A Qualitative Investigation of the Referral Process From School Counselors to Mental Health Providers

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Abstract

This qualitative study explores the referral process to mental health providers by school counselors, as perceived by school counselors. Using an open-ended survey instrument, school counselors were asked to describe the referral process, including prevalence, decisional factors, follow-up, and evaluation. Results suggest that school counselors value mental health providers, engage in collaborative relationships, and utilize these relationships throughout referral situations, but that communication and teaming between these two sets of professionals may be lacking after the referral is made. Implications for mental health professionals and school counselors and recommendations for best practices are presented.

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Referring students to appropriate and helpful mental health care is a critical function of a school counselor's role in a school (Brown & Trusty, 2005; Ritchie & Partin, 1994). This function results from the school counselor's responsibility as the initial mental health care provider for many students (Paisley & McMahon, 2001), especially given the range and severity of mental health issues that students experience in school environments (Mills, Stephan, Moore, Weist, Daly, & Edwards, 2006). More specifically, given the complex needs of students and school communities, it is unlikely that school counselors alone can facilitate optimal interventions to all students and situations, at all times. Thus, in addition to any direct mental health services rendered, an important role of school counselors is assessing students' needs and matching their needs with appropriate and comprehensive care in the community (Amatea & Clark, 2005; American School Counselor Association [ASCA], 2005).

Professional School Counselor and Referrals to Mental Health Providers

A professional referral is defined as "the transfer of a client to another counselor" (Gladding, 2006, p. 121). When counselors experience professional or personal circumstances that hinder the delivery of appropriate services, a referral is a way to meet the needs of the client. For school counselors, the ASCA National Model (2005) includes specific language regarding referrals, including examples of when a referral might be appropriate and to whom school counselors typically refer students.

Counselors use referral sources to deal with crises such as suicidal ideation, violence, abuse, depression, and family difficulties. These referral sources may

> include mental health agencies, employment and training programs, juvenile services and other social and community services. (p. 42)

While the National Model does not provide school counseling professionals with direction regarding the process of a referral, the ASCA *Code of Ethics* (2004) underscores when referrals might be appropriate and provides further information about ethical referral activity:

> The professional school counselor makes referrals when necessary or appropriate to outside resources. Appropriate referrals may necessitate informing both parents/guardians and students of applicable resources and making proper plans for transitions with minimal interpretation of services. Students retain the right to discontinue the counseling relationship at any time.

Although referring a student to another mental health professional is commonplace and some professional guidance exists related to appropriateness of and basic ethical parameters for referral behaviors, the referral process itself is not well defined in the literature. In fact, school and mental health literature are each generally limited to reasons for referral (e.g., client needs exceed counselor competence; [Ritchie & Partin, 1994; American Counseling Association, 2005]), decisional factors (e.g., the law in child abuse reporting [Bryant & Milsom, 2005]). The resulting lack of clearly delineated referral processes and the limited description of factors that influence those processes leave little means to evaluate the effectiveness of referral practices or outcomes. This lack of professional standard is especially troubling for school counselors, who are often encumbered with large caseloads, preoccupied with

administrative duties, and generally lack the comprehensive training and supervision to meet the mental health needs of all students.

School Mental Health Services

In a report generated by The President's New Freedom Commission on Mental Health (2003), the status of mental health services for children and adolescents is generally inadequate, often marginalizing already underserved populations. Based upon their findings, the Commission asserted that mental health services in schools are a critical component in rebuilding our mental health system for children. Fortunately, schools are a uniquely appropriate venue for the delivery of mental health services to children and adolescents (Weist & Murray, 2007). This being said, often schools are mired with internal and external forces that inhibit adequate and comprehensive care to the students they serve.

Contemporary schools are often equipped with a variety of mental health professionals and services (Teich, Robinson, & Weist, 2007). Although fortunate schools are readied with diverse means to meet the mental health needs of students, in the majority of schools, it is solely the school counselor who provides the mental health service to students, often in the form of preventative care (Brown & Trusty, 2005). Additionally, school counselors are charged with providing services that respond to immediate student needs which can be delimited by the scope of the school counselor's total responsibilities in the school.

School counselors refer students when the level of care needed is outside the scope of school-based services, for legal reasons, or when mental health counselors hold expertise specific to a student's needs that exceed the school counselor's

expertise (Ritchie & Partin, 1994). The majority of the literature on referrals is specific to supporting students in need of high levels of care (e.g., those in crisis [Brown & Trusty, 2005], with serious familial, emotional, or mental health issues [Allberg & Chu, 1990], or with disabilities that require specialized care [Lockhart, 2003]) or when referrals are a legal requirement (e.g., suspected child abuse; Bryant & Milsom, 2005). This is consistent with Ritchie and Partin's findings that emotional concerns were a primary reason for referrals made at all levels and that child abuse was among the top three referral reasons at the elementary and middle school levels.

Decisional Factors for Mental health Referrals in Schools

Ethical guidelines related to the referral process can provide a school counselor support when the presenting problem is outside of his or her scope of expertise, when the counselor is without the sufficient resources to provide appropriate mental health response, and when decision factors related to the presenting student problem are considered by the school counselor. For example, Siehl and Moomaw (1991) found that low comfort level of working with suicidal clients led to high referral rates of clients disclosing suicidal ideation. Bryant and Milsom (2005) found that the law, evidence of child abuse, and student safety concerns were primary decisional factors in school counselors' choice to refer to Child Protective Services. Limited resources (e.g., counselor-student ratio) have been cited as a decisional factor that is not specific to the presenting problem (Ekstrom, Elmore, Shafer, Trotter, & Webster, 2004).

Purpose of the Study

The purpose of this study was to examine issues related to the referral process to mental health professionals from school counselors, as viewed by school counselors,

in order to identify both areas of strength and impediments to the referral process. Based upon the data garnered, this study might provide insight into the prevalence of referrals from school counselors to mental health professionals, the decisional processes that school counselors engage in prior to referrals, the processes affiliated with the referral, and assessments of the effectiveness of the referral process. The results from these findings can also provide a foundation for the development of theory and best-practice recommendations for school and mental health providers related to the nuanced nature of referrals in schools. Findings from this study can supplement the dearth of existent research, especially given that much of this research was published over ten years ago and did not focused on the referral process from school counselors to other mental health providers (e.g., Celotta, 1995; Thompson, 1995).

Method

This exploratory qualitative study used a series of theory-based, open-ended questions positioned within a structured survey (see Fontana & Frey, 2000). This method was used to provide tentative theory related to the existing referral practices of school counselors to mental health providers who typically perform services outside of the immediate school environment. Such methodology not only illuminates the strengths and challenges inherent to the referral process but also provides a conceptual framework from which school counselors and mental health providers may use to guide practice.

Participants

In order to reach a diverse sample of school counselors while minimizing the impact of researcher bias on sample, data were solicited from a random sample of

school counselors employed in a two Midwest states. The usable data were aggregated into a total sample of 28 to be coded and analyzed. From the total sample, 11 of the respondents reported to work in elementary schools (39.3%), 8 in middle schools (28.6%), 7 in high schools (25%), and 2 in schools designated as either K-12 or multi-level (7.1%). The majority (*n* = 21; 75%) of total respondents reported to be female. Ethnically, the aggregated sample was predominately of Caucasian descent (*n* = 24; 85.7%), with the remainder of the sample reporting being of Latino/a descent (*n* = 2; 7.1%); African-American descent (*n* = 1; 3.6%); and Multiethnic descent (*n* = 1; 3.6%). The age reported by participants ranged from 23 to 68 years (M = 41.3; SD = 6.5). Respondents to the survey averaged 11.9 years working experience (SD = 7.3), ranging between 2 and 30 years of experience. Finally, data were collected to ascertain the total number of students that each counselor is formally assigned to work with in their day-to-day activities as a school counselor. Respondents were assigned an average of 445.6 students (SD = 179.9), ranging from 147 to 1100 students.

Instrument: Structured-Interview Questions

The questionnaire developed for the purpose of this study resulted from a thorough review of the research-based and theoretical literature germane to school counselors' use of mental health referrals to mental health care providers (e.g., Brown & Trusty, 2005; Ritchie & Partin, 1994). Additionally, questions were formulated based upon the authors' clinical experiences as school counselors and mental health providers, and training experiences counselor educators. Prior to the interviews, the researchers reevaluated the survey prompts to ensure that they met the needs of the study and were not presented in a manipulative or influential manner. After that review,

an outside reader who is a practicing school counselor provided feedback on the instrument indicating that the survey items were clear, that the prompts would elicit the desired data, and that the survey was representative of the process of referrals in schools. The eleven questions asked are listed in Table 1.

Procedure

To ascertain the perceptions and usages of referrals for school counselors, the researchers collected, coded, and analyzed the qualitative data based upon the aforementioned structured survey prompts. Each of the completed survey instruments was then disseminated to each of the members of the research team (i.e., the three first authors) to be analyzed, coded, and reported.

Analysis

To analyze the data and ensure the verifiability of each of the themes, the research team utilized multiple triangulation strategies. Analysis of the data included an independent read of the total data by each member of the research team, a combined read and consensus-building phase, comparison with the existing literature, and the substantiation offered by an outside reader. In order to ensure fidelity to the respondents, the researchers repeatedly returned to the original data to ensure that the themes aligned with data offered by the school counselors surveyed.

During the first phase of independent coding, the researchers employed traditional qualitative mechanisms of analysis to verify each of the possible themes (e.g., comparative analysis, content analysis, schema analysis; Glaser & Strauss, 1967, Silverman, 2000). Specifically, each member of the research team read each survey response individually. During these initial reads, each researcher examined the data for

Table 1

School Counselor Perception of Mental Health Referral Survey

Mental health referral is defined as any act that you perform as a school counselor that assists a student and/or a student's guardian in locating another mental health provider, preparing that student to work with another mental health provider, and/or transferring the student to another mental health provider.

1. According to the definition above, to how many students did you provide a mental health referral in the previous 12 month period? _____
2. In your experience as a school counselor, how does that number compare to how many mental health referrals you typically make each 12 month period?

   A. far more B. more C. about the same D. fewer E. far fewer
3. How do you decide when to refer a student to another mental health professional?
4. Under what circumstances would you choose NOT to refer a student to another mental health professional?
5. Describe the steps you take when you refer a student, from the time you first meet the student until the process is completed.
6. As a school counselor, when do you consider the referral is complete?
7. How do you choose the specific mental health professional to whom you refer the student?
8. What guidance, if any, do you have from school, administration, and/or district to help you make referral decisions?
9. How do you determine if your referral was successful?
10. What happens after you make a referral?
11. How do you feel about the process of referring a student to another mental health professional?

themes relative to each of the survey items. After independent themes were designated, the researchers examined the preliminary themes of the other members of the research team. From this second set of data analysis, jointly established thematic categories were rendered and presented to the research team for consideration and consensus building. Final categorical themes were determined by consensus of the research team. Next, these categorical themes were independently used to recode the original data. Final tallies of data points for each categorical theme were considered for inter-rater reliability by comparing the assigned codes for data by each reviewer (i.e., if two out of the three reviewers agreed that a given data point fit in a particular categorical theme).

Finally, in order to provide further reliability, the outside reader independently read and coded the data according to the research team's categorical themes. Final themes and data codes were then determined by consensus between the research team and outside reviewer. This outside reader verified that the data reflected the referral process as she conceptualized it.

Results

Results for this study were organized in domains (i.e., related research questions from the survey instrument), categorical themes and sub-themes (i.e., salient constructs grouped from the data), and data-points (i.e., representing the total number of responses for each theme in the data).

Prevalence of Mental Health Referrals by School Counselors

The first domain represents the prevalence of school counselor-generated mental health referrals provided in the previous 12 months and the comparison of the prevalence of referrals during that time with what a school counselor perceives to be

typical in a 12-month period. The twenty-eight school counselors made an average of 16.2 referrals (SD = 27.9) within the previous 12 months. Prevalence of referrals ranged between 1 and 150 referrals during the previous 12 months and is illustrated in stratified groups in Table 2. In terms of continuity between the number of referrals made during the past 12 months and a typical 12 month period, 24 (82.8%) school counselors reported "About the Same" number of referrals were made, 4 (13.8%) school counselors reported that the current 12 month period represents "More" referrals than is typical, and 1 (3.4%) school counselor reported that "Fewer" referrals were made in the current 12 month period. No counselor responded that either "Far More" or "Far Fewer" referrals were made in the previous 12 month period than would be typical during any other given 12 months.

Table 2

Referrals Reported in the Previous 12 Months

Range of Referrals	Referrals in Previous 12 Months	Percent of Counselors
1-5	9	32.1
6-10	10	35.7
11-20	3	10.7
21-30	4	14.3
50	1	3.6
150	1	3.6

Decisional Factors and Referral

The second domain explored school counselors' decisional factors in making a mental health counseling referral. This domain constituted three questions from the survey and, therefore, was grouped into three separate sub-domains: (a) Reasons School Counselors Decide to Refer; (b) Circumstances When School Counselors would Choose not to Refer; and (c) Guidance in Referral Decisions (e.g., resources, principals, district-level counselors).

In response to the survey question that asked school counselors how they decided to refer a student to another mental health professional, data were categorized into the following five themes: Outside School Counselor Competence or Duties, (n = 22), Family Issues (n = 8), Time/Number of Sessions (n = 7), Team Decision (n = 7), and Intervention Not Working (n = 7). The first theme, Outside School Counselor Competence or Duties, were data points including activities outside of the school counselors' programs, resources, or competences. The second theme involved counseling situations where the school counselor deemed that referent situation dealt with family issues; "I may refer for relationship and communication issues in family".) The third theme represented those data points whereupon the respondent reported that multiple sessions were necessary or longer periods of direct service contact (e.g., "when the situation requires more than about six sessions"). The fourth theme represented those occasion where the school counselor and another individual (e.g., social worker, teacher, parent) made a joint decision to refer (n = 7). The fifth theme for referral decisions was when an existing intervention(s) that the school counselor was employing was deemed ineffective in promoting student successes.

When asked to describe those situations when one would choose not to refer a student, the data were grouped into five themes: Relevance to a Comprehensive School Counseling Program (n = 11); Referral Not Appropriate (n = 5); Within School Counselor Competence (n = 4); Parental Consent or Request (n = 4); and Progress with Intervention (n = 3). The first theme, Relevance to a Comprehensive School Counseling Program, included responses such as "can be solved in the school environment," "related to academics, personal/social, or career related," "when brief counseling is beneficial," and when "limited to our students." The second theme was when the school counselor assessed that the Referral was Not Appropriate (e.g., "When I believe the student does not require long term therapy or assistance"). The third theme represented those occasions when the respondent perceived the situation within their Competence. The fourth theme, Parental Consent or Request, included those incidents when the parent refused to consent to a referral for their child or made special request for direct services imparted specifically by the school counselor. The fifth theme was Progress with Intervention, which included such data points as "When adjustments in lifestyle, behavior modifications, and other interventions seem successful."

When asked to describe what guidance, if any, the respondent received from their respective school, administration, and/or district in making referral decisions, the resultant data-points were grouped into the following five themes: None (n = 9); District Partnership or Referral List (n = 8); School Mental Health Colleagues (n = 7); Supervision from School Administrator or Colleagues (n = 7); and Insurance (n = 1). The first theme, None, was coded when the counselors relied exclusively on their own professional history or "judgment" and minimal policy guidelines (e.g., "none – other

than we don't want to be the ones paying for it"). The second theme, District Partnership or Referral List, referred to assistance such as "district resources (EAP) that are offered free of charge," the "district has contracted with an agency and provided a school social worker," or "referral book developed through counseling department." The third theme, School Metal Health Colleagues, represents those data points where the respondents mentioned referral support from other members of the professional school community that they were affiliated with (e.g., "the school social worker and fellow counselors are good support system for the decision process"). The fourth theme, Supervision from School Administrator or Colleagues, was denoted by data points such as "recommendations from counseling coordinator" and "assistant superintendent in charge of student services helps guide the counselors in the referral process." The fifth theme for this domain, Insurance, was coded for when the "family insurance can also be a factor."

The Process of Making a Referral

The third domain explored the processes of the referral. When asked to describe the steps they take when referring a student (i.e., from first meeting until the completion of the process), respondents' input was coded into eight themes: Involve Parent (n = 22); Direct Services/Speaking with Student (n = 20); Provide Resource or Referral List (n = 13); Speak with Referral Source or Make Referral (n = 13); Assess the Situation (n = 10); Consult with School Personnel (n = 10); Paperwork or Document (n = 7); and Follow-up (with student, parent, or referent; n = 6). Although it is apparent that there exist explicit themes from the data relative to the referral process, an affixing thematic consideration must qualify that these processes were not reported as discrete or

isolated themes; instead, respondents reported these themes sequentially and systematically. To represent the meaning content associated with this domain, the following quotation is an exemplar of the processes used by school counselors during the referral process:

> "I meet with the students, discuss the issue, address the immediate concern, offer resources. At this point, I contact parents, offer outside resources and pass on the contact information. If a social worker referral is appropriate I will contact our district (or SSD) social worker for her help, as well. EAP that we have offered their services. If a parent makes an appointment, EAP notifies us that an appointment was made."

When asked, "when do you consider the referral complete?" respondents' data were categorized into five themes: Transfer of Care (n = 16); Follow-up (n = 11); Provided Referral Information (n = 11); Student Progress (n = 2); and Never Complete (n = 1). The first theme in the perceived completion of a referral, Transfer of Care, included "turning over to outside agency" and "if the family follows through and [the student] is actually seen by an outside professional." The second theme, Follow-up, was subcategorized into the following five themes: Follow-up with Parent (n = 3); Follow-up with Referral Source (n = 3); Follow-up with Student (n = 2); Follow-up with Teacher (n = 1); and Follow-up Generic (n = 2). Provided Referral Information, the third theme in this domain, ranged from "the parent is given a list of outside counselors" to "when the parent has necessary information and acts on it." The fourth theme, Student Progress, was coded based upon responses such as "when the student is successfully attending sessions and improvements are seen." The final theme, Never Complete, was resultant

of one sampled counselor who responded, "a referral is never complete, there is always follow-up."

In response to the survey question, "How do you choose the specific mental health professional to whom you refer the student?", data were categorized into six themes. These themes include from a Referral List (n = 9), from Feedback (n = 8); based upon Financial Need (n = 7); School Counselor Does Not Make the Referral Decision (n = 7); based on Presenting Problem or Issue (n = 6); and School or District Program or Relationship (n = 4). Data points from the first theme, Referral List, include resources that had been generated within the school of employment, district-wide, and by the counselor independently. The second theme, Feedback, represented the perceived value that school counselors had with a particular referent based upon past collaboration, consultation with other school counselors, or through other related mental health resources. Financial Need, the third theme in this domain area, were such data points such as the school counselor considering the financial limitations of the family, referring based upon insurance, and seeking out sliding scale or no-charge mental health services. The fourth theme from the data, School Counselor Does Not Make the Referral Decision, included data points such as "I do not, our school social worker makes that referral," "I outline as many options available in my area to parent, they decide who to choose," and simply "I don't." The fifth theme, Presenting Problem or Issue was categorized for those responses that referred to the counselor making a referral choice to a specific mental health provider, based upon the specific treatment needs of the student or family. The sixth theme, School or District Program or Relationship, included statements such as "our district offers Employee Assistance Plus

services to all of our students/ families (free of charge)" and "our district has a voucher system and through a grant will pay for 3 to 5 visits for those families who would otherwise not be able to afford counseling."

Follow-up Considerations Relative to Referrals

The fourth domain comprises the data relative to the respondents' reported follow-up activities after having made a mental health referral. This domain area was represented in two survey questions, first asking the respondents how they determined the success of a referral and, then asking them to respond to their practices after a referral has been made. The two sub-domain areas are explicated below.

When prompted with the question "How do you determine if your referral was successful?" respondents' resulting data points were coded within the following main themes: Feedback (n = 19); Signs of Improvement (n = 16); Complete with Contact (n = 4); and Unsure (n = 1). The first theme, Feedback, was defined as occasions when the school counselor utilized responses from various stakeholders including parents, students, teachers, and referent mental health professionals. Data points associated with the second theme, Signs of Improvement, include example responses such as "if I see improvement in the student, and I know they are participating in an outside counseling process" and "if the student is able to fit comfortably back into the school community." The third theme of Complete with Contact represents those data points where the respondents indicated success contingent upon the student receiving outside services (e.g., "If a parent tells me they contacted a place and the child is receiving services). The fourth theme, Unsure, was categorized for the respondent who responded with statements such as, "Hard to say."

Three main themes were categorized for the question, "What happens after you make a referral?": Follow-up (n = 24); Does not Initiate Follow-up (n = 10); and School-based Observations or Services (n =4). The first theme, Follow-up, had three subordinate themes: Follow-up with Teacher or Parent (n = 13); Follow-up with Student (n = 7); and Follow-up with Referent Provider (n = 4). The second theme, Does not Initiate Follow-up, includes the following examples of responses: "Sometimes I hear from the district psychologist or student. Sometimes I don't;" "More times than not, the parent does not follow through with the counseling;" and "It is up to the parents and the student to follow through on getting the outside counseling help needed." The third theme, School-based Observations or Services, includes data points such as "by the child's behavior" and "monitor student closely in school."

Assessment and Evaluation of the Referral Process

The final domain explored responding school counselors' assessment and evaluation of the referral process by asking, "How do you feel about the process of referring a student to another mental health professional?" Four themes emerged from this domain area: Grateful (n = 12); Apathetic or Accepting of Role (n =11); Frustrated (n = 4); and Process Underdeveloped (n =3). The first theme, Grateful, represented responses for school counselor appreciation for the supplemental services rendered and the referent mental health counselors' competence. An example of the Grateful theme is the following:

> "It is imperative that we have resources in the community available to work in depth with students for evaluations and in therapy. The school counselor does

not have time to do therapy in the school setting even though we have the training."

The second theme, Apathetic or Accepting of Role, is constituted of those data points whereupon the responding school counselor has accepted referral as a component of the job (e.g., "I feel that it is a necessary part of the job" and "I am a school counselor – I don't do therapy – I am not trained in mental health – in today's school environment referrals for students with mental health issues is the best I can do"). The third theme, Frustrated, include frustration with parents (e.g., "I am often frustrated because parents will not follow-through, so their child doesn't receive the services they need"), limited choices in referral options, and undesirable outcomes. The fourth theme, Process Underdeveloped, was represented by such data points as "The process isn't formalized," "a vital resource that is unfortunately underutilized," and "we could use an updated list provided by our community."

Discussion

Prevalence Findings

As exhibited in the results, there was a large range in the number of annual referrals reported by sampled counselors. Within that range, over two-thirds (i.e., 67.8%) of respondents reported making ten or fewer mental health referrals over the previous twelve months. Despite the large range, school counselors each seemed to feel that the number of referrals reported was consistent with the number made during other twelve month periods. An average of 3.7% of students directly served by responding school counselors received a mental health referral. Given the prevalence of suicidal ideation and violence in the general student population (e.g., CDC, 2004; 2005;

DeVoe et al., 2005) this number seems relatively low and could reflect the number of potential referral situations that go unnoticed by school counselors, inefficiency in the referral process, or factors specific to the referral situations of the counselors sampled.

Decisional Factors

The primary themes related to school counselors' decisions to refer were relevance of the presenting problem to school counselors' skills, expertise, and role within the school. These themes emerged both in terms of when to make a mental health referral and when a referral was deemed unnecessary. These counselor or counseling program centered findings seems consistent with the finding that just over half of respondents do not consult with other personnel regarding how or where to refer students.

Another theme that emerged around decisional factors was one of collaborative approaches to mental health referrals. Nearly half (i.e., 46.9%) of respondents reported consulting with school mental health professionals and/or administrators to help guide the mental health referral process. Over a quarter (38.9%) of respondents indicated that a team decision-making approach was taken in determining whether a referral would be made. The consultation regarding the decision to refer or the diffused responsibility of referrals (e.g., "Our social worker makes that referral") may explain the low number of referrals.

Referral Process

Throughout the referral process, responding school counselors indicated that parents play a key role in several areas. School counselors indicated contacting and involving parents at multiple points during the mental health referral process, from the

initiation of the process (i.e., assessment of needs) through the evaluative follow-up phase (i.e., determining if the referral was successful and helping the student progress).

Additionally, mental health referral may be made for reasons including issues within the family and, therefore, outside the context of school. Parents were cited both as proponents of and barriers to the referral process. Multiple school counselors indicated that parents were able to request that a referral be made thus facilitating the referral process. Others indicated frustration that the referral process was reliant on parents' active support such as follow through with appointments.

When taken in aggregate, the responses garnered in this study appear to be well-developed and consistent with the recommendations from the literature (e.g., Brown & Trusty, 2005). In particular, the responses included the provision of direct services to students, assessment, involvement of parents, consultation with school personnel, provision of resource or referral information, contact with the referral resource, documentation and paperwork, and follow-up with the student, parent, teacher, and non-school mental health provider. These steps delineate what a referral would consist of, from initial contact and assessment through a multi-faceted follow-up for evaluative purposes. Thus, this process indicates a best practices compilation that school counselors may use to inform and guide how they approach mental health referrals with their own students.

Evaluation of the Referral

Despite the comprehensive nature of the process as it is described above, no respondents indicated following all of these steps in their entirety. It is possible that these best practices may be mitigated by school counselors' feelings of frustration and

apathy toward the mental health referral process. Respondents indicated on multiple occasions that there may be a premature detachment or disengagement from the referral process. For example, a number of participants reported not actively following up on a referral, or considered their part of the referral process complete upon handing a resource list to parents or transferring care to a non-school mental health provider. Without follow-up, school counselors have no way of evaluating whether the referral was appropriate or successful. Another factor that may contribute to a less comprehensive approach to the mental health referral process may be the perception that a parent would not follow through on a referral. This might disrupt the referral process prematurely or even prevent potential referrals from being considered.

Implications for School and Mental Health Professionals

The data revealed a need for improving the communication and process surrounding mental health referrals. Ongoing communication with the student, parents, school personnel, and mental health providers allows a treatment plan to be implemented at home and at school. For this to happen it may be important for either the school counselor or the mental health provider to act as the liaison among the stakeholders (i.e., student, parents, school personnel).

School counselors should consider proactively learning about the mental health providers in the area and establishing collegial relationships prior to referring students. Initial contacts might include calling to learn more about the services they provide and their availability to take on new clients. Questions might include what hours do you see clients (e.g., after school / evenings)? Do you have existing relationships with other providers with whom you typically work (e.g., a psychiatrist for medication management,

or other therapists for family counseling)? What types of presenting problems are you most comfortable working with? What information is most helpful for me to pass along to you when I refer a student? How best can I follow up with you if you begin seeing a student at my school?

Mental health professionals can do the same. Establishing partnerships with school counselors by making initial contacts to learn more about a particular school and what presenting concerns and overall issues the school counselor is seeing might strengthen the relationship. Questions might include are you seeing any trends or themes in the presenting concerns your students face at school? Do you need assistance from the community with addressing these concerns? How might my agency be able to assist with these concerns? How can I best follow up with you if I begin seeing a student from your school?

Although much of this information may already be available on a referral list generated by a district or a counseling department, the initial contact with one another can set the stage for future communication. Particularly important might be establishing expectations for communication – what the mental health professional can expect from the school and what the school can expect from the mental health professional. These conversations may be referenced as referrals are made throughout the school year or subsequent years.

Creating a referral checklist might be an efficient way of ensuring that all steps (direct contact with the student, involving parents, consulting with school personnel, completing paperwork such as an informed consent to release of information, providing resources, contacting the referent, and following up) are being considered in each

referral. A checklist serves as a reminder to a school counselor to take each step but also provides the flexibility to omit steps that may not be appropriate in a given situation. A simple check form might serve to standardize the referral process and may be shared with district administrators for consideration as a system-wide guide.

Mental health professionals might become familiar with such a checklist too, so that they are aware of the necessary steps in the process. If such a checklist does not exist in a school district near where a mental health counselor practices, then he or she could serve as a consultant in developing a standardized process. A standard guide will not only help school counselors but also might ease the referral process for mental health professionals as well. With a standardized procedure in place, perhaps all parties will be better informed and aware of the process of making a mental health referral.

Limitations and Recommendations for Future Research

Although precautions were taken to minimize threats to internal and external validity, there are several potential limitations of this study. First, data collection was dependant on the use of volunteer participants. Respondents may differ from non-respondents in ways including interest in the referral process and use of referrals.

A second limitation is the reliance on participant self-report, notably susceptible to bias (Heppner, Kivlighan, & Wampold, 1999). For example, participants might describe the process as they wish it were, rather than how it truly is. In addition, participants were asked to summarize their referral experiences in brief responses, which does not allow for detailed descriptions of how referrals might differ from student to student or family to family. These results, therefore, are only an initial indication of how the responding school counselors perceive the referral process in general, and

should be interpreted with caution and allowances for adjustments that may be made on a case-by-case basis.

Third, although researchers used random sampling procedures to maximize external validity, the sampling frames were lists of school counselors provided by the Departments of Education in two Midwestern states. Due to the inclusion of school counselors employed only in two states in close proximity in the Midwest, it is possible that the training experiences of the participants surveyed are limited primarily to training programs in and around those states, and are not representative of training experiences provided nationwide. In addition, due to the inclusion of only public schools in these states, it is not possibly to generalize these results to school counselors employed in parochial, private, or independent schools or to school counselors employed in public schools in other areas of the country.

Fourth, although the purpose of this study was exploratory, the findings and interpretations of the findings might not necessarily reflect the data. In the effort to collect a broad sample, researchers used a written survey instrument, as opposed to a more elaborative face-to-face non-structured interview, and did not follow-up with the respondents for another level of triangulation. As a result, researcher bias may have occurred both in the development of the data collection instrument and the interpretation of the findings.

Finally, the researchers made a decision to sample only school counselors although mental health services are provided by a variety of individuals in schools. While this potentially limits the usability of the data to other types of providers, the concession to use school counselors covers the most ubiquitous mental health provider

in schools and does not necessarily inhibit the implications for other mental health providers.

Many of these limitations can provide future researchers with areas of inquiry that will expand understanding of the appropriateness and processes of referral practices. Future research might include other types of qualitative methods, including more naturalistic means of capturing data, to gather more detailed information about the referral processes. For example, a more expansive and unstructured interview might yield more rich and exhaustive information. Also, sampling a broader population of school counselors might ensure that the findings would be generalizable to counselors from differing parts of the country and across varied schooling demographics. Finally, future research can include data collection directed at other school professionals involved in referrals. Extending data collection to other professionals (e.g., school psychologists, school social workers) might provide new information about best practices related to a referral or even provide an external perspective about the effectiveness of school counseling practices when a referral has been enacted.

Conclusion

School counselors are frequently the initial mental health care provider for many students (Paisley & McMahon, 2001). Providing services includes recognition, assessment, and referral when students' individual needs exceed the role, expertise, or resources of that school counselor. This study is an initial look at perceptions and process of referrals from school counselors to other mental health personnel. The data highlight the importance of collaborative relationships between school counselors, students, guardians, other school professionals, and mental care providers. Based upon

the data, the researchers recommend a multi-step referral process that includes initial contact, assessment of student needs, involvement of parents, consultation with appropriate school personnel, provision of referral information and resources, ongoing with the referent, paperwork and documentation, evaluation based on follow-up with all involved stakeholders.

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