the level of preparedness provided by their educational programs, and (d) additional training required in Virginia.

Comfort Levels with Counseling Skills

Virginia school counselors' had the greatest level of comfort regarding the following counseling skills: (a) collaboration/teamwork (M = 95.2, SD = 8.9), (b) consultation with parents, teachers, and administrators (M = 94.8, SD = 9.0), and (c) individual counseling (M = 92.0, SD = 12.1). Virginia school counselors' had the lowest level of comfort with the following counseling skills: (a) using the DSM to diagnose

client issues (*M* = 34.5, *SD* = 34.1), (b) treating and assessment (*M* = 50.1, *SD* = 32.5) and family counseling (*M* = 57.2, *SD* = 29.7). (For a complete listing of Counseling Skills see Appendix C, Table C5).

School counselors' level of comfort in addressing counseling skills was examined across their stages of development (based on Rønnestad and Skovholt's (2003) development model) using the statistical test of Fisher's Analysis of Variance (ANOVA). The assumption of homogeneity of variances was tested by using Levene's test. All the of the counseling skills met the assumption except (a) consultation with parents, teachers, and administrators (*M* = .027). These counseling skills did not meet the assumption of the homogeneity of variance and were testing for differences using the Welch Robust Test for Equality of Means. No significant differences were found in the counselors' counseling skills across the theoretical stages of counselors' professional development.

Comfort Levels with Common Counseling Issues

Virginia school counselors' had the greatest level of comfort helping students with the following issues: (a) academic concerns (*M* = 92.6, *SD* = 12.4), (b) stress management (*M* = 91.2, *SD* = 12.4), and (c) relationship concerns (*M* = 91.2, *SD* = 12.0). Virginia school counselors' had the lowest level of comfort with the following issues: (a) immigration concerns (*M* = 61.0, *SD* = 29.4), (b) addiction and substance use (*M* = 61.1, *SD* = 28.7) and (c) spirituality (*M* = 71.2, *SD* = 28.8). (For a complete listing of counseling issues see Appendix C, Table C4).

School counselors' level of comfort in addressing counseling skills was examined across their stages of development (based on Rønnestad and Skovholt's (2003) theory)

using the statistical test of Fisher's Analysis of Variance (ANOVA). The assumption of homogeneity of variances was tested by using Levene's test. All of the variety of issues met the assumptions except for (a) Academic Concerns, (b) Transitions and Post-Secondary Planning, and (c) Grief/Loss which were then tested using a Welch's ANOVA. Significant differences were found among Novice Counselors and those at the Senior and at the Experienced levels of development in the areas of (a) abuse/neglect (F (2, 385) = 3.454, p = .033, η^2 = .018, (b) immigration concerns (F (2, 385) = 3.507, p = .031, η^2 = .018, (c) divorce (F (2, 385) = 3.486, p = .032, η^2 = .018, (d) academic concerns (F (2, 385) = 6.111, p = .002, η^2 = .031, and (e) grief/loss (F (2, 385) = 5.408, p = .005, η^2 = .027. Even though there were statistically significant differences, the effect sizes for all were small indicating no meaningful difference.

Counselors' Perception of Their Preparedness

Virginia school counselors were asked if their education provided the necessary courses and training to prepare them for working with PK-12 students who exhibit mental health concerns. The school counselors who responded reported: (a) *completely* (n = 88, 22.3%), (b) *mostly* (n = 203, 51.5%), (c) *a little* (n = 89, 22.6%), or (d) *not at all* (n = 14, 3.6%). Virginia school counselors were also asked if their education provided the necessary courses and training to prepare them for working with PK-12 students who exhibit substance use concerns. The school counselors who responded reported: (a) completely (n = 32, 8.1%), (b) mostly (n = 114, 28.9%), (c) *a little* (n = 183, 46.4% or (d) not at all (n = 65, 16.5%).

A one-way (Fisher's) Analysis of Variance (ANOVA) was used to determine there were significant differences in school counselors' comfort levels in addressing students' mental health issues across their reported levels of preparedness. The assumption of the homogeneity of variances was tested by using Levene's test and most of the disorders did not meet the assumption requiring the robust Welch's ANOVA. There were statistically significant differences in addressing all mental health concerns across all levels of preparedness. The post hoc revealed for most of the diagnoses, there were significant differences in comfort levels across all levels of preparedness with the average level of comfort diminishing as the preparedness level was less. When there were differences in the average level of comfort by preparedness, there were either between *a little* and *not at all* or between *completely* and *mostly*. The post hoc test revealed no differences between the levels of preparedness of *a little* and *not at all* for the diagnoses: (a) Disorders Primarily Diagnosed in Children, (b) Cognitive Disorders, (c) Schizophrenia and Other Psychotic Disorders, (d) Somatoform Disorders, (e) Factitious Disorders and (f) Impulse Control Disorders. The diagnosis that did not demonstrate significant differences across the level of preparedness between *completely* and *mostly* in the Post Hoc Test were: (a) Anxiety Disorders, (b) Sexual/Gender Identity Disorder, (c) Impulse-Control Disorders, and (d) Substance-Related Disorders (For a complete listing of counselors' perception of their preparedness see Appendix C, Table C6).

An examination of Virginia school counselors' education and whether it provided the necessary courses and training to prepare them for addressing mental health concerns was examined according to their professional stage of development. Virginia school

counselors in the Novice Professional stage of Rønnestad and Skovholt's (2003) development model who responded (a) *completely* (*n* = 59, 31.1%), (b) *mostly* (*n* = 95, 50%), (c) *a little* (*n* = 35, 18.4%), and (d) *not at all* (*n* = 1, 0.5%). Virginia school counselors in the Experienced Professional stage of development reported (a) *completely* (*n* = 19, 15.7%), (b) *mostly* (*n* = 66, 45.5%), (c) *a little* (*n* = 30, 24.8%), and (d) *not at all* (*n* = 6, 5%). Virginia school counselors in the Senior Professional stage of development reported (a) *completely* (*n* = 8, 10.8%), (b) *mostly* (*n* = 35, 47.3%), (c) *a little* (*n* = 24, 32.4%), and (d) *not at all* (*n* = 7, 9.5%). A chi-square test was calculated to determine if school counselors' assessment if their education and training prepared them for working with students who have mental health concerns was independent of counselors' phase of professional development. A significant interaction was found (X^2 (6, 385) = 31.055, $p <$ .000. $_{Cramer}$ = .284), but the effect size was weak.

An examination of Virginia school counselors' education and whether it provided the necessary courses and training to prepare them for addressing substance use concerns was examined according to their professional stage of development. Virginia school counselors in the Novice Professional stage of Rønnestad and Skovholt's (2003) development model who responded (a) *completely* (*n* = 19, 10%), (b) *mostly* (*n* = 58, 30.5%), (c) *a little* (*n* = 88, 46.3%), and (d) *not at all* (*n* = 25, 13.2%). Virginia school counselors in the Experienced Professional stage of development reported (a) *completely* (*n* = 8, 6.6%), (b) *mostly* (*n* = 32, 26.4%), (c) *a little* (*n* = 58, 47.9%), and (d) *not at all* (*n* = 23, 19%). Virginia school counselors in the Senior Professional stage of development reported (a) *completely* (*n* = 3, 4.1%), (b) *mostly* (*n* = 20, 27%), (c) *a little* (*n* = 34,

45.9%), and (d) *not at all* (n = 17, 23%). A chi-square test of independent was calculated to determine if school counselors' assessment if their education and training prepared them for working with students who have substance abuse concerns was independent of counselors' phase of professional development. No significant interaction was found.

Counselor Education and Training

No significant differences were discovered across the theoretical stages in whether or not the school counselors graduated from a CACREP-accredited program (X^2 (2, 385) = 4.806, $p < .09$). Of the educational courses Virginia school counselors had taken during their training, a chi-square test reflected significant differences in whether or not they had taken specific coursework between those who had not graduated from a CACREP-accredited program, but the strength of the association was weak in all cases.

Table 2

Chi-Square Reflecting Differences in Specific Coursework

Coursework	Chi-square	*p* value	Cramer's V
Family counseling	5.521	.019	.118
Psychopathology/abnormal psychology	3.980	.046	101.
Diagnostic (DSM) counseling	10.343	.001	.162
Ethics and professional practice	5.463	.011	.128
Addiction/substance abuse	6.066	.014	.124
Crisis/trauma	4.482	.034	1.07
100 practicum	10.128	.001	.160
600 internship	30.081	.000	.276

Educational training was examined according to whether or not participants graduated from a CACREP-accredited school counseling program. Virginia school counselors were asked what educational courses and training they received. The five educational courses taken by a majority of the respondents was: (a) counseling theories (*n* = 392, 71.3%), (b) group counseling (*n* = 382, 69.5%), (c) ethics and professional practice (*n* = 375, 68.2%), (d) individual counseling (*n* = 367, 66.7%), and (e) multicultural issues/working within the educational system and human development (*n* = 332, 60.4%). The five educational courses taken the least among respondents were: (a) pharmacology (*n* = 31, 5.6%), (b) couples counseling (*n* = 37, 6.7%), (c) advanced skills group (*n* = 86, 15.6%), (d) consultation (*n* = 116, 21.1%), (e) family counseling (*n* = 159, 28.9%). An examination of the educational courses taken by school counselors according to Rønnestad and Skovholt's (2003) development model regarding the (a) Novice (*n* =

269), (b) Experienced (*n* = 172), and (c) Senior Professional (*n* = 92) phases indicated Senior Professionals had the greatest majority of individuals who had taken a majority of the courses identified in the survey over the Novice or Experienced Professional phases. Novice Professionals had the majority of participants who had taken the following courses: (a) Research and Evaluation (*n* = 167, 62%), (b) Multicultural Issues/Work within Educational System (*n* = 178, 66.1%), and Minimum 600 Hour Internship (*n* = 158, 58.7%). The Experienced Professionals had the majority of participants who had taken the following courses: (a) Diagnostic (DSM) Counseling (*n* = 57, 33.1%), (b) Addiction/Substance Use (*n* = 59, 34.3%), and Minimum 100 Practicum (*n* = 109, 63.3%).

The Virginia school counselors who participated in the survey who took the following courses: (a) Diagnostic (DSM) Counseling (*n* = 177, 32.2%), (b) Addiction/Substance Abuse (*n* = 172, 31.3%), and (c) Psychopathology/Abnormal Psychology (*n* = 214, 38.9%) which was less than half of the Virginia school counselors who participated in this study identified taking any educational courses/training. The DSM is the primary tool for diagnosing and understanding symptoms of various mental health and substance use disorders. In addition, there were significantly less than half of the Virginia school counselors who participated in this study identified taking educational courses/training in Addiction/Substance Abuse demonstrating an inadequate number of school counselors trained in the area of substance use given the rising number of students presenting in schools with substance use concerns. Subsequently, less than half of the Virginia school counselors who participated in the study identified taking educational

courses/training in Psychopathology/Abnormal Psychology which provides an understanding into behaviors and symptoms contributing to mental health and substance use concerns. These three courses: (a) Diagnostic (DSM) Counseling, (b) Addiction/Substance Abuse, and (c) Psychopathology/Abnormal Psychology are at the crux of understanding mental health and substance use concerns and yet significantly less than half of the Virginia school counselors who participated in the survey reported these educational courses were not required or part of their academic experience during their pursuit in becoming a school counselor.

In all cases, school counselors were more likely to take these courses in CACREP-accredited programs but even among those graduating from CACREP-accredited program large percentages did not take coursework in (a) Family Counseling (58%), (b) Psychopathology/Abnormal Psychology (43%), (c) Diagnostic (DSM) Counseling (51%), (d) Addiction/Substance Abuse (53%) and (d) Crisis/Trauma (48%). Comparing those who had taken and those who had not taken specific courses across the theoretical stages, a chi-square test revealed only significant differences in one course, multicultural issues, and this demonstrated a weak effect size (X^2 (2, 538) = 10.919, $p <$ .004, Cramer's V = .124).

Examining coursework through the lens of counselors' report of their preparedness using the response options of (a) *completely* or *mostly* and (b) *a little* or *not at all*:

Table 3

Total Number and Percentages of Council for Accreditation of Counseling and Related Education Programs Courses Taken by Virginia School Counselors

Did your education provide the necessary courses and training to prepare you for working with students who exhibit mental health and/or substance abuse concerns:				
Education	Mostly or completely		A little or not at all	
	Count	Row N %	Count	Row N %
Counseling theories	289	73.7%	103	26.3%
Group counseling	284	74.3%	98	25.7%
Minimum 100 practicum	245	74.5%	84	25.5%
Individual counseling	274	74.7%	93	25.3%
Ethics and professional practice	282	75.2%	93	24.8%
Research and evaluation	253	76.4%	78	23.6%
Human development	255	76.8%	77	23.2%
Child/adolescent counseling	249	76.9%	75	23.1%
Minimum 600 hour internship	247	78.7%	67	21.3%
Multicultural issues	265	79.8%	67	20.2%
consultation	96	82.8%	20	17.2%
Appraisal and assessment	180	82.9%	37	17.1%
Psychopathology/abnormal psychology	179	83.6%	35	16.4%
Family counseling	133	83.6%	26	16.4%
Crisis/trauma	161	84.3%	30	15.7%
Couples counseling	32	86.5%	5	13.5%
Addiction/substance abuse	150	87.2%	22	12.8%
Diagnostic (DSM) counseling	157	88.7%	20	11.3%
Advance skills group	78	90.7%	8	9.3%
Pharmacology	29	93.5%	2	6.5%
Totals	44	55.0%	36	45.0%

Continuing Education

Virginia school counselors reported that during the past year they took the following number of classes, seminars, or trainings regarding mental health concerns: (a) 1-2 classes (n = 162, 41.4%), (b) 3-4 classes (n = 133, 34%), (c) 5-6 classes (n = 35, 9%), (d) 7-8 classes (n = 11, 2.8%), (e) 9-10 classes (n = 8, 2.0%), (f) over 10 classes (n = 23, 5.9%), and (g) none (n = 19, 4.9%). Virginia school counselors reported that during the

past year they took the following number of classes, seminars, or trainings regarding substance use concerns: (a) 1-2 classes (*n* = 131, 33.5%), (b) 3-4 classes (*n* = 19, 4.9%), (c) 5-6 classes (*n* = 7, 1.8%), (d) 7-8 classes (*n* = 1, 0.3%), (e) 9-10 classes (*n* = 1, 0.3%), (f) over 10 classes (*n* = 2, 0.5%), and (g) none (*n* = 230, 58.8%).

Required Training

In the survey, Virginia school counselors were asked if they had taken the additional Training in the Recognition of Mental Health Disorder and Behavioral Distress now required as of July 1, 2017 when Virginia school counselors received their license or were renewing their license. A total of 253 (46.0%) school counselors responded with *yes that they had taken the additional training*. A total of 138 (25.1%) responded with *no they had not taken the required additional training*. A total of 241 (43.8%) reported they did not find the additional training helpful and 150 (27.3%) reported the additional training was helpful.

At the end of the survey, there was a question asking Virginia school counselors if there was additional information/training they would have liked the required additional training Recognition of Mental Health Disorder and Behavioral Distress to include. The comments made by school counselors in reference to this question could be categorized into three main themes: (a) in-depth mental health training, (b) preventing and addressing substance abuse and best approaches for helping students and families, and (c) areas where additional training was still needed.

Virginia school counselors who responded to this question about additional training needs specific to in depth training in mental health had the following comments:

- “Great information though would love to discuss more in depth how to help struggling students. What steps should be taken or how to counsel students with mental health needs.”
- “Best Practices regarding Helping Students with Mental Illnesses succeed in school”
- “High level of training in the area of anxiety and depression”
- “Schizophrenia and schizoid-affective disorders. Bi-Polar disorders. Personality disorders”
- “DSM Treatment Planning”
- “More focus on the elementary age child; most of the scenarios were from adolescents, ”
- “More preventative measures to support students with suicidal ideation”
- “Navigating legal aspects of student suicidal ideation”
- “More on trauma concerns of students”
- “Strategies to help with behavior associated with trauma”

Virginia school counselors who responded to this question about additional training needs specific to preventing and addressing and best approaches helping students and families had the following comments:

- “Substance abuse”
- “substance abuse prevention best practices for young children”
- “More on Substance Abuse in elementary age students”
- “Collateral Damage from Parental Substance Abuse and Abandonment”

- “Substance abuse in the family”
- “Practical strategies and implementation. Dealing with parents who are in denial.”

Virginia school counselors who responded to this question about areas where additional training is still needed commented:

- “For counselors it should be more in depth...”
- “It needs to be face to face and not on a webinar. It was hard to follow and have a
- discussion if it is online.”
- “The training needs to be held over several days.”
- “More info for younger children and helping families recognize”
- “More cultural awareness”
- “Targeted training/interventions on working with specific disorders. Particularly how to support them in the school setting.”
- “Application to younger students – the course is mostly for ages 12 and up, and I work with Elementary students.”
- “Focus on common disorders to the high school age group”
- “The School Counselors in school are doing less and less mental health services and more data input.”
- “We have been saturated with “Mental Health” info and training, our issue is having the time to deal with it and all the other things we would like to do with our students”

- “Ways of using solution focused counseling and in particular how to use it in groups and to foster hope”
- “504 information and services. What is our role in these services as school counselors, and how does mental health fall within this framework? As a school counselor I am a 504 case manager with at least 20 504 students. I cannot believe these services are not mandated by the state to be assigned to special education. Our school district will never reach the 80/20 ratio as long as we have these “other duties as assigned”.
- “Resources for working with these students in various situations. For example, getting students help when their parents do not believe they have a mental health disorder. How to write 504s/IEPs that will provide additional support to students while in school.”
- “Collaboration with staff in schools; although the training was helpful to refresh school counselors’ minds on these concerns, I also felt like it was like training a nurse to put on a Band-Aid – the majority of us are already trained mental health professionals and it would be beneficial for non-mental health professionals to take this as well. I feel that school counselors still have to advocate for themselves in order for their roles to be more understood because they are often not seen as “real” mental health professionals.
- “Recognition is fine but what to do about it in school when outside treatment cannot be accessed is the issue.”

- "I would like for teachers, administrators, division leaders, and other staff members to be trained and receive mental health training every year."
- "I would like there to be joint trainings with other individuals in a school setting who can work together to address student needs. It should not be a counselor only job. This should include social worker, psychologist, behavioral specialists. I often am unaware of what each of these professionals is doing with the child and I believe it would be more effective if we used common language and worked as a team."

Summary/Conclusions

Virginia school counselors participated in a survey to examine their level of comfort working with PK-12 students who exhibit mental health and/or substance use concerns. A total of 550 Virginia school counselors participated with 390 of those participants completing the survey in its entirety. The survey examined Virginia school counselors' comfort levels regarding (a) DSM-5 diagnoses, (b) common counseling issues, and (c) counseling skills.

The survey incorporated an examination of Virginia school counselors' years of professional experience according to Rønnestad and Skovholt's (2003) development model and whether or not that impacted their level of comfort working with PK-12 students with mental health and substance use concerns. The results of the survey indicated that there were no significant differences between Virginia school counselors' level of comfort working with students with mental health and/substance use concerns based on Rønnestad and Skovholt's (2003) development model. Also, no significant

differences were found across the theoretical stages of counselors' professional development according to Rønnestad and Skovholt's (2003) development model regarding school counselors' counseling skills and their comfort levels in addressing common counseling skills.

The survey indicated that 80% of the Virginia school counselors who participated in the survey identified that their education and training *completely* or *mostly* prepared them for addressing the mental health and substance use concerns of PK-12 students. However, 20% of the Virginia school counselors who participated in the survey identified that their education prepared them *a little* or *not at all* for addressing the mental health and substance use concerns of PK-12 students. These findings demonstrate that on average at least 20% of Virginia school counselors do not identify their education and training to be adequate in preparing them to address the mental health and substance use needs of students. This raises significant concern as to what additional education and training is needed in order for these school counselors to be completely or mostly prepared to address the mental health and substance use concerns of students. With this large percentage of Virginia school counselors who identify feeling *a little* or *not at all* prepared indicates a need for educational courses and training for school counselors to be more aligned with the mental health and substance use concerns school counselors are encountering in their work with students. At this moment, the education and training available to school counselors needs to be adjusted and changed to meet the rising mental health and substance use concerns of students in schools. Areas where Virginia school counselors identified as needing more education and training in areas such as: (a) best

practices helping students with mental health concerns, (b) preventative measures for suicidal ideation, (c) advanced training in anxiety and depression, (d) DSM treatment planning, (e) specific strategies for addressing trauma, and (f) strategies for addressing substance use across various age groups.

Chapter 5: Conclusion

Introduction

The continuing rise in school shootings and the concern for student safety has created significant public discussions about the role of school counselors' readiness to address PK-12 students' mental health and/or substance use concerns. In PK-12 schools in the United States today, students are faced with acts of bullying, school shootings, suicides, and an ongoing need for help and support to navigate through the daily challenges arising from various mental health and/or substance use concerns. These concerns manifest in (a) declines in school attendance; (b) poor academic performance; (c) difficulty in overall physical, emotional, and mental development; and (d) the likelihood of mental health problems persisting into adulthood. School counselors have found their professional roles evolving from a focus on normal human growth and development and career preparation to being at the forefront of addressing mental health and/or substance use needs for PK-12 students (Carlson & Kees, 2013).

This study focused on Virginia school counselors because as of July 1, 2017, the Virginia State Senate passed Bill 1117 mandating Virginia school counselors to have training in the following areas: (a) mental health disorder and behavioral distress, (b) depression, (c) trauma, (d) violence, (e) youth suicide, and (f) substance use. Recently, Virginia Governor Northam proposed $99 million toward new school counselor positions in the next 2-year budget to address the rising needs of PK-12 students' mental health and substance use concerns (VSCA, 2019). This suggested a need for understanding

counselors' level of comfort in addressing various DSM-5 diagnoses, counseling skills, and areas school counselors identify needing additional training.

The purpose of this quantitative descriptive survey was to identify (a) the frequency with which Virginia school counselors encountered students displaying mental health and/or substance use concerns, (b) school counselors' level of comfort in recognizing mental health and substance use concerns, (c) if school counselors' professional development influenced their comfort levels addressing mental health and substance use, and (d) areas in which school counselors believed they needed additional training.

This descriptive research study used survey research methodology to examine school counselors in the State of Virginia. Over 3,000 school counselors in the State of Virginia were sent invitations to the survey via their school e-mail; 550 Virginia school counselors responded to the survey and 390 of those school counselors completed the survey in its entirety, yielding a 95% confidence level with 5% margin of error resulting in an accurate portrayal of Virginia school counselors. The demographics of the respondents, for school geographic location, race, and years of experiences, also supported this assertion.

Data analysis to answer the research questions indicated (a) Virginia school counselors are seeing more students displaying symptoms of mental health concerns than substance use, (b) school counselors are most comfortable with mental health issues that are commonly manifest in school children but less comfortable with severe disorders or those less commonly seen, (c) counselors' phase of professional development did not

influence their comfort levels in dealing with students' mental health and substance use issues.

On average, in the 30 days prior to completing the survey, school counselors encountered 19 students with mental health concerns and 4 students with substance use concerns. Virginia school counselors identified their greatest level of comfort was in recognizing (a) anxiety disorders, (b) disorders primarily diagnosed in children, and (c) cognitive disorders. Virginia school counselors identified their lowest levels of comfort working with PK-12 students diagnosed with (a) factitious disorders, (b) schizophrenia and other psychotic disorders, and (c) somatoform disorder. Using Rønnestad and Skovholt's (2003) development model revealed no significant differences in the counselors' comfort levels addressing mental health and/or substance use concerns across the theoretical stages of counselors' professional development. Virginia school counselors identified (a) trauma, (b) mental health disorders, (c) substance use, (d) youth suicide, and (e) violence as areas in which they needed additional training.

The lack of significant differences across Rønnestad and Skovholt's (2003) development model was surprising due to the inherent assumption of this theory that the professional development of counselors' knowledge base and experience grows as they move through the six phases of development.

Interpretation of Findings

Alignment with the Body of Knowledge in the Literature

A total of 80% of all chronic mental health disorders originate in childhood, with at least half beginning prior to the age of 14 years old (Child Mind Institute, 2017).

Currently, one in five children under the age of 18 years of age suffer from a mental health condition with suicide as the second leading cause of death among adolescents 12 to 17 years old (Bor et al., 2014). The CDC reported that during 2017, there were 517 suicides among children ages 10 to 14 years old and a total of 6,252 suicides among individuals ages 15 to 24 years old (National Institute of Mental Health, 2020). A total of 75% of students struggling with mental health concerns are not receiving the necessary mental health services (Paolini, 2015; Stagman & Cooper, 2010). Tegethoff et al. (2014) indicated that frequently children and adolescents in need of mental health services do not receive actual treatment until almost a decade after initial symptoms start to emerge. Most (80%) of all chronic mental illness originates in childhood prior to 17 years of age, with half beginning prior to the age of 14 years old (Child Mind Institute, 2017). The need for mental health and substance use support among students continues to rise.

Moon et al.'s (2017) survey of 786 educators in a Midwestern state found that more than 96% were likely to encounter students with mental health needs, with 93% (*n* = 679) feeling moderately to severely concerned about students' mental health concerns. In this survey research, reporting about the last 30 days, over 70% of Virginia school counselors encountered students with either mental health or substance use concerns. Moon et al.'s (2017) and the current study aligned in the finding that counselors are seeing a large number of students with mental health and substance use concerns.

Alignment with Carlson and Kees' (2013) Study

This study used a survey adapted from Carlson and Kees' (2013) study, which examined a national sample of school counselors. As shown in Table 4, results of this

study demonstrated alignment with Carlson and Kees' (2013) results regarding the top three areas with which counselors had the most or the least comfort. Generally, the top two areas completely aligned with the third areas differing only in (a) mental health concerns least comfortable in addressing, and (b) counseling skills most and least comfortable employing. These results suggested that Virginia school counselors' areas of comfort are similar to those of counselors across the nation and, more importantly, those areas have manifested little significant changes in the past 6 years. This may be an indicator that school counselor training programs are not changing quickly enough to keep up with the changing roles of school counselors.

Table 4

Comparison Between Nationwide Sample and Virginia Sample

Carlson and Kees' (2013) Nationwide Sample	Current Study (2019) Virginia Sample
Mental health concerns most comfortable addressing	
Anxiety disorders	Anxiety disorders
Disorders primarily diagnosed in children	Disorders primarily diagnosed in children
Cognitive disorders	Cognitive disorders
Mental health concerns least comfortable addressing	
Factitious disorders	Factitious disorders
Schizophrenia and other psychotic disorders	Schizophrenia and other psychotic disorders
Sleep disorders	Somatoform disorders
Specific student concerns most comfortable addressing	
Academic concerns	Academic concerns
Relationship concerns	Relationship concerns
Stress management	Stress management
Specific student concerns least comfortable addressing	
Immigration concerns	Immigration concerns
Addiction/substance use	Addiction/substance use
Spirituality	Spirituality
Specific counseling skills most comfortable employing	
Consultation with parents, teachers, and Administrators	Consultation with parents, teachers, and Administrators
Collaboration and teamwork	Collaboration and teamwork
Ethical practice	Individual counseling
Specific counseling skills least comfortable employing	
Using the DSM to diagnose client issues	Using the DSM to diagnose client issues
Family counseling	Family counseling
Treatment planning	Treating and assessment

Theoretical Framework

Rønnestad and Skovholt's (2003) development model proposed six phases to examine the professional development of counselors. In this research I used this development model to provide an understanding of how school counselors gain and build professional experience across their careers and how that might influence their comfort levels in addressing students' mental health and substance use concerns. The data collected and analyzed from the study found no significant differences in Virginia school counselors' comfort levels in addressing students' mental health and substance use concerns as counselors' progressed across the (a) novice professional, (b) experienced professional, and (c) senior professional phases of development. These results are contradictory to assumptions drawn from Rønnestad and Skovholt's (2003) development model, which are that counselors' professional development and identity builds upon itself as an individual moves through the six stages of the development model. This research explored if counselors' professional development based on Rønnestad and Skovholt's (2003) development model would make a significant difference in how school counselors' saw their educational preparedness. While significant differences were found among the phases of professional development in preparedness to address mental health concerns, the small effect size indicated no meaningfulness.

Finding Support Counselors' Need for More Training to Address Mental Health and Substance Use Disorders

The DSM is the primary tool for diagnosing and understanding symptoms of various mental health and substance use disorders. In addition, there were significantly

less than half of the Virginia school counselors who participated in this study identified taking additional educational courses/training in Addiction/Substance Abuse demonstrating an inadequate number of school counselors trained in the area of substance use given the rising number of students presenting in schools with substance use concerns. Less than half of the Virginia school counselors who participated in the study identified taking educational courses/training in Psychopathology/Abnormal Psychology which provides an understanding into behaviors and symptoms contributing to mental health and substance use concerns. These four courses: (a) Diagnostic (DSM) Counseling, (b) Addiction/Substance Abuse, (c) Psychology/Abnormal Psychology, and (d) Crisis/Trauma are at the crux of understanding mental health and substance use concerns and yet significantly less than half of the Virginia school counselors who participated in the survey reported these educational courses were not required or part of their academic experience during their pursuit in becoming a school counselor. There were significantly less than half of the Virginia school counselors who participated in this study identified taking additional educational courses/training in Addiction/Substance Abuse demonstrating an inadequate number of school counselors trained in the area of substance use given the rising number of students presenting in schools with substance use concerns.

These findings suggested that the additional training in the Recognition of Mental Health Disorder and Behavioral Distress required as of July 1, 2017; while moving in the direction of expanding mental health and substance use training for Virginia school counselors, it does not currently fully meet the needs of what school counselors identified

as needing in order to improve their level of comfort in addressing mental health and substance use needs of students.

Summary of Findings

There is a continual rise in demands from communities for school counselors' professional roles to further expand to include students' mental health and substance use concerns as clearly evidenced by the Virginia legislation. This current study confirmed that Virginia school counselors are seeing students who have mental health and substance use concerns. Current research study also indicated that Virginia school counselors are not comfortable with addressing students' more serious mental health and substance use concerns and only a few school counselors indicated their educational training and preparation they received prepared them to meet the growing mental health and substance use problems of PK-12 students.

By framing this study with Rønnestad and Skovholt's (2003) model of counselor development, this research was able to confirm that increased professional development and experience does not equate to counselors' greater comfort levels in addressing students' mental health and substance use concerns.

The findings of this study being so similar to the previous study by Carlson and Kees' (2013) exemplified the immediate need for changes to be made in the area of school counselors educational training and ongoing professional development in order to become more in sync and compatible with the rising mental health and substance use needs of students. This lack of variation in school counselors' comfort levels with mental health and substance use concerns between the two studies 6 years apart demonstrates the

lack of school counselors' training not staying current with the increasing training needs of school counselors in the areas of mental health and substance us concerns. When the training and professional development opportunities being currently provided to school counselors do not meet their needs then they cannot meet the rising mental health and substance use needs of students.

Limitations of Study

The purpose of this study was to gain a richer understanding into Virginia school counselors current comfort levels working with PK-12 students with mental health and/or substance use concerns as well as what additional training would be most beneficial for them. Virginia school counselors were selected due to the recent passing of the Senate Bill 1117 in Virginia requiring additional mental health training for school counselors who are seeking licensure or renewing their license in the State of Virginia (VA Code §22.1-298.1, 2018). While aligning with the study's purpose, a limitation to generalizing from the study was collecting data only from Virginia school counselors.

The data for the study was collected from August-September 2019 when most schools are beginning their school year. The timeframe of this study could have limited the number of students school counselors observed in the previous 30 day timeframe who presented with mental health and/or substance use concerns; it is possible if the survey was conducted later in the school year there could have been increased reports of students who displayed symptoms of mental health or substance use concerns.

Another potential limitation to the study representing all Virginia school counselors was some counties/cities in Virginia were not included in the email due to not

having a school website or having a website that did not include the contact information of the school counselors. An additional limitation to the research study included the error by the researcher in leaving out the age range of 55 to 64 years old in the demographics section of the survey. This was brought to the attention of the researcher by two participants toward the end of the data collection process.

Recommendations for Further Research

This research study demonstrated no significant differences from Carlson and Kees' (2013) study regarding school counselors comfort levels addressing the mental health and substance use concerns of students. The similarities in results from the study in 2013 and this current study demonstrated the educational training and ongoing professional development of school counselors has stayed relatively the same in spite of the changing roles of school counselors in schools. This current survey being so similar to the results of the previous study by Carlson and Kees (2013) exemplifies the immediate need for changes to be made in the area of school counselors educational training and ongoing professional development in order to become more in sync and compatible with the rising mental health and substance use needs of students. This lack of variation in school counselors' comfort levels with mental health and substance use concerns between the two studies 6 years apart demonstrates the lack of school counselors' educational and professional trainings not staying current with the increasing training needs of school counselors in the areas of mental health and substance abuse concerns. Thus, the training and professional development opportunities being currently

provided to school counselors does not meet the needs of the school counselors, which as a by-product does not meet the rising mental health and substance use needs of students.

This examination of Carlson and Kees' (2013) study and the current study with the data results being similar to one another demonstrates a need for a closer examination of the current educational and training curriculum currently being offered and approved by CACREP in order to determine how the current curriculum can be expanded to meet the increasing mental health and substance use needs of PK-12 students. The current study demonstrates an ongoing need for an expansion in current curriculum being offered to school counselors. This is an area where additional research is necessary in order to identify specific courses and where additional courses may be needed. The current study identified the current comfort levels of school counselors and areas where additional training is desired. From this stepping off point, next steps in this area of research would include a closer examination of the current courses and training of school counselors and how the curriculum can be further developed and evolved to the extent where school counselors are able to identify increased comfort levels in addressing students mental health and substance use concerns. Therefore, additional research ought to be conducted to identify what specific educational and training needs and curriculum would best prepare school counselors working with students' who have mental health and substance use concerns.

This study used Rønnestad and Skovholt's (2003) development model where the professional development of counselors occurs in six phases. The study demonstrated how the intent or underlying assumptions in Rønnestad and Skovholt's (2003)

development model was not accurate in the sense that it suggested counselors progress through six phases based on their years of experience with an underlying assumption that counselors knowledge and expertise continue to progress as they move through the six phases. The results of this study do not support the underlying theoretical assumptions in Rønnestad and Skovholt's (2003) development model and, in fact, are contraindicated in regard to how school counselors view their level of comfort addressing mental health and substance use. Additional research needs to be conducted in order to identify what exemplary qualities school counselors possess and what qualities might be imbued over the professional development of school counselors. Researching and studying the professional development of school counselors as a means of gaining a true understanding of their lived experiences throughout their professional development in their school counseling careers.

Areas of further research could include exploring the lived experiences of school counselors throughout their professional careers and how this impacts their work with students with mental health and substance use concerns. Other areas of research could include the impact of school counselors work with PK-12 students in various grades and age groups and at what specific points are interventions for mental health and substance use most effective.

Implications

Positive Social Change

This research study has the potential for initiating and creating positive social change within school systems by emphasizing the great need for mental health and/or

substance use support for students throughout school systems in the United States. Shining light on this growing need within schools creates an opportunity for school administrators to initiated additional opportunities for school counselors to spend time working with students on their most immediate needs and less on administrative requirements where their expertise is not as crucial and necessary as it is in their direct contact addressing the mental health and/or substance use of students.

Adding to the current body of knowledge on the subject of PK-12 mental health and substance use and contributing data which can further help to support the growing need for more school counselors in schools. Additional school counselors' in school creates more opportunities for more students to be helped and supported in their times of need dealing with mental health and/or substance use concerns.

An implication of this research study was discovering that school counselors' level of comfort regarding mental health and/or substance use concerns was not specific nor influenced by their current stage of professional development according to Rønnestad and Skovholt's (2003) development model. This was in direct opposition to the underlying assumptions within Rønnestad and Skovholt's (2003) development model. This discovery could possibly influence the ways in which this current development model is utilized and how future researchers look at and examine professional development models. The current research study demonstrated that school counselors' professional development was not determined by the amount of years they were working in their professional careers. For example, the Virginia school counselors who participated in this research study who identified 1 year, 10 years, or 20 years of

experience as school counselors did not demonstrate a greater or lesser level of comfort working with students with mental health and/or substance use concerns which was contradictory to what Rønnestad and Skovholt's (2003) development model theoretical framework suggested.

Conclusion

There is a continuing need for additional mental health and substance use support in schools for students throughout the United States. PK-12 students' needs in the areas of mental health and substance use concerns continues to rise requiring school counselors to be at the forefront of providing help and support to students. The professional requirements of school counselors have dramatically shifted to addressing the rising needs of students exhibiting mental health and substance use concerns. School counselors' comfort levels regarding mental health and substance use showed little change from Carlson and Kees' (2013) survey to this study's current survey conducted 6 years later suggesting school counselors have not been provided the education and training needed to best address the rising mental health and substance use concerns of students. There is a growing movement with schools and legislatively to increase the education, training, and continuing education requirements of school counselors in the areas of mental health and substance use due to noticing rise in mental health and substance use needs of students in this country. Providing the best mental health and substance use support to address the PK-12 students requires school counselors to have education and training specific to addressing and meeting the rising mental health and substance use concerns of students. Meeting the mental health and substance use

concerns of PK-12 students starts with school counselors' level of comfort addressing mental health and substance use concerns.

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Appendix A: Survey

Survey for Virginia School Counselors

1. **Are you currently working as a school counselor in the State of Virginia?**
   - Yes
   - No

Credentials

2. **How many years have you been licensed as a school counselor?**

_____.

What additional licenses do you hol Please mark all that apply.

- Licensed School Counselor
- Licensed Social Worker
- Licensed School Psychologist
- Licensed Professional Counselor (LPC)
- Licensed Marriage and Family Therapist (LMFT)
- Other (please specify) _____.
- None

3. **How many years have you been actively working as a school counselor?**

_____.

4. **How many years have you been licensed as a school counselor in the State of Virginia?**
   - 1-9 years

- 10-19 years
- 20 or more years

Demographics

5. **Please specify your gender.**
    - Female
    - Male
    - Transgender
    - Other _____.
6. **Please specify your ethnicity.**
    - Asian/Pacific Islander.
    - Black/African American.
    - Hispanic or Latino.
    - Native American or American Indian.
    - White.
    - Other _____.
7. **Please specify your age.**
    - 18-24 years old
    - 25-34 years old
    - 35-44 years old
    - 45-54 years old
    - 55-64 years old

- 65-74 years old
- 75 years or older

With what grade levels do you currently wor Please mark all that apply.

- Elementary Children (K-5th grade)
- Middle School/Junior High (6th-8th grade)
- High School (9th-12th grade)

8. **In Virginia, what city or county is the school where you are employed?**

_____.

9. **How would you characterize the area where you are employed as a Virginia school counselor?**

- Rural
- Suburban
- Urban

How are students primarily referred to a school counselo Please mark all that apply.

- Student
- Peer
- Parent
- Teacher
- Principal
- Outside Agency
- Other: Educational Professionals

Professional Experience

10. Please indicate your level of comfort in working with students living with the following DSM diagnoses. Please base your response on your training and experience apart from your expectations.

- **Disorders Primarily Diagnosed in Children**

0_____100

- **Cognitive Disorders**

0_____100

- **Mental Disorder Due to a General Medical Condition**

0_____100

- **Substance-Related Disorders**

0_____100

- **Schizophrenia and Other Psychotic Disorders**

0_____100

- **Mood Disorders**

0_____100

- **Anxiety Disorders**

0_____100

- **Somatoform Disorders**

0_____100

- **Factitious Disorders**

0_____100

- **Sexual/Gender Identity Disorders**

0_____100

- **Eating Disorders**

0_____100

- **Sleep Disorders**

0_____100

- **Impulse-Control Disorders**

0_____100

- **Adjustment Disorders**

0_____100

- **Personality Disorders**

0_____100

11. Please indicate your level of comfort in your counseling skills in each of the following areas. Please base your response on your training and experience apart from your expectations.

- **Individual Counseling**

0_____100

- **Group Counseling**

0_____100

- **Family Counseling**

0_____100

- **Testing and Assessment**

0_____100

- **Using the DSM to Diagnose Client Issues**

0_____100

- **Treatment Planning (Goals and Objective)**

0_____100

- **Ethical Practices**

0_____100

- **Consultation with parents, teachers, and administrators**

0_____100

- **Collaboration/teamwork**

0_____100

- **Counseling Research**

0_____100

- **Program Development & Evaluation**

0_____100

12. Please indicate your comfort level in helping students with the following issues.

Please base your response on your training and experience apart from your employers' expectations.

- **Academic Concerns**

0 100

- **Transitions and Post-Secondary Planning**

0 100

- **Relationship Concerns**

0 100

- **Stress Management**

0 100

- **Addiction and Substance Use**

0 100

- **Multicultural Concerns**

0 100

- **Abuse/Neglect**

0 100

- **Suicidal Concerns**

0 100

- **Grief/Loss**

0 100

Concerns Related to Living in Poverty (homelessness and hunger)

0 100

- **Immigration Concerns**

0 100

- **Spirituality**

0_____100

- **Divorce and Family Disruption**

0_____100

13. In the last 30 days, how many students have you worked with who exhibit mental health concerns?

- 0_____100

14. In the last 30 days, how many students have you worked with who exhibit substance use concerns?

- 0_____100

Education

15. Please indicate which of these courses you completed as part of your education and training for your current position. Please mark all that apply.

- Counseling Theories
- Individual Counseling
- Child/Adolescent Counseling
- Group Counseling
- Couples Counseling
- Family Counseling
- Advances Skills Group
- Psychopathology/Abnormal Psychology
- Appraisal and Assessment in Counseling

- Diagnostic (DSM) Course
- Research and Evaluation
- Ethics and Professional Practice
- Multicultural Issues/Working within the Educational System
- Consultation
- Addictions/Substance Abuse
- Pharmacology
- Crisis/Trauma
- Human Development
- Minimum 100 Hour Practicum
- Minimum 600 Hour Internship

16. **Did you graduate from a Council for Accreditation of Counseling & Related Educational Programs (CACREP) school?**
    - Yes
    - No
17. **Did your education provide the necessary courses and training to prepare you for working with students who exhibit mental health concerns?**
    - Completely
    - Mostly
    - A little
    - Not at all

18. Did your education provide the necessary courses and training to prepare you for working with students who exhibit substance use concerns?

- Completely
- Mostly
- A little
- Not at all

What additional training subjects would be most beneficial for you? Please mark all that apply.

- Mental health disorders
- Trauma
- Violence
- Youth Suicide
- Substance use

<u>Continuing Education</u>

19. In the past year, how many continuing education classes, seminars, or trainings regarding the subject of mental health concerns have you taken?

- 1-2
- 3-4
- 5-6
- 7-8
- 9-10

- over 10
- None

20. **In the past year, how many continuing education classes, seminars, or trainings regarding the subject of substance use have you taken?**
    - 1-2
    - 3-4
    - 5-6
    - 7-8
    - 9-10
    - over 10
    - None
21. **Have you taken the additional Training in the Recognition of Mental Health Disorder and Behavioral Distress now required of Initial Licensure and License Renewal (School Counselor Developments) implemented in July 1, 2017?**
    - Yes
    - No
22. **If you have taken the additional training in the Recognition of Mental Health Disorder and Behavioral Distress implemented July 1, 2017 did it provide new additional information on mental health and behavioral distress that you did not know prior to the training?**
    - Yes

- No

If you have taken the additional training in the Recognition of Mental Health Disorder and Behavioral Distress Implemented July 1, 2017 is there additional information you would like the training to included

_____

Acknowledgement

This survey has been adapted from a survey originally developed by Angie D. Waliski, Ph.D and developed further by Laurie A. Carlson, Ph.D and Nathalie A. Kees, Ed.D

Appendix B: Pilot Study Tables

Table B1

Frequency Analysis of Students with Mental Health and/or Substance Use Concerns in the Last 30 days

	In the last 30 days, how many students have you worked with who exhibit mental health concerns?	In the last 30 days, how many students have you worked with who exhibit substance use?
Valid	10	11
Mean	7.00	2.64
Standard Deviation	8.615	4.802

Table B2

Virginia School Counselors Level of Comfort Addressing Mental Health and Substance Use Problems

Disorders	*N*	Min.	Max.	*M*	*SD*
Schizophrenia and Other Psychotic Disorders	11	16	90	51.73	22.392
Factitious Disorder	11	16	95	60.64	25.820
Sleep Disorders	11	6	100	64.55	27.696
Somatoform Disorders	11	16	100	65.45	25.296
Personality Disorders	11	8	87	67.27	23.191
Cognitive Disorders	11	14	100	68.91	23.535
Substance-Related Disorders	11	15	100	69.73	25.219
Eating Disorders	11	9	100	71.73	23.074
Mood Disorders	11	16	95	72.09	27.649
Disorders Primarily Diagnosed In Children	11	16	100	72.36	24.837
Mental Disorders Due to General Medical Condition	11	15	100	72.91	25.489
Sexual/Gender Identity Disorder	11	39	100	73.27	22.913
Adjustment Disorder	11	7	100	73.55	26.804
Impulse-Control Disorder	11	5	100	75.18	27.290
Anxiety Disorders	11	16	100	81.00	24.269

Table B3

Additional Trainings Needed by Virginia School Counselors to Increase Level of Comfort Working with PK-12 Students with Mental Health and Substance Use

	Frequency	Percent	Valid Percent	Cumulative Percent
Mental Health Disorders	6	2.1	20.7	20.7
Trauma	7	2.5	24.1	44.8
Violence	3	1.1	10.3	55.2
Youth Suicide	8	2.8	27.6	82.8
Substance Use	5	1.8	17.2	100.0
Total	29	10.3	100.0	

Appendix C: Research Study Results

Table C1

Frequency Analysis of Educational Courses Taken by Virginia School Counselors During their Training

	n	Percent
Counseling Theories	392	71.3
Individual Counseling	367	66.7
Child/Adolescent Counseling	324	58.9
Group Counseling	382	69.5
Couples Counseling	37	6.7
Family Counseling	159	28.9
Advance Skills Group	86	15.6
Psychopathology/Abnormal Psychology	214	38.9
Appraisal and Assessment in Counseling	217	39.5
Diagnostic (DSM) Counseling	177	32.2
Research and Evaluation	331	60.2
Ethics and Professional Practice	375	68.2
Multicultural Issues/Working within the Educational System	332	60.4
Consultation	116	21.1
Addiction/Substance Abuse	172	31.3
Pharmacology	31	5.6
Crisis/Trauma	191	34.7
Human Development	332	60.4
Minimum 100 Practicum	329	59.8
Minimum 600 Hour Internship	314	57.1

Table C2

Total Participation of Virginia School Counselors Based on the City or County Where Employed

	n
Chesterfield County	46
Fairfax County	41
Prince William County	41
Loudoun County	26
Norfolk County	21
Virginia Beach	18
Stafford County	17
Henrico County	17
Roanoke	15
Spotsylvania County	10
Washington County	9
Hampton	9
Shenandoah County	8
Montgomery County	8
Augusta County	8
Caroline County	7
Richmond City	7
Portsmouth City	7
Arlington County	7
Bedford County	6
Campbell County	6
Frederick County	6
Gloucester County	6
Rockingham County	6
Wythe County	5
Fauquier County	4

table continues

Henry County	4
Wise County	4
Winchester City	4
Poquoson County	4
Hanover County	4
Lynchburg City	4
Greene County	4
Suffolk County	4
Culpeper	4
Albemarle County	3
Botetourt County	3
Buckingham County	3
Charlottesville City	3
Chesapeake	3
Galax City	3
Newport News	3
New Kent	3
Halifax County	3
Staunton City	3
Northumberland County	3
Fluvanna County	3
Russell	3
Williamsburg City	3
Danville	3
Alexandria City	2
Amelia	2
Bristol City	2
Dinwiddie	2

Orange County	2
Lancaster	2
Lexington	2
Louisa County	2
Powhatan	2
Martinsville County	2
Mecklenburg County	2
Nottoway County	2
Patrick	2
Petersburg City	2
Pittsylvania County	2
Lexington	2
Nelson County	2
Northampton	2
Smyth County	2
King George	2
Warren County	2
Waynesboro City	2
Alleghany County	1
Bath County	1
Broadway	1
Callaway	1
Chester County	1
Clarke County	1
Franklin	1
Gate City	1
Goochland County	1
Hanover County	1
Radford	1

table continues

Lovington	1
Lunenburg	1
New Castle	1
Dickenson	1
Fort Union	1
Amherst	1
Quicksburg	1
Harrisonburg	1
Madison County	1
Page County	1
Powhatan	1
Prince George	1
Standardsville County	1
Southampton	1
Southwest	1
Scott	1
Pulaski	1
Radford City	1
Fluvanna	1
Rockbridge	1
York	1

table continues

Table C3

Comfort Levels of Virginia School Counselors Addressing Mental Health and Substance Use with PK-12 Students

	M	SD
Disorders Primarily Diagnosed in Children	76	23
Cognitive Disorders	72	23.7
Mental Disorder Due to a General Medical Condition	71.5	23.9
Substance-Related Disorders	62.6	27.6
Schizophrenia and Other Psychotic Disorders	49.6	30.3
Mood Disorders	70.8	27
Anxiety Disorders	81.4	21.6
Somatoform Disorders	51.6	33
Factitious Disorders	46.8	32.1
Sexual/Gender Identity Disorders	67	29.4
Eating Disorders	63.5	28.4
Sleep Disorders	55.1	30.5
Impulse-Control Disorders	71.9	26.9
Adjustment Disorders	70.9	27.3
Personality Disorders	56.3	29.5

Table C4

Comfort Levels of Virginia School Counselors Using Various Counseling Skills

	M	*SD*
Collaboration/Teamwork	95.2	8.9
Consultation with Parents, Teachers, and Administrators	94.8	9.0
Individual Counseling	92.0	12.1
Group Counseling	84.6	18.2
Family Counseling	57.2	29.7
Treating and Assessment	50.1	32.5
Using the DSM to Diagnose Client Issues	34.5	34.1
Treatment Planning/Goals and Objectives	59.3	31.9
Ethical Practice	91.0	13.7
Counseling Research	70.4	26.7
Program Development	77.3	22.5

Table C5

Comfort Levels of Virginia School Counselors with Common Counseling Issues

	M	*SD*
Academic Concerns	92.6	12.4
Stress Management	91.2	12.0
Relationship Concerns	89.2	16.3
Immigration Concerns	61.0	29.4
Addiction and Substance Use	61.1	28.7
Spirituality	71.2	28.8
Transitions and Post-Secondary Planning	84.8	22.5
Multicultural Concerns	80.2	19.3
Abuse/Neglect	83.9	18.8
Suicidal Concern	83.7	18.7
Grief/Loss	83.4	18.0
Concerns Related to Living in Poverty (homelessness and hunger)	81.7	20.5
Program Development and Evaluation	77.3	22.5
Divorce and Family Disruption	85.6	17.2

Table C6

ANOVA of Virginia School Counselors' Perception of Preparedness Regarding Mental Health and Substance Use

Disorders		Sum of Squares	df	Mean Square	F	Sig
Disorders primarily diagnosed in children	Between Groups	28346.184	3	9448.72	20.961	0.00
	Within Groups	175802.794	390	450.776		
	Total	204148.977	393			
Cognitive Disorders	Between Groups	24534.737	3	8178.246	16.99	0.00
	Within Groups	18772.437	390	481.365		
	Total	212267.211	393			
Mental Disorders Due to a Medical Condition	Between Groups	31417.923	3	10472.641	22.47	0.00
	Within Groups	181770.973	390	466.079		
	Total	213188.896	393			
Schizophrenia and Other Psychotic Disorders	Between Groups	50533.252	3	16844.417	21.829	0.00
	Within Groups	300945.309	390	771.655		
	Total	351478.561	393			
Mood Disorders	Between Groups	47138.744	3	15712.915	26.531	0.00
	Within Groups	230979.297	390	592.255		
	Total	278118.041	393			
Anxiety Disorders	Between Groups	35744.537	3	11914.846	32.209	0.00
	Within Groups					
	Total					
Somatoform Disorders	Between Groups	48264.596	3	16088.199	17.009	0.00
	Within Groups	368891.488	390	945.876		
	Total	417156.084	393			
Factitious Disorder	Between Groups	41703.325	390	13901.108	15.243	0.00
	Within Groups	355661.385	390	911.952		

	Total	397364.711	393			
Sexual/Gender Identity	Between Groups	36063.475	3	12021.158	15.628	0.00
	Within Groups	299993.124	390	769.213		
	Total	336056.599	393			
Eating Disorders	Between Groups	34078.941	3	11359.647	16.371	0.00
	Within Groups	270624.033	390	693.908		
	Total					
Sleep Disorders	Between Groups	30351.23	3	10117.077	12.139	0.00
	Within Groups	320050.242	384	833.464		
	Total	3540401.472	387			
Impulse-Control Disorder	Between Groups	29983.609	3	9994.536	15.623	0.00
	Within Groups	249489.805	3	639.717		
	Total	279473.414	393			
Adjustment Disorder	Between Groups	47717.278	3	15905.759	26.539	0.00
	Within Groups	233742.793	390	599.34		
	Total	281460.071	393			
Personality Disorder	Between Groups	46108.819	3	15369.606	20.725	0.00
	Within Groups	289225.414	390	741.604		
	Total	335334.234	393			

Appendix D: Permission to Use Survey

From: "Carlson,Laurie" <Laurie.Carlson@ColoState.EDU>
Subject: RE: Reg. School-Based Mental Health Services Survey and article
Date: April 4, 2020 at 10:30:02 AM EDT
To: Megan Hines <megan.hines@waldenu.edu>

To whom it may concern,

This email serves to grant Megan Hines permission to use my previously developed instrument, "The School-Based Mental Health Services Survey," for data collection related to her doctoral dissertation.

LAURIE CARLSON
Pronouns: she, her, hers
For more information regarding why pronouns are important see: https://www.mypronouns.org/what-and-why

Associate Professor
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From: "Carlson,Laurie" <Laurie.Carlson@ColoState.EDU>
Subject: RE: Reg. School-Based Mental Health Services Survey and article
Date: April 4, 2020 at 10:30:52 AM EDT
To: Megan Hines <megan.hines@waldenu.edu>

To whom it may concern,

This email serves to grant Megan Hines permission to reprint my previously developed instrument, "The School-Based Mental Health Services Survey," as an appendix in her doctoral dissertation.

LAURIE CARLSON
Pronouns: she, her, hers
For more information regarding why pronouns are important see: https://www.mypronouns.org/what-and-why

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