School Mental Health
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REVIEW PAPER

Roles and Functions of School Mental Health Professionals Within Comprehensive School Mental Health Systems

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Abstract
Mental health concerns are on the rise among youth, contributing to a growing need for school-based mental health services. However, challenges to service provision arise due, in part, to workforce shortages, service fragmentation, and inefficient allocation of staff time. The current study describes the professional competencies and time allocation of four school-based mental health professions (i.e., school counselors, school psychologists, school social workers, and school nurses) in order to demonstrate how schools can leverage the skills of their existing staff to coordinate a comprehensive approach to support student mental health. First, we identified the core clinical competencies needed to implement the key features of comprehensive school mental health systems. Then, we crosswalked these clinical competencies with the training standards of the four professions. Finally, we conducted a systematic review of the literature to understand how these professionals' time is allocated, as well as their responsibilities related to the provision of mental health services. Results demonstrated that, although all four professions receive training in most of the core competencies needed to implement comprehensive school mental health services, their skillsets are often underutilized in day-to-day practice. Thus, we concluded that there are at least two untapped opportunities for school leaders to support student mental health—first, maximize the use of school mental health professionals through task-shifting (i.e., reassigning tasks less central to mental health service delivery to other staff), and second, implement an integrated model of school mental health services to efficiently leverage the mental health training of professionals.

Keywords School mental health professionals · Professional competencies · Time allocation · Roles and functions · Service coordination · Interprofessional collaboration

Introduction

Poor mental health can have a serious adverse impact on youth wellbeing and future success (Clayborne et al., 2019). Prior to the COVID-19 pandemic, youth mental health concerns (e.g., anxiety and depressive symptoms) were on the rise in the USA and throughout much of the world (Burns & Gottschalk, 2019; Mojtabai & Olfson, 2020). Since the pandemic began, rates of psychological distress among young people have increased further (Racine et al., 2021; Sharma et al., 2021). Accordingly, more educators and health professionals are identifying mental health as one of students' greatest needs (American Academy of Pediatrics, 2021; Iachini et al., 2016), and researchers, policy makers, and global institutions are calling for increased access to effective school-based mental health supports (Kern et al., 2017; UNICEF, 2021; U.S. Department of Education [ED], 2021). To support student mental health needs effectively and sustainably, it is critical to develop and strengthen the capacity of schools to implement comprehensive school mental health (SMH) systems. SMH systems coordinate services to promote the social and emotional development of students, which can have a positive and lasting impact on

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youth achievement, behavior, and wellbeing (Sanchez et al., 2018; Taylor et al., 2017). These services are often provided by a diverse set of professionals (e.g., school counselors, psychologists, social workers, and nurses) who function in both similar and unique ways (Ball et al., 2010). However, barriers to efficient SMH service provision arise due to (a) fragmented service delivery across providers (Weist et al., 2012) and (b) budgetary constraints and workforce shortages (Whitaker et al., 2019). This study describes the SMH competencies and time allocation of school-based professionals so that schools can leverage the skills of their existing staff and coordinate an integrated and comprehensive approach to support student mental health.

Core Components and Challenges of School Mental Health Systems

SMH services refer to a continuum of supports and interventions designed to prevent, identify, and treat student mental health challenges and to promote student wellbeing and success. Because of the wide scope of activities that fall within SMH, researchers and experts document key practices and strategies that are pertinent to effective service delivery. Hoover et al. (2019) synthesize the knowledge and guidance of over 75 SMH experts and leaders, gleaned over multiple national convenings. They delineated eight core features of comprehensive SMH systems (e.g., a multitiered system of support [MTSS] approach for addressing mental health). The last feature (i.e., funding) is likely to be implemented by school administrators, while the others are likely to require the support of SMH professionals. The National Center for School Mental Health (NCSMH) and the Mental Health Technology Transfer Center (MHTTC, 2019) outline similar features in their national SMH curriculum, and they identify an additional key feature of SMH systems: cultural responsiveness and equity. These eight features (excluding funding) are: (a) well-trained specialized support personnel, (b) family–school–community collaboration, (c) needs assessment and resource mapping, (d) multitiered systems of support (MTSS) approach, (e) mental health screening, (f) evidence-based practice, (g) effective use of data, and (h) culturally responsive and equitable mental health practices (see Table 1 for additional detail). Together, these features describe the clinical competencies needed by SMH providers and reflect the need for SMH systems to prevent, assess, support, and monitor student mental health needs of varying intensities within an MTSS framework. Specifically, MTSS describes a model of service delivery in which schools deliver supports and interventions to students in varying intensities. With respect to SMH, tier one focuses on mental health promotion and prevention for all students; tier two focuses on prevention and early intervention for students identified as at-risk or experiencing mild impairment; and tier three focuses on individualized interventions for students with more serious concerns (Hoover et al., 2019). When these key features occur, schools are able to deliver services in a comprehensive and coordinated manner that reduces disparities and responds to the diversity of students and families.

Although there are various barriers to effective and sustainable SMH provision, two pervasive barriers are service fragmentation and staff shortages (Eiraldi et al., 2015; Weist et al., 2017). First, service fragmentation occurs when mental health supports are provided in relative isolation and there is a lack of coordination and role clarity among SMH providers (Weist et al., 2012). While there is growing evidence for the positive impact of interprofessional collaboration on SMH service provision and student mental health outcomes (Bates et al., 2019; Reaves et al., 2022), school-based providers report relatively low rates of service coordination, which may lead to duplication of services and inadequate service provision (Santiago et al., 2014). Challenges to effectively coordinating mental health services include role confusion and disciplinary differences (Mellin & Weist, 2011). Without a clear understanding of the professional mandates and job responsibilities of distinct SMH disciplines, SMH team members are not likely to recognize how their roles can complement the expertise of other providers and disputes or confusion may arise over who should be responsible for certain tasks (Markle et al., 2014). Understanding and discussing the roles and responsibilities of distinct professions can improve the functioning and effectiveness of SMH teams (Borg & Pålshaugen, 2018).

Second, national workforce shortages and limited funding to hire and train professionals mean that schools have difficulty staffing—and subsequently implementing—comprehensive SMH services (Shelton & Owens, 2021). Although SMH services engage a wide range of professionals, national shortages of SMH providers mean that schools often face supply shortages of qualified SMH practitioners (Health Resources and Services Administration [HRSA], 2015). These shortages likely contribute to an overburdening of staff, leaving little time for SMH service provision and coordination (Mellin & Weist, 2011). Thus, opportunities may exist for tasks to be shifted among (or away from) SMH professionals to increase schools' capacity to support student mental health. A thorough understanding of the mental health competencies of SMH professions along with the ways their time is allocated may help guide decisions about how to best allocate tasks to maximize impact on student mental health.

School Mental Health Professionals

In the subsections below, we provide an overview of the training and competencies of school counselors, school nurses, school psychologists, and school social workers.

Table 1 Crosswalk of SMH professional standards with clinical competencies needed to implement the key features of comprehensive SMH systems

Key features of comprehensive SMH systems	Aligned SMH professional competencies	School counseling	School nursing	School psychology	School social work
Well-Trained Specialized Instructional Support Personnel: Comprehensive SMH systems must be adequately staffed with personnel trained to provide assessment, diagnosis, counseling, education, therapy, and other necessary mental health services	a. Conduct and interpret mental health assessments	X	Standard 1	Domain 1	Standard 3
	b. Identify mental health disabilities	X	Standard 2	Domain 4 (4th Practice)	Core Areas (6th Area)
	c. Provide mental health counseling	B-SS 3	Standard 5 (11th Competency)	Domain 4 (2nd Practice)	Guiding Principle 3: Tier 2
	d. Provide mental health education	B-SS 5.b	Standard 5B	Domain 4 (1st Practice)	Standard 10
	e. Provide mental health therapy	X	X	Standard II.3.12	Guiding Principle 3: Tier 3
Family–School–Community Collaboration: Comprehensive SMH systems create intentional structures to meaningfully involve students, families, and community partners in the provision of mental health care	a. Collaborate with students and families	B-SS 6	Standard 5 (1st Competency)	Domain 7 (6th & 7th Practices)	Guiding Principle 2
	b. Collaborate with community providers and partners	B-SS 6	Standard 18 (5th Competency)	Domain 4 (9th Practice)	Standard 10
Needs Assessment and Resource Mapping: Comprehensive SMH systems strategically assess SMH needs and systematically identify available resources for the provision of mental health services	a. Conduct mental health needs assessments	B-PF 9.b	Standard 18 (8th Competency)	Domain 5 (4th Practice)	Standard 3
	b. Conduct mental health resource mapping	B-SS 4	Standard 16	Domain 6 (2nd Practice)	Guiding Principle 2
Multitiered System of Support (MTSS): Comprehensive SMH systems ensure all students have access to a full array of layered supports, including universal promotion supports (e.g., schoolwide programming: Tier 1), targeted programs (e.g., early intervention or brief individualized interventions: Tier 2), and treatment services (e.g., individualized therapy for significant distress and functional impairment: Tier 3). Professional development and support for staff as well as family–school–community partnerships are foundational elements of MTSS	a. Facilitate an MTSS approach for supporting mental health	X	Standard 4 (3rd–6th Competencies)	Domain 5 (8th Practice)	Guiding Principle 3
	b. Provide mental health professional development for staff	B-SS 5.d	Standard 5B (9th Competency)	Domain 5 (2nd Practice)	Standard 10
	c. Establish and maintain family–school–community partnerships	B-SS 6.a	Standard 10	Domain 7 (2nd Practice)	Standard 10
	d. Facilitate Tier 1 universal mental health promotion supports	B-PF 9.a	Standard 5B	Domain 6. (6th Practice)	Guiding Principle 3: Tier 1
	e. Provide Tier 2 targeted supports and early intervention services	B-SS 3.b	Standard 5 (10th–12th Competencies)	Domain 6. (5th Practice)	Guiding Principle 3: Tier 2
	f. Provide Tier 3 individualized intervention and treatment services	X	Standard 4 (1st Competency)	Domain 4 (2nd Practice)	Guiding Principle 3: Tier 3

Table 1 (continued)

Key features of comprehensive SMH systems	Aligned SMH professional competencies	School counseling	School nursing	School psychology	School social work
Mental Health Screening: Comprehensive SMH systems use evidence-based processes and psychometrically validated screening tools to systematically identify students in need of additional mental health supports	a. Conduct mental health screening	X	X	Domain 5 (7th Practice)	Standard 3
Evidence-Based and Emerging Best Practices: Comprehensive SMH systems select and use mental health prevention and interventions strategies that are research-supported and consistent with best practices	a. Use evidence-based and emerging best practices	B-PF 1.c	Standard 13	Domain 9	Standard 4
Data: Comprehensive SMH systems use data to plan, monitor, and document the impact of mental health supports and services	a. Systematically track and monitor mental health data outcomes	B-SS 1.h	Standard 3	Domain 4 (8th Practice)	Standard 5
	b. Use and create data systems to facilitate SMH data collection	B-PA 2	Standard 1 (1st Competency)	Domain 1 (7th Practices)	Standard 3
	c. Use data-driven decision-making to inform SMH planning	B-PA 3	Standard 6	Domain 1 (4th Practice)	Standard 5
Cultural Responsiveness and Equity: All components of comprehensive SMH systems consider and are responsive to the specific cultural values, beliefs, and behaviors of families and communities. Comprehensive SMH systems ensure access to mental health supports and services in a manner that is equitable and reduces disparities across all students	a. Engage in culturally responsive mental health practices	B-PF 6	Standard 8	Domain 8 (3rd Practice)	Standard 9
	b. Ensure SMH practices are equitable and reduce disparities	B-PA 2	Standard 8 (11th–12th Competencies)	Domain 8 (9th Practice)	Standard 11

SMH school mental health. Examples of professional and ethical standards that reflect the clinical competencies needed to implement the key features of comprehensive SMH systems are presented for each SMH profession. Competencies that were not reflected in professional standards documents are denoted by "X." The example standards reference: ASCA (2019; school counseling); ANA and NASN (2017; school nursing); NASP (2020; school psychology); and NASW (2012; n.d.; school social work)

We focus on these four disciplines because they (a) have professional, often graduate-level training in supporting the mental health of students; (b) are typically certified at the national- and/or state-level; and (c) are frequently identified in SMH policy and guidance (see, e.g., Cowan et al., 2013; Every Student Succeeds Act [ESSA], 2015). While their specific roles may vary, these staff are routinely assigned duties to provide mental health services in schools and recognized as SMH providers (Whitaker et al., 2019). We refer to standards set out by leading professional organizations in the USA to summarize the competencies of each of these professionals as it relates to mental health service provision. Finally, because there have been widespread calls across the four disciplines for increased engagement in tasks supporting student mental health (see, e.g., Berzin et al., 2011; DeKruyf et al., 2013; Puskar & Bernardo, 2007; Splett et al., 2013), there is a need to examine how the professional training standards across professionals may contribute to the provision of SMH service in shared and unique ways. By understanding how the professional training backgrounds of diverse service providers align with the key features of comprehensive SMH systems (Hoover et al., 2019; NCSMH & MHTTC, 2019), we expect to equip leaders with the knowledge to successfully allocate resources (e.g., staff expertise and time), coordinate responsibilities, and implement comprehensive SMH programs. Thus, in the current study, we aim to support schools' efforts to meet the rising mental health needs of youth (American Academy of Pediatrics, 2021) by linking a national model for effective SMH (Hoover et al., 2019; NCSMH & MHTTC, 2019) to the professional competencies of school staff who are likely to be leading efforts to implement these services.

In the subsections below, we briefly describe the training and roles of the four mental health professionals but acknowledge that these professionals may be assigned duties outside of mental health (e.g., supporting students' academic, career, or physical health outcomes). In addition, the requirements to work in these fields vary by state and may not adhere to professional standards. Therefore, SMH provider's competencies may differ based on their training and credentialing status.

School Counselors

School counselors support the success of all students by promoting and enhancing student academic, postsecondary, and social–emotional outcomes. They are licensed (or certified) by the state in which they are employed. Although licensure requirements vary, most states require school counselors to graduate from a master's-level school counseling program to complete supervised experiences in school settings, pass a comprehensive examination, and complete continuing education (American School Counselor Association [ASCA], n.d.-b). The Council for Accreditation of Counseling and Related Educational Programs (CACREP) accredits approved school counseling training programs, and the National Board of Certified Counselors offers the specialized National Certified School Counselor (NCSC) credential to those who qualify.

According to ASCA (2019), school counselors collaborate with others to create a school culture of success for all, use data to identify needs and evaluate efforts, and provide direct and indirect services, including: advisement in large group, classroom, small group, and individual settings; counseling in small group and individual settings; consultation to support student success; referrals for students who require extensive mental health support; and planning and assessment of school counseling programs. The 2019 student-to-school counselor ratio was 444:1 (Whitaker et al., 2019), nearly twice as high as the recommendation of 250:1 (ASCA, n.d.-c).

School Nurses

School nurses promote student health, facilitate optimal development, and advance academic success. Although most school nurses have a bachelor's degree in nursing (BSN; Willgerodt et al., 2018), some states allow for licensure at the associate's level. Licensure as a Registered Nurse (RN) requires a passing score on the licensure examination and completion of continuing education. Although there are no specific requirements differentiating a school nurse from other nurses, the National Association of School Nurses (NASN) recommends a BSN degree as the entry-level qualification and encourages school nurses to seek advanced skills to competently needs within school settings (American Nurses Association [ANA] & NASN, 2017). Nationally, the Commission on Collegiate Nursing Education (CCNE) accredits approved nursing programs, and the National Board for the Certification of School Nurses (NBCSN) offers the Nationally Certified School Nurse (NCSN) credential to qualified school nurses.

According to the ANA and NASN (2017), school nurses bridge health care and education, provide care coordination, and collaborate to promote student success. They provide health education and address a wide range of health-related barriers, including mental health issues; physical and emotional disabilities; chronic health needs; and social determinants of health. In addition, school nurses contribute to special education teams by providing expertise in assessment, diagnosis, and health planning. The 2019 student-to-school nurse ratio was 936:1 (Whitaker et al., 2019), higher than the recommended 750:1 ratio (ANA & NASN, 2017).

School Psychologists

School psychologists apply expertise in mental health, learning, and behavior to help youth succeed. Licensure (or certification) requirements vary by state; most require at least a masters or specialist degree plus a 1-year internship from a school psychology program, completion of school-based practicum and internship experiences, a passing score on the school psychology Praxis examination, and completion of CE (National Association of School Psychologists [NASP], 2020). Nationally, NASP approves training programs and offers the Nationally Certified School Psychologist (NCSP) credential to qualified school psychologists. Although not the focus of this study, the American Psychological Association (APA) also accredits doctoral-level school psychologists who receive more extended training in mental health intervention, assessment, and research. We focus on school psychologists with masters or specialist-level training because they represent the largest portion of school psychologists practicing in school settings (83%) relative to doctoral school psychologists (17%; Goforth et al., 2021).

According to the NASP (2020), school psychologists partner with families, educators, and community stakeholders to create safe, healthy, and supportive learning environments. They possess expertise in assessment, psychopathology, diagnosis, and special education law as well as competencies in 10 domains: (a) data-based decision-making, (b) consultation and collaboration, (c) academic interventions and instructional supports, (d) mental and behavioral health services and interventions, (e) schoolwide practices to promote learning, (f) services to promote safe and supportive schools, (g) family, school, and community collaboration, (h) equitable practices for diverse students, (i) research and evidence-based practice, and (j) legal, ethical, and professional practice. The 2019 student-to-school psychologist ratio was 1382:1, nearly triple the recommended 500:1 ratio (NASP, 2020). The reasons for severe shortages of school psychologists are multifaceted and include a shortage of faculty and financial resources requiring creative solutions for addressing workforce needs (Bocanegra et al., 2022).

School Social Workers

School social workers coordinate the efforts of schools, families, and communities to help students. Most states require school social workers to have a master's degree in social work (MSW), although some only require a bachelor's (BSW). The generalized Licensed Clinical Social Worker (LCSW) credential requires an MSW, supervised training experience, a passing score on a licensure exam, and completion of continuing education. Although no specific requirements differentiate a school social worker from other social workers, the National Association of Social Workers (NASW, 2012) recommends an MSW degree as the entry-level qualification and encourages school social workers to seek specialized knowledge of education systems and approaches to teaching and learning. Nationally, the Council on Social Work Education (CSWE) accredits approved social work training programs, and NASW offers the Certified School Social Work Specialist (C-SSWS) credential to qualified school social workers.

According to the NASW (2012), school social workers: provide schoolwide, small group, and individualized interventions; implement prevention efforts; and foster school environments that are safe, fair, and emphasize early intervention and positive behavioral supports. In addition, school social workers provide crisis intervention and consultation as well as participate in the special education assessment process. The 2019 student-to-school social worker ratio was 2106:1 (Whitaker et al., 2019), eight times the recommendation of 250:1 (NASW, 2012).

Current Study

To address challenges promoting student mental health, schools must leverage the skills of their current workforce—whose mental health training is often underutilized (Schaffer et al., 2021)—in a coordinated and efficient manner. The present study seeks to facilitate the successful implementation of comprehensive SMH systems by describing the relevant knowledge and skills of existing staff as well as potential untapped resources (e.g., staff expertise and time) that could be dedicated to SMH service provision (Damschroder et al., 2009). Through a better understanding of how the professional competencies of school staff, trained in mental health service delivery, align with the skills needed to implement comprehensive models of SMH services and how school staff currently spend their time and provide these services, schools will be better equipped to plan and execute effective SMH services by identifying implementation leaders, appropriately allocating resources and expertise, and aligning roles and responsibilities in an integrated approach. Specifically, we examined two questions. First, how do the competencies needed to implement the core features of comprehensive SMH services align with the training standards for the following professions: school counseling, school psychology, school social work and school nursing? To answer this question, we engaged faculty trainers to crosswalk training standards against a best practice framework for implementing comprehensive SMH services (Hoover et al., 2019; NCSMH & MHTTC, 2019). Second, how do SMH professionals currently employed by schools use their time and training? To answer this question, we conducted a systematic literature search examining time use among SMH staff.

Research Question 1: Crosswalk of SMH Frameworks with SMH Professional Training

Methods

The core clinical competencies needed to implement the key features of comprehensive SMH systems were identified based on two widely used frameworks (Hoover et al., 2019; NCSMH & MHTTC, 2019) and summarized into eight domains (see Table 1). Next, we conducted a crosswalk of these competencies with the standards of practice for each of the SMH professions. Standards of practice were identified using the professional and ethical standards of national organizations (ASCA, 2019; ANA & NASN, 2017; NASP, 2020; NASW, 2012, n.d.). Two researchers independently coded each profession to determine whether each competency was reflected in the standards. To promote accuracy in our findings and interpretations, at least one coder for each SMH profession was currently employed as university faculty in the respective field. Initial inter-rater reliability (IRR) was established for the crosswalk (overall IRR = 89%; counseling = 73%; nursing = 86%; psychology = 100%; and social work = 95%). Discrepancies in coding were discussed until consensus was reached.

Results

Results from the crosswalk are presented in Table 1. Findings suggest that each of the four professions shares many of the clinical competencies needed to implement the key features of comprehensive SMH systems. Overall, the standards of each profession reflected 73% (school counselors) to 100% (school psychologists and school social workers) of the SMH competencies. Results suggest that 100% of the professions included in the review are trained in each of the competencies associated five of the eight key features of comprehensive SMH systems: (a) family–school–community collaboration, (b) needs assessment/resource mapping, (c) evidence-based practice, (d) data use, and (e) cultural responsiveness/equity. While there were discrepancies in training across the remaining three domains, each profession also shares specific competencies in mental health counseling and education, staff professional development, SMH partnerships, as well as Tier 1 and Tier 2 mental health services and supports.

Differences also emerged across the professional training standards for school counselors, nurses, psychologists, and social workers. For example, school psychology and school social work standards included competencies related to the provision of mental health therapy (i.e., longer-term mental health interventions for students with more severe and/or persistent needs), whereas school counseling and school nurse standards emphasized training in short-term, targeted, and/or crisis counseling (i.e., brief, problem-focused interventions). In addition, school psychology and school social work standards included training standards on the systematic screening for mental health. Finally, standards for school nursing, psychology, and social work included training on assessing and identifying mental health disabilities, facilitating the implementation of a tiered support system, and providing mental health services for students identified within Tier 3 (i.e., those with indicated mental health needs). In contrast, the school counseling standards discussed restricted use of assessment and tiered support principles (i.e., only within the context of school counseling programs) and emphasized making referrals to other school- and community-based providers for students with long-term mental health needs.

Research Question 2: Systematic Review of SMH Professionals' Time Use and Regular Duties

Methods

A literature search was conducted on March 29, 2021, to identify research studies which described how the professions included in this study used their time in school. To identify these studies, authors used search terms used the following search terms and Boolean operators: SU ("school psycholog*" OR "school counsel*" OR "student counsel*" OR "school social work*" OR "school nurs*") AND SU ("workload" OR "caseload" OR "responsibilit*" OR "time" OR "duties" OR "job characteristics" OR "role*") (SU = subject or keyword; *designates allowance of alternative word endings within search results). Due to the changing standards of the SMH professions, the search range was restricted to the earliest year that current standards were published (NASW, 2012). We used EBSCO to search for refereed articles published in English between 2012 and 2021 (March) within the following databases: ERIC, APA PsycINFO, Academic Search Alumni Edition, Education Research Complete, and Academic Search Complete. Additionally, Google Scholar was scanned to identify missed articles.

Studies were included if they: (a) were published in an English-language, peer-reviewed journal between 2012 and 2021 (March); (b) were empirical studies; (c) reported quantitative data about SMH professionals' time allocation and/or mental health responsibilities; and (d) reported on the activities of school counselors, nurses, psychologists,

and/or social workers in US public schools. The following types of research were considered beyond the scope of this review and were therefore excluded: (a) investigations of time allocation and roles with respect to specific populations or activities (e.g., role within response-to-intervention systems); (b) participant samples comprised of SMH trainees; and (c) studies that did not allow for meaningful comparisons of time allocation (i.e., time was not operationalized as hours or percentages).

Identified articles were screened according to Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021). Records retrieved from the database searches were imported into Endnote and de-duplicated. Screening and eligibility assessment were conducted in an un-blinded manner by authors. The titles and abstracts were screened to exclude any studies that obviously violate the above criteria. Any studies that potentially met the inclusion criteria were retrieved and the full text assessed for inclusion. For each study included in the synthesis, data were collected regarding the study characteristics (e.g., year published and type of publication), methodology (e.g., sample size and demographics), and outcomes (e.g., time allocation across general activities, specific mental health responsibilities, and barriers/facilitators to implementing mental health services). Two researchers independently reviewed each study and coded information according to the procedures recommended by Wilson (2009). Initial inter-rater reliability (IRR) was established for each subsection of the coding document (overall IRR = 92%; study characteristics = 97%; methods = 88%; time outcomes = 98%; mental health duty outcomes = 88%, and facilitator/barrier outcomes = 92%). Discrepancies in coding were resolved by consensus.

Data Synthesis

Results were organized by profession and outcome (i.e., time, SMH duties, and SMH facilitators/barriers outcomes). When studies disaggregated time results (e.g., reported by geographic area), the average (for numerical percentages/hours) or mode (for categorical outcomes) was used. When studies reported time categorically (e.g., 0–5% or 5–10%), an average time was computed and assigned (e.g., 0–5% was transformed to 2.5%).

Time outcomes were organized in six domains: (a) intervention (e.g., direct prevention and intervention); (b) consultation (e.g., indirect consultation and support); (c) assessment (e.g., evaluation to inform service planning); (d) family (e.g., parent support); (e) related coordination and professional enhancement (e.g., service coordination and student-focused meetings); and (f) miscellaneous: paperwork/documentation (e.g., report writing) and unrelated activities (e.g., statewide testing, committee work not related to students, and bus/cafeteria duty). Time results were then summed by domain, and a percentage with respect to total time reported was calculated (e.g., if total percentages exceeded 100%, time was calculated as a percentage of the total).

Results

Study Selection

The EBSCO search identified 1208 articles (see Fig. 1 for the PRISMA flow diagram). An additional article was identified through a Google Scholar search. After duplicates were removed, 975 records were screened to determine eligibility, resulting in the exclusion of 916 articles. The full texts of each of the remaining articles ($n = 59$) were then retrieved and assessed for eligibility. Of these, 50 were excluded for the following reasons: (a) did not include quantitative data describing the general time allocation and/or specific mental health responsibilities of SMH professionals ($n = 23$); (b) were not empirical ($n = 16$); (c) did not allow for meaningful comparisons in time allocation ($n = 5$; e.g., utilized Likert-type scales with descriptions of time allocation, such as "I occasionally do this" or "I frequently do this," and did not operationalize time as hours or percentages; see, Waalkes et al., 2019); (d) only reported qualitative data ($n = 3$); and (e) participants were outside of the USA ($n = 1$) or (f) were SMH trainees ($n = 1$). An additional article was later excluded, as it used the same data as an included study (Mau et al., 2016). In total, nine articles were included in the final synthesis: six reported on time allocation and three reported on specific mental health responsibilities. Across selected studies, the majority of participants were female ($M = 88\%$ across studies, range = 79–100%) and White ($M = 86\%$ across studies, range = 67–95%).

Time Outcomes

Of the six studies that reported time outcomes, two reported on school counselors, one reported on school nurses, two reported on school psychologists, and one reported on school social workers. Studies used various methods to study time allocation (e.g., how time was measured and the inclusion, grouping, and operationalization of various activities), and time outcomes were categorized according to the domain that best represented the activities (see Table S1 for the full delineation of study outcomes into time categories). For example, Kelly and Whitmore's (2019) Indirect Services outcome was categorized within the consultation domain but included aspects of both consultation and coordination, and Bahr et al. (2017) Tier 1, 2, and 3 outcomes were categorized within the intervention domain but included aspects of both intervention and assessment. In addition, the degree to which specific domains were represented varied across studies, and

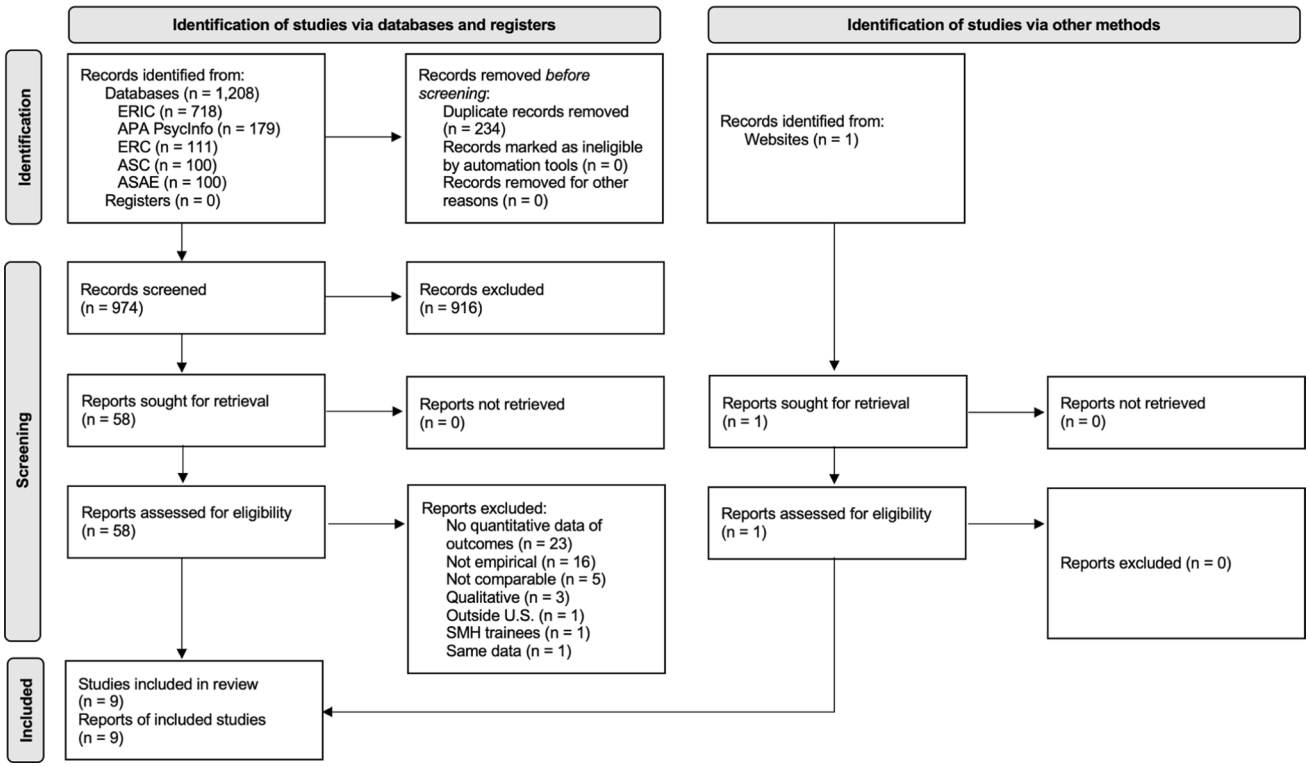

Fig. 1 Flow diagram of systematic review

some domains were not represented at all. For example, two studies (Albritton et al., 2019; Willgerodt et al., 2018) did not include any activities that might fall in the miscellaneous category. Similarly, only studies that reported on school psychologists included assessment activities as individual categories (excluding statewide testing for counselors). For example, Kelly and Whitmore (2019) included compliance assessment activities within their Documentation outcome, but this outcome was categorized within the miscellaneous: paperwork/documentation" domain, because it is described predominantly as writing reports and documenting activities. Similarly, Neyland-Brown et al. (2019) include needs assessment, evaluation of student progress, and documentation activities within their coordination activities outcome, but this outcome was categorized here within the related coordination/professional enhancement domain, because it primarily refers to program coordination and professional development. In addition, school nurses may have included screening activities when responding to the direct care outcome reported by Willgerodt et al. (2018), but this outcome was categorized here under "intervention." These methodological discrepancies should be considered when interpreting the results.

Results suggested variability across professions in the time spent providing services related to student mental health (see Fig. 2). Findings suggested that school counselors, school nurses, and school social workers spend more time implementing interventions (e.g., direct services), while school psychologists spend more time conducting assessments (e.g., screening and individual evaluations) and providing consultation (e.g., problem-solving and data teams). Notably, of the studies that collected information on miscellaneous activities ($n = 4$), each SMH profession spent a significant amount of time (22–41%) engaged in documentation and paperwork activities as well as activities unrelated to their field.

With respect to specific activities, Table 2 ranks the time allocation of SMH professionals according to the activities they spend the most and the least time conducting. The top activity for each profession directly related to supporting student wellbeing. However, miscellaneous tasks ranked in the top three activities for each of the four studies that included such outcomes. These results show that school counselors spend a considerable amount of their time conducting non-counseling duties (e.g., scheduling courses and coordinating schoolwide testing; Mau et al., 2016; Neyland–Brown et al., 2019); school psychologists spend a large portion of time writing assessment reports and completing paperwork (Bahr et al., 2017); and school social workers spend much of their time on documentation (e.g., documenting services and writing reports;

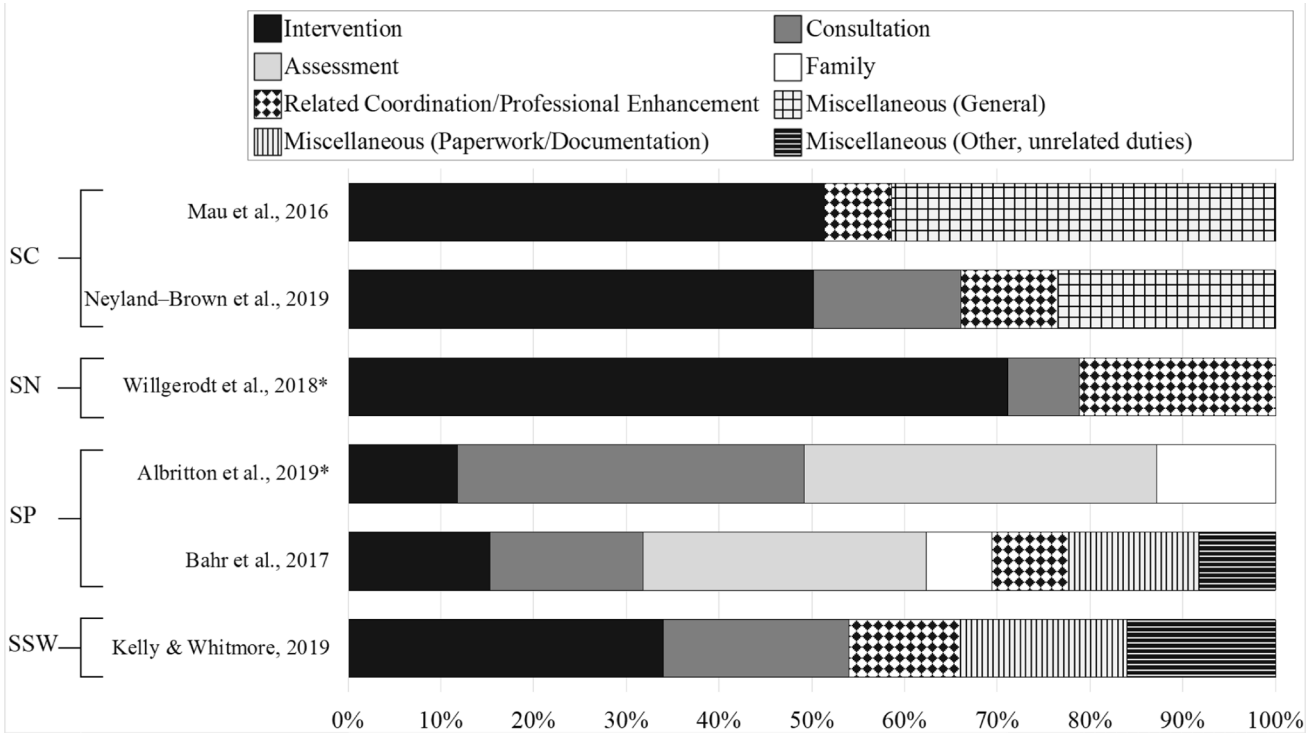

Fig. 2 Time allocation of SMH professionals. *Note*. *SC* school counselors. *SN* school nurses. *SP* school psychologists. *SSW* school social workers. Due to variability in the inclusion and operationalization of time outcomes across studies, synthesized time allocation results should be considered in context. The delineation of how individual study time outcomes were organized can be found in the Supplemental Materials.*Study did not measure activities in the miscellaneous category

Kelly & Whitmore, 2019). The only study that reported on school nurses did not include miscellaneous activities.

Most studies did not differentiate activities that support student mental health from activities that support student achievement, physical health, or general success (i.e., Kelly & Whitmore, 2019; Willgerodt et al., 2018). Among studies that provided some differentiation regarding the focus of activities (e.g., academic versus career development), findings suggested that professionals tend to spend a limited time addressing mental health needs. Mau et al. (2016), for example, found that high school counselors spent about 50% of their time providing direct intervention to students, but only a quarter of direct intervention time focused on personal or school problems—the majority of interventions focused on college, career, and academic development. Similarly, most of the service-related activities reported by Bahr et al. (2017) and Albritton et al. (2019) did not differentiate between mental health and other supports; however, activities that clearly reflected mental health supports represented about 14% (Albritton et al., 2019) to 17% by (Bahr et al., 2017) of school psychologists' total time. Neyland-Brown et al. (2019) asked their participants to indicate separately, with respect to all activities, the percentage of time spent addressing student mental health. Their results indicated that about 36% of school counselors' time was spent supporting mental health.

Two studies included in the time outcomes synthesis also asked participants to rank their preferred activities in addition to their actual activities. Both studies concluded SMH professionals would prefer to be engaged in more mental health services than they currently are conducting. Bahr et al. (2017) noted that some of the greatest discrepancies were for "mental health interventions (#2 preferred, #9 actual), counseling (#5 preferred, #17 actual), and positive behavior interventions and supports (PBIS: #10 preferred, #18 actual). By comparison, "paperwork (#3 actual, #25 preferred) and report writing activities (#2 actual, #21 preferred) were not strongly preferred yet consumed considerable work time" (p. 586). Similarly, Neyland-Brown et al. (2019) found a significant discrepancy between the actual and preferred activities of school counselors; they concluded that "school counselors feel that they are not being used to address the mental health needs of their student population" (p. 12). Specifically, school counselors want to spend less time engaged in non-counseling duties (e.g., bus duty and class scheduling) and more time providing mental health services, such as group interventions.

Table 2 Rankings for time spent conducting specific activities: three highest and three lowest activities

Study	←Highest			Lowest→		
	Three highest ranked activities			Three lowest ranked activities		
School counselors						
Mau et al. (2016)	College readiness/selection/application	*High school course choice/scheduling*	Personal/academic/career development	Other counseling activities	Job placement/job skill development	Non-counseling activities
Neyland–Brown et al. (2019)	Counseling	*Other (e.g., test coordination, committees)*	–	–	Curriculum	Coordination
School nurses						
Willgerodt et al. (2018)[a]	Direct Care	Case management	–	–	Administrative/teacher support	Professional development
School psychologists						
Albritton et al. (2019)[a]	Individual evaluations (SpEd)	Consultation (individual students)	Family Engagement	Consultation (schoolwide programs)	Assessment of classroom quality	Screening/Progress monitoring
Bahr et al. (2017)	Problem-solving consultation	*Report writing*	*Miscellaneous paperwork/recordkeeping*	Tier 2: Progress monitoring/intervention	Research	Programmatic interventions
School social workers						
Kelly and Whitmore (2019)	Direct service	Indirect services	*Documentation*	School Wide Prevention	Supervision/Mentoring	Crisis/Non-Caseload

For studies that only reported on five activities, the top and bottom two activities were included in this table. Miscellaneous activities are italicized. SpEd = special education

[a]Study did not collect information regarding time spent conducting miscellaneous activities (e.g., paperwork, test coordination, committees, and other non-specialized duties)

Primary Mental Health Responsibilities of SMH professionals

Three additional studies provided insight into the specific mental health responsibilities of three of the four SMH professions (no studies of school social workers were identified). Most and least frequented responsibilities are summarized in Table 3. Nearly all school counselors reported providing crisis counseling, coordinating with parents to support students' mental health, and making referrals to outside mental health providers; and more than half provided mental health counseling and classroom programming. School counselors were least likely to use assessments to monitor and promote students' mental health (Fan et al., 2019). Eklund et al. (2020) found that, on average, school psychologists spend more time providing universal mental health supports (5–9 h per week) versus targeted services (1–4 h per week). While nearly three-quarters of school psychologists reported providing mental health consultation, only a third reported providing direct mental health services. Finally, school nurses were observed to most frequently engage in indirect and medication-related mental health services; the provision of direct mental health services and assessment were ranked lowest (Bohnenkamp et al., 2015).

The studies reviewed also provided some insight into the barriers and facilitators for engaging in responsibilities associated with SMH care. School nurses reported a lack of training, tools, methods for obtaining consent, and follow-up resources as the top barriers to conducting mental health screenings (Bohnenkamp et al., 2015). Eklund et al. (2020) reported on factors that may facilitate the provision of mental health services among school psychologists. Administrator support and improved school psychologist-to-student ratios were ranked highest, followed by more training and collaboration among other SMH professionals.

Discussion

As mental health needs of students in K-12 schools increase, particularly since the COVID-19 pandemic began, it is critical that schools leverage the training of their current workforce to provide SMH services in a coordinated and efficient manner. This review aimed to help schools facilitate the successful implementation of comprehensive SMH systems by describing the relevant knowledge and skills of existing staff as well as existing resources (e.g., staff time) that could be reallocated to SMH service provision (Damschroder et al., 2009).

Table 3 Rankings of specific mental health duties performed by SMH professionals

Profession/Study/ Duty type	←Highest						Lowest→
School counselors							
Fan et al. (2019)							
General practices	Crisis counseling (93.2%)	Coordinate with parents to support student MH/ development (93.1%)	Refer to outside MH providers (92.2%)	One-on-one MH counseling (87.4%)	Classroom-based preventions programs to support MH (72.5%)	Group MH counseling (60.7%)	Psychological assessments to promote MH (31.6%)
School nurses							
Bohnenkamp et al. (2015)							
Screening practices	Do not conduct MH screenings (1)	Screen for Anxiety (2)	Screen for Depression (3)	Screen for Suicide (3)	Screen for Behavioral Issues (4)	Screen for Substance/ Alcohol Abuse (5)	Screen for ADHD (6), Trauma (7), or Psychosis (8)
Service practices	Communicate with parents about MH (1)	Refer to other SMH professionals (2)	Administer (3)/Monitor (4) medication	Refer to community MH professionals (5); Crisis response teams (6)	MH consultation (7); Brief (1–2 sessions) MH counseling (8)	MH education (9); MH assessment (10); Cognitive-Behavioral intervention (11)	Other (12); Substance abuse (13)/Extended (14) counseling
School psychologists							
Eklund et al. (2020)							
General practices	Consultation related to MH (72.1%)	Crisis intervention (33%)	Individual counseling (32%)	Schoolwide prevention programming (31%)	Suicide or threat assessment (23%)	Group counseling (20%); Universal MH screening (12%)	Classroom-wide interventions (7%); Other (6%)

MH mental health. Fan et al. (2019) and Eklund et al. (2020) reported the percentage of participants who engaged in each activity. Bohnenkamp et al. (2015) reported the response frequency rank order for each activity

Results suggest that school counselors, school nurses, school psychologists, and school social workers share many of the clinical competencies needed to implement the key features of comprehensive SMH systems. Each discipline's professional standards emphasized common themes related to evidence-based practice, data use, and consultation skills, which are necessary for effective mental health service provision (Hoover et al., 2019; NCSMH & MHTTC, 2019). Unfortunately, it appears that these skills are un- and under-utilized. In particular, school counselors, psychologists, social workers, and nurses are now graduating with professional degrees that emphasize assessment and intervention services in response to youth mental health needs. However, our review of time allocation studies suggests that most of these professionals spend time in non-mental health related duties (e.g., completing paperwork or engaging in duties unrelated to their clinical expertise, as reflected in a large portion of time classified as "miscellaneous"). This means that, while these professionals are likely to have the skills necessary to respond to the mental health needs of students, schools are not routinely drawing on the specialized mental health knowledge staff possess.

These results are a reason for concern but also optimism. Findings suggest that schools can respond to calls for increased access to school-based mental health services for students (see, e.g., UNICEF, 2021; U.S. ED, 2021) by (a) clarifying and coordinating the roles of distinct SMH professionals and (b) shifting less specialized tasks away from SMH professionals to use the breadth and depth of their mental health training—a move that would align with widespread calls across professions (DeKruyf et al., 2013; Splett et al., 2013). For schools with limited access to SMH providers, results point to two promising considerations for redeploying SMH staff in ways that effectively and efficiently support student success. First, the results suggest that a variety of SMH professionals are likely to have the professional expertise enabling them to support the delivery of SMH services. Second, current SMH professionals may be assigned duties that do fully leverage their expertise (e.g., administrative of case management duties). Thus, if these types of tasks were shifted to other staff, current providers may be able to engage in a wider range of SMH activities. We conclude that there may be untapped opportunities for collaboration and coordination across disciplines given shared expertise in many of the core functions associated with SMH services. Finally, schools may also consider leveraging community mental health providers to expand capacity of school teams to address youth mental health teams. Although community mental health providers were not included in this review, the use of community-based mental health providers in school settings can be an effective way to expand capacity especially when resources are devoted to coordinating care across community and school settings and allow opportunities for community and school staff to collaborate on student mental health needs (Splett et al., 2017; Weist et al., 2006). These recommendations are consistent with integrated models of mental health care wherein providers from various professional backgrounds and settings proactively collaborate with each other to ensure efficient and equitable provision of mental health services (Eber et al., 2019; Splett et al., 2017).

Professional Training: Common Themes and Unique Perspectives

As schools struggle to hire qualified SMH professionals due to national shortages of providers (Whitaker et al., 2019), the crosswalk of professional training standards against SMH competencies revealed both common themes and unique disciplinary perspectives. As school leadership consider strategies to deploy SMH staff, understanding these perspectives may be useful for determining how to staff SMH services. Importantly, results do not provide insight into an "ideal" ratio or staffing model; instead, we summarize professional training and alignment with a comprehensive SMH framework to allow school leaders to make informed staffing decisions. By delineating the unique competencies and their overlap with key features of comprehensive SMH systems, we hope to increase efficient use of existing SMH professionals and maximize benefits to students.

Training standards for all the SMH professionals included in this review emphasized many of the core competencies needed to implement comprehensive SMH services (Hoover et al., 2019). Unfortunately, these professionals also frequently report being assigned job responsibilities that are not aligned with their core set of competencies—for example, many professionals report spending a large amount of time on administrative duties (e.g., paperwork and scheduling; Bahr et al., 2017; Mau et al., 2016) that do not directly relate to SMH. Thus, school leaders may be able to capitalize on elements of training shared across professionals when considering how to best implement comprehensive SMH services. For example, collaborating with families and community partners is a shared training competency jointly identified across the professions (ASCA, 2019; ANA & NASN, 2017; NASP, 2020; NASW, 2012). Therefore, depending on availability of specific staff in a particular school (or school district), leaders may leverage the expertise of counselors, psychologists, nurses, or social workers when implementing structures to collaborate with families and community organizations in support of student mental health. Similarly, each profession shares competencies in mental

health counseling; thus, schools facing staff shortages can utilize the skills of diverse SMH professionals to meet the increasing mental health needs of youth, particularly post-COVID (Mojtabai & Olfson, 2020; Racine et al., 2021).

Results also provided insight into additional factors that school leaders and SMH professionals should consider when allocating tasks. First, it is important to consider that different professions may possess distinct skills in certain domains. For example, with respect to the provision of Tier 2 mental health services, school counseling standards emphasize competencies in counseling to address student needs and promote social-emotional development (ASCA, 2019), whereas school nursing standards emphasize the provision of responsive counseling and intervention in areas such as teen pregnancy, death of family members, and substance abuse. Similarly, at Tier 3, school psychology and school social work standards reflect individualized and long-term mental health counseling and consultation, whereas school nursing standards reflect medication treatments and health consultation for complex cases. Finally, the standards of only two professions—school psychology and school social work—reflected competencies related to universal mental health screening and mental health therapy, which are critical to effective SMH systems (Dowdy et al., 2014; Kern et al., 2017). Thus, school leaders should consider the scope of skills when making hiring decisions and assigning tasks. Whenever possible, schools should coordinate the unique expertise of specific professionals to efficiently meet the mental health needs of students.

Similarly, the degree to which professional standards reflected each competency varied across fields. For example, MTSS is specifically described within the professional standards of school psychologists and school social workers, whereas school nursing standards refer more generally to components of a public health approach that promotes a continuum of services. Although the school counseling standards discuss using principles of MTSS, the national school counseling association, ASCA (n.d.-a), specifically identifies the coordination of a schoolwide MTSS approach as an inappropriate activity for school counselors. Similarly, the degree to which individual SMH providers' competencies align with those reflected in their fields' professional standards may vary—providers may possess competencies not reflected in their standards or vice versa. For example, identification of mental health disabilities was reflected in the competencies required to become a C-SSWS; however, not all individuals employed as social workers in schools have this certification (Kelly et al., 2015). Similar discrepancies may exist between the standards of professional organizations and individual professionals' adherence to those standards. For instance, while ASCA (2019) discourages school counselors from providing long-term mental health therapy, some have argued that school counselors are well-suited to provide these services (Lambie et al., 2019). Thus, the crosswalk is meant to provide general guidance regarding SMH competencies across professions, but it may not accurately represent the breadth and depth of SMH training of any particular provider.

Finally, although the competencies identified in this study were determined using the standards of leading professional organizations, this does not ensure that prospective SMH providers have been trained using these models. Due to variations across states in professional requirements and the changes in training requirements over time, current and prospective hires may have diverse qualifications. Thus, schools should consider the national certifications held by SMH professionals, the accreditation status of their training programs, and their previous experiences when determining the competencies of current and prospective hires.

Task Shifting: Maximizing the Time of School Mental Health Staff

Results from this study also suggest that there may be an opportunity to shift the prioritization of tasks for SMH professionals to maximize opportunities for SMH staff to practice in ways most consistent with their professional training. For example, school counselor responsibilities related to non-counseling duties (e.g., test coordination; Wilder, 2018) may be shifted toward supporting student mental health (DeKruyf et al., 2013). Similarly, school psychologist duties may be able to be shifted away from an emphasis on special education eligibility and toward an emphasis on prevention and the provision of SMH services (Dowdy et al., 2014; Splett et al., 2013). This task shifting model may be one way to address concerns that SMH staff express about a lack of time to address student mental health (Hanchon & Fernald, 2013).

Strategies for task shifting include both (a) re-allocating current tasks away from SMH professionals to other individuals with less extensive qualifications and (b) aligning the roles of SMH professionals to promote an integrated approach. Most evidently, miscellaneous tasks (e.g., scheduling, test coordination, and record keeping) may be able to be reassigned to other school professionals or support can be provided to reduce the demands of the tasks (e.g., personnel support or streamlining procedures). Also, some have suggested that SMH professionals may use their training in mental health to support or supervise other school staff (e.g., teachers or paraprofessionals) who could provide direct intervention supports which focus on either mental health promotion (Tier 1) or manualized curriculums targeting academic or life skills (Tier 2; Eber et al., 2019). Finally, the mental health services provided by distinct SMH professionals, which have traditionally been siloed, may be

integrated into a single system of delivery. In this integrated system of tiered supports, multidisciplinary SMH teams collectively select and monitor all interventions, regardless of who implements it, and clearly delineate roles and responsibilities to prevent overlap (Eber et al., 2019).

Task shifting, however, does require schools to carefully consider practical, ethical, and legal implications of shifting staff duties (Eber et al., 2019; McQuillin et al., 2019). Practically, this approach requires organizational shifts and role changes for staff (e.g., reallocation of tasks, shifting the role of all educators to include prevention-based mental health supports, and integrating the separate responsibilities of SMH providers into a single, team-based model), which may be met with resistance and necessitates iterative evaluation of how these changes impact other school services, as well as staff wellbeing and workload. Ethically, when planning to task-shift, it is critical that the personnel who assume new responsibilities are provided adequate training, supervision, and oversight to ensure services are provided in a competent and transparent manner. Legally, clear policies and procedures need to be implemented to protect student privacy and confidentiality in a manner that does not impede effective service delivery within an integrated system. In addition, schools need to make certain that they are complying with state laws related to organizational staffing requirements.

Limitations and Future Directions

There were important limitations within the current study. For the crosswalk, we relied on the key components of comprehensive SMH systems outlined in Hoover et al. (2019) and NCSMH and MHTTC (2019) to determine the SMH professional competencies. These documents may not reflect all the competencies needed by SMH professionals; however, we attempted to reduce potential bias by using guidance developed by multidisciplinary teams of experts and leading national organizations. In addition, we relied on the standards of leading national organizations, which may not reflect the competencies and mandates of all individuals within each respective profession. Future research may consider investigating the perceived competencies of individual providers to determine alignment with the core components of SMH systems. Finally, we restricted our crosswalk to four school-based mental health professions; however, there are a variety of other professionals who support the emotional and behavioral health of students (e.g., behavior analysists) and/or collaborate on expanded SMH teams (e.g., community clinicians). We chose to focus on school counselors, nurses, psychologists, and social workers because these professionals are often specifically trained and certified to deliver mental health services to students in schools, and they are frequently identified in SMH policy and literature (see, e.g., Cowan et al., 2013; ESSA, 2015; Whitaker et al., 2019). Still, results should not be considered an exhaustive review of the competencies of all professionals who may provide SMH services.

Limitations were also present in the systematic review. First, the variety of methods used to measure time allocation did not allow for a perfect comparison of time allocation. To allow for comparisons across studies, we assigned numerical percentages to each activity based on the central tendency of categorized times with respect to the sum of all activities. Although this method provides insight into time allocation and promotes interpretability, it is not exact. In addition, most studies utilized reflective measures of time allocation (e.g., estimates), which may increase measurement error. Finally, some of the time outcomes included activities that reflected more than one domain (as defined in the synthesis), and the activities measured within the studies reflected the domains to varying degrees—sometimes not at all. When certain activities were not reflected in a study's time outcomes, participants may have disregarded them when responding or may have included them within other categories. To better understand time allocation and how it differs across professions, future research should consider including all SMH providers in the same participant sample and use appropriate time study methods.

Conclusions

Results suggest that school counselors, nurses, psychologists, and social workers share many of competencies needed to implement comprehensive SMH systems, but that and the breadth and depth of their unique and specialized skillsets in mental health are often underutilized. Thus, opportunities exist for schools to leverage their current workforce to increase access to SMH services and effectively meet the rising mental health needs of students. Specifically, there may be a variety of ways in which schools can staff SMH programs given the common and unique competencies across disciplines; schools should clarify and align the responsibilities of distinct SMH professions to ensure comprehensive, efficient, and effective service provision. For example, all professions share competencies in mental health counseling; however, schools could coordinate the unique expertise of distinct professions by having school nurses respond to situational stressors, assigning school counselors short-term counseling cases, and delegating universal screening and long-term therapy to school psychologists and social workers. Finally, SMH professions spend a considerable amount of their time on activities that may not require their expertise. Thus, opportunities exist for schools to shift those tasks to staff with less extensive qualifications to maximize

opportunities for SMH professionals to engage in tasks that prioritize and leverage their mental health training. By understanding how the clinical competencies of SMH professionals align with the key features of comprehensive SMH systems and how these staff are currently utilized, schools can efficiently plan and execute effective mental health services.

Supplementary Information The online version contains supplementary material available at https://doi.org/10.1007/s12310-022-09535-0.

Declarations

Conflict of interest We have no conflicts of interest to disclose.

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