School Mental Health (2023) 15:967–984
https://doi.org/10.1007/s12310-023-09599-6

ORIGINAL PAPER

Navigators and Negotiators: An Ecologically Informed Qualitative Study of Providers' Perspectives on Their Roles in School-Based Mental Health Services

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Accepted: 11 July 2023 / Published online: 16 August 2023

Abstract

School-based mental health services (SMHS) offer a unique opportunity to embed support within a key developmental context, yet little research has examined SMHS providers' fit within schools' complex ecologies. Using a social-ecological framework, this qualitative study draws on focus groups with 67 SMHS providers from two large mental health systems to examine how school setting characteristics and interactions with school actors influenced their experiences providing SMHS. Thematic analysis revealed the importance of feeling valued by and connected to school staff, which facilitated strong ongoing communication and more effective collaboration. Providers described a flexible approach to communication and collaboration, including leveraging opportunities for informal conversation (e.g., in hallways or classrooms) to overcome barriers and boost their perceived value and connectedness. Opportunities for communication and connectedness were enhanced when providers worked in fewer schools, held roles on interdisciplinary teams, spent time in common spaces, when school staff shared providers' understanding of mental health and SMHS, and when school policies and structural features facilitated their inclusion. Providers also discussed the variety of factors, including their place in the school ecology, that informed student wellbeing (e.g., disciplinary versus supportive responses to challenging student behaviors). This study suggests potential mechanisms on individual, school, and district levels to strengthen SMHS providers' value and connectedness within the school ecology, and the importance of these factors to maintain strong communication and collaboration and effectively support youth and families.

Keywords School mental health services · Psychotherapists · Social ecological model · Qualitative research

Introduction

For years, research has indicated that significant numbers of youth in the USA have emotional or behavioral challenges that warrant treatment (Perou et al., 2013). Given that youth spend a sizable portion of their time in schools, and the logistic barriers to clinic-based services (e.g., transportation, parent availability), it is unsurprising that schools are the most common venue for youth mental health services (Duong et al., 2021). Schools may be particularly critical venues for service provision in historically oppressed communities impacted by multiple intersecting stressors (Cappella et al., 2008), where youth experience increased risk for emotional and behavioral challenges as well as heightened barriers accessing effective treatments from other settings (Santiago et al., 2013). Because schools are key settings for mental health service delivery, it is important to understand how those who do the work of providing SMHS navigate and experience them. In this qualitative study, we focused on mental health professionals tasked largely with providing therapy within schools (i.e., providing "Tier 3" services within the context of a multi-tiered system of support). We applied a social-ecological framework to examine how SMHS providers navigate school settings to provide care to students and families, and how organizational and relational factors

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contribute to or detract from their mental health promotion and support goals.

Professional SMHS providers who offer therapy—generally master's level social workers and counselors—vary in their association with their school system. Some are employed by school districts, while others are employed by external agencies and provide services to schools through contracts and inter-agency agreements (Kern et al., 2017; U.S. Department of Education, 2022). In addition to delivering individual and family-focused mental health interventions, providers may respond to mental health or behavioral crises, consult with school staff and others involved in student/family welfare (e.g., representatives of child services or the juvenile legal system), and participate on behavioral health teams. Research indicates SMHS are more effective when they include parents, teachers, or peers; leverage multiple modalities; and integrate program content into general classroom curriculum (Rones & Hoagwood, 2000). However, providers offering therapy to students and families in schools often provide services that do not integrate or overlap with other school programming, and the providers themselves frequently operate in relative isolation (Mellin & Weist, 2011). Challenges to effective service provision have been documented in relation to provider shortages (Eiraldi et al., 2015; U.S. Department of Education, 2022), inadequate coordination of services on both individual and systemic levels (Adelman & Taylor, 2009; Weist et al., 2017), schools' identification of academic achievement as a competing priority with mental health (Atkins et al., 2017), and uneven use of evidence-based practices (Owens et al., 2014).

Complexities around SMHS often reflect the substantial challenges schools face more broadly. Predictably, challenges are heightened in under-resourced, high-need communities and schools (Farahmand et al., 2011). Dramatic disparities along racial, socio-economic, and rural/urban lines in school resources, teacher stress and burnout, and staff retention have plagued school systems for decades (Bowers et al., 2018; Condron & Roscigno, 2003; Shernoff et al., 2011). The psychosocial needs of youth in oppressed and marginalized communities can interact with resource disparities to compound challenges, overwhelming limited resources, and impeding teachers' capacity to educate (Atkins et al., 2017). Providers delivering SMHS under these conditions must regularly navigate these complex, unique, and overextended contexts. Extant research has explored barriers and facilitators to the implementation of evidence-based practices and programs in school settings (e.g., Locke et al., 2019; Massey et al., 2021; Wassink-de Stigter et al., 2022). A better understanding of SMHS providers' naturalistic experiences navigating their school setting outside of implementation efforts could build on this literature to provide key insights toward improved SMHS.

Schools as Ecological Systems

Social-ecological models emphasize that individuals, settings, communities, and broader cultural and sociopolitical contexts influence and are influenced by one another (Bronfenbrenner, 1979; Stokols, 1992). The functioning of settings and communities can be understood by referring to principles with roots in the natural sciences, including adaptation, succession, cycling of resources, and interdependence. These principles emphasize that relationships among factors and across levels are complex and dynamic, and alterations in one area can result in cascading effects throughout the system (Kelly, 1966; Trickett et al., 1985). The "ecological perspective" reflected in this study also stresses that people are active shapers of their environments rather than passive responders, and their behavior serves an adaptive function in context (Trickett, 2009).

Educational research leveraging social-ecological perspectives has illuminated how the dynamic relationships among factors (e.g., various individual school actors, school climate, disciplinary policies, district-level and federal funding) can influence staff and student health, achievement, and behavior (e.g., Hong et al., 2012; Trach et al., 2018). It also incorporates a developmental perspective, emphasizing not only the complex contributing factors that inform school experiences, but also the enormous influence of these experiences on student wellbeing and development over time (Dunn et al., 2015). For example, school environment-related factors including teacher autonomy, principal leadership, and student and community problems have been linked to teacher satisfaction (Moore, 2012), which in turn predicts teacher effectiveness (Ostroff, 1992). Lastly, social-ecological models applied to SMHS have highlighted unique opportunities to support youth (Atkins et al., 2010, 2017; Dunn et al., 2015)—for example, by leveraging connections between teachers to promote the adoption of positive behavior support strategies (Atkins et al., 2015); or enhancing coordination of SMHS with multi-tiered systems of support to more effectively identify and serve students with higher needs (Weist et al., 2022).

Prior research examining SMHS providers' perspectives and experiences has often focused on their perspectives regarding the implementation of specific treatment protocols or interventions (e.g., Connors et al., 2021). Within this body of literature, several studies have utilized an ecological perspective to understand how the school ecology influences or is influenced by the individuals who provide SMHS by examining school-level implementation barriers. Examining SMHS providers' broader perspectives and experiences regarding their day-to-day work in schools and leveraging an ecological perspective can clarify how

providers might respond to the realities of school settings, and how their responses may in turn shape that of other individuals and the functioning of the system in full.

Elevating the voices of SMHS providers about their broader experiences in school settings is strategic for two reasons. First, SMHS providers possess unique insight into the mental health needs of students and their families and the effects of various school characteristics on student mental health. Thus, they are well positioned to identify potential modifications to the school environment to promote the wellbeing of all students, and particularly students who may benefit from additional supports. Second, understanding the effects of various school actors and factors on SMHS provider experiences and practices can clarify opportunities to enhance provider wellbeing, their integration into the school community, and their capacity to implement effective practices, thereby improving the quality of services for students and families and enhancing school-level capacity to promote mental health.

Present Study

In this qualitative study, we drew on a social-ecological model that demarcates six levels of influence on individuals' experiences—society, policies, communities, organizations, relationships, and individual (Michaels et al., 2022). Aiming to understand the most proximal factors influencing SMHS providers' daily experiences delivering services to students attending low-resourced schools in economically marginalized communities, we focused primarily on two levels: the organizational and relational. Additionally, we drew on constructs identified in the Consolidated Framework for Implementation Research, or CFIR—a widely used framework that outlines key constructs at multiple levels associated with implementation outcomes (Damschroder et al., 2009; Kirk et al., 2015). Though this study was not focused on the implementation of a specific intervention or innovation, leveraging CFIR constructs (e.g., external policies, structural characteristics of a setting, relational networks) framed our inquiry around the conditions under which providers sought to promote SMHS broadly. We sought to examine SMHS providers' perspectives regarding how school organizational factors (e.g., policies and norms, resources, and school-community relations) contribute to, or detract from, promotion of mental health and support for SMHS. We also examined how providers characterize their relationships and interactions with other school actors (i.e., *all* individuals who find themselves operating inside of schools), including school personnel (e.g., teachers, administrators, guidance counselors, secretarial staff, security guards, etc.), students, and families, focusing on relational factors they may perceive as barriers or facilitators to the promotion of mental health and support for SMHS. Although we did not explore individual contributions to these ecological systems as a separate set of factors, we examined providers' decision-making processes and behaviors in response to organizational and relationship-level factors.

Method

Guided by a constructivist-interpretivist paradigm emphasizing the equal validity of different individuals' lived realities in the process of knowledge generation (Ponterotto, 2005), we used a phenomenological qualitative research design that drew on semi-structured focus groups to generate a grounded description of SMHS providers' multifaceted and divergent experiences and perceptions (Smith, 2017). In keeping with this paradigm and the data analysis approach used, we acknowledge that our roles as researchers and our lived experiences play an active role in the presentation and interpretation of data (Braun & Clarke, 2021). The coding team included the first, third, and fourth authors: respectively, an early career researcher with a PhD in clinical psychology and White Ashkenazi Jewish woman from a background of educational and financial privilege; a PhD student in clinical-community psychology and second-generation Asian American woman with several marginalized identities raised in a large metropolitan area; and a PhD student in clinical psychology and White woman from a background of educational and financial privilege. None of the authors have worked as SMHS providers in the schools and systems where this study's participants worked, and have markedly different lived experiences. However, all authors had previous experience working in the schools and systems under consideration here in the context of an ongoing applied research partnership, and had preexisting working relationships with the SMHS providers who participated in this qualitative study. All authors also had considerable experience conducting SMHS research more broadly, and providing clinical services. In keeping with our research paradigm, we conceptualize knowledge production as highly situated and contextual (Braun & Clarke, 2021), and see the differences and overlaps in our experience and perspectives with one another and with this study's participants as a valuable resource rather than a source of potential "bias."

Setting and Participants

Two mental health service systems employed providers who participated in this setting. System 1 was a mental health services subsidiary of a large urban public school district serving a West Coast U.S. city; the school district employed providers, who worked within its integrated school mental health clinics. The majority (> 70%) of students in the district were Latinx and qualified for free/reduced lunch.

System 2 was a state-level department of mental health in a Southeastern U.S. state; providers delivered SMHS through contracts between school districts and regional centers, which operated multiple regional sub-offices that in turn each served multiple schools. The racial/ethnic background of students served by providers in the catchment area included in the present study was 50% Black/African American and 50% White; approximately 75% qualified for free/reduced lunch. Both mental health systems reflect significant geographical and organizational dispersion, as well as many layers to their hierarchical organization, and considerable within-system organizational variability. Providers from both mental health systems participated in a multisite randomized controlled trial (RCT) of an intervention to help providers identify and address challenges related to treatment engagement (Chorpita & Becker, 2017–2022). This RCT was launched three years before data collection for this qualitative study, though some providers joined their respective mental health systems, and thus joined the RCT, after its launch. Participant demographic information organized by mental health system is provided in Table 1.

Procedures

Prior to conducting this study, approval from the Institutional Review Boards of the investigators' universities and participating study sites were secured. Informed consent was obtained from all providers. For System 1, four in-person focus groups were conducted during a day-long event related to the larger trial. Providers were given breakfast and lunch, and the day was recognized as a professional development day. The focus groups consisted of approximately 10 providers each and lasted ~90 min. These focus groups were conducted in February 2020, with plans to convene providers from System 2 for a similar event shortly thereafter. Due to the onset of the COVID-19 pandemic, System 2 providers were unable to convene in person for a similar event. Instead, eleven small 2–3 person focus groups and one individual interview were conducted on a HIPAA-compliant video conferencing platform, each lasting ~60 min. These focus groups were conducted in February and March of 2021. Demographic data collection occurred concurrently with focus groups. Because the COVID-19 pandemic precluded the use of incentives (e.g., meals, release from work demands) that were available to System 1 providers, System 2 providers were compensated with a $25 electronic gift card for their time.

Semi-structured focus groups were led by the first author, the third author, the fourth author, or a facilitator affiliated with the larger trial and trained on the focus group protocol. Given the size of the in-person focus groups for System 1, each was attended by undergraduate or graduate research assistants who served as note-takers and timekeepers. Focus group leaders took notes and kept time for the smaller focus groups in System 2. The protocol consisted of three sections: the first was developed explicitly for this study to examine providers' experiences in schools; the second and third sections were more directly germane to the larger trial. All interviews were audio-recorded and subsequently transcribed by research assistants.

Table 1 Participant demographic information

Variable	Agency 1 ($n=41$)	Agency 2 ($n=26$)
Average age in years (SD)	36.2 (8.6)	46.0 (10.1)
Gender (%)		
Woman	36 (87.8)	25 (96.2)
Man	5 (12.2)	1 (3.8)
Race (%)		
Latinx/Hispanic	37 (90.2)	0 (0.0)
Black/African American	0 (0.0)	20 (76.9)
White/European American	3 (7.3)	6 (23.1)
Asian/Asian American	1 (2.5)	0 (0.0)
Education (%)		
MA/MS/MSW	40 (97.5)	26 (100.0)
PhD	1 (2.5)	0 (0.0)
Average number of schools served (SD)	1.6 (1.1)	2.4 (1.3)
Average days per week at each school (SD)	2.4 (1.5)	1.9 (1.2)
Average clients on caseload (SD)	18.4 (10.7)	31.6 (16.5)

Data Analysis

Processes associated with thematic analysis (Braun & Clarke, 2006, 2019, 2021) guided our analytic approach. Consistent with the elements of "codebook thematic analysis" (Braun & Clarke, 2021), a preliminary set of constructs was developed inductively through an initial review of the transcripts, then modified deductively by cross-referencing relevant constructs identified in the CFIR (Damschroder et al., 2009). *Outer Setting* constructs included "Needs and Resources of Those Served by the Organization" and "External Policy & Incentives;" *Inner Setting* constructs included "Structural Characteristics," "Networks & Communications," "Culture," and "Access to Knowledge & Information." "Knowledge & Beliefs about the Innovation," a CFIR construct nested under the domain *Characteristics of Individuals*, was modified to reflect others' knowledge and beliefs about SMHS. Codes were then iteratively revised or removed, defined with rules of application, and organized into categories to produce a codebook. The codebook was pilot tested with one focus group transcript in which all coders practiced segmenting the transcript into meaningful coding units, or excerpts, and assigning codes to the excerpts (Saldaña, 2013). Discussing the pilot results

facilitated further refinement of the codebook. The final codebook included the codes presented in Table 2, plus codes to identify the actors referenced in each excerpt (e.g., teachers, school administrators, parents/caregivers, etc.), codes to indicate the description of barriers and facilitators, and codes to indicate the strategies providers leveraged or suggested to address identified barriers. In our coding process, one coder excerpted and coded a transcript, a second coder then independently coded the excerpted transcript, and the two coders then reviewed coding and resolved discrepancies. If consensus could not be reached, the third coder would serve as a "tiebreaker." This phase of coding was conducted using SocioCultural Research Consultants LLC. (2021) Dedoose (Version 9.0.46) [Software]. Consistent with the elements of "reflexive thematic analysis" (Braun & Clarke, 2021), we thoroughly reviewed the coded excerpts collectively and reflected on the content discussed within the transcripts. Consistent with reflexive thematic analysis' "interpretive reflexive process," we acknowledged how each coder's subjective knowledge and skills informed these reflections, and conceptualized this research subjectivity as a resource for knowledge production rather than a problematic or eradicable marker of bias. We developed initial themes from these reflections and created a thematic map of factors influencing providers' experiences working in schools through a process of topic consolidation, refinement, and reorganization. These processes of engaging with the data in multiple ways helped us define and finalize themes. Of note, the social-ecological perspective grounding this study emphasizes the complex interactive influences of factors across multiple levels, including but not limited to or centered on the mental health systems that employed provider participants. Thus, creating comparisons across systems was not a primary goal for this study nor an explicit part of data analysis. However, as we reviewed themes, we reflected on the similarities and differences of providers' experiences within their unique contexts.

Results

The themes that we identified through the process of thematic analysis are presented below.

Organizational Factors

School District and School-Level Policies

Providers reflected on how school district and school-level policies impacted both the services they provided and the degree to which mental health was integrated in the broader school ecosystem. Providers noted that school policies related to permissions for exchanges of information impacted their ability to collaborate with students' teachers to facilitate mental health services in and out of the therapy room. Competing priorities such as district and state testing policies also made teachers hesitant to release students for services during class time or allot additional time in the school day for mental health curriculum. As one provider explained:

> It is hard for the schools because they do have all these plans and test scores and state demands, district demands, and seeing progress with their education, so it's hard for schools to like, they know that mental health and wellness has to be addressed, otherwise they can't get to education, but they have all these demands on them to perform.

School Characteristics

"School characteristics" included school infrastructure (e.g., the size of a school, whether students rotate classes); school climate (i.e., the quality and character of school life as experienced by students, parents, and school personnel; National School Climate Council, 2012); school culture (i.e., the values and beliefs evident in the way a school operates; Fullan, 2007); relationships between other members of the school community; and individual characteristics of school community members other than the study participants.

School Infrastructure Characteristics, Culture, and Climate Providers described how varied school infrastructural characteristics and their placement within the infrastructure influenced their experiences providing SMHS. For example, some schools supplied providers with designated private spaces for their work. This was seen as particularly beneficial when positioned near the offices of guidance counselors, social workers, and/or school administrators. Others were provided with inadequate or inappropriate spaces. One described a school that provided them with a storage closet to use as their workspace, with frequent interruptions from school staff accessing the space, even when the provider was working with students. Providers also noted that school infrastructural characteristics were associated with school culture and climate, particularly in comparing elementary schools with middle and high schools. Providers noted that elementary schools, which were generally smaller, had climates characterized by relatively strong communication among school staff. They were also seen as more welcoming, and more supportive and nurturing toward students. In contrast, middle schools were seen as less networked and less supportive toward students, and high schools were seen as least networked and least supportive. Relatedly, providers observed that high schools more frequently leveraged exclusionary discipline, whereas elementary schools were

Table 2 Codes used to scaffold thematic analysis

Code	Code definition	*Illustrative Quote*
External policies & incentives	A broad construct that includes policies and regulations, external mandates, recommendations and guidelines, and public or benchmark reporting	*Recently, there has been a big shift on when the school refers, like for a high-risk client. Like somebody who has recently had suicidal ideation. Um, we-just as an office have had this big push where when they refer, we ask if they can provide the safety plan already. Because a lot of the times with these high-risk clients, we already know we are going to see them like soon like really fast, they are going to be at the top, so instead of having them come in and us having to do another safety plan.*
Clinic characteristics	Aspects that define a clinic's characteristics or processes/resources related to the clinic (e.g., number of providers, caseload, supervision, documentation)	*I'm primarily clinic-based, so I think it's convenient that we work for the district because we have access to things that maybe other clinicians don't throughout the field, like grades online. We have the same system that is connected to grades, so that's something that maybe like a nonprofit or somebody that's not in the district wouldn't have access to. But because I'm in the clinic, I am limited to contact with teachers, so it would also be the same procedure as trying to contact them, get them to call us back, scheduling, so at least on my end it's similar, um but I do think it's helpful to have some of the same programs to look into IDs and things like that.*
School characteristics	Aspects that define a specific school, the school system or resources related to the school (e.g., employees, budgets, physical resources, location)	*I think sometimes too, the school climate is not warm enough for students, so sometimes teachers and administrators or other support-supporting staff on campuses um are very um…um, what's the word? Like they put students down, or—and that, you know, that doesn't contribute to their positive behaviors, so they'll get labeled or, you know, they're just harsh on some of the um consequences that they get. So I think that sometimes that sets them back rather than supporting them or helping them.*
Knowledge and beliefs	Non-provider individuals' understanding of, attitudes toward, or beliefs regarding topics such as mental health challenges and services	*Because [teachers] go to school to teach and so the behaviors, you might be thinking you're dealing with ADHD. Well, this might work for ADHD, but you do it for trauma and you've triggered something and "Darn that kid is really acting up in my class." Um and teachers aren't doing it on purpose, they just don't know.*
Student & Family Characteristics	Characteristics of the students and families served by the school and providers, including but not limited to clinical diagnoses and severity, financial needs, age of youth, etc	*Some students that are more um they're presenting with more externalizing behavior, I find it's easier to take them out of class because the teachers may find like some relief in having that student out of class. But if they're kind of a kid that kind of flies under the radar, maybe they're just very depressed or you know they're experiencing some other symptoms, then there is more pushback like, "Oh well I'm, you know, I'm giving them some like notes right now so they can't come."*
Access to knowledge and information	Access to training or other formats for acquiring useful information, knowledge, or skills to serve students receiving mental health services or promote mental health in broader student body	*The teachers really didn't talk much, all they wanted you to do was come get the kid. But, um they really didn't try to work with me much to control their behaviors or help let them use their coping skills… I kind of wanted to work with the teachers. Because some of the stuff that they got sent to me about, if they could have just used that one coping skill or take that five-minute break and go to the bathroom and come back, then, they-they wouldn't have to come to me or go to the um to the principal or anybody else. So, it was, I would rather for them like to have a conversation with me um so they can kind of know where me and the kid is at, and what-and what they could possibly do to help with the um behaviors.*

Table 2 (continued)

Code	Code definition	*Illustrative Quote*
Networks and communications	Nature and quality of social networks and of formal and informal communications between other individuals	*Even the teachers, if they are talking among themselves about behaviors that a student is having, a teacher that's been here for a couple of years will say like, "You need to refer them to Miss [Provider]."*
Communication and interaction	Communication or interaction between providers and other individuals in the school ecology and/or involved in the lives of students receiving services	*Whereas others, you know, they just seemed to be so hectic that I hardly ever, you know, got an opportunity to speak with the teachers* per se*, but I would either go to the administration or the school [guidance] counselor, but I'm not, I did not feel as if, you know, it was as effective as those that were more hands on.*
Connectedness and belonging	Sense of providers' place and feelings about their relationships with others or the degree to which they feel networked or welcomed in the school	*I just feel like there should be some form of connection. Even though we're part of the district, I feel like we're like a different component. It just makes it hard to really be able to collaborate with everybody and work as a team to meet the students' needs because we're kind of just seen as outsiders instead of like, you know, colleagues, that we're there to provide support.*
Exclusionary discipline[a]	Discussion of the presence or absence of punitive and/or disciplinary actions by schools or school actors, both in response to students on providers' caseloads and to students in general	*It was kind of more lenient before expelling them because, at alternative school, like the smallest little thing can get you expelled for the year, but they would kind of work with them more, and then they will also, even though sometimes, they're my client, I'm not there all the time, they will also let them see the guidance counselor, or the school-based therapist, or if it's just a child that's just having a lot of issues, all three of us will come together and try to come up with a plan to see how we could work with that child, but—and sometimes the principal, if he knows they are on my case, he would try to work with them too so…. Some of my kids were able to get on a 504 Plan to assist them with their behavior… Um, and they-they always would kinda let me kind of work with them a little before they expel them.*

These codes were applied to transcript excerpts. Excerpts tagged with each code were reviewed together to scaffold the generation and refinement of the themes presented in text

[a]Exclusionary Discipline was not included in the codebook; rather, this topic emerged through thematic analysis

more likely to connect students' challenging behavior to their wellbeing and identify a need for additional supports.

Providers observed that some schools' cultures were oriented toward promoting mental health and supporting student engagement in services as needed. For example, providers described some schools' commitment to integrating mental health promotion groups or social emotional learning (SEL) curricula and practices, and the diffusion of this information across school staff. "I've seen the guidance counselors go and teach social- emotional and um, the teachers will take, you know, coping skills that we've talked about and let the child use them in the classroom or remind them." Other schools' cultures were seen as focused on academic achievement to the exclusion of mental health promotion. For example, in the focus group in which some providers described the promotion of mental health and SEL activities, one provider responded by describing a school's requirement that 90-min SEL lessons from a standardized curriculum be fit into 30-min lessons. Others in the focus group then responded that they worked in schools that had rejected the inclusion of SEL curricula completely. Providers felt these choices primarily reflected the external pressure schools faced to deliver academic outcomes, though in a few cases they felt individuals within the schools simply placed limited value on social and emotional functioning. In tandem, providers described considerable variability in how readily or frequently schools leveraged disciplinary versus supportive responses to student issues. Some providers described schools that permitted students with known mental health needs to see their provider, a guidance counselor, or other supportive school staff if they experienced challenges at school. Other schools, in contrast, were described as more inclined toward punitive responses, and less likely to leverage mental health resources to respond to behavioral challenges.

School Personnel and Families' Knowledge and Beliefs Providers described numerous ways in which school personnel and families' knowledge of, and beliefs related to mental health challenges and services influenced how they interacted with students, with each other, and with SMHS providers. For example, providers observed that schools responded differently to students based on their developmental stage. Compared with older students, providers remarked that younger students were treated with more sensitivity and compassion, and their challenging behaviors were more frequently conceptualized as mental health concerns. Providers also observed that school administrators and teachers' knowledge and beliefs impacted how they were able to provide services, with teachers' knowledge and beliefs noted as particularly influential. For example, providers reported that teacher knowledge of mental health challenges and services enhanced communication and the quality of care that providers could offer students. As one explained:

> The teachers, if they noticed some of the symptoms of like, if a student is in the classroom and they're experiencing or having symptoms of anxiety, what they would do is refer the children to the guidance counselor, the guidance counselor would do their own little assessment and determine if the child needs to be referred to mental health.

Providers observed that disruptive behaviors, externalizing problems, and trauma appeared to be most frequently misunderstood and stigmatized. Providers also shared instances when they felt teachers and administrators missed or misinterpreted the cause of student disruptive behaviors (e.g., as primarily attention-seeking rather than a trauma response). Providers described how these attributions contributed to decisions to discipline, suspend, or expel students rather than refer them to SMHS or work with their existing provider. For example, one provider said:

> I just went to a re-entry meeting for a client that just came out of detention center. And he's going back and forth, and sitting at the meeting like those police officers, the principal, and everything was so punitive. And you know, "We need to get him out of the school and out of the area. It's a danger to the school," and you know. I'm thinking, 'cause I know the client, I know he has a very long history of trauma, gangs—he's in gangs, so he's been exposed to shootings, murders, and stuff like that.

Providers also described difficult situations in which they perceived that caregivers were not given information about mental health challenges and services, and when they held stigmatizing beliefs around mental health challenges and services. Providers observed that these beliefs sometimes led to service refusal, or consenting to services but refusing to allow information-sharing between providers and other school personnel. Both stigma and a misunderstanding of services were also seen to contribute to suboptimal engagement in the services provided to their children. Some providers described how these challenges could be engendered or exacerbated by poor communication from the school: "Even when parents are referred, they're not always explained why they're being referred. Or often times, it's again kind of going back to like, it's almost seen as a punishment. And then that really affects treatment because there is no buy-in from the very beginning, it's like well we have to be here, the school told me I have to be here." This quote illustrates another point made by multiple providers: poor and/or infrequent communication between school personnel and students/families, reflecting both individuals' understanding of the challenges that students were experiencing

and educators' many competing demands, could sometimes result in tense or antagonistic relationships between school personnel (particularly teachers and school administrators) and students with mental health needs and their families.

School Networks Providers described some schools as possessing strong communication and collaboration networks across individuals. Providers connected the quality and quantity of communication about students' mental health and engagement in mental health services to the value that each school placed on mental health promotion. In schools in which mental health promotion seemed to be valued highly, a variety of school staff communicated observations or concerns to one another, resulting in a higher volume of referrals for services as well as an overall culture of nurturing and support for students. Providers characterized other schools as relatively low in communication and collaboration. This was attributed largely to understaffing, competing demands, and time scarcity for school staff, which in some cases contributed to high turnover that further weakened networks.

Relational Factors

Relational factors pertain to providers' relationships with others in the school community, including school staff, students, and families. However, discussions focused primarily on providers' relationships with school staff.

Visibility and Value

Providers emphasized the importance of feeling both visible to and valued by others in the school community. When they did not feel visible and valued, they described feeling like "outsiders." For example, one provider described their frustration upon being given a visitor's sticker by a school's front desk staff. Another said:

> I just feel like there should be some form of connection. Even though we're part of the district, I feel like we're like a different component. That just makes it hard to really be able to collaborate with everybody and work as a team to meet the students' needs because we're kind of just seen as outsiders instead of like, you know, colleagues, that we're there to provide support.

Providers described feeling appreciated, visible, and valued through their involvement in student-specific meetings (e.g., IEP meetings), or all-staff or team meetings. Similarly, providers felt valued when they were given a designated, centrally located office space. However, providers held differing opinions on how they preferred to be integrated into a school. Some appreciated that school administrators and teachers called on them to support students in crisis, and to participate in meetings and other opportunities for decision making. These providers felt these gestures promoted a stronger and more collegial working relationship with other school staff. Others felt these requests pulled them away from the primary task of providing ongoing services to students on their caseloads. Particularly given the heavy demands on their time, these providers felt that schools demonstrated they understood and valued providers and the work they did by leaving them alone to complete prioritized tasks.

Providers also described ways in which their presence in school sometimes buffered against disciplinary responses to student behaviors or concerns, and instead facilitated a response aligned with understanding these behaviors or concerns as mental health related. For example, providers described intervening on behalf of students to prevent disciplinary action and direct decision-making toward the provision of further supports, and some described being included in disciplinary meetings to offer recommendations.

Communication and Connectedness

Providers emphasized the fundamental importance of their own communication with others, and of their sense of connectedness and belonging within the schools. As one provider said, "in order to make a difference, you have to be a part of that community." They characterized communication and connectedness as bidirectionally related: stronger relationships enhanced and sustained higher quality and quantity of communication, and stronger communication fostered a sense of connectedness. Communication often occurred during informal encounters—for example, "they [teachers] would seek me out in the hallway and say, "So what do you do? Like, I have a kid I might want to refer." Providers also described how they took advantage of natural opportunities for communication to build relationships as well as discuss specific issues.

> I'm a talkative person so, I actually go up and talk… I find myself sometimes standing in the hallways with the teachers and…if I see one out in the hallway, I could go up and talk to them and then say, "Hi, I always saw you here but I never knew who you were." You know just kind of introduce myself to them.

Providers emphasized the value of exchanging information with multiple individuals, and particularly teachers. Under the most facilitative conditions, teachers provided information about students' behavior in the classroom, and allowed providers to collect their own information (e.g., via classroom observations). Guidance counselors shared information about students' histories and current academic performance. Caregivers provided information about their families' needs and strengths and their children's functioning outside of school, as well as provided consent for providers

to communicate with school staff and other providers. Because of the unique potential contributions of these different individuals, providers valued strong linkages to all of them. Broadly, providers characterized their relationships with other school personnel as collaborative and positive.

Providers described how their communication and connectedness with others sometimes varied as a function of students' presenting problems. When serving students with externalizing problems, other school personnel were sometimes inclined to perceive them as advocates for students and antagonists of the school, rather than as colleagues with shared goals of ensuring student wellbeing. As one provider described it, "they kind of see the provider as an advocate for the child and not a colleague, and I've had that concern before." This difference in perspectives resulted in tense relationships between providers and other school staff. Another provider explained:

> I think a lot of the times that it unfortunately depends on what the student is presenting with. So, you get more support if it's a, like, depressive or anxious child versus if it's your disruptive um kid who's causing more of a ruckus or like…more challenging behaviors. Um, so you get kind of looked at in a different way depending on the two. And it's almost like a lack of patience, too, where it's like, "Oh, you've seen them twice now, like why are they still behaving this way? And why haven't you fixed them?"

Providers also shared how school personnel sometimes communicated with them only when they deemed it necessary and were less willing to communicate in response to providers' invitations.

> Well usually when we get a referral it's because they needed that support, so they're looking for us for most of the answers. So a lot of times it's kind of like out of need they're probably reaching out, but I think once the situation maybe subsides or is stabilized, then it's harder to keep maintaining that connection. And then it depends on their personality, it depends on like the school environment and climate.

Providers were invested not only in receiving information from others to inform their work, but also in providing information and support to others—for example, around mental health referral protocols and classroom management strategies. Several providers also described their role educating school staff on the links between behaviors and mental health needs, and consulting with both parents and school staff on disciplinary issues. As one described:

> [A parent] may call and say, 'well my child got suspended from school and they want her to go to the district to do a disciplinary hearing.' And I say, 'make sure before you open your mouth in the hearing that [Provider] is part of his hearing. If not, they will say things that you don't understand… So if I would go, they always say '[Provider], what is your recommendation, what would you recommend,' and I said, 'I would recommend that this is this child's first offense, allow me to work with him or her, let me do – instead of doing one time a week, let me push it up to two times a week, so we can combat some of these struggles, some of these challenges that he's going through, you know, because it's gonna take all of us to really help. And let me work with the parents to help understand what's going on with, you know.' If I'm not there, I mean, they-you have to be that mouthpiece for that child.

In schools described as densely networked overall, providers felt well integrated into communication and consultation. They described being integrated both informally—e.g., through impromptu conversations with teachers and other school staff—and formally—e.g., through invitations to participate in meetings about specific students or about addressing student mental health needs broadly. As one provider explained:

> I had a strong team in the school system, where I work with the whole community in the school—from the cafeteria workers, to the janitors, to the school psychiatrist, to school guidance counselor, everybody, teachers, administrators, we were all involved and that's how we made a difference in the child's life.

Additionally, providers identified specific school staff who were key in linking providers to school networks. These individuals were frequently school employees tasked with SMH and student supports (as opposed to SMHS providers employed by external mental health systems or by the school district, as study participants were), and less frequently principals, assistant principals, or specific teachers. Providers emphasized the importance of this linking role and highlighted the negative impact on their work when these linking individuals were divided among multiple schools, turned over, or faced too many competing demands to communicate frequently or effectively with them. Providers also described the negative impact on communication and connectedness when they themselves were "spread thin" due to clinical demands, administrative duties, and placement in multiple schools. These factors diminished their regular presence and ability to embed themselves in each school's unique community, build individual connections, and engage in informal modes of communication (e.g., catching a teacher in the hallway or lounge).

> If you're not in the schools all the time like some of the schools I have, it's not as detailed I guess or not—because you're not there all the time and they don't see

you all the time. They don't know you as well. So it's not as personal I guess you could say. If anything, it's more like a business type of deal thing instead of a business personal type of deal thing I can do.

Providers also observed that decisions around whether to address a specific situation with disciplinary versus supportive responses often seemed related to which school staff were present at the time of the incident. For example, if a student engaged in disruptive or concerning behavior on a day when the provider was present, the student might be sent to the provider, or the provider might be able to intervene on the student's behalf. If the situation occurred on a day when the provider was not present, school personnel might summon a guard or school resource officer (i.e., a police officer), send a student to the principal's office or home, or suspend or expel a student. Thus, providers saw their connectedness to others within a school ecosystem and their opportunities for communication as vital factors contributing to their ability to divert students from exclusionary discipline.

Discussion

Existing research suggests that SMHS providers are best positioned to support students' mental health when they have (1) effective clinical skills; (2) instrumental affordances (e.g., private space to meet students); (3) agreement from all school stakeholders that student mental health is integral to academic success; (4) when they are viewed as part of the school team; and (5) when the schools feel welcoming to students and families (Eiraldi et al., 2015). By applying an ecological perspective to explore how SMHS providers perceived and responded to interpersonal and organizational contexts when promoting mental health and providing mental health services, this study illuminated potential pathways through which schools impede or facilitate both SMHS providers' work providing direct services to youth, and mental health promotion and support for students more broadly. Providers characterized themselves as highly agentic navigators and negotiators within these systems, but also acknowledged their actions and experiences were fundamentally constrained by higher-level organizational factors that created a container for their experiences, decisions, and actions. However, though providers worked within two very different mental health systems in very different geographic locales, we did not find marked mental health-system level differences in providers' descriptions of their experiences navigating school ecologies. This may reflect the complex and variable nature of the mental health systems, which yields significant within-system variability, or the individual-level variability of the providers within each mental health system. It is also possible that the absence of marked differences across mental health systems reflects some foundational similarities related to U.S. schools and communities that are revealed when a provider is asked about their local school ecology.

Organizational Factors: The Multilevel Interplay Between Policies and School Characteristics

Policies across levels had a large impact on SMHS providers' ability to deliver services. In keeping with research documenting the deleterious consequences of high-stakes testing legislation for under-resourced school systems (Darling-Hammond, 2007; Husband & Hunt, 2015), district and state level policies and expectations, such as meeting testing benchmarks or following rigid curriculum requirements, were seen to add stress to the school systems in which providers worked. Providers observed that, even if unintentionally, district-level policies could contribute to a school culture that deprioritizes mental health for a focus on academics, despite school personnel's understanding of the importance of mental health promotion and support. With large student-to-teacher ratios, high pressures around test scores, inadequate pay, and a host of other factors contributing to high teacher stress and burnout (e.g., Shernoff et al., 2011; Steiner & Woo, 2021), it is also unsurprising that providers described challenges fully engaging teachers to address students' mental health needs—challenges exacerbated by providers' own large caseloads and work across multiple schools. Our findings are consistent with prior studies examining specific implementation efforts, which have highlighted competing demands and responsibilities from school administrators and teachers; lack of therapeutic spaces in schools, and logistical barriers reflecting that "the school environment can be hectic and crisis driven" (Corteselli et al., 2020; Langley et al., 2010). Broadly, providers' experiences highlight that though mental health supports may nominally exist consistently across schools, the actual presence and quality of supports available within different schools are influenced by those schools' idiosyncratic enforcement of state and district-level policies.

Providers were also sensitive to variability in schools' infrastructure, culture, and climate. Some schools were perceived as more welcoming to providers and others less so—a particularly notable distinction comparing the relatively positive climate at elementary schools to middle and high schools, which is substantiated by prior research (Bear et al., 2017). Providers suggested these variations may be attributable both to infrastructural differences (e.g., closer teacher-student relationships when students do not rotate classrooms) and gentler, more mental health-aligned attitudes toward younger students. Relatedly, a connection was drawn between limited school resources and the perceived marginalization of mental health. Providers felt less valued

when they were provided suboptimal working spaces and when other school personnel seemed not to have time for them. Whereas many studies have documented the difficulties providers encounter navigating overburdened and under-resourced schools (e.g., Corteselli et al., 2020, Powers et al., 2010), our study highlights the possible impact on providers' sense of themselves *in relation to* other school staff, and the feedback loop into their ongoing efforts to support students under these conditions. For some providers, placement in multiple schools compounded challenges establishing productive working relationships. Others noted the distribution of resources, influenced by school policies, as integral to advancing mental health for youth, particularly in underserved schools (Atkins et al., 2017). This study suggests subtle but critical potential mechanisms through which the allocation of physical and human resources can impact SMHS.

Additionally, providers identified the mental health-related knowledge and beliefs of various school staff as extremely important to their work and to student mental health, and observed variability on a school and individual level. Schools characterized on the whole as exhibiting greater knowledge about mental health and shared beliefs in the importance of mental health were seen to support better collaboration and communication between providers and school staff. Conversely, schools with less information and value placed on mental health demonstrated poorer shared understanding of students' needs and providers' roles, and miscommunication between providers and school personnel, resulting in a sense of providers' alienation from the school ecosystem. Providers noted when individual school staff members, particularly teachers, seemed to possess more information and beliefs aligned with the importance of mental health promotion, teachers' interactions with students were more supportive, they referred more students to SMHS, and were more willing to collaborate with providers following referral.

Providers also commented on challenges related to some caregivers' knowledge and beliefs about mental health. They noted that stigmatizing beliefs about mental health resulted in confusion and distrust about treatment and referral of services—a phenomenon documented in other studies (e.g., Hurley et al., 2020), and one that may be particularly salient given that these families frequently held racially or ethnically minoritized identities and lived in communities impacted by economic marginalization (Whaley, 2001). Consequently, providers desired more training on interacting with caregivers. Prioritizing caregiver engagement may be particularly important given not only that caregiver consent is necessary to initiate treatment, but also that caregivers play a key role in effective treatment for youth (Barnett et al., 2020). Further, providers in this study espoused beliefs that student mental health is promoted most effectively, and they are best able to fulfill their roles, when all school and home environments are activated as supportive and promoting, rather than relying on SMHS providers to "fix" certain students. This aligns with recent work enhancing coordination and synergy between SMHS and other multi-tiered systems of support in schools (Weist et al., 2022) and evidence that service models bridging home and school are necessary to support students with mental health needs (Atkins et al., 2015, 2017).

Although some providers may have experienced or characterized certain challenges with other school staff or caregivers as individually situated, we understand these challenges, too, from an ecological perspective. Individuals' behaviors do not reflect individual deficits; rather, their behaviors reflect the systems in which they are embedded. So many complex and interrelated factors influence the behaviors that different individuals select, and others' interpretations of these behaviors—to name just a few, individuals' own and others' race, ethnicity, class, gender, and network centrality, in addition to myriad factors at higher levels of the social-ecological model including structural racism, marginalization, and oppression. The ecological perspective also emphasizes the adaptive nature of behaviors in context, and the adaptive utility of diversity in the behaviors that individuals apply—"no one kind of adaptive behavior fits all" (Trickett, 2009, p. 396). Though individuals' adaptive behaviors may be experienced by others as suboptimal, systemic adjustments are more likely to shift these behaviors than individually targeted responses.

Relational Factors: Building Communication Pathways and Enhancing Connections

School-based intervention research often focuses on formalized consultation models (e.g., Sheridan & Kratochwill, 2007), on consultation or coaching to promote uptake of specific evidence-based practices (e.g., Kraft et al., 2018), or on broad best practices for engaging and supporting stakeholders (e.g., meeting consistently with stakeholders throughout implementation initiatives; Massey et al., 2021). These bodies of literature offer valuable guidance for implementation support strategies; however, it is also important to consider informal consultation and collaboration opportunities, and how those opportunities may be generated through building and maintaining durable ongoing relationships. Providers in our study described relationship building as instrumental to increasing their visibility and value to other school staff, which they identified as a critical precondition for bi- or multidirectional knowledge exchange and collaborative problem solving. Previous qualitative research similarly highlights the importance of communication and connectedness between school staff to better support students (e.g., Dimitropoulous et al., 2022; Mellin & Weist, 2011; Shernoff et al., 2015), and some SMHS models have

focused on relationship development to generate and capitalize on natural opportunities for informal but substantive communication (e.g., Mehta et al., 2019; Rusch et al., 2019).

Providers in this study defined themselves as active shapers of these relationships, approaching school personnel with warmth, empathy, and flexibility while leveraging their mental health expertise to demonstrate their value. Similar attributes have been identified as important for other school-based mental health messengers to possess, such as charisma, credibility, and a welcoming disposition (Boyd et al., 2017; Larson et al., 2022). As noted above, providers also placed a premium on time and availability. They noted when they were able to spend sufficient time in a school, they were able to develop and maintain strong, productive relationships with other school personnel; importantly, this allowed them more leeway to navigate other school staff's time scarcity. With stronger relationships established, providers found it more feasible to collaborate with school personnel initially disinclined or unable to provide students with optimal support. Their reflections suggest that providers have opportunities both in the moment and over the long term to influence others' perceptions of students' difficulties and the optimal responses to those difficulties. However, time scarcity and competing demands can obstruct the development of strong connections and, consequently, optimal student outcomes. Of note, some researchers have invoked ecological perspectives to call for a "paradigm shift" in the approach to SMHS, fundamentally reimagining the form and content of SMHS to integrate fully with other school goals and practices (see Atkins et al., 2010, 2017). Though providers in this study leveraged notable creativity and flexibility to enhance collaboration and communication, some competition for limited resources—for example, students' and teachers' time—may be unavoidable if the field continues to rely on and replicate SMHS models that are imported from other settings rather than crafted with schools' ecosystems in mind.

Organizational and Relational Influences on Supportive Versus Disciplinary Responses to Students

Providers' reflections on school discipline offer a novel contribution to SMHS research, clarifying how the presence of certain school personnel, as well as the strength and quality of relationships between school personnel, may contribute to the interpretation of and response to challenging behaviors or situations. Providers' observations align with research indicating suspensions, office discipline referrals, and juvenile legal system referrals can be reduced when SMHS professionals provide consultation to teachers (Perry et al., 2008) and play a role in multi-tiered emotional and behavior support (Bohnenkamp et al., 2021). In line with research demonstrating the value of coordinating SMHS with school-wide practices (Weist et al., 2022), providers noted increased opportunities to support students at risk of disciplinary action when they could be present consistently at a school and well-integrated into its daily functioning. This increased embeddedness enhanced their value and visibility in the school, which they could leverage to support students in moments of crisis, and during consultations and other opportunities to shift other school staff's mindsets and practices. If their place in the school ecology afforded these pathways, providers could promote diversion away from disciplinary, punitive, or criminalizing responses, and toward responses grounded in care and rehabilitation.

Providers also identified countervailing forces contributing to increased likelihood of punitive disciplinary responses—for example, involving school police. Research examining the direct impact on students of police involvement in school mental health crises is limited (Choi et al., 2021); however, students with mental health challenges, particularly racially or ethnically minoritized youth, are disproportionately subjected to school discipline, arrest, and incarceration (Homer & Fisher, 2020). The presence of police in schools also corresponds with increased rates and severity of disciplinary responses, particularly for students of color (Crosse et al., 2022).

Despite minimal evidence that police presence in schools enhances school safety (Gottfredson et al., 2020), rates of police in schools have almost doubled in the past twenty years. Currently, police are placed in approximately 58% of public schools, and another 22% of students attend schools staffed with security guards (Diliberti et al., 2017). However, schools are rarely sufficiently staffed with mental health providers. As of 2019, 14 million students attended public schools with police but no counselor, nurse, psychologist, or social worker, and roughly 90% of students attended schools that failed to meet recommended ratios of SMHS providers to students (Whitaker et al., 2019). Providers in this study reported operating under such conditions. They reported carrying large caseloads, balancing many competing demands, and working in multiple schools. Providers descriptions of responses to students' behaviors and needs suggest that punitive versus mental health-oriented pathways may be determined less by students' behaviors than the presence of certain school personnel, the competence of others, and the relationships among the network of adults within a school. If this is so, resource allocations to police versus mental health supports may have highly consequential impacts for students beyond their receipt of SMHS.

Implications

This study illuminates several opportunities for research related to SMHS providers' and other school actors' roles and connections in the ecosystems of schools. Research

that examines variations in implementation and outcomes of school policies across different school settings may be valuable, given providers' descriptions of differing policy interpretation and implementation in their schools and the consequences for their work. Given that multiple school staff's time scarcity was identified as a critical barrier to providers achieving their goals, examining SMHS promotion and student outcomes in relation to provider caseload, the number of schools in which they work, and teacher class sizes and competing demands may also fill important gaps in our understanding of the contributors to high quality service provision and student mental health. We must remember that the significant underfunding that characterizes contemporary U.S. education and mental health systems, and the extremely challenging conditions under which schools and mental health systems in oppressed and marginalized communities consequently operate, is a result of policy and decision-making, not an immutable reality. As providers in our study readily acknowledged, no amount of individual accommodation can fully make up for these structural and systemic factors.

With so many school-level factors informing SMH promotion, future research can also explore concretely how these factors influence student outcomes. For example, how are external policies around testing and academic achievement, school climate, relationships between school actors, and mental health knowledge and beliefs of school actors related to one another? Taken separately or together, how do these factors affect SMH promotion, relationships between providers and other school actors, and student mental health? Given the importance that providers in this study placed on their relationships with others, additional research exploring relational factors can also offer valuable contributions to our collective understanding of SMHS and the optimal promotion of student wellbeing. For example, social network analyses could explore how SMHS providers' network embeddedness (i.e., the quantity and quality of their ties to other school actors in aggregate) and the quality of individual relationships with other school actors enhances collaboration, use of mental health supports both by the providers and other school actors, and student outcomes. It may be valuable to explore student outcomes beyond mental health and academics, such as those related to exclusionary discipline or criminalization.

Additionally, future research could ask more pointed questions to elicit perspectives about how regional organizational context affects the work of providers within the local ecology of their schools. More broadly, future studies could examine a range of factors influencing the delivery of SMHS and the experiences of providers related to the *Outer Setting* domain (e.g., school districts, mental health systems), and to communities (e.g., geographic/regional characteristics). However, such research would ideally continue to reflect the high intra-organizational diversity and variability that the ecological perspective indicates.

Providers in our study identified several additional policy and practice changes they believed would facilitate their efforts. For example, they suggested it would be valuable to train teachers and other school staff to promote identification of mental health difficulties, and practices to support students more compassionately and effectively in the classroom and throughout the school. Providers also suggested education around mental health services, including referral processes, the role of providers and the importance of communication and collaboration, and how mental health treatment progresses over time. Providers believed this would enhance their relationships with other school staff and their capacity to provide high-quality mental health services. Some providers described their own ad-hoc attempts to provide psychoeducation, with varying success; however, they suggested it would be more effective if trainings were offered through official channels, as this would emphasize the value school and/or district administrators placed on mental health promotion and SMHS. High quality research on interventions to enhance the capacity of school staff to identify and respond to mental health concerns is limited (Yamaguchi et al., 2020); however, emerging research suggests the utility of interventions such as Youth Mental Health First Aid (YMHFA), which supports adults who have frequent contact with students by increasing mental health literacy (i.e., knowledge and education related to mental health symptoms and services; Jorm, 2000) and confidence interfacing with SMHS and decreasing negative attitudes toward students (Gryglewicz et al., 2018). Though additional research is needed to understand the behavioral changes on training recipients associated with these interventions (Forthal et al., 2022), YMHFA may offer a helpful framework to enhance school personnel's knowledge and attitudes regarding student mental health.

As others have noted (e.g., AAP, 2021; Adelman & Taylor, 2020), this is a critical moment to advocate strongly for school policy that promotes student mental health given the state of children's mental health and the renewed focus on it in national discourse. The ecological perspective adopted for this study highlights how critical it is that school policies to address student mental health and wellbeing do not simply incentivize or mandate the adoption of specific packaged programs or evidence-based practices for SMHS providers or other school actors, nor focus on specific mental health concerns. This may result in a variety of practices and programs that come together to form an inefficient, uncoordinated, and heavily overtaxed system (Chorpita & Daleiden, 2014; Trickett & Rowe, 2012). School actors will find ways to accommodate to the best of their abilities, as providers in our study described, and the system will thus move toward equilibrium; however, it may be an equilibrium

in which student mental health and wellbeing continue to be poorly served. In considering the systemic factors that influence SMHS providers' work, this study aligns with calls for school and district-wide policy changes that structurally enhance the collaborative work of those within these complex systems in their efforts to promote and serve student mental health (see Hoover, 2018; Reaves et al., 2022).

Limitations

The present study does not reflect the viewpoints of caregivers, students, or other school personnel. Future research would benefit from examining their perspectives regarding SMHS and the interplay between school ecological factors and student mental health. Further, because some focus group facilitators had existing working relationships with some participants, and because participants sometimes had existing relationships with one another within their focus groups, their responses may have been influenced by social desirability bias. Providers' participation in this study may also have been influenced by focus group format, which, as noted above, differed across systems as we adjusted procedures following the advent of the COVID-19 pandemic. It is possible that the larger focus group format in which providers from System 1 participated offered fewer opportunities for each participant to contribute to the conversation, and may have felt less comfortable as a venue for some people to discuss their experiences and perspectives. Participating in a focus group conducted in-person versus virtually may also have contributed to differing comfort levels across providers. Moreover, variations in communication styles reflecting regional and other cultural norms as well as individual differences may have influenced participants' openness to sharing. Interviewing System 1 providers in February 2020 and System 2 providers in March and April of 2021 also meant that we captured provider perspectives at radically different moments in our collective experience. There are many potential factors related both to provider/mental health system context (e.g., caseloads, system-wide and regional office resources/culture/climate, length of experience) and to study design that may have contributed to what providers experienced and what they shared with us; in keeping with the social-ecological perspective employed in this study, we do not assert that we are able to disentangle the influence of these factors, and for this reason we did not aim to set up a comparison between the experiences and perspectives of providers from two mental health systems. Rather, we sought to reflect the variability and overlaps in providers' perspectives and experiences, and believe that our study benefitted from providers' diverse experiences. This study reflects the notable variability present within large systems, school districts, and schools, and provided an opportunity to gain a rich and nuanced understanding of SMHS providers' experiences and shaping role within the unique and complex ecologies in which they were embedded.

Conclusion

This study explored SMHS providers' everyday experiences navigating complex organizational and relational dynamics in schools. Their reflections highlight the importance of integrating developmentally appropriate mental health promotion into all aspects of school life (Eccles et al., 1993), and the development of durable and mutually beneficial relationships between school actors, as well as across home and school settings, to enhance coordination of student supports. Ultimately, the optimal settings and relationships that providers described, as well as the impediments to those settings and relationships existing, reflect policy decisions that dictate school resources as well as the cumulative interactive effect of many organizational and interpersonal factors. SMHS research, policy, and practice that reflects the complexity of these settings and relationships best positions us to support student wellbeing, and the wellbeing of everyone in a school community.

Acknowledgements The authors thank Karen Guan for her involvement in protocol design and data collection, the research assistants at UCLA and the University of South Carolina who supported data collection and transcription, the providers who participated in these focus groups, and the supervisors and administrators who supported these efforts.

Funding This work was supported by the University of South Carolina's Advanced Support for Innovative Research Excellence (ASPIRE) Program (PI: Lakind; Co-PI: Becker) and the William T. Grant Foundation (PI: Chorpita; Co-PI: Becker). The authors have no competing interests to declare.

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