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ORIGINAL PAPER

Principal Perspectives on Addressing Youth Mental Health Within Schools

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Abstract

This study examined principal perspectives on barriers and strengths or assets associated with the delivery of school mental health services in their school and considered whether the common determinants that principals identify vary by geographic locales (i.e., city, suburban, town, and rural). Participants were 638 principals from across the four locale categories. Principals completed open-ended survey questions that addressed perceived barriers and strengths or assets with the delivery of school mental health. Thematic analysis was conducted of principal responses. There were differences in the most common barriers principals identified across locale. For example, principals in suburban areas identified lack of personnel, principals in cities identified a lack of a shared understanding about mental and behavioral health and associated services, and principals in towns and rural areas identified financial concerns as primary barriers in addressing student mental health needs. Across all four locales, the most common stated strength or asset in schools was having school-based mental and behavioral health personnel and resources. Implications for practice and future research are discussed.

Keywords School mental health · Mental and behavioral health · Principals · Geographic Locale

Introduction

Within the United States, approximately 13–20% of youth experience mental health (MH) symptoms that would qualify for a clinical diagnosis in any given year (Perou et al., 2013). Unfortunately, the MH needs of youth often go unmet (e.g., Jensen et al., 2011; Substance Abuse & Mental Health Services Administration, 2019). Partly in response to these unmet needs, schools have been identified as a target context for the provision of MH prevention and intervention services (Atkins et al., 2010). Indeed, data consistently suggest that schools are a common service delivery site for youth to access MH services (e.g., Carta et al., 2015; Green et al., 2013). Implementation of MH services in schools can increase access and reduce barriers for receiving services in community mental health settings (Weist et al., 2013).

The public health framework of multitiered systems of support (MTSS) is commonly utilized for school mental health (SMH). Within a MTSS framework, SMH prevention and intervention services are organized and implemented across three tiers of universal, targeted, and intensive supports (Weist et al., 2013). Foundational to effective SMH services are (a) data-based decision making, (b) implementation of evidence-based practices and associated implementation support (e.g., social and emotional learning at Tier 1), (c) consultation with key stakeholders (e.g., consultation to support individualized emotional and behavioral needs), and (d) collaboration across tiers to support a continuum of mental health services in school (Eklund et al., 2020). School mental health professionals, such as school psychologists, social workers, and counselors work with school teams to create safe and supportive environments. They also work with groups of students and with individual students and families to support targeted or intensive mental health needs.

Despite the need for SMH services, the delivery of SMH services has been plagued by problems with implementation and sustainment (Evans et al., 2013; Owens et al., 2014). The problems implementing and sustaining SMH services exists across school locales. However, there are important differences across locales that may influence SMH implementation and sustainability. For

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example, schools in suburban and city locales often have district-wide SMH teams along with school-level teams. In contrast, in rural locales there is a lack of capacity at the district and school level for SMH systems and practices (Monk, 2007; Showalter et al., 2017). This lack of capacity may take the form of an insufficient number of personnel (Goforth et al., 2017) or limited SMH options within a school or community (Nichols et al., 2017).

To address concerns around the implementation and sustainment of SMH practices, researchers have emphasized the importance of studying SMH determinants (i.e., barriers and facilitators; Forman et al., 2009; Owens et al., 2014). To gain an in-depth understanding of determinants of successful SMH implementation, it is important to gain insights from key SMH stakeholders. Extant research has documented the perspectives of teachers (Reinke et al., 2011), interventionists (Langley et al., 2010), and intervention developers (Forman et al., 2009). One key influential factor for the implementation of SMH practices is principal support and leadership (Forman et al., 2009; Langley et al., 2010). For example, Forman et al., (2009) reported that SMH intervention developers identified that (a) leadership style and behaviors of principals are facilitators, (b) principals can act as champions for SMH practices, and (c) principal support can address implementation barriers.

Despite recognizing the importance of school principals for SMH implementation, relatively few studies have examined principals' perspectives on SMH determinants. Iachini et al., (2016) conducted interviews of 18 principals within one rural school district in South Carolina engaged in a university-school district partnership to understand their perspectives on SMH and school improvement. Principals indicated MH supports were needed among their students and staff, including a need for additional MH training for school staff. However, Iachini et al.'s study did not gather principal perspectives on barriers and facilitators to the implementation of SMH, leaving open questions about how to address MH needs principals identified.

In a dissertation study, Petersen, (2019) interviewed five urban elementary administrators in Nebraska regarding their beliefs on expanded SMH systems and necessary SMH training for school personnel. Principals indicated that having organized, systematic, and tiered structures help to facilitate the implementation of SMH systems. Principals identified components of their existing SMH systems that they deemed effective, which included (a) Positive Behavioral Interventions and Supports (PBIS), (b) training and professional development for teachers, (c) implementation of interventions with students, (d) screening, (e) problem-solving teams, (f) building relationships with students, (g) school counseling programs, and (h) increased responsiveness to mental health issues. Principals noted that more professional development for teachers on MH and SMH systems would help foster the development, implementation, and sustainability of SMH services.

Blackman et al., (2016) interviewed six principals, three assistant principals, and one exceptional children's program coordinator from six urban schools in North Carolina to gain their perspectives regarding the implementation process of a specific SMH program as part of a university-school district collaboration. Main themes for the successes of their schools in implementing the program included (a) functioning leadership teams; (b) strong relationships built between SMH service providers and teachers, students, and parents; and (c) teacher education and support in mental health. As for implementation challenges, principals noted that logistics (e.g., time, space) could be a barrier and that they could foresee challenges with sustaining implementation if there were not sufficient policies, processes, and administrative support in place for SMH services. The Blackman et al. study suggested important facilitators and barriers to implementation SMH services but did not identify specific systems or practices that could address MH needs.

These investigations relied primarily on interviews of small samples, which allows for an in-depth understanding of their perspectives, but limits the diversity in principal perspectives represented (Blackman et al., 2016; Iachini et al., 2016; Peterson, 2019). Alternatively, Frabutt and Speech, (2012) surveyed 346 principals across the United States to understand their views on SMH. The top three themes about their school's greatest needs were personnel, finances, and specific issues. As for principals' views on the MH professional development needs of their staff, the top themes were a need for specific trainings, a general expression of a need for training, and training focused on building awareness of mental health and efficient student identification. Finally, the top three themes of successful strategies in their schools to support student MH were having specific programs, curriculum and interventions; personnel; and communication between home and school. A primary limitation of the Frabutt and Speach study is that it only yielded perspectives fromprivate Catholic elementary schools.

Another potentially impactful factor unexplored is the extent to which contextual factors, such as school locale, might impact the determinants principals perceive in their schools. Previous research suggests that implementation of high-quality and effective SMH programs may be particularly difficult in rural communities (Mara et al., 2017). SMH services are considered especially important in rural communities due to unique barriers to accessing community mental health supports (e.g., due to geographic isolation; Blackstock et al., 2018). Moon et al., (2017) found that educators in rural regions were significantly more likely to report having no mental health professionals employed in their schools as compared to educators in urban and suburban regions. Furthermore, three of the studies reviewed herein only gathered

principal perspectives specific to one locale, including rural (Iachini et al., 2016) or urban (Blackman et al., 2016; Peterson, 2019). Frabutt and Speech, (2012) included principals across locales but did not focus on the locale during analysis. Having increased knowledge of possible patterns of determinants that principals perceive across school locales could benefit research around tailoring implementation strategies to the needs of schools in specific locales.

There are limitations of the previous literature on principal views on SMH that need to be addressed. First, most prior research included small sample sizes ($N = 5$–18) of principals within the same school district (Blackman et al., 2016; Iachini et al., 2016; Peterson, 2019). The only study with a larger sample size ($N = 346$) of principals across school districts focused on private Catholic elementary schools, which could have different determinants to SMH implementation than public schools (Frabutt & Speach, 2012).

A second limitation is that two of the previous studies investigated the perspectives of principals who worked in schools where there were pre-existing university-school district partnerships (Blackman et al., 2016; Iachini et al., 2016). Principals in schools who have connections with universities may have different perspectives than principals in schools without university connections on the most salient barriers and facilitators to SMH implementation due to the potential resources and supports from the university-school district partnerships. Finally, the potential influence of school locale on the perspectives of principals on facilitators and barriers to implementing SMH is unexplored. Altogether, there is a need to understand the perspectives of a large sample of school principals across different school districts in different geographic locales to gain a better understanding of the potential patterns of barriers and facilitators for SMH implementation.

The purpose of this study was to gain an understanding of principal perceptions of potential barriers and facilitators associated with the delivery of SMH services and to consider whether the common determinants that principals identify vary by geographic locales (i.e., urban, suburban, town, and rural). Through analysis of narrative feedback from surveys of principals, we addressed the following research questions: (a) What do principals across school locales perceive as barriers in their schools to address student mental health? (b) What do principals across school locales perceive as strengths or assets in their schools to address student mental health?

Method

Participants and Setting

Participants were 638 principals from a statewide random sample of schools in a Midwestern state in the United States. We took a simple random sample of 1,173 principals from a publicly available sample frame. In total, 1,173 principals were invited to participate. Six-hundred eighty-two principals completed the survey, with 638 principals completing open-ended questions about barriers or strengths or assets in addressing student mental health. The final response rate was 54.39%. One moderately sized school district (total student enrollment ≈ 20,000) and specialized schools, including virtual, alternative, special education, and vocational schools were not included in the statewide random sample. Table 1 includes demographic characteristics of principals. The average principal age was 48.31 years ($SD = 7.46$). Approximately 45% of principals reported as female and about 94% of principals reported as White. The majority of principals (87%) reported completing a Master's degree as their highest degree earned. Principals worked in schools across four locale categories: city ($n = 107$), suburb ($n = 132$), town ($n = 137$), and rural ($n = 262$). By comparison, in this state there are 557 schools in cities, 413 schools in suburban areas, 411 schools in towns, and 915 schools in rural areas. Locales were defined using the National Center for Education Statistics (NCES) Urban-Centric locale codes (Geverdt, 2019). *Cities* are defined as territories located inside an Urbanized Area (i.e., densely developed territories with at least 50,000 or more people) and inside a Principal City (i.e., largest incorporated place within a Core Based Statistical Area). *Suburbs* are territories outside of a Principal City and inside an Urbanized Area. *Towns* are territories inside an Urban Cluster (i.e., urban areas with at least 2,500 and less than 50,000 people). Rural locales are census-defined rural territories not included in an Urban Area or Urban Cluster (Geverdt, 2019). Principals reported

Table 1 Demographic characteristics of principals

	% Total ($N = 638$)
Mean (*SD*) age	48.31 (7.46)
Gender	
Female	44.57
Male	55.29
Race/ethnicity	
Black or African American	2.09
Hispanic or Latino	1.39
American Indian or Alaska Native	0.42
Two or more Races	0.42
White	93.45
Highest degree earned	
Bachelor's degree	2.65
Master's degree	87.47
Specialist's degree	2.23
Doctoral degree	4.46

working in elementary schools (55%), junior high or middle schools (19%), and high schools (23%). The average school included 421.62 students ($SD = 309.77$).

Statewide support for SMH includes many components. State departments have developed and made readily available trainings on SMH principles, systems, and practices (e.g., social-emotional learning, trauma sensitive practices). In addition to trainings, there is statewide and regional technical assistance available for schools to support implementation and sustainment. There are also funds available that school districts can apply for around targeted areas (e.g., school-based health services). Funds for school-based health services grants are made available through the statewide budget authorized approximately 4 years ago.

Measure

Principals completed a survey that included two questions designed to examine their perceptions of the barriers and strengths in their school for addressing student mental health needs: (a) "Thinking about addressing student mental health needs, what are your school's two biggest barriers?" and (b) "Still thinking about addressing student mental health needs, what are your school's two biggest strengths or assets?" These questions were designed from an implementation science perspective that suggests gleaning school administrator perceptions of determinants can provide useful information in promoting adoption and sustained implementation of schoolwide services (McIntosh et al., 2013). The survey also included questions that examined individual and school characteristics. The sample size for the two questions varied as some participants did not respond to both questions. Specifically, there were 635 (99.53%) total responses to the question about barriers and 630 (98.75%) total responses for the question about strengths. The sample size of responses also varied across locale. For the question about barriers, there were 106 (17%), 132 (21%), 136 (21%), and 261 (41%) total responses for the city, suburb, town, and rural locales, respectively. For the strengths question, there were 107 (17%), 132 (21%), 133 (21%), and 258 (41%) total responses for the city, suburb, town, and rural locales, respectively.

Procedure

Surveys were distributed and processed in Spring 2019 through a Midwestern state university's survey center. The survey center sent principals a pre-notification letter with a $5 pre-incentive, followed by an email invitation, two follow-up email reminders, and then a paper survey mailing. Principals completed the survey online or by mail. They received $20 by mail after completing the survey.

Coding and Analysis

Positionality

Positionality refers to an individual's world outlook and their relationship to a research study (Holmes, 2020). As such, positionality is embedded with epistemological, ontological, methodological biases, and assumptions. Therefore, it is important to understand positionality and its influence on research. For this study, the coding and analysis team included five graduate students in a doctoral school psychology program and one student in an undergraduate program at a university in a Midwestern state in the United States. Five members of the team identified as White women and one identified as a Black woman. One completed her K-12 education in a city, two in suburbs, two in towns, and one in a rural locale as defined by NCES (Geverdt, 2019). All members on the coding and analysis team were affiliated with a project focused on rural education research and the five graduate students were trainees on a federally funded doctoral training grant. In addition, all the team members had a vested interest in and understanding of school mental health. The two faculty supervisors conduct research on school mental health and rural education. The team met on average once every 2 weeks to discuss coding and analysis, outline explicit and clear coding descriptions, assess interrater reliability, and detail the reasoning behind coding decisions. Coders reflected on their positionality relative to their coding. During meetings, coders were encouraged to describe their positionality and ways in which their positionality might be influencing their coding. Feedback and discussion about positionality that followed supported coders in making coding decisions that centered on participant comments.

Design

We designed a qualitative descriptive study (Kim et al., 2017) that used an exploratory approach to identify themes from principal responses about barriers and strengths to address student mental health needs. Extant research has promoted qualitative analysis to better understand aspects of school mental health, such as services and supports for students with emotional and behavior concerns and family-school partnerships (Garbacz et al., 2018; Leech & Onwuegbuzie, 2007; Nastasi & Schensul, 2005).

Analysis

Two university faculty members trained students in coding and analysis procedures. Training activities included didactic sessions and mock coding sessions with performance feedback. After training, faculty provided ongoing supervision.

The analysis involved three main stages: unitization, minor categorization, and major categorization. Unitization drew meaning from responses by identifying individual ideas (i.e., units) in each response and categorization grouped units with similar themes into minor and then major categories (Patton, 2002). For unitization and minor categorization, the team was split into two groups of three, with one group focused on barriers and the other focused on the question concerning strengths or assets. For major categorization, five graduate students and one of the faculty supervisors met to group minor categories with similar themes into larger categories. Credibility checks of the coded data assessed inter-coder reliability.

Unitization

Unitization was completed in two stages (Patton, 2002). First, two team members from each group (i.e., strengths or barriers groups) analyzed responses and constructed a unitization manual. Units were separated so that each unit captured one specific strength or barrier. Units did not include rationales for strengths or barriers. In the unitization manuals, a fraction of the units extracted from principal responses were included for reference during double coding. Specifically, 18 (2.8%) of the units extracted from principal responses for the barriers question and 15 (2.4%) of the units from principal responses for the strengths question were used during double coding. After the entire response set for a locale was unitized, a team member, who was unaware of the initial unitization, conducted unitization independently for all units. After double coding, each team resolved disagreements through group consensus. Point-by-point exact agreement for unitizing strengths for each locale ranged from 93.2% to 96.8% ($M = 95.6\%$). Point-by-point exact agreement for unitizing barriers for each locale ranged from 90.5% to 97.8% ($M = 93.3\%$).

Categorization

After unitization, two team members from each group sorted individual units into categories by examining units for similar themes. The a priori minimum number of units for minor categories was 3% of the total units (Patton, 2002). Given differences in the number of units across locales, the minimum number for minor categories varied. For both questions, the minimum number of units for each minor category was 4, 4, 5, and 8 for the city, suburb, town, and rural locales, respectively. The team grouped minor categories into major categories with all decisions made through group consensus. Categories were named based on the main idea captured in the units.

Credibility was maintained throughout categorization. Two members from each team created a minor categorization manual with operational definitions of categories and examples and non–examples. After initial categorization, the third team member, who was unaware of the initial process, used the manual to categorize a random 25% of the units for interrater agreement checks (McIntosh et al., 2013). Interrater agreement for categorizing strengths for each locale ranged from 83.4% to 89.4% ($M = 84.9\%$). Interrater agreement for categorizing barriers for each locale ranged from 85.8% to 92.7% ($M = 90.6\%$). Following the categorization double–coding, each team met to resolve disagreements through group consensus.

Results

This analysis resulted in major and minor categories for principal perspectives across four school locales (i.e., city, suburb, town, and rural) for each question. The findings are organized below by question and locale. Each major category is reported with the percent of units from each respondent group per question. Due to space limitations, the top two major categories and all corresponding minor categories are described in detail. All major and minor categories are listed in the corresponding tables.

Question 1 What do principals across school locales perceive as barriers in their schools to address student mental health?

City Perspectives

Based on the total number of units ($N = 216$) city principals shared in their responses, the main barriers within the school to addressing student mental health were identified as the following major categories: (a) lack of a shared understanding about MH and MH services ($n = 52$; 24%) and (b) financial concerns ($n = 40$; 19%). Major and minor categories along with quotations from city principals are included in Table 2.

Lack of a Shared Understanding about MH and MH Services

The largest major category of barriers was a lack of a shared understanding about MH and MH services and included the following minor categories: challenges with MH service acceptance and follow-through ($n = 24$ [46%]), lack of mental health literacy and training ($n = 12$; 23%), lack of alignment between school and community MH services ($n = 6$; 12%), problems with family engagement ($n = 6$; 12%), and stigma ($n = 4$; 8%). The minor category of challenges with MH service acceptance and follow-through referred to principals noting a lack of "parent follow through" and "parents not giving consent for treatment." Lack of mental health literacy and training referred to principals describing

Table 2 City perspectives on barriers

Major categories	Minor categories	Unit quotations
Lack of a shared understanding about MH and MH services (52)	Challenges with MH service acceptance and follow-through (24)	"Parent willingness to seek services"
	Lack of mental health literacy and training (12)	"Professional development for staff"
	Lack of alignment between school and community MH services (6)	"Lack of community partnerships"
	Problems with family engagement (6)	"Lack of parental engagement or follow through"
	Stigma (4)	"Stigma associated to seeking treatment"
Financial concerns (40)	Lack of funding for school-based MH supports (25)	"Funding"
	Challenges with insurance (9)	"Insurance coverage"
	High cost of MH services for families and parents (6)	"Expenses of the services"
Lack of personnel (37)	Lack of school staff (15)	"Not enough staff"
	Lack of qualified MH providers (12)	"Proper licensed professional work with students"
	Lack of MH providers in the school (10)	"Need another mental health therapist at our school"
Lack of services, programming, and resources for MH (32)	Lack of MH services, programming, and resources in the school (18)	"Access to mental health services within the school"
	Lack of MH services, programming, providers, and resources in the community (10)	"Availability of community resources"
	Lack of resources (4)	"Resources"
Time constraints (21)	Lack of availability and scheduling of MH providers and services (17)	"Access to timely care from licensed professionals"
	Challenges with time (4)	"Time"
Lack of access to MH services and providers (15)	Challenges with access to MH services and providers (15)	"Access to health care"
Issues related to MH screening and diagnostic assessments (7)	Issues related to MH screening and diagnostic assessments (7)	"Formal process to identify/help students"
High magnitude of student MH need (6)	High magnitude of student MH need (6)	"The needs are great"
Family adversity (6)	Family adversity (6)	"Poverty"

$N = 216$

that "teachers need more training on how to cope with their trauma" and a lack of "staff knowledge of identifying/supporting mental health needs." The remaining minor categories were lack of alignment between school and community MH services, problems with family engagement, and stigma. These responses included when city principals referenced "no formal community network," "parental support," and "stigma," respectively.

Financial Concerns

The second largest barrier major category was financial concerns and included the following minor categories: lack of funding for school-based MH supports ($n = 25$; 63%), challenges with insurance ($n = 9$; 23%), and high cost of MH services for families and parents ($n = 6$; 15%). The minor category of lack of funding for school-based MH supports included principals noting "inadequate funding of special service staff" and "funding for certified professionals." Challenges with insurance referred to responses such as "parents without insurance or funding for treatment." The minor category of high cost of MH services for families and parents included references of "cost" and a lack of "funding for families."

Suburb Perspectives

Based on the total number of units ($N = 266$) suburb principals identified in their responses, the main barriers were identified as the following major categories: (a) lack of personnel ($n = 66$; 25%) and (b) financial concerns ($n = 63$; 24%). Major and minor categories along with quotations from suburb principals are included in Table 3.

Lack of Personnel

The largest major category of barriers was lack of personnel and included the following minor categories: lack of MH providers in the school ($n=25$; 38%), lack of qualified MH providers ($n=14$; 21%), lack of school staff ($n=14$; 21%), and lack of MH providers in the community ($n=13$; 20%). The minor category of lack of MH providers in the school referred to principals noting specific barriers such as "not enough psychologists" and "lack of onsite support." Lack of qualified MH providers was another barrier in principal responses that referenced qualified and trained personnel such as "lack of trained personnel to provide district support." As for lack of MH providers in the community, suburb principals referenced "few mental health providers in our community."

Financial Concerns

The second largest major category of barriers was financial concerns ($n=63$; 24%) and included the following minor categories: lack of funding for school-based MH supports ($n=43$; 68%), high cost of MH services for families and parents ($n=12$; 19%), and challenges with insurance ($n=8$; 13%). The minor category of lack of funding for school-based MH supports included units such as "funding priorities within the budget" and "money." High cost of MH services included when principals stated "cost" and "equity for affording outside services and evaluations." Principal responses such as "high deductibles in insurance" represented the minor category of challenges with insurance.

Town Perspectives

Based on the total number of units ($N=268$) town principals identified in their responses, the main barriers were identified as the following major categories: (a) financial concerns ($n=72$; 27%) and (b) lack of a shared understanding about MH and MH services ($n=64$; 24%). Major and minor categories along with quotations from town principals are included in Table 4.

Table 3 Suburb perspectives on barriers

Major categories	Minor categories	Unit quotations
Lack of personnel (66)	Lack of MH providers in the school (25)	"Lack of school guidance counselor"
	Lack of qualified MH providers (14)	"Licensed clinicians"
	Lack of school staff (14)	"Staffing"
	Lack of MH providers in the community (13)	"Access to community based professional counselors"
Financial concerns (63)	Lack of funding for school-based MH supports (43)	"Lack of funding"
	High cost of MH services for families and parents (12)	"High cost"
	Challenges with insurance (8)	"Insurance"
Lack of a shared understanding about MH and MH services (46)	Challenges with MH service acceptance and follow-through (19)	"Parent follow-through"
	Lack of mental health literacy and training (14)	"Lack of training for staff"
	Stigma (7)	"Stigma"
	Problems with family engagement (6)	"Parental support"
Lack of services, programming, and resources for MH (29)	Lack of MH services, programming, and resources in the school (15)	"No in district options or resources"
	Lack of resources (14)	"Resources"
Time constraints (28)	Lack of availability and scheduling of MH providers and services (19)	"Long wait time"
	Challenges with time (9)	"Time"
Challenges with accessibility (17)	Challenges with access to MH services and providers (13)	"Access to care"
	Transportation (4)	"Transportation"
Issues related to MH screening and diagnostic assessments (11)	Issues related to MH screening and diagnostic assessments (11)	"No universal screener"
High magnitude of student MH need (6)	High magnitude of student MH need (6)	"Needs extend beyond the scope of school staff"

$N=266$

Financial Concerns

The largest major category of barriers was financial concerns and included the following minor categories: lack of funding for school-based MH supports ($n=44$; 61%), challenges with insurance ($n=14$; 19%), and the high cost of MH services for families and parents ($n=14$; 19%). The minor category of lack of funding for school-based MH supports included when principals referenced "lack of additional funds" and "funding for on-site personnel." Challenges with insurance included units like "lack of monetary resources for families without insurance." The minor category of high cost of MH services for families and parents included units of "not having funds for families" or "parents with limited resources."

Lack of a Shared Understanding about MH and MH Services

The second largest major category of barriers was lack of a shared understanding about MH and MH services ($n=64$; 24%) and included the following minor categories: challenges with MH service acceptance and follow-through ($n=32$; 50%), problems with family engagement ($n=14$ [22%]), lack of mental health literacy and training ($n=13$; 20%), and lack of alignment between school and community MH services ($n=5$; 8%). The minor category of challenges with MH service acceptance and follow-through referred to principal responses such as "getting the parents to realize how severe their child's needs are" and "stigma." Family engagement appeared as another barrier with units such as "lack of parent support" and "parent participation." The remaining minor categories were lack of mental health literacy and training and a lack of alignment between school and community MH services. These remaining minor categories included principal responses such as "building staff capacity to not shame, blame, or judge students and families" and "no support from county social services," respectively.

Rural Perspectives

Based on the total number of units ($N=538$) rural principals stated in their responses, the main barriers were identified as the following major categories: (a) financial concerns

Table 4 Town perspectives on barriers

Major categories	Minor categories	Unit quotations
Financial concerns (72)	Lack of funding for school-based MH supports (44)	"Funding"
	Challenges with insurance (14)	"Treatment options for uninsured"
	High cost of MH services for families and parents (14)	"Lack of funding for families"
Lack of a shared understanding about MH and MH services (64)	Challenges with MH service acceptance and follow-through (32)	"Getting the families to be open to seeking support"
	Problems with family engagement (14)	"Parent support/follow through"
	Lack of mental health literacy and training (13)	"Professional development for the teachers"
	Lack of alignment between school and community MH services (5)	"Wrap around services"
Lack of personnel (59)	Lack of school staff (21)	"Inadequate staffing ratios"
	Lack of MH providers in the community (17)	"Not enough providers"
	Lack of qualified MH providers (16)	"Lack of licensed mental health staff"
	Lack of MH providers in the school (5)	"No school social workers"
Lack of services, programming, and resources for MH (28)	Lack of MH services, programming, and resources in the community (13)	"Limited resources in our community"
	Lack of resources (9)	"Resources"
	Lack of MH services, programming, and resources in the school (6)	"Lack of access to on site mental health services"
Time constraints (24)	Lack of availability and scheduling of MH providers and services (17)	"Students wait for 3–6 months to get an appointment"
	Challenges with time (7)	"Time"
Challenges with access to MH services and providers (15)	Challenges with access to MH services and providers (15)	"Access to providers"
Issues related to MH screening and diagnostic assessments (6)	Issues related to MH screening and diagnostic assessments (6)	"Identifying students that are new to our school or district"

$N=268$

($n=132$; 25%) and (b) lack of a shared understanding about MH and MH services ($n=115$; 21%). Major and minor categories along with quotations from rural principals are included in Table 5

Financial Concerns

The largest major category of barriers was financial concerns and included the following minor categories: lack of funding for school-based MH supports ($n=87$; 66%), high cost of MH services for families and parents ($n=25$; 19%), and challenges with insurance ($n=20$; 15%). The minor category of lack of funding for school-based MH supports referred to principals noting funding barriers for "personnel," "training," and to "screen students." High cost of MH services for families and parents referred to principal responses such as "financial barriers that our families face" and "lack of funding for families." The minor category of challenges with insurance included when rural principals referenced "outside services not covered by family's insurance" and "insurance companies."

Lack of a Shared Understanding about MH and MH Services

The second largest major category of barriers was lack of a shared understanding about MH and MH services and included the following minor categories: challenges with MH service acceptance and follow-through ($n=45$; 39%), lack of mental health literacy and training ($n=23$; 20%), problems with family engagement ($n=20$; 17%), stigma ($n=15$; 13%), and problems with home-school community alignment ($n=12$; 10%). The minor category of challenges with MH service acceptance and follow-through referred to principals noting "student refusal to receive services" and "parents not wanting their child to receive services." Lack of mental health literacy and training referred to units such

Table 5 Rural perspectives on barriers

Major categories	Minor categories	Unit quotations
Financial concerns (132)	Lack of funding for school-based MH supports (87)	"Funding concerns"
	High cost of MH services for families and parents (25)	"Cost to families"
	Challenges with insurance (20)	"Lack of health insurance"
Lack of a shared understanding about MH and MH services (115)	Challenges with MH service acceptance and follow-through (45)	"Getting families to commit to the help"
	Lack of mental health literacy and training (23)	"staff training"
	Problems with family engagement (20)	"Parent involvement"
	Stigma (15)	"Social stigma"
	Problems with home-school-community alignment (12)	"Struggle to get parents connected"
Lack of personnel (114)	Lack of school staff (37)	"Limited staffing"
	Lack of MH providers in the community (27)	"No local professionals"
	Lack of qualified MBH providers (25)	"Access to quality, trained, licensed people"
	Lack of MH providers in the school (25)	"Access to mental health professionals AT school"
Challenges with accessibility (60)	Challenges with access to MH services and providers (32)	"Access to mental health providers"
	Challenges related to rural isolation from MH services (28)	"Lack of access to mental healthcare in rural areas"
Lack of services, programming, and resources for MH (50)	Lack of MH services, programming, and resources in the school (21)	"No mental health services available in my school"
	Lack of resources (19)	"Resources"
	Lack of MH services, programming, and resources in the community (10)	"Limited county resources"
Time constraints (48)	Lack of availability and scheduling of MH providers and services (28)	"Waiting lists are sometimes 6 months long"
	Challenges with time for MH services (20)	"Time"
Issues related to MH screening and diagnostic assessments (19)	Issues related to MH screening and diagnostic assessments (19)	"lack of screener"

$N=538$

as "education of parents on what the service may look like and why it is needed" and "providing training to staff that is beyond the awareness level." Problems with family engagement included responses such as "parent support in a proactive manner" and "parental support for collaboration." The remaining minor categories were stigma and problems with home-school community alignment including responses such as "parents not ready to deal with a mental health diagnosis" and "cannot get a service provider to work with us."

Question 2 What do principals across school locales perceive as strengths or assets in their schools to address student mental health?

City Perspectives

Based on the total number of units ($N = 179$) city principals identified in their responses, the top two strengths within the school to addressing student mental health were identified as the following major categories: (a) school-based MH personnel and resources ($n = 86$; 48%) and (b) supportive school climate for MH ($n = 68$; 38%). Major and minor categories along with quotations from city principals are included in Table 6.

School-Based MH Personnel and Resources

The largest major category of strengths was school-based MH personnel and resources and included the following minor categories: MH programming in the school ($n = 38$; 44%), school-based mental health provider ($n = 20$; 23%), MH professional development and trainings for staff ($n = 16$; 19%), and the presence of one or more school counselors ($n = 12$; 14%). The minor category of MH programming in the school related to respondents noting "family services onsite" and a "mental health clinic in our school." School-based mental health provider was another strength as one principal described having a "clinical psychologist" and another mentioned a "full-time school social worker." The remaining minor categories were MH professional development and trainings for staff and having school counselor(s). MH professional development and trainings for staff included when principals referenced "mental health training for all staff" and "professional development for staff." As for having school counselor(s), principals stated "counselor."

Supportive School Climate for MH

The second largest major category of strengths was supportive school climate for MH ($n = 68$; 38%) and included the following minor categories: school staff as mental health advocates ($n = 32$; 47%), school environment characteristics ($n = 27$; 40%), and caring staff attitudes ($n = 9$; 13%). The minor category of school staff as mental health advocates was identified from responses such as, "dedicated and skilled student services staff," a "professional learning community that embraces weekly student-centered conversations about students with mental health needs," and "teachers who are very well versed in culturally responsive practices." School environment characteristics referred to principals describing "relationships with our students" and "staff willing to work together." The remaining minor category associated with this major category was caring staff attitudes and included when city principals referenced "caring and supportive staff."

Table 6 City perspectives on strengths

Major categories	minor categories	Unit quotations
School-based MH personnel and resources (86)	MH programming in the school (38)	"Being able to offer mental health services at school"
	School-based mental health provider (20)	"Full time school psychologist"
	MH professional development and trainings for staff (16)	"Entire staff have been trained in restorative justice practice and mindfulness"
	Having school counselor(s) (12)	"Full time guidance counselor"
Supportive school climate for MH (68)	School staff as mental health advocates (32)	"Staff are very cognizant of mental health needs"
	School environment characteristics (27)	"Trusting environment"
	Caring staff attitudes (9)	"Caring staff"
Focus on building family relationships and support (10)	Focus on building family relationships and support (10)	"Great relationships with families"
School and community funding and support for engagement in MH services (8)	School and community funding and support for engagement in MH services (8)	"Outside resources available to school personnel"
Working with community services (7)	Working with community services (7)	"Community partnerships"

$N = 179$

Suburb Perspectives

Based on the total number of units ($N = 223$) suburb principals identified in their responses, the main strengths within the school to addressing student mental health were identified as the following major categories: (a) school-based MH personnel and resources ($n = 117$; 52%) and (b) supportive school climate for MH ($n = 74$; 33%). Major and minor categories along with quotations from suburb principals are included in Table 7.

School-Based MH Personnel and Resources

The largest major category of strengths was school-based MH personnel and resources, including the following minor categories: MH programming in the school ($n = 46$; 39%), school-based mental health provider ($n = 37$; 32%), the presence of one or more school counselors ($n = 17$; 15%), and MH professional development and trainings for staff ($n = 17$; 15%). The minor category of MH programming in the school referred to principals noting programming such as "SEL in the classroom and at the universal level." School-based mental health provider was another strength as principals described having "school psychologists and social workers" and an "on site therapist." The remaining minor categories were having school counselor(s) and MH professional development and trainings for staff. The minor category of having school counselors included references to a "school counseling program" and having a "school counselor." As for MH professional development and trainings for staff, principals stated "staff well trained in collaborative and proactive solutions model" along with "teacher training on trauma informed care."

Supportive School Climate for MH

The second largest major category of strengths was supportive school climate for MH ($n = 74$; 33%) and included the following minor categories: school staff as mental health advocates ($n = 30$; 41%), school environment characteristics ($n = 25$; 34%), and caring staff attitudes ($n = 19$; 26%). The minor category of school staff as mental health advocates referred to principals noting "staff understanding and buy-in" and "staff acknowledgement that addressing mental health needs is important." School environment characteristics referred to principals describing "staff consistency" and "team approach/problem solving." The remaining minor category was caring staff attitudes and included when suburban principals stated, "staff want to help and care about students greatly."

Town Perspectives

Based on the total number of units ($N = 229$) town principals identified in their responses, the main strengths within their schools to addressing student mental health were identified as the following major categories: (a) school-based MH personnel and resources ($n = 96$; 42%) and (b) supportive school

Table 7 Suburb perspectives on strengths

Major categories	Minor categories	Unit quotations
School-based MH personnel and resources (117)	MH programming in the school (46)	"Onsite counseling services for students"
	School-based mental health provider (37)	"Certified mental health therapists in each of our buildings within the district"
	Having school counselor(s) (17)	"Counseling staff"
	MH professional development and trainings for staff (17)	"Professional development for trauma informed care and compassionate classrooms"
Supportive school climate for MH (74)	School staff as mental health advocates (30)	"Staff awareness that mental health is a concern and, on the rise,"
	School environment characteristics (25)	"Supportive school culture"
	Caring staff attitudes (19)	"Staff that care"
Focus on building family relationships and support (13)	Focus on building family relationships and support (7)	"Using available resources and providing parents with info about outside services"
	Home-school communication practices (6)	"Open communication between home and school"
Working with community services (12)	Working with community services (6)	"Reaching out to community resources"
	Characteristics within the community (6)	"Small school that allows for deep relationships to be built"
School and community funding and support for engagement in MH services (7)	School and community funding and support for engagement in MH services (7)	"Fiscal support"

$N = 223$

climate for MH ($n=89$; 39%). Major and minor categories along with quotations from principals in towns are included in Table 8.

School-Based MH Personnel and Resources

The largest major category of strengths was school-based MH personnel and resources and included the following minor categories: school-based mental health provider ($n=34$; 35%), MH programming in the school ($n=25$; 26%), MH professional development and trainings for staff ($n=21$; 22%), and the presence of one or more school counselors ($n=16$; 17%). The minor category of school-based mental health provider included units such as "a district mental health coordinator" and "access to some private providers who are willing to come into schools to provide services." Principals suggested MH programming in the school was a strength by noting they "have created tier II interventions for students in need of SEL skills" and have "strong procedures for completing risk assessments." The remaining minor categories were MH professional development and trainings for staff and having school counselor(s). MH professional development and trainings for staff referred to "ongoing training in SEL and trauma informed practices" and "all staff trained in mental health first aid." As for the presence of one or more school counselors, town principals noted "school counseling services" and others referenced a "school counselor."

Supportive School Climate MH

The second largest major category of strengths was supportive school climate for MH ($n=89$; 39%) and included the following minor categories: school staff as mental health advocates ($n=36$; 40%), school environment characteristics ($n=29$; 33%), and caring staff attitudes ($n=24$; 27%). The minor category of school staff as mental health advocates referred to principals noting "commitment by district to mental health" and "staff is willing to do anything it takes with their day to allow children to receive the help they need". School environment characteristics referred to principals mentioning "hard work ethic" and "compassion/concern for students." The remaining minor category was caring staff attitudes which included when principals referenced "caring staff" and "caring and empathetic staff who go out of their way to help families and guide them to the needed support."

Rural Perspectives

Based on the total number of units ($N=441$) rural principals identified in their responses, the main strengths within the school to addressing student mental health were identified as the following major categories: (a) school-based MH personnel and resources ($n=320$; 73%) and (b) working with community services ($n=73$; 17%). Major and minor categories along with quotations from rural principals are included in Table 9.

School-Based MH Personnel and Resources

The largest major category of strengths was school-based MH personnel and resources and included the following minor categories: school staff as mental health advocates ($n=129$; 40%), MH programming in the school ($n=90$; 28%), school-based mental health provider ($n=68$; 21%),

Table 8 Town perspectives on strengths

Major categories	Minor categories	Unit quotations
School-based MH personnel and resources (96)	School-based mental health provider (34)	"In house counseling offerings"
	MH programming in the school (25)	"Restorative practices"
	MH professional development and trainings for staff (21)	"Staff trained in trauma informed care"
	Having school counselor(s) (16)	"School counseling staff"
Supportive school climate for MH (89)	School staff as mental health advocates (36)	"Acknowledge and support students who have mental health needs"
	School environment characteristics (29)	"Students looking out for each other"
	Caring staff attitudes (24)	"Very empathetic and caring staff"
Working with community services (19)	Working with community services (13)	"Willingness to partner with outside counselors, doctors, etc."
	Characteristics within the community (6)	"Small community"
Focus on building family relationships and support (14)	Focus on building family relationships and support (14)	"People are willing to have difficult with families and offer places to get support"
School and community funding and support for engagement in MH services (11)	School and community funding and support for engagement in MH services (11)	"Community support"

$N=229$

and having school counselor(s) ($n = 33$; 10%). The minor category of school staff as mental health advocates referred to principals stating "Staff + administration applying for grants + searching for resources." MH programming in the school was another strength as principals described "screening tools with our county to assess students and determine needs" and using "zones of regulation." The remaining minor categories were school-based mental health provider and the presence of one or more school counselors. School-based mental health provider included when principals referenced "school psychologists" and "outside therapist comes to our school." As for having school counselor(s), principals referenced a "great school counseling department."

Working with Community Services

The second largest major category of strengths was working with community services ($n = 73$; 17%) and included the following minor categories: characteristics within the community ($n = 40$; 55%) and working with community services ($n = 33$; 45%). The minor category of characteristics within the community referred to principals noting "a tight knit school community" and "we know our kids and their families very well." As for working with community services, principals referenced "referring out" and a "collaborative effort to bring onsite mental health professional into our district."

Discussion

With a sample across city, suburban, town, and rural locales, this study highlighted principal perspectives about barriers and strengths in their schools to addressing the mental health needs of students. This study adds to the existing literature about perspectives on SMH by focusing specifically on the perspectives of school principals, who hold an important and unique role in supporting implementation of SMH services. Previous research on this topic has been limited to exploring single locales (Blackman et al., 2016; Iachini et al., 2016; Peterson, 2019) or specific school types, such as private Catholic elementary schools (Frabutt & Speach, 2012).

Main Findings

In terms of most frequently identified barriers to addressing student MH, principals had different perceptions across locales. Principals in rural and town settings most frequently identified financial concerns as a barrier. This major category included lack of funding for SMH supports, challenges with insurance, and high cost of MH services for families and parents. However, the barrier most frequently identified from principals in suburbs was lack of personnel, including minor categories of lack of MH providers in the school, lack of qualified MH providers, lack of school staff, and lack of MH providers in the community. In the city locale, the largest major category was a lack of shared understanding about MH and MH services. The major category of a lack of shared understanding about MH included the following minor categories: challenges with MH service acceptance and follow-through to utilize services by students and parents, lack of mental health literacy and training for school staff and parents, lack of alignment between school and community MH services, problems with family engagement, and stigma. Although the top barrier major categories across locales differed, the personnel and finance needs align with perspectives of principals in private Catholic elementary schools (Frabutt & Speach, 2012). Additionally, the most identified barriers in the present study were lack of personnel (suburb), lack of shared understanding about MH (city), and financial concerns (rural, town). These barriers are similar to barriers identified by teachers in Reinke et al., (2011), who identified an insufficient number of school mental health professionals, lack of training on mental health,

Table 9 Rural perspectives on strengths

Major categories	Minor categories	Unit quotations
School-based MH personnel and resources (320)	School staff as mental health advocates (129)	"Recognizing students with mental health concerns"
	MH programming in the school (90)	"Behavior supports and PBIS"
	School-based mental health provider (68)	"District school social worker"
	Having school counselor(s) (33)	"Excellent school counselors"
Working with community services (73)	Characteristics within the community (40)	"Know the students very well"
	Working with community services (33)	"Community partnerships"
School and community funding and support for engagement in MH services (25)	School and community funding and support for engagement in MH services (25)	"Recent grant"
Focus on building family relationships and support (23)	Focus on building family relationships and support (23)	"Strong relationships with parents"

$N = 441$

and lack of funding for SMH services. The present study's major category of a lack of shared understanding about MH includes a minor category of a lack of mental health literacy and training for school staff and parents, which aligns with the theme of a lack of training on mental health from Reinke et al., (2011); however, the present study's major category is more inclusive of other related barriers that contribute to a lack of shared understanding about MH beyond a lack of training. Overall, this comparison of the present study and prior literature suggests that teachers and principals hold similar viewpoints of main barriers, but that the major categories for each locale highlight which barrier principals perceive as most prominent.

In terms of strengths for addressing student MH, regardless of school locale, principals reported having existing school-based MH personnel and resources most frequently. This major category included two minor categories focused on different types of SMH providers, consisting of (a) school counselors and (b) other SMH providers (e.g., school psychologists, community mental health providers working in schools). In our analysis, school counselors were the only SMH provider that was reported at a high enough frequency to create a separate minor category. The other minor categories within the major category of having existing school-based MH personnel and resources were having MH programming in the school, MH professional development and trainings for staff, and having school staff who act as mental health advocates. This finding aligns with previous studies in which administrators have identified having personnel whose jobs are dedicated to addressing student MH as one of the major themes related to successful strategies for supporting student socio-emotional wellness and mental health (Frabutt & Speach, 2012). Additionally, administrators recognized that often these key personnel are critical, but in short supply (Frabutt & Speach, 2012). Indeed, across rural, town, and city locales, single respondents noted MH personnel as a strength while also sharing that more MH personnel are needed. Another major category of strengths was having a supportive school climate for MH, which was noted as a strength in all locales except for rural schools. Previous research has found that a positive school climate is associated with lower rates of problematic student behaviors and mental health problems, along with increased psychosocial wellbeing (Aldridge & McChesney, 2018). Multiple principals noted that an "equity mindset" and having "teachers who are very well versed in culturally responsive practices" are important. Additionally, working to enhance the school climate is recommended as a way for teachers and staff to promote student MH without requiring teachers to gain training in specialized skills required for targeted MH interventions (Aldridge & McChesney, 2018). However, it is necessary to note that having a supportive school climate for MH was not identified as one of the greatest strengths to SMH by principals in rural schools. This reflects previous findings that suggest students in rural schools rated their schools to be less safe and engaging than their suburban peers (Nguyen et al., 2021).

Limitations and Future Directions

This study had several limitations that should be considered when interpreting the results. First, the study only included principals from a single Midwestern U.S. state, and thus the identified themes could be location specific. For instance, it is possible that many of these principals may have received similar training within their state and hold similar opinions towards student mental health. Future research could expand the scope by examining the perceptions of principals from different locales and geographical regions throughout the U.S. to identify larger geographical trends and differences. An additional noteworthy factor is that the rural locale had nearly twice as many respondents as any of the other locales. Given there were fewer principals who participated from the city, suburb, and town locales, there may be perspectives from principals who were not included in the present study, which may have led to the identification of different categories. Future research could involve gathering more data from these other locales to better understand a broader range of principal perspectives.

The method of written survey responses had some limitations to understanding principal perspectives. The questions that the principals responded to in the survey were specific (i.e., two biggest barriers and two strengths or assets) and there was a short answer box for responses, which may have limited the length of principal responses. Overall, principals provided succinct responses without much detail. Thus, the viewpoints of these principals were not fully captured. Future research could consider providing additional instruction to respondents about the amount of detail to provide in their responses by giving length guidelines or asking them to explain their answers. Additionally, future research could utilize other information gathering techniques, such as semi-structured interviews or focus groups to allow principals the opportunity to share detailed opinions and for researchers to ask follow-up questions.

Future research may also consider collecting and including data from teachers, parents, or students, in combination with school principals, regarding their perspectives of barriers and strengths or assets to SMH services. This would allow the opportunity to compare the perspectives of parents, teachers, students, and principals to determine the extent to which they are aligned or disconnected. This may be helpful in identifying relevant areas to target when working to improve SMH practices and policies because each stakeholder group's perspectives might enrich overall understanding of SMH implementation (Castillo, 2020).

Principals have varying experiences with SMH. Some principals may have a background working in SMH whereas other principals may have only attended trainings in SMH. It would be helpful for future research to collect information about principals' experiences with SMH, prior training in SMH, or their understanding of SMH. These factors may influence the nature of their responses and could offer targeted implications.

Implications

There are several implications from this study. Principals identified a variety of strengths within their schools and there was consistency across locales about the importance of having SMH personnel and resources. This included having access to SMH providers and counselors in the building, as well as SMH programming and SMH professional development and trainings for staff. It may be helpful for SMH professionals to build on school strengths, such as administrator support, staff buy-in, effective teaming, and existing resources as avenues to minimize the impact of a lack of MH personnel (McIntosh et al., 2014). Additionally, principals across locales identified different strengths that may be unique to their own locale or school setting. For instance, the second top major category from principals in towns, suburbs, and cities was having a supportive school climate for MH, whereas working with community services was identified as the second top strength in rural schools. It may be helpful for school MH professionals to carefully consider specific details about strengths of their school and community as they consider tailored approaches to supporting student MH at their school. In this way, school strengths to supporting student MH can be leveraged to further develop or improve school mental health services. For instance, in school improvement research, utilizing evaluation data to identify and highlight school strengths, rather than focusing solely on the school weaknesses, has been identified as important to recognize and sustain practices, enhance pride of the school community, and promote positive attitudes towards evaluation and improvement efforts (Aderet-German & Ben-Peretz, 2020).

Interestingly, many of the strengths identified by principals were also identified as potential barriers, thus indicating the importance of these key features in schools' ability to be flexible and responsive in supporting student mental health. For instance, a lack of personnel was one of the top three barriers across all locales, whereas having SMH personnel and resources was the top asset that principals identified. These findings align with the themes highlighted from the principals in the private Catholic elementary schools, as personnel was identified as a top theme for both the school's greatest need and the successful strategies to support student MH (Frabutt & Speach, 2012). This suggests that efforts focused on addressing shortages and increasing availability of SMH personnel could be beneficial for supporting student MH.

In addition to commonalities, there were barriers that were unique to certain locales. Distinctions across locales highlights that a one size fits all approach to supporting schools in their SMH systems might not truly benefit all students across locales equally, as there is a need to focus on tailored supports. Nguyen et al., (2021) reached similar conclusions regarding the need to consider relevant contextual factors to tailor efforts to improve school climate and student well-being in rural contexts by exploring principal perspectives about strengths and barriers in their schools. With a large sample of principals across geographic locales, this study provides insight into key areas of focus for schools to improve their school mental health efforts.

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