ADDRESSING STUDENT MENTAL HEALTH NEEDS BY PROVIDING DIRECT AND INDIRECT SERVICES AND BUILDING ALLIANCES IN THE COMMUNITY

Given that 20% of students experience mental health issues that interfere with school performance and most of these students will turn first to their school for help, school counselors need to consider how they can best serve this population. This article describes how school counselors can address the mental health needs of students by providing direct services, accessing community resources, and working with school staff and community service providers. The article provides case examples and guidelines for building alliances.

pproximately 14-20% of school-aged children are diagnosed with mental health or behavioral disorders (National Academy of Sciences, 2009). Even more alarming is the fact that the mental health needs of students are unmet (National Scientific Council on the Developing Child, 2008). Estimates are that between 70 and 80% of school-aged children with a diagnosed mental disorder do not receive treatment (Greenberg et al., 2003; Mendez, Carpenter, LaForett, & Cohen, 2009). Parents, teachers, and students seek help from the school and the school counselor, yet the school counselor's ability to respond can be limited by large caseloads, inadequate training, or lack of awareness of community resources (Kaffenberger, 2011). The challenge to school counselors is how to meet the increasing mental health needs of students, given the barriers to service provision.

According to the American School Counselor Association (ASCA), the primary responsibility of school counselors is to provide direct and indirect services, 80% or more of the time, to students (ASCA, 2012a). Direct services are delivered through the core curriculum, individual student planning, and responsive services including individual and small group counseling interventions to address social, emotional, and mental health needs of students. Indirect services include making referrals and consulting and collaborating with others to serve students. ASCA's position statement on student mental health states that, to adequate-

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ly provide services to all students, school counselors should "advocate and collaborate with school and community stakeholders to ensure that students and their families have access to mental health services" (ASCA, 2009). Given the number of students requiring mental health counseling, school counselors must identify resources and build alliances in their communities

in small groups. The school counselor works directly with students to assess the mental health concerns and, when appropriate, works with the family to make referrals to community resources for ongoing services.

Although school counselors are charged with assisting all students by addressing their social/emotional, academic, and career needs (ASCA,

ka, Zhang, & Wells, 2002; Santos de Barona & Barona, 2006). Schools also are seeing large increases in students with depression and anxiety, autism spectrum disorders (ASDs), and other specific mental health needs (Centers for Disease Control and Prevention, 2007; Clauss et al., 2010; National Institute of Mental Health, 2012). Addressing the mental health issues that interfere with school success is essential in order to close achievement gaps in our schools.

> GIVEN THE NUMBER OF STUDENTS REQUIRING MENTAL HEALTH COUNSELING, SCHOOL COUNSELORS MUST IDENTIFY RESOURCES AND BUILD ALLIANCES IN THEIR COMMUNITIES TO INCREASE THEIR ABILITY TO HELP MORE STUDENTS AND INCREASE ACCESS TO MENTAL HEALTH SERVICES.

to increase their ability to help more students and increase access to mental health services. This article shares the story of one elementary school counselor who addresses the mental health needs of her students by providing direct services, building alliances within the school and community, and accessing community resources. The authors offer suggestions for providing services and building alliances.

BARRIERS TO PROVIDING MENTAL HEALTH SERVICES

As stated above, providing direct and indirect services to address emotional and mental health issues that keep students from being successful at school is the primary responsibility of the school counselor (ASCA, 2009, 2012a). The school counselor is often the first person in the school to hear the concerns of teachers and parents, or to hear directly from the student (Farmer, Burns, Phillips, Angold, & Costello, 2003; Teich, Robinson, & Weist, 2008). Short-term counseling and crisis intervention services can be provided to students individually and

2007), barriers exist that can prevent school counselors from adequately addressing the mental health needs of their students. Three of the barriers that interfere with the school counselor's ability to serve students include increased number of students in need of services, limited access to community mental health services, and issues related to school counselor caseloads and training (Kaffenberger, 2011).

The current economic crisis has put even more pressure on state and district education budgets resulting in cutbacks that have affected funding for mental health services within the school and in the community (Griffin & Farris, 2010). While funding has decreased, the need for mental health services for students has increased. Demographic changes to the U.S. school-age population, including an increase in students living in poverty, have increased the need for services (Clauss-Ehlers, Weist, Gregory, & Hull, 2010). At risk for mental health services are the more than one million homeless children (National Center on Family Homelessness, 2009). Furthermore, research indicates a higher incidence of unmet learning and emotional disorders with the increasingly larger numbers of culturally and linguistically diverse students (Katao-

The second issue is the difficulty students with mental health needs have in accessing community mental health services. The reality is that students are more likely to follow through with school-based services due to the barriers to accessing community mental health services. As stated above, only 20% of students receive needed mental health services (Cappella, Frazier, Atkins, Schoenwald, & Glisson, 2008; Greenberg, et al., 2003; Mendez et al., 2009). Of the 20% of students receiving services, most will receive services in school (Adelman & Taylor, 2010; Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001). A national review of mental health services conducted in 2006 concluded that school professionals provide the majority of the mental health services that students receive (Adelman & Taylor, 2010; Teich et al., 2008). In a somewhat older study, Catron, Harris, and Weiss (1998) found that approximately 96% of students follow through with school-based mental health services, while only 13% follow through with community mental health center referrals. Accessing appropriate community mental health services complicates this issue. Minorities and students living in poverty receive even fewer mental health services and are less likely to take advantage of community mental health services (Atkins et al., 2006; Bringewatt, & Gershoff, 2010; Cappella et al., 2008; Garland et al., 2005). Many parents do not have the resources, financial or otherwise, to seek counseling beyond the school day. This disparity in access to services has increased the call for comprehensive

school-based mental health services (Adelman & Taylor, 2010; Greenberg et al., 2003; Kutash, Duchnowski, & Lynn, 2006). The U.S. Surgeon General and the President's New Freedom Commission have promoted schools as an appropriate setting for mental health care provision and have recommended improving and expanding mental health programs in schools (New Freedom Commission on Mental Health, 2003; U.S. Department of Health and Human Services, 2000). School-based mental health services also have additional benefits; for example, research demonstrates that school-based mental health services help overcome barriers to initiating mental health care and may reduce the stigma associated with seeking care (Bringewatt & Gershooff, 2010; Snowden & Yamada, 2005).

The last barrier this article presents related to mental health service provision to students is school counselors' inability to adequately provide mental health services to all of the students in need of help, due to large case-loads, multiple responsibilities, lack of awareness of community resources, and, in some cases, lack of training (Adelman, & Taylor, 2010; Kaffenberger, 2011). Although some school counselors receive training in graduate school to identify and treat mental health issues affecting students, the Council for Accreditation of Counseling & Related Educational Programs (CACREP, 2009, 2012) does not mandate a psychopathology course for school counseling students. Therefore, school counselors may benefit from receiving additional in-service training as part of their professional development.

Successfully meeting the mental health needs of all students may require new methods and service delivery models, and will be dependent on collaboration among all of the adults in the child's environment and access to mental health professionals in the local community (Adelman & Taylor, 2010; Griffin & Farris, 2010; Kazak et al., 2010). As challenging and difficult as helping students with mental disor-

ders appears to be, the case examples of one elementary school counselor provide a glimpse into how to go about providing direct services to students while building alliances and thereby meeting student needs. What follows are four case studies, described by the second author, that demonstrate the range of service provided by a school counselor from direct to indirect services. The school counselor provided direct services to students and also built alliances with other professionals within the school and in the community. To reflect the collaborative efforts of these professionals with the school counselor, "we" will be used in cases where a team was directly involved in supporting the student's mental health needs, and "I" will be used to reflect the individual efforts of this school counselor. The el-

disorder, school anxiety, school refusal, and panic disorder.

I used evidence-based cognitive behavioral counseling strategies and counseling games to teach coping and self-regulation skills to the students with anxiety. Games tend to reduce student anxiety and enhance retention of coping and self-regulation skills. The evidence-based programs and resources I used were the I Can Program, including the books *I Can Handle a Bad Day*, and *I Can Choose Better Behaviors* (Goodman-Scott, O'Rorke-Trigiani, & Lindsey, 2012; O'Rorke-Trigiani, Goodman-Scott, Lindsey, & Dworken, 2012a), the Coping Skills Game (Childswork/Childplay, n.d.), and Bridge over Worried Waters game (Franklin Learning Systems, 2009).

Delivered individually or in group counseling, the interventions that are

> STUDENTS ARE MORE LIKELY TO FOLLOW THROUGH WITH SCHOOL-BASED SERVICES DUE TO THE BARRIERS TO ACCESSING COMMUNITY MENTAL HEALTH SERVICES.

ementary school site had a population of about 1000 students and is located in the southeastern United States. The school counselor (second author) is one of two school counselors serving the students at this school.

Case Example 1: Providing Direct Services to Students with Anxiety

As a school counselor, I have worked with children with acute and ongoing anxiety. Mental health services for students who experience anxiety that interferes with their academic and social/emotional school functioning is an important direct service provided by school counselors. According to estimates, approximately 13% of children and 25% of adolescents will experience anxiety during their schooling (National Institute of Mental Health, 2012). Types of anxiety experienced by children and adolescents include social anxiety, generalized anxiety, post-traumatic stress disorder, obsessive-compulsive

most effective with students with anxiety train them to use the skills of self-talk, reframing, and coping. Students can be taught the differences between problem thinking patterns and positive self-talk. They can practice positive self-talk by keeping a visual list of positive self-talk statements, such as "I can handle this," "I handled this before," and "The things I worry about have not happened." Students can also think about and discuss what they would say to a friend with similar worries and then incorporate this in their own positive self-talk statements. Worried students are often harder on themselves than others. Peers in the group can challenge negative thinking patterns, suggest alternative ways of thinking, and provide valuable feedback. Understanding that others have similar struggles can be reassuring for a student.

Before students begin an anxiety/coping skills group, they are asked to list what coping skills they currently

use. The students are then taught coping skills and positive self-talk. As the group is ending, students are asked to list the strategies and coping skills they know and use. A review of several coping skills groups' pre- and post-test data found that students reported an 867% increase in their knowledge and use of coping skills (O'Rorke-Trigiani, 2010). One hundred percent of the students were able to list more coping skills in the post-test than in the pre-test (O'Rorke-Trigiani, 2010).

School counselors also need to be prepared to identify and collaborate with community mental health professionals to address student anxiety. For example, I can support the work of the community mental health professional by assessing the student's level of anxiety during the school day, collecting data on the frequency, duration, and intensity of panic attacks. Community mental health professionals want timely and accurate feedback on their interventions and medication effectiveness and can, in conjunction with the school counselor, identify appropriate goals and facilitate skill development.

social skills to reduce her anxiety, and the psychiatrist administered medications. The frequency of the student's panic attacks was reduced. She also participated in an anxiety group to maintain and reinforce coping skill development. Currently, she is no longer having panic attacks and is assisting others in learning positive self-talk.

Case Example 2: Working Systemically to Provide Direct Services to ESOL Students with Mental Health Needs using Parent Counseling and Education

National data demonstrates that the public school system is becoming increasingly diverse (Clauss-Ehlers et al., 2010). As I reviewed my school's data over the last 2 years, I realized that our student population had changed rapidly, with Korean students increasing from only a handful to more than 10% of our population—more than 100 students. The counseling team had been working on a case-by-case basis when we discovered common themes with the Korean students' adjustment and academic progress. We were

our Korean students and their families and advocated for additional resources. As a result of our ongoing communication and collaboration with our principal, we hired a Korean-speaking family liaison that helped with outreach to the community. We were more effectively answering individual questions from Korean parents; however, I knew that we needed to better understand this population in order to address the students' social, emotional, and academic needs. Some of our students continued to have difficulty adjusting to classroom routines and interacting with other students, and were experiencing anxiety. We asked our family liaison to conduct a survey of our Korean parents to further understand their needs in transitioning to our school. The Korean parents reported that they needed strategies to motivate their children to achieve, to encourage positive conflict resolution and socialization, and help with the basic routines of American schooling, school culture, and expected student behaviors, as well as general parenting information.

I looked for other options in the community and found the Korean Family Counseling Center. With their knowledge of both home and school environments, they were able to understand the Korean community's needs and to educate the school counseling and educational staff. The Korean Counseling Center provided details about Korean education, socialization, and family systems to help us design more effective interventions and to facilitate the students' adjustment. As counseling colleagues, we quickly formed a productive and collaborative alliance to meet the students' and families' needs. And we helped the Korean counselors understand our classroom and playground environments and what we needed the Korean parents to understand in order to facilitate and promote positive adjustment in our school.

With greater understanding of the Korean population at our school, we developed an intervention that began with parent education. We believed

> # MENTAL HEALTH SERVICES FOR STUDENTS WHO EXPERIENCE ANXIETY THAT INTERFERES WITH THEIR ACADEMIC AND SOCIAL/EMOTIONAL SCHOOL FUNCTIONING IS AN IMPORTANT DIRECT SERVICE PROVIDED BY SCHOOL COUNSELORS.

Working collaboratively with parents and community mental health providers, school counselors can increase student success in coping with anxiety. For example, one of my students was experiencing panic attacks at school and at home. The child, her private psychiatrist, her mother, and I developed a plan of action for managing the panic attacks at school. We collaborated on anxiety management strategies and used common language to help her use positive self-talk and other cognitive behavioral strategies. I worked with her at school on her

already implementing many parenting programs but our Korean parents could not take advantage of these programs due to the language barrier. We examined data from our collaborative learning teams, analyzed the contents of our individual parent conferences and feedback from our students about their understanding of school rules and expectations, and from this data determined that more proactive and preventive interventions were necessary to help this population with their academic and social adjustment.

I began exploring options to help

that by engaging families in parent education we were preventing future problems for many of the students. Our family liaison invited each Korean family to the workshops. Counselors from the Korean Family Counseling Center also attended our parent workshops and helped us target our interventions, answer questions, and provide general support. The parents learned about resources in the school, including the counseling department and the Parent Teacher Organization, and were able to connect to other Korean parents.

We conducted a post-test at the end of each parent workshop and found that 95% of our parents rated the programs as highly effective or effective in meeting their needs. Further, the Korean parents' attendance at the workshop was over 85%. As we focused on parent involvement, our volunteer rates grew 600%, according to our School Improvement Plan data. The Korean parents donated a large amount of food to the international luncheon. These donations and their staffing of the tables at the luncheon resulted in a very successful event that raised a record amount of money to fund additional resources for the school. Parent conferences decreased in frequency and length, and the parents became active participants in our school community. Many now serve in leadership positions on our Parent Teacher Organization.

Having gained the trust of the Korean community, we considered how to provide direct mental health services to the students who were struggling with adjustment to our school. This required modification of some of our counseling strategies by increasing the use of pictures while our students were learning English. We were able to observe the children who were struggling to adjust, and collect and analyze behavioral data to determine which behaviors were interfering with the children's adjustment. Many students needed to understand personal space, turn-taking, eye contact, and conflict resolutions skills that are different in our school setting. For example, one

DELIVERED INDIVIDUALLY OR IN GROUP COUNSELING, THE INTERVENTIONS THAT ARE MOST EFFECTIVE WITH STUDENTS WITH ANXIETY TRAIN THEM TO USE THE SKILLS OF SELF-TALK, REFRAMING, AND COPING.

of the Korean students was struggling with conflict resolution skills and adapting to our school. By observing the child in the classroom and on the playground, the teachers and I identified which behaviors were interfering with his success in school and with friends. I then utilized evidence-based strategies, including *I Can Join In, I Can Choose Better Behaviors*, and social skills games to provide direct instruction in new behavior and social skills for the classroom and the playground (Goodman-Scott, 2008; Goodman-Scott et al., 2012; O'Rorke-Trigiani, Goodman-Scott, Lindsey, & Dworken, 2012a,b; Wang & Spillane, 2009). After teaching and practicing the behavioral and social skills in the school counselor's office, I observed the students' use of the skills in other settings, including the playground and small groups. I collaborated with the classroom and English as a Second Language teachers to reinforce and fine-tune the student's social and behavioral skills.

The Korean student's mother actively participated in our parent workshops and learned new techniques that helped her son adjust. His mother shared that she recognized he was different from other children but in Korea, it would have been shameful to seek help. She was more than willing to obtain help at school, yet family members discouraged her from seeking help outside our school. As a result of these interventions, I was able to help overcome stigma to mental health services present in her community and reduce logistical barriers, thus improving access to care (Bringewatt & Gershoff, 2010). She also benefited from consulting with our Korean counseling colleagues after the parent workshops. By the following year, the student was

able to make and keep friends and his discipline referrals were nonexistent. He also assisted with new students arriving from Korea by talking about the differences between the two school systems.

Case Example 3: Providing Direct Services to Students with Autism
Our population was changing in other ways, too; we were seeing an increase in students with autism. National research was also demonstrating a sharp rise in autism spectrum disorders (Centers for Disease Control and Prevention, 2007; National Institute of Mental Health, 2012). Students with autism spectrum disorder (ASD) struggle with transitions, adjustment to new environments, and new people, and favor strict adherence to routines (National Institute of Mental Health, 2012).

With increasing numbers of students with ASD and other identified emotional, behavioral, and learning disabilities being included in the regular classroom setting, classroom teachers need more support. School counselors are ideally suited to provide leadership in this area (O'Rorke-Trigiani, 2003). ASCA reinforced the professional school counselor's role with children with special needs in its position statement by outlining areas of service to include direct services, collaboration with fellow professionals, and membership on the multidisciplinary school team (ASCA, 2004). Although school counselors can be an excellent resource for children with ASD, they may need additional training in order to provide effective strategies to help these students be successful in the classroom. School counselors who establish collaborative partnerships with special education and speech and language clinicians

may benefit from learning additional strategies for providing direct mental health services to students with ASD.

At my school, we formed an alliance between the school counseling team and the special education team to strengthen our mental health interventions, including coping skills, behavioral supports, and social skills training, and to increase our ability to support students with ASD. As a team, we co-taught lessons, accessed training, co-led groups, and shared resources. We also collaborated on

cian, special education teacher, school social worker, and a parent ambassador (volunteer). Although our parent ambassador spoke the child's first language, the child didn't communicate with her or with other students who spoke her language. Many team members thought she was going through a silent period that is expected as second language learners transition to a new language and cultural environment (Foppoli, 2006). After monitoring her progress, the team realized she needed more assistance.

free services with their treatment studies and found an anxiety study at the National Institute for Health that included a free evaluation and cognitive behavior therapy for study participants. I called the principal researcher, explained the case, and enrolled our student in the study. The mother wanted to attend and we arranged for translation and transportation. The researchers conducted the assessment and also were puzzled. They made a tentative selective mutism diagnosis but our student did not meet the study specifications. They tried to assist us but no services on site were available. Frustrated, we vowed to continue to seek additional resources. I worked on coping skills, but knew we needed more psychological help.

Concurrent with our pursuit of additional resources, the speech and language clinician and I co-led a social skills group to foster her communication skills, at first nonverbally and through writing. Language barriers and financial issues continued to challenge our progress in obtaining additional services. Even though there were cultural barriers to seeking help, we had the family's support. The child's mother was also concerned about her daughter's ability to communicate in either language. We formed an alliance with her through regular communication, using our parent ambassador to explain each step in the process. She gradually felt more comfortable, asking questions and seeking help for school paperwork and routines. Through our continued advocacy, we helped the mother obtain employment and insurance that allowed the family to get the mental health services she needed.

We began to see small changes with our combination of interventions and collaboration. The child began to read social signals and communicate nonverbally with facial expressions and body language. Next she began to communicate in writing and on the computer. During her final year, she communicated verbally with a select group of friends in nonacademic settings. We provided a briefing of the interventions to the next school.

> ## THE KOREAN COUNSELING CENTER PROVIDED DETAILS ABOUT KOREAN EDUCATION, SOCIALIZATION, AND FAMILY SYSTEMS TO HELP US DESIGN MORE EFFECTIVE INTERVENTIONS AND TO FACILITATE THE STUDENTS' ADJUSTMENT.

IEP goals and evaluated their progress together. Social skills stories and self-regulation strategies, in particular, we found to be effective methods to reach all students with social skills problems (Gray, 2011). Together, we developed several more didactic social skills books called the I Can Program to teach and promote social and self regulation skills across environments using simple language and graphic visuals (Goodman-Scott et al., 2012; O'Rorke-Trigiani et al., 2012a,b). Parents and teachers read and reread the stories with the children regularly, and through repetition, students learn appropriate responses. Data from IEP progress reports, feedback from parents and teachers, and school counselor intervention evaluation reports demonstrated the effectiveness of our team approach and materials.

Case Example 4: Providing Direct Services to Students with Challenging Mental Health Needs

We were presented with a challenging case. We had a student who was not speaking at school despite the interventions and services of a diverse and determined team including the school counselor, speech and language clini-

Our first step was to obtain background information and identify any medical issues. Our parent ambassador talked with the student's mother and learned that the child had blood sepsis when she was 18 months old. No medical records were available and the medical care available in her country was inadequate, according to the mother's report. Was the mutism due to a medical issue? The school social worker and school counselor identified, utilized, and eventually exhausted the free medical resources available to help this student, but we needed more medical information.

Our next step was to seek additional medical evaluations. We had to look outside the school and county resources for help. We called local neurologists and community members and we were able to get a free neurological assessment and detailed audiology evaluation based on these contacts. The neurologist encouraged us to look for more psychological assistance specifically to confirm or reject a diagnosis of selective mutism.

With this medical information, we explored how to obtain free psychological counseling services. We looked for research organizations that provide

IMPLICATIONS FOR SCHOOL COUNSELORS

The four case examples presented demonstrate the way one school counselor provided direct and indirect services while building alliances to better serve the students in her school. The reality is that school counselors cannot serve all of the students who present with mental health disorders without building alliances within the school and the surrounding community. The school counselor began by reviewing school data to understand the needs of the students in her school, and followed up by exploring the resources available within her school, school district, and community. Building alliances takes time and there is no substitute for the kind of networking, interviewing, and researching that is required to be educated about the types of available services and support. This school counselor was able to serve students by providing direct services and acquiring the specific knowledge and skills to address the mental health needs of her students by building alliances within her school community, with mental health providers in her community, and with other agencies in the community. The authors offer the following strategies to school counselors to assist them in providing mental health services to their students and building alliances.

Provide direct services. School counselors should and do provide direct mental health services to students. School counselors are in an ideal position to provide crisis and short-term counseling, conduct the initial phases of assessment and remediation, and work with parents to facilitate appropriate recommendations and referrals when additional therapy is needed. Their relationship with parents is critical to helping parents understand the mental health needs of their children.

Reducing barriers to learning through the provision of mental

health services makes a difference. Many positive changes have been associated with school-based mental health care including increased attendance and commitment, increased social competence, and improved test scores (Hoagwood et al., 2007; Walker, Kerns, Lyon, Bruns, & Cosgrove, 2010; Wilson & Lipsey, 2007). Despite this research and the U.S. Surgeon General's call for more school-based mental health services, school counselors continue to face barriers to providing mental health services. Given that most school counselors have a student caseload that exceeds ASCA's recommended 250:1 ratio (ASCA, 2012b), to assume that school counselors are able to provide all of the mental health services needed by students is unrealistic. The needs of students have changed drastically over the last 20 years, as evidence by the research previously outlined, so the ratio also should change. In fact, in response to the recent tragedy in Newtown, Conn., President Obama proposed increasing the number of school counselors to provide needed mental health care services in schools (Strauss, 2013).

School counselors may benefit from additional training in order to provide direct services to students with specific mental disorders. By collaborating with other professionals, school coun-

training, that can be used in the school setting (Hoagwood et al., 2001, 2007). Funding for additional training based on the needs of each school's population, as determined by school-based data, is necessary.

Build alliances within the school. Building alliances within the school community (e.g., teachers, special education, speech and language clinicians, parent liaison, school psychologist, social worker, administrators), as demonstrated in the four case studies, involves sharing responsibility for the success of all students. Helping educational professionals in the school understand the importance of reducing mental health barriers so that students can learn is an important responsibility of the school counselor (Adelman, & Taylor, 2010; ASCA, 2009; Catron et al., 1998; Kaffenberger, 2011; Rones & Hoagwood, 2000). Treatment gains can be enhanced by providing mental health services in the school setting (Adelman, & Taylor, 2010; Evans, 1999; Weare, 2000). The most effective interventions are integrated into the learning environment (Rones & Hoagwood, 2000) and encourage the adults in the school community to support and reinforce mental health goals through parent and teacher education and consultation. Mental health services, including follow-up and monitoring, are most effectively

> SCHOOL COUNSELORS WHO ESTABLISH COLLABORATIVE PARTNERSHIPS WITH SPECIAL EDUCATION AND SPEECH AND LANGUAGE CLINICIANS MAY BENEFIT FROM LEARNING ADDITIONAL STRATEGIES FOR PROVIDING DIRECT MENTAL HEALTH SERVICES TO STUDENTS WITH ASD.

selors can learn new strategies, attend diverse trainings, access new materials, and improve their direct services to students. As part of their professional development, school counselors can continue to build their knowledge base about effective evidence-based skills and strategies, such as social skills

provided in the child's natural setting, school and home, and will therefore require collaboration among all the adults in the child's life (Kazak et al., 2010).

Principals play an important part in recognizing the school counselor as the provider of mental health services

by encouraging the school counselor to focus on the student's social and emotional needs so that barriers to learning can be removed. In addition, principals who support new and innovative programs to meet the needs of all students, such as the program for Korean students described in this article, and give support to ending ineffective programs are critical to the delivery of needed mental health services to students

be another source of information about the culture or attitudes toward receiving mental health, or may even provide specific resources, such as a counseling center, or financial or social support (Cappella et al., 2008). Paraprofessionals who share demographic characteristics or have conquered similar challenges can also be an appropriate resource for the student and family. Local and national advocacy groups such as Parents of Children

their ongoing relationships with students, parents, teachers, and community members, professional school counselors can provide direct services and establish alliances both within and outside the school to provide and coordinate mental health services for the students in their school. ■

THE REALITY IS THAT SCHOOL COUNSELORS CANNOT SERVE ALL OF THE STUDENTS WHO PRESENT WITH MENTAL HEALTH DISORDERS WITHOUT BUILDING ALLIANCES WITHIN THE SCHOOL AND THE SURROUNDING COMMUNITY.

Build mental health alliances in the community. Building mental health alliances in the community will involve first getting to know what resources exist. Usually, a community has a variety of private and community-based mental health service providers. The school counselor will need to build a resource list of names, contact information, fee schedules, and specialties. Ideally, the school counselor can visit or meet the various service providers. Networking with other school counselors in the district also will help build the available resource list. By working collaboratively with specific mental health providers concerning a specific student, the school counselor will build relationships.

Build other alliances in the community. School counselors should also consider other community alliances when looking for help with their students with mental health disorders. Community social services agencies may be able to assist with financial support or referrals to agencies that provide services for free or on a sliding scale. Often, community social service agencies publish a handbook of community resources that can be invaluable to the school counselor. Religious organizations with ties to specific cultural or ethnic groups may

with Autism (http://www.parentsof-childrenwithautism.org/) and online organizations such as Support for Families of Children with Disabilities (http://www.supportforfamilies.org/) are two examples of online resources that can provide information, support and referral sources. Other alliances worth exploring are with local colleges and universities with a research interest in a particular mental disorder, or volunteer programs aimed at supporting community members.

CONCLUSION

School counselors are expected to meet the needs of all students. In order to accomplish this goal, school counselors can and should provide direct and indirect services to students with mental health needs. In some cases, school counselors may need additional training to provide direct services to students. In addition to working directly with students to address their mental health issues, school counselors should also develop and tap new resources to help all students reach their potential. One way to increase service provision is to build alliances within and outside the school community (Kazak et al., 2010). Through

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