



School Principals' Perceived Barriers and Facilitators to the Normalization of School-Based Mental Health Services: A Multimethod Investigation

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Abstract

Schools have become primary providers of mental health services for children and adolescents (Kern et al. in *School Mental Health* 9:205–217, 2017). Within schools, school principals play a significant role in the implementation of school-based mental health (SBMH; Langley et al. in *School Mental Health* 2:105–113, 2010). This multimethod study aimed to investigate school principals' perceptions of SBMH, specifically in how they view SBMH and what barriers and facilitators they identify to successful implementation. School principals from 244 public schools in the United States completed a survey, and 19 principals also participated in semi-structured interviews. Data from a quantitative measure based on Normalization Process Theory (NPT; Finch et al. in *BMC Med Res Methodol* 18(1):1–13, 2018) indicated that while principals strongly believe SBMH will become a normal part of their work in the future, their responses to whether they are familiar with SBMH and see it as a normal part of the current work were less robust. Results from a framework analysis of the qualitative results identified barriers and facilitators to the implementation of SBMH within and outside of schools, thus aligning with implementation science frameworks such as the Exploration, Preparation, Implementation, and Sustainment (EPIS; Moullin et al. in *Implement Sci* 14:1–1, 10.1186/s13012-018-0842-6, 2019) framework. The findings may inform SBMH policy in light of the increasing number of children and adolescents with mental health needs (Hoover and Bostic in *Psychiatr Serv* 72(1):37–48, 2021).

Keywords School-based mental health · School principal · Leadership · Community mental health provider · Implementation science

Introduction

Due to the significant number of students presenting with mental health (MH) needs, school administrators endorse the importance of providing MH services within schools (Kern et al., 2017). School-based mental health (SBMH) consists of a wide range of services delivered by school- or

community-based personnel that promote the social, emotional, and behavioral functioning of youth within the school setting through universal screening, prevention, and intervention (Doll et al., 2017; Suldo et al., 2014). The provision of services varies, with some schools offering a comprehensive package of services and others devoting more resources to academics or behavior interventions (Green et al., 2022). SBMH provides an efficient mechanism by which services can be delivered (Doll et al., 2014). Although most youth with MH needs do not receive services, those that do often receive them at school (Weist et al., 2012). Thus, public schools have become primary providers of MH services for youth (Weist et al., 2012) and addressing the challenges of implementing SBMH is crucial (Kern et al., 2017).

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Barriers to Effective SBMH Implementation

While SBMH can provide remarkable benefits to students, numerous barriers to the implementation of SBMH have been documented (van Vulpen et al., 2018). A recent scoping review (Richter et al., 2022) used the Consolidated Framework for Intervention Research (CFIR; Damschroder et al., 2009) to identify factors that affect the implementation of SBMH services. The review identified factors in both the outer (i.e., factors outside an organization that impact implementation) and inner setting (i.e., factors within an organization that impact implementation) CFIR domains (Damschroder et al., 2009; Richter et al., 2022). Identifying implementation barriers according to domains such as the outer and inner setting can help researchers and practitioners identify modifiable barriers to target with implementation strategies (Bruns et al., 2019).

In conjunction with Richter et al. (2022) review, there are several examples of organizational barriers that have been identified in the SBMH literature. Systems-level constraints such as limited personnel and funding (Ormiston et al., 2023) are a recurring barrier to SBMH, both of which inhibit the effective implementation of SBMH (Langley et al., 2010; van Vulpen et al., 2018). Referrals for school-based services often far exceed the available personnel to provide those services (Maag & Katsiyannis, 2010). In rural schools, for instance, personnel trained to provide SBMH services, such as school psychologists, are limited as schools struggle to provide adequate and appropriate MH services to students due to high student-to-professional ratios (Goforth et al., 2021). Another organizational barrier is the recruitment and retainment of “highly qualified” individuals (Edwards & Sullivan, 2014). While educators recognize the importance of MH support for students in need, many teachers indicate they lack adequate training to identify needs and/or provide support to students (Ormiston et al., 2021). In the inner setting, communication, goals, feedback, and administration support were routinely identified as factors impacting SBMH implementation (Richter et al., 2022).

In addition to organizational factors, individual factors such as stigma, or negative beliefs and attitudes related to MH, can be a barrier to seeking out SBMH services (Bowers et al., 2013; Maag & Katsiyannis, 2010), a perspective endorsed by educators (Bowers et al., 2013). Further, a perceived lack of familial support and caregivers’ lack of awareness that students have MH needs have been identified as significant barriers to students receiving services (van Vulpen et al., 2018). Multiple studies within the aforementioned scoping review highlighted the importance of engaging with actors and partners (e.g., teachers, caregivers, students) as a factor impacting the implementation

of SBMH (Richter et al., 2022). Both determinants of evidence-based practice implementation and broader service access are relevant to this paper given our exploration of school principal’s perspectives on barriers and facilitators to SBMH service delivery. To implement SBMH effectively, it is recommended to adhere to evidence-based practice recommendations (Kern et al., 2017). However, also relevant is the ability to access mental health services (Weist et al., 2012).

To achieve an inclusive and coordinated framework of care, community-based MH services should be woven into the provision of SBMH services (Doll et al., 2014) rather than simply placed in a school without purposeful integration into the school system (Weist et al., 2012). A recent large-scale examination of community mental health providers (CMHPs) embedded within school systems resulted in a significant, positive impact on school climate and significant decreases in disciplinary practices resulting in suspension, expulsion, and alternative placements after controlling for factors such as socioeconomic status, climate ratings, and school locale (DiGirolamo et al., 2021). Ineffective collaboration with CMHPs (Weist et al., 2012) along with the structure of CMHPs’ contractual services, however, may limit who can receive services (Kern et al., 2022), such as only students who are Medicaid-eligible (Raines, 2018).

School Principals and SBMH Initiatives

Evidence suggests that school principals recognize the substantial needs of student and teacher MH and are key leaders for change (Kern et al., 2017). Administrator support is critical to the success of SBMH service implementation and overcoming barriers (Richter et al., 2022). Effective school-based leadership has been found to be one of the most impactful drivers of successful implementation (Lyon & Bruns, 2019; Radaelli & Sitton-Kent, 2016; Shapiro et al., 2020). Implementation climate, or the extent to which employees perceive that using evidence-based practices is valued by an organization, has also been found to be highly associated with principal implementation leadership (Williams et al., 2022). While there is ample evidence regarding the impact of administrators on implementation efforts in the healthcare sector (Birken et al., 2012), evidence suggests that leadership in education is unique because of its distributed nature (Locke et al., 2019). Therefore, investigating principals’ perceptions of SBMH services may provide a deeper understanding of the challenges to implementing MH services in schools.

School leaders’ perceptions can impact both implementation as well as the effectiveness of services (Breisch et al., 2020), and principals often act as gatekeepers to the adoption and implementation of services (Baker et al., 2021) and evidence-based practices (Odom et al., 2020).

When acting as champions of SBMH services, principals can affect change using messaging, schedule changes, and personnel allocation to support implementation efforts (Odom et al., 2020). Conversely, a lack of administrative support has been found to be a reason why students with MH needs “fall through the cracks” (Reinke et al., 2011, p. 8). Indeed, when school leaders are perceived as not being invested in a SBMH program, it can be seen as a significant barrier to commencing implementation of the program (Langley et al., 2010). For example, school leaders may choose to prioritize professional development or other competing priorities which limits the time and resources available for SBMH (Zhang et al., 2022). Therefore, it is vital to examine how principals perceive and understand their role in SBMH.

Implementation Science

In research on principals’ perceptions of SBMH, principals seldom discussed SBMH on a systems or organizational level (Frabutt & Speech, 2012). This finding is important considering the difficulty schools have in implementing system-wide SBMH (Lyon & Bruns, 2019). Successful systems-level change requires knowledge of implementation science (IS; Conoley et al., 2020). Defined as “methods to promote the systematic uptake of evidence-based practices into routine practice” (Eccles & Mittman, 2006, p. 2), IS offers researchers and practitioners useful frameworks for increasing the successful implementation of SBMH (Forman et al., 2013). IS and systems change methods can increase the likelihood of successful implementation of SBMH, particularly when paired with a focus on the social processes inherent in school-based implementation (Castillo, 2020). Previous research suggests that principals view SBMH as a current and future priority (Briesch et al., 2020; Reid, 2021). Therefore, assessing barriers and facilitators from principals’ perspectives may be beneficial for the successful dissemination and implementation of SBMH (Baweja et al., 2016; Blackman et al., 2016). Theories, models, and frameworks (TMFs) are commonly used in IS to make hypotheses about why implementation was or will be successful (Nilsen, 2015). Combining two or more frameworks in a study can be a useful method for investigating different aspects of implementation (Moullin et al., 2020). As such, two commonly used frameworks, Normalization Process Theory (NPT; May & Finch, 2009) and the Exploration, Preparation, Implementation, and Sustainment (EPIS; Aarons et al., 2011) framework, were used in this study to identify barriers (i.e., EPIS) and to help understand how SBMH may be a normal aspect of school services (i.e., NPT).

Normalization Process Theory

NPT is a theory from IS that uses social processes to explain how practices are implemented, embedded, and integrated into routine practice (i.e., implementation processes; May & Finch, 2009; McEvoy et al., 2014). The theory consists of four constructs: coherence (i.e., what is the work?), cognitive participation (i.e., who does the work?), collective action (i.e., how does the work get done?), and reflexive monitoring (i.e., how is the work understood?; Wood, 2017). Respectively, principals’ responses to the underlying questions behind NPT constructs can help researchers positively engage principals regarding perceptions of SBMH, getting others involved, integrating a program into a school, and assessing implementation to increase sustainability. Thus, NPT can be a useful framework for assessing principals’ perceptions of the implementation of SBMH.

The Exploration, Preparation, Implementation, and Sustainment Framework

While the NPT framework is useful for understanding implementation processes, it is not designed to identify specific factors that may help or hinder implementation (Nilsen, 2015). Thus, we utilized the EPIS framework to address NPT’s shortcomings. The EPIS Framework is a multi-level IS framework with phases used for guiding implementation and identifying barriers and facilitators (Aarons et al., 2011; Moullin et al., 2019). EPIS uses the domains of outer and inner contexts to delineate external or internal factors to an organization. The EPIS framework also helps guide implementation across four phases, including exploration (i.e., deciding whether an intervention is needed and should be used), preparation (i.e., planning to implement an intervention), implementation (i.e., integrating the practice into routine use), and sustainment (i.e., maintaining the implementation of interventions over time; Moullin et al., 2019). EPIS has been used in the SBMH literature to understand the contextual factors important for implementation (Locke et al., 2019), and to improve the implementation of MH screening practices (Connors et al., 2021a, 2021b). The EPIS outer context and inner context domains were used in this study to identify and categorize barriers and facilitators relevant to the implementation of SBMH services.

Present Study

As previously stated, administrative leadership is critical to the success of SBMH services (Kern et al., 2017). Thus, the present study investigated principals’ perceptions regarding SBMH, specifically how they view SBMH

and perceived barriers and facilitators to implementation. Guided by NPT and the EPIS framework, we sought to answer two research questions:

1. To what extent do school principals view SBMH as a normal school practice?
2. According to school principals, what determinants (i.e., barriers and facilitators) impact SBMH service delivery?

Method

Participants

Participants consisted of a sample of 244 public school principals in a Midwestern state recruited from a publicly available statewide database via a purposive sampling method (Nardi, 2018). The sample represented approximately 13% of public school principals in the state and was predominantly (i.e., 90%) White. The racial demographics of our quantitative sample are representative of

Table 1 Participant demographics (N=225)

Characteristic	Survey n (%)	Interview n (%)
<i>Age</i>		
31–40	46 (20%)	4 (21.1%)
41–50	108 (48%)	10 (52.6%)
51–60	59 (26%)	5 (26.3%)
61–70	12 (5.3%)	0 (0%)
<i>Education level</i>		
Doctorate (e.g., Ph.D., Ed.D., Psy.D.)	30 (13%)	3 (15.8%)
Masters/Specialist (e.g., MA, MS, M.S.Ed, Ed.S.)	195 (87%)	16 (84.2%)
<i>Race</i>		
Black (African or African American)	7 (3.1%)	0 (0%)
Latinx and/or Hispanic and/or Spanish Origin	3 (1.3%)	1 (5.3%)
Multiple races	5 (2.2%)	0 (0%)
Prefer not to answer	7 (3.1%)	0 (0%)
White (Caucasian)	203 (90%)	18 (94.7%)
<i>Gender</i>		
Female	102 (45%)	7 (36.8%)
Male	119 (53%)	12 (63.2%)
Prefer not to answer	4 (1.8%)	0 (0%)
<i>School population</i>		
3001 +	2 (0.9%)	0 (0%)
2001–3000	6 (2.7%)	1 (5.3%)
1001–2000	16 (7.1%)	2 (10.6%)
501–1000	84 (37%)	7 (36.8%)
1–500	117 (52%)	9 (47.4%)
<i>Grades in School Building</i>		
9th–12th grade	76 (32%)	10 (53%)
6th–8th grade	98 (42%)	10 (53%)
Pre-Kindergarten–5th grade	183 (66%)	13 (68%)
<i>Location size</i>		
Large City (More than 1,000,000 people)	13 (5.8%)	0 (0%)
City (100,001–1,000,000 people)	37 (16%)	1 (5.3%)
Town (15,001–100,000 people)	62 (28%)	8 (42.1%)
Small Town (3001–15,000 people)	60 (27%)	3 (15.8%)
Village (1001–3000 people)	17 (7.6%)	2 (10.5%)
Hamlet/rural area (1000 people or fewer)	36 (16%)	5 (26.3%)

N = 225 due to missing data, demographic data does not equal the overall sample size. Participants were allowed to choose multiple items for the grade variables

Table 2 Interviewee school characteristics (N = 19)

ID	School population	Local population size
P01	1001–1500	Town (15,001–100,000 people)
P02	1–500	Village (1001–3000 people)
P03	1–500	Hamlet/rural area (1000 people or fewer)
P04	501–1000	Town (15,001–100,000 people)
P05	2001–2500	Town (15,001–100,000 people)
P06	501–1000	City (100,001–1,000,000 people)
P07	501–1000	Small Town (3001–15,000 people)
P08	1–500	Hamlet/rural area (1000 people or fewer)
P09	501–1000	Hamlet/rural area (1000 people or fewer)
P10	1–500	Town (15,001–100,000 people)
P11	1501–2000	Town (15,001–100,000 people)
P12	1–500	Town (15,001–100,000 people)
P13	501–1000	Town (15,001–100,000 people)
P14	1–500	Hamlet/rural area (1000 people or fewer)
P15	1–500	Town (15,001–100,000 people)
P16	501–1000	Small Town (3001–15,000 people)
P17	1–500	Hamlet/Rural area (1000 people or fewer)
P18	501–1000	Small Town (3001–15,000 people)
P19	1–500	Village (1001–3000 people)

the state, as 92.1% of the state’s principals identify as White (see Table 1; Snyder et al., 2019). Nineteen interviews were completed during the qualitative phase of the study. Eighteen participants identified as White and one identified as Latinx and/or Hispanic. Seven participants identified as female, while 12 identified as male (see Table 2 for participants’ school characteristics and IDs).

Design

This study is part of a larger project examining school principals’ roles in implementing SBMH. Our theoretical orientation involved a critical realist perspective. We sought the independent truth in our analysis but recognized that the interpretation of the results is influenced by our cultural backgrounds and experiences (Ritchie et al., 2013). The study design is descriptive for both the qualitative and quantitative results. While this limits causal claims, a descriptive design can be a useful method for answering educational research questions that cannot be observed directly (Cook & Cook, 2008). Research question one was answered quantitatively, while research question two was answered qualitatively. We collected quantitative data concurrently from an online-administered survey and qualitative semi-structured interviews.

Overall Procedures

In June 2021, email invitations to participate in the study were sent out to 1,802 school principals across the state using the Qualtrics platform (Qualtrics, 2021). Participants were asked to complete a 98-item survey and were given the option of signing up to complete an interview. Three reminder emails were sent out at intervals to increase participation rates (Dillman et al., 2014). The survey was open for 10 weeks. A total of 300 principals responded to at least one item in the survey for a response rate of 17.7%. Participants who completed less than 40% of the study, thus failing to complete any study measures, were removed ($n = 56$), leaving 244 participants for the study sample. Among the variables used for analyses, there was less than 1% missing data. All participants were asked to indicate if they were interested in being contacted for a follow-up interview. Among the 225 participants, 53 (24%) indicated an interest in being interviewed. All interested participants were contacted to schedule an interview and 25 responded. Due to scheduling difficulties, only 19 interviews were conducted.

Quantitative Procedures

In the quantitative component, participants initially rated 22 items on the survey that asked how well SBMH services were delivered in their schools. The Implementation Leadership Scale (ILS; Torres et al., 2017) Supervisor version and the Implementation Citizenship Behavior Scale (ICBS; Ehrhart et al., 2015) were completed. Finally, participants completed the Normalization MeASURE Development (NoMAD) questionnaire (Finch et al., 2018), which contained 24 items to assess perceptions of implementation using NPT constructs. For the purposes of this paper, we limited our quantitative analyses to the first three ‘normalization’ items, that assess whether participants believe a practice is currently a normal part of their work, their level of familiarity with the practice, and whether they believe the practice will be a normal part of their work in the future. With input from the other authors, the first author adapted the NoMAD for this study, a procedure encouraged by the developers of the NoMAD (Finch et al., 2018). We substituted the term “SBMH services” for “the intervention” from the original measure. SBMH services were defined on the first survey item as “the implementation of prevention and intervention services designed to improve the condition of students’ social-emotional and psychological well-being.” The three normalization items allowed participants to indicate if the question was irrelevant or if they chose not to answer. Descriptive statistics were calculated for the NoMAD results using the statistical software R version 4.2.0 (R Core Team, 2022).

Qualitative Procedures

An interview guide was developed and piloted with the first participant. Semi-structured interviews were conducted with 19 participants by the first author and held over the Zoom platform. The interview protocol for the larger project consisted of three sections on their views of the value of SBMH services, their roles in the implementation of SBMH services, and barriers to implementation. For this study, the analysis was limited to participants’ responses to the questions, “What are the biggest barriers to the successful implementation of SBMH services in your school?” and “What are the biggest factors that help the implementation of SBMH services in your school?” Interview data were professionally transcribed and analyzed using framework analysis, a form of thematic analysis designed to produce systematic and transparent results for applied policy research (Ritchie et al., 2013). The analysis began deductively with pre-determined overarching themes of ‘Inner Context’ and ‘Outer Context’ from the EPIS framework (Aarons et al., 2011) and ‘Barriers’ and ‘Facilitators’ within each domain. Specific barriers and facilitators were coded inductively to identify the types of barriers discussed by participants (Ritchie et al., 2013). Coding and summarization were completed using the MAXQDA (2020) qualitative data analysis software.

Following the protocol from Ritchie et al. (2013), once the interviews were transcribed, the first and second authors read all the transcripts while noting commonalities and possible themes and met regularly to discuss a preliminary set of themes and subthemes. Next, three transcripts were double-coded using the preliminary framework, and so on, until no new themes were identified after transcript nine. This process was followed by indexing, which consisted of systematically applying the thematic framework back to the raw data. Participant accounts were labeled according to the preliminary codebook while allowing the identification of new themes. Charting followed, which

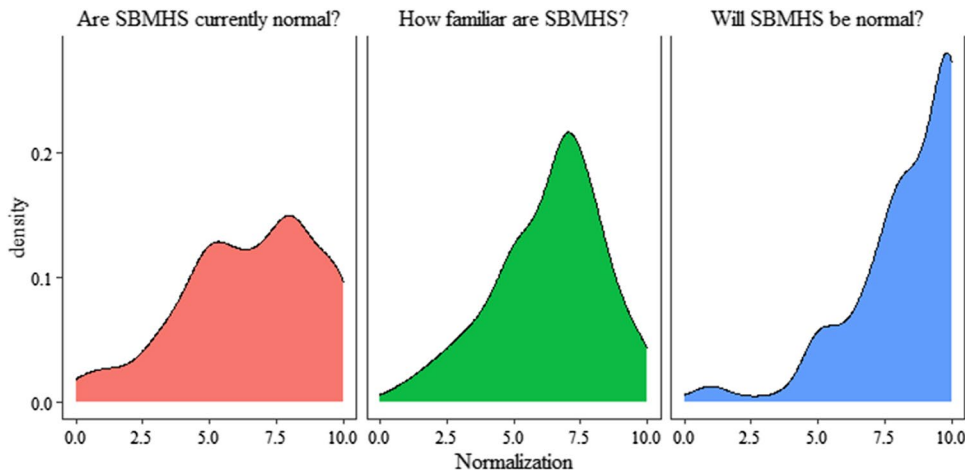
involved summarizing indexed sections of the data along with relevant quotations. Finally, key elements of the summaries across themes were identified to determine common elements within each theme.

Results

School principal perceptions of the normalization of providing SBMH services were investigated through the Normalization subscale of the NoMAD. The overall NoMAD scale demonstrated excellent reliability (Cronbach’s Alpha $[\alpha] = 0.88$; McDonald’s Omega $[\omega] = 0.91$), with strong internal consistency ($\alpha = 0.87$ and $\omega = 0.88$) on the Normalization subscale. The overall mean score for the Normalization subscale was 7.00 ($SD = 1.97$) on a scale from 0 (“Not at all”) to 10 (“Completely”), suggesting participants largely believe SBMH is a normal practice in their schools, although not yet fully adopted and normalized. Further, participants indicated that SBMH services are somewhat familiar ($M = 6.32$, $SD = 2.07$) and a normal part of their work ($M = 6.42$, $SD = 2.54$). However, participants indicated a belief that SBMH will be a larger part of their work in the future ($M = 8.25$, $SD = 2.00$). Participants’ responses to the normalization items were visualized in Fig. 1.

Participants reported a range of views related to barriers and facilitators for SBMH implementation. For each barrier principals described, they also offered facilitators for SBMH. Barriers and facilitators were identified under two parent themes from the EPIS framework: the outer and inner contexts. We further specify both barriers and facilitators within each theme. To see a visual representation of the qualitative results, refer to the Supplementary Materials. Of note, as results are presented, Participant 1, Participant 2, and so on will hereafter be referred to as “P01”, “P02”, and so on through “P19”.

Fig. 1 Normalization of SBMH Services. *Note.* Curve height signifies an increasing number of responses to the scale below. Items were rated on a 1–10 scale. SBMHS represents School-Based Mental Health Services



Outer Context

Barriers

Participants noted both broad and more specific barriers from outside the school context that interfere with the normalization of SBMH. First, the lack of funding was a major barrier to the implementation of SBMH. P14 stated, “I really can’t think of anything else that limits us other than finances.” This barrier inhibits a variety of schools, regardless of size or locale: “Schools are always having financial trouble. We really are. Even the big ones that have the money, they struggle with it too” (P11). One recurring source of frustration around funding was due to policies created by the state government: “just don’t give us unfunded mandates. Don’t tell us social-emotional learning is important. And then don’t fund it” (P05). Another difficulty was the reliance on specific insurance requirements (e.g., students eligible for Medicaid versus private insurance) to connect students to services provided by CMHPS in the school setting. In some schools, CMHPS were only able to work with students “that qualify based on insurance” (P06), while other principals noted students “have to be on Medicaid to qualify” for services (P05). Insurance barriers and the lack of funding for SBMH left participants with a sense of frustration and subsequent reluctance to normalize MH services (P11).

In combination with funding barriers, participants endorsed a broad sense of stigma toward MH and the provision of SBMH services. Although principals largely regarded SBMH as beneficial, they also emphasized “we face a large stigma when it comes to mental health” (P16). Participants stressed “we are always dealing with stigma” (P07) and “we’re working on... getting our community to understand the depth, the real need that we have here, and to talk about mental health in a positive way and be open to that” (P18). School locale was noted to play a role in stigma and attitudes toward MH. A principal, who previously worked in an urban district but moved to a rural one, commented that in rural areas “their attitudes are going to be a little different on mental health” (P02). A principal working in a rural district commented on the political stigma associated with critical race theory (CRT) and SEL (P07) while another rural principal noted that “We’re seeing a lot of political conflation of SEL with other things that people think are bad” (P09). It is noteworthy that among the ten participants (P02, P03, P07, P08, P09, P10, P12, P16, P18, P19) who noted stigma as a barrier, eight self-identified as working in rural (N=3), village (N=2), or small town (N=3) schools.

While principals expressed a desire to implement SBMH services, they struggled to balance competing demands with the accountability standards from entities external to the

school, thus limiting the normalization of SBMH. Some participants make decisions about the role of schools by questioning “how are we supposed to meet all of these academic demands when we don’t even have a child that may want to or is ready to learn?” (P12) as compared to solely making “sure students can pass a standardized test to satisfy the government that our schools are doing well” (P04). In contrast, other administrators purport “academics is our primary focus” (P13), especially at the secondary level (P10). Participants indicated balancing a student’s academic needs with their MH needs can be difficult since “there really isn’t a dedicated period of time for students to go receive the additional services that they may need that wouldn’t impact their academics” (P01) due to missed instruction.

For some, participants stressed time was “the biggest resource that we lack” (P08). Limited time and competing demands were noted to influence resource allocation and the provision of different types of services. For example, principals recognized the importance of removing additional duties from MH providers’ workload to better utilize their time (P12). Additionally, P04 remarked, “Schools are held [responsible] to meet the statutes as laid out by the state. At the same time, they’re also now being tasked to make sure that their students have a good mental health frame of mind.” The need to balance competing demands from outside the school contributes to a sense of pressure and burnout from within. P15 reported “the pressure is unbelievable” to ensure students pass state assessments, leading to burnout amongst staff from trying to balance the demands (P02):

And it’s like well, that’s another thing that they’re trying to lay on schools...we need to take care of their mental and physical health, we need to make sure that they are also learning these academics but yet we also need to make sure that we are getting the proper data through testing this, that, and the other, and try to do that in 180 days. (P08)

To begin meeting student MH needs, schools partner with CMHPS to provide services, such as individual counseling, to students with intensive needs at the Tier 3 level. However, principals highlighted difficulties related to service delivery and gaining access to CMHPS as barriers to the implementation of SBMH services. Working with CMHPS was described by P10 as “a disaster” because “their communication is very lacking” and service times “seemed to lag” compared to the more immediate ability to gain access to their school-based services. Already mentioned funding limitations led CMHPS to have a “much smaller” (P06) caseload compared to school-based providers. Additionally, gaining access to CMHPS proved difficult for some, especially in rural areas. One principal reported it “becomes a struggle because we don’t have a lot of outside resources in our community. We search them out. We try to find them,

but it's not as much as...I would like" (P11). To compound this issue, there was a perception they "could just do their thing and not really achieve any results...There was no accountability" (P10).

Facilitators

Despite the abovementioned barriers, participants described facilitators external to the school to enhance the normalization of SBMH. First, the lack of state funding for SBMH led many principals to seek grants (P07). Without additional grants, schools would not be able to provide as many quality MH services for students. For instance, one principal reported, "If we didn't get the grant, I don't know if we would have been able to implement [MH services] as well as we did" (P12). The lack of SBMH funding led some principals to spend considerable resources and time self-funding their MH services.

We work really hard to try to find money to do that, especially now I feel like public education funding is cut a lot. And it's always on the chopping block, which makes no sense. So we have to try to find outside resources. (P11)

As such, the continued allocation of SBMH grant funding and administrator's applying for such funds (e.g., P03, P07, P09, P11, P14, P15, P18, P19) can serve as a facilitator for SBMH.

Another facilitator involved contracting with CMHPs, as several regarded partnerships with CMHPs as desirable (P13), sharing they are "amazing" (P15) and reporting "we're pretty blessed" to have them (P17). P08 indicated the partnership with a CMHP "allow[s] for more one-on-one intervention therapy-based counseling." For those principals without established CMHP partnerships, they indicated community programming is on their "wish list" (P06), particularly for the work that can be done to support families (P07, P16). For example, P09 reported:

And so then for me, that is where the value lands for those community partnerships because I can't really serve mom...I can't really serve foster parent. We can help a kid and we might be able to target [a] program for them, but being able to have that partnership that allows some connection to the community [is] just essential so that we can provide as much wraparound support for a kid in their whole family as possible.

Participants recommended principals get creative in balancing competing demands by prioritizing time in students' schedules to meet MH needs, because "if the schools don't address that, it won't get addressed" (P19). Participants largely agreed that integrating MH into the school day "is one of those ongoing challenges that we face" (P06), and

several participants shared their ideas for creating time in the school day where students can receive MH support (e.g., P03, P05, P12). Some principals noted that their attitudes toward MH have evolved and can contribute to the normalization of SBMH services:

I have changed my mind a lot when it comes to this, that if you work on teaching and learning, that the mental health aspect will just come with that, and now I don't think that's true. You have to really give attention to that. (P03)

Further, since principals have some authority to prioritize school-wide initiatives, their personal beliefs regarding meeting student MH needs at school also influence the beliefs of teachers and their commitment to SBMH (P11).

Inner Context

Barriers

Participants identified personnel shortages and prevailing stigma and attitudes towards MH as factors that interfere with the normalization of SBMH. The lack of qualified MH providers both within the school and regarding CMHPs was regularly noted as a barrier to the implementation of SBMH services. While participants indicated "the need is skyrocketing" (P06), they also reported "it's very difficult... to find licensed and certified individuals who can provide services to our students" (P02). Hiring providers was characterized as increasingly difficult, with positions sometimes going unfilled for months (P08). Adding to the difficulties with hiring new personnel, participants expressed concerns their SBMH providers were "spread too thin so that they're not always available for those kinds of [MH] needs for the kids" (P12). In another case, a principal reported, "I have one social worker for 600 students. Is that enough? Heck, no. We definitely need more people to help service these kids" (P05). The personnel challenges resulted in cases where students went months "without therapy, without any treatment at all" (P02). Furthermore, principals recognized the toll it takes on providers: "If you're just focused on mental health issues in schools, I mean that's a big job. It's a stressful job" (P15).

Participants indicated stigma surrounding MH is pervasive across students, families, and teachers within the school context, impeding the normalization of SBMH. Stigma shared by students and families was endorsed as a "limiter to services" (P07) and impacted students' willingness to seek out MH services. Students were described as "reluctant to contact us" (P03) because they "don't ever want to admit that anything's wrong" (P19); this hesitancy corresponded with caregiver resistance to SBMH services. Participants attributed this difficulty to caregivers' lack of knowledge

regarding SBMH services (P08) or a denial that their child needed service: “I know my child doesn’t need that. We’re fine” (P09). Blame was likewise considered a factor that impacted stigma, with one principal expressing that caregivers may feel that “if you need mending, from a mental health perspective, somebody could easily lay blame on not just the kid, but the parents” (P10).

Staff attitudes toward MH, more broadly, were also reported to impact the normalization of SBMH initiatives. Multiple principals indicated staff members’ views on SBMH vary (e.g., P07, P12) such that “some folks really love it, some folks really don’t” (P09). They suggested a lack of understanding regarding the importance of student MH as a top priority is a barrier to normalization (e.g., P08). For example, P07 shared teachers question their role in student MH:

[Teachers are]...asking us the same questions maybe some of our community is. Is this the right thing to be doing? Am I capable of doing this? What is my training? What is my licensing? Is this something that I am going to be able to do with your backing?

Principals also indicated that school staff members’ lack of training might contribute to their reluctance to incorporate SEL programming, which is often a key component of system-wide initiatives due to the personnel shortage described above. Further, P12 reported personal priorities and values of staff members impact normalization because “we’re not all going to think the same or maybe value things the same way.”

Beyond differing priorities, knowledge, opinions, and values related to SBMH, principals reported that teacher burnout and secondary traumatic stress, especially during the COVID-19 pandemic, influenced teacher buy-in for SBMH (e.g., P12, P13). Principals expressed concern for “add[ing] one more thing to their plate” (P05) by having to hold teachers accountable for “growth on [state standardized assessments], mastery, and standards” (P17) while they manage student behavior and balance their “own mental health issues” (P13). This demonstrates the link between how outside factors permeate individual viewpoints, which impact additional barriers within the school context (e.g., staff attitudes toward MH) that interfere with the normalization of SBMH. Some reported teachers don’t see supporting student MH as part of their role, stating teachers “didn’t get into this to be a psychiatrist or a psychologist or a social worker” (P02).

Facilitators

All participants reported superintendent or school board support for SBMH is a key facilitator for the normalization of SBMH. When district-level administrators are supportive,

building-level administrators “do what [they] want” (P05), like hire trained MH personnel (P06), and “allow us to open up some resources to sustain those [MH] programs” (P09). Emphasizing the importance of getting buy-in from the school board to fund SBMH, one principal noted, “[t]hey’re the ones that decide where the money is spent. So to be able to have that buy-in is huge for us...our board will, and they have started to, allocate funds” (P11). For others whose administrators are “open to [SBMH], just not actively”, there may be some confusion on the importance of student MH, a sentiment shared by P16: “I don’t think they have any real clear picture on what mental health is... they don’t realize... mental health is across the board.”

District-level confusion was exacerbated by competing demands (e.g., “I’d say it’s a mixed bag at the top level of how important it is versus how do you balance it with the academic piece” [P13]). However, when district administrators view MH as a priority, the confusion alleviates: “it starts at the top, and if you don’t have that support that it’s really tough to make things like this go” (P19). Overall, leadership was a shared facilitator for normalizing SBMH: “I don’t think we would have done it to the extent that we are without the district leadership” (P03).

A second facilitator noted by participants centers on providing PD and training related to SBMH (e.g., P09, P10, P12, P17), in contrast to the barrier related to stigma and attitudes toward MH. PD on student MH from the district level was beneficial (P18), and building-level PD helped foster a “culture shift” (P17). When principals prioritize SBMH and communicate this to staff by “bringing it into their evaluation somehow, or you know, letting them know that this is not an option,” SBMH is more normalized. Finally, participants reported a desire to “put on some more professional development for our parents in order for them to just fully be aware of the need for the services” (P11), a helpful strategy for P01 and P11.

Discussion

This study employed a multimethod approach to explore the extent to which principals view SBMH as a normal school practice and to identify the barriers that interfere with its normalization. Given the benefits of providing MH services within schools (Kern et al., 2017), and the leadership role school principals play in implementing school-wide initiatives, we sought to understand how and why SBMH becomes or does not become “routine and normal components of everyday work” in schools (May & Finch, 2009, p.535). When practices become normalized, they are “routinely embedded,” (May et al., 2009, p.2), a goal for SBMH (Owens et al., 2014). The current study elicited a range of

responses from principals regarding the normalization of SBMH and barriers and facilitators for implementation.

SBMH Normalization

Quantitative results examined the extent to which school principals view SBMH as a normal school practice, and found participants were mostly familiar with SBMH, although they did not consider it as a currently normalized practice. More optimistically, participants perceived SBMH to become a normal part of their work in the future. Taken together, this can help shape the direction of the next steps for SBMH implementation. Since SBMH is yet to be fully normalized (Hoover & Bostic, 2021), it is important we understand what barriers interfere with normalization. Our follow-up interviews are consistent with an IS research agenda for SBMH answering a call for the examination of principal leadership before implementing SBMH initiatives to determine how barriers are perceived and managed (Owens et al., 2014).

Barriers to SBMH Normalization

Upon investigation into barriers that interfere with the normalization of SBMH service delivery, qualitative themes were identified under two EPIS domains: (1) outer context and (2) inner context. The EPIS outer context describes factors external to the entity or organization (e.g., policy environment), whereas the inner context describes factors within the entity or organization (e.g., internal policies and staffing; Moullin et al., 2019). Utilizing a deductive and inductive approach, the authors categorized reported barriers based on the context with lack of funding and insurance requirements, stigma and attitudes toward MH, competing demands, relying on community agencies to provide services falling within the outer context, and personnel shortage and stigma and attitudes toward MH falling within the inner context. Barriers elucidated from this study are prevalent throughout the existing SBMH literature.

SBMH is viewed as a marginalized agenda due to the competing demands from external sources that exert academic pressures and provide limited resources for MH services (Weist et al., 2012), despite literature that demonstrates a positive relationship between SBMH services and student academic performance (DiLeo et al., 2022). Principals' concerns about the need to balance competing demands in the current study are shared by other school professionals (Author et al., 2022; Willis et al., 2019), and likely influence schools as a “gray zone” in which SBMH is not normalized into typical school practice and is viewed as an “extra service” (Weist et al., 2012, p. 98). The shortage of trained MH professionals is another barrier that continues to be a problem (Shelton & Owens, 2021), impacting SBMH service

provision and normalization. Training in student MH is lacking for school staff, and student-provider ratios for trained staff surpass the recommended ratios due to a shortage of personnel and increased student MH needs (Ohrt et al., 2020; Reinke et al., 2011). These barriers are coupled with limited funding sources and MH stigma. Without sufficient funding, principals are tasked with the extra responsibility of applying for grants to implement MH services. Additionally, MH stigma continues to influence community acceptance and help-seeking behavior (Bharadwaj et al., 2017).

Similar to previous SBMH research (Richter et al., 2022), we identified outer context factors such as funding (Locke et al., 2015) and government policies (Massey et al., 2021) that impact service delivery. A surprising result was the disparity between the number of codes identified in the inner (95) and outer (160) contexts. This disparity is significant because the outer context can make implementation difficult due to many of the factors being unmodifiable (e.g., funding; Bruns et al., 2019). One possible explanation for the increased outer context factors is that the participants were school principals; thus, they may have increased contact and knowledge of outer context factors. Compared to the inner context, there is a paucity of research on outer context factors in schools with the EPIS (Suhreinerich et al., 2021). Future SBMH research should examine how to identify and modify outer context factors (e.g., policy; Crable et al., 2022) that may help the implementation of SBMH services on a school or district level. Additionally, given the diversity of state standards regarding SBMH services (Eklund et al., 2018), future research should consider how different state-level outer context factors (i.e., policy) impact SBMH service implementation. Of note, our findings are congruent with recent SBMH research which identified stigma as a notorious barrier in rural schools (Garbacz et al., 2022). These results suggest that future research is needed to understand how to improve dissemination of SBMH in rural schools, in particular.

Another unexpected result of this study was the discussion related to CMHPs as both a barrier and facilitator to the implementation of SBMH. The study took place in a state requiring schools to enter into a memorandum of understanding with CMHPs to provide SBMH services, demonstrating the link between external factors and the inner context of the school system (i.e., “bridging factors” in the EPIS framework; Lengnick-Hall et al., 2020; Moullin et al., 2019). Contracting has been identified as an important bridging factor with bi-directional influences, where, in the case of this study, the school and CMHP both have influence on student outcomes (Lengnick-Hall et al., 2020). Although mandated, CMHP access was difficult for some participants, while others noted issues such as delayed wait times for CMHPs to initiate services. Funding and insurance requirements were also discussed, with the ultimate

desire for more availability of services to be provided within the school setting by school personnel or CMHPs. Further, barriers related to privacy, parental involvement, differing diagnostic systems and training (e.g., special education law versus the clinical diagnosis), and organizational structures impact effective collaboration with CMHPs (Villarreal & Castro-Villarreal, 2016). Collaboration with CMHPs has been shown to improve SBMH service provision (Reeves et al., 2022), and initial evidence from the IS literature suggests that effective teamwork is positively associated with implementation outcomes such as implementation climate (McGuier et al., 2023). Therefore, future SBMH research should prioritize the identification and testing of implementation strategies relevant to teamwork and collaboration with CMHPs (McClain et al., 2022).

Facilitators and Recommendations for SBMH

In contrast, participants provided facilitators and recommendations such as applying for grant funds, partnering with CMHPs, advocating for government support, using creativity to balance competing demands, garnering superintendent or school board support, and providing staff with PD related to MH. Participants noted that government policies could prioritize SBMH by requiring students to receive MH education in school. In combination with government support, principals largely endorsed the need for superintendent or school board support. Recommendations regarding the need for administrator support and funding were also captured in interviews with principals and assistant principals regarding the expansion of a SBMH project in an urban school district (Blackman et al., 2016). As such, the coalescence of inner and outer factors working toward SBMH programming is required for the normalization of SBMH.

More specifically, implementation strategies can be used to address and reduce the impact of barriers, defined as “approaches or techniques used to enhance the adoption, implementation, sustainment, and scale-up (or spread) of an innovation” (Kirchner et al., 2020, p. 2). While commonly used in the healthcare sector, Cook and colleagues (2019) adapted an established compilation of implementation strategies for use in schools (Powell et al., 2015). In addition to individual strategies, higher-order classifications of strategies were developed to assist with strategy selection such as dissemination, implementation process, integration, capacity-building, and scale-up strategies (Leeman et al., 2017). There have been several investigations into the use of implementation strategies for SBMH services (e.g., Eiraldi et al., 2023; Smith et al., 2022). Dissemination strategies, designed to target awareness and attitudes, are particularly relevant for SBMH service implementation, given our finding that stigma was a barrier in the inner and outer context (Leeman et al., 2017). This may include individual strategies such

as developing SBMH service packaging for a customized audience (e.g., administrators, community members, caregivers). Customizing dissemination efforts for each school or communities’ unique context may be critical given that participants in rural areas often identified stigma as a barrier to the implementation of SBMH services. Dissemination strategies may also represent an opportunity to leverage the distributed nature of leadership in schools, as the best individuals to convey information and increase buy in may not be school administrators but teachers, paraprofessionals, caregivers, and community leaders. To address participant concerns with CMHP collaboration, we suggest using individual strategies from Leeman et al. (2017) classifications such as implementation processes (e.g., establishing goals and objectives, engaging stakeholders), integration (e.g., revising professional roles, establishing new care teams), and capacity-building (e.g., training to build capacity, peer networking).

In addition to efforts at the school and district level, dissemination strategies can be targeted to policymakers in order to address other barriers identified in this study (e.g., funding and competing demands). Frameworks such as the EPIS can be used to target policy-level outcomes (Crabbe et al., 2022). As dissemination strategies and outcomes are crucial for improving the implementation of SBMH services (Baker et al., 2021), dissemination strategies should remain a priority in the SBMH research agenda.

Limitations and Future Directions

One limitation of this study is the use of only school principals as participants, considering that distributed leadership may be a key feature of implementation in schools (Locke et al., 2019). Future research should examine how other professionals, such as teachers and school psychologists, perceive SBMH services using the NoMAD. The unit of study was SBMH services as a whole, which may have also limited our findings. Future research should consider using the NoMAD to investigate educators’ beliefs regarding specific interventions (e.g., Trauma-focused interventions; Carlson et al., 2021; Connors et al., 2021a, 2021b). Additionally, the design of this study is cross-sectional, thus limiting any causal claims that could be inferred from the data. Another limitation is that demographic characteristics were not collected for students.

We recommend future research stratify qualitative data by scores on the ILS to further examine the relationship between these two data sources. Future research should assess principals’ perceptions of coherence, cognitive participation, collective action, and reflexive monitoring related to SBMH to further examine implementation processes related to SBMH via NPT. To further conceptualize what SBMH currently looks like, we suggest future research

obtain SBMH providers' perspectives on the current state of MH service delivery in schools to document practitioner perspectives and recommendations. Research exploring successful collaborations with CMHPs is warranted as well as follow-up studies to monitor the evolution of the normalization of SBMH.

Conclusion

To our knowledge, this is the first study that used NPT and the NoMAD measure to examine the implementation of SBMH services. As a framework rarely used in education research thus far (Wood, 2017), this study represents the first step in using NPT to improve SBMH service delivery. Additionally, this is one of few studies that have garnered school principal perspectives related to SBMH (e.g., Blackman et al., 2016; Iachini et al., 2016). Therefore, this study provides a promising initial look at the current state of SBMH normalization as well as barriers and facilitators to implementation through the EPIS framework.

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Declarations

Conflict of interest The authors have no conflicts of interest to report.

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