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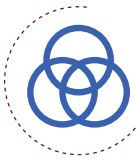
Positive Behavioral
Interventions & Supports

SCHOOL MENTAL HEALTH INTEGRATION:

Lessons Learned from
Implementation of the
Interconnected Systems
Framework Across Two Local
Education Agencies

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School Mental Health Integration: Lessons Learned from Implementation of the Interconnected Systems Framework across Two Local Education Agencies

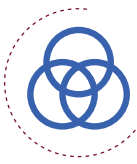
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Purpose

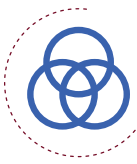
Coaches and district leaders can use this brief to support their efforts of aligning and integrating School Mental Health (SMH) and Positive Behavioral Interventions and Supports (PBIS). The experiences of two districts are described to provide context in the application of the Interconnected Systems Framework (ISF).



The Interconnected Systems Framework (ISF) is a streamlined approach to (a) promote students' mental health and social, emotional, and behavioral wellness and (b) eliminate barriers inherent in systems that have previously operated separately. Specifically, the ISF integrates school mental health (SMH) within the Positive Behavioral Interventions and Support (PBIS) framework, creating a single system of service delivery for schools' and districts' multi-tiered systems of support (MTSS) focused on prevention (Tier 1), early intervention (Tier 2), and more intensive intervention (Tier 3; Barrett et al., 2013; Eber et al., 2020). This brief highlights examples from schools that participated in a randomized controlled trial testing the effects of the ISF, the *Project About School Safety* (PASS; National Institute of Justice [NIJ] Award No. 2015-CK-BX-0018, Principal Investigator, Mark D. Weist, Please note this statement from the NIJ, Office of Justice Programs, U.S. Department of Justice – *The opinions, findings, and conclusions or recommendations expressed in this publication are those of the authors and do not necessarily reflect those of the Department of Justice*). A number of manuscripts on this large study are being written, with the first published study focusing on proximal variables (e.g., team functioning; student identification for and receipt of Tier 2 and 3 programming) and school discipline (Weist et al., in press).



PASS involved more than 31,000 students from 24 elementary schools: 12 schools in Charleston County, South Carolina, and 12 schools in Marion County, Florida. One-third of the schools (4 per district) implemented PBIS only, one-third implemented co-located SMH (i.e., with no purposeful connection to PBIS), and one third implemented ISF (see Splett et al., 2019, for additional study details). After the study, researchers interviewed key practitioners (e.g., school administrators, district coaches, mental health coaches, clinicians), with the goal of better understanding perceived benefits and challenges of implementing the ISF from school and mental health systems perspectives.



This brief describes themes that emerged from the interviews. Specifically, practitioners described (a) the value of a multi-tiered approach to integrating mental health clinicians (MHC) within school settings, (b) how data sharing across agencies (i.e., community mental health and school system) enhanced the vertical alignment and integration of data-based decision making across tiers, (c) the importance of integrated professional development across agencies (i.e., community mental health and school system) to ensure common language across agency professionals, (d) challenges experienced in implementing ISF, and (e) recommended teaming and coaching strategies for district and school level teams to address these barriers. The concluding case study demonstrates exemplary implementation for district and school level practitioners.

Mental Health Integration across Multi-Tiered Systems of Support

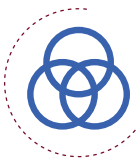
As mental health continues to be a top priority in schools, perhaps now more than ever before, there is a need to break down silos of service delivery and increase the confidence and competence of ALL school staff to rigorously and continuously support the mental health and social, emotional, and behavioral wellbeing of ALL youth. A common theme across interviews was that a multi-tiered approach to integrating MHCs in school was crucial to help all staff understand

the value and benefits of ISF. The traditional role of MHCs—providing services to individual students and families—was enhanced by integrating SMH into the PBIS framework, creating a multi-tiered system that supports the mental health and social, emotional, and behavioral wellbeing of ALL students.

When districts and schools get started with an integrated approach, they often map out the available resources and interventions already in use by school and clinical staff. One practitioner stated:

"[the collaboration] allowed us to kind of see a larger scope of available services that were out there and how we could use those. Sometimes we're not even aware of what services we can connect to, so I think all of those were great benefits and of course you know just building a capacity to serve more families."

In contrast to the traditional approach of referring families to specialty mental health centers and limiting the receipt and effectiveness of services, the integration of SMH within the PBIS framework results in a single system of service delivery across all three tiers and ensures all students receive timely support at an intensity matched to their level of need.



Data Sharing and Data-Based Decision-Making

During interviews, practitioners indicated that data sharing across agencies enhances data-based decision making seamlessly across tiers. When MHCs engaged in data-based decision making as part of their roles as integral members of the MTSS team, their clinical perspective enhanced Tier 1 discussions proactively and early in the problem-solving process. For example, MHCs were part of the MTSS team

- reviewing social, emotional, and behavioral universal screening data,
- providing input on school-wide social, emotional, and behavioral curricula and instruction decisions,
- co-teaching the school-wide social, emotional, and behavioral skills, and
- supporting staff social, emotional, and behavioral learning through professional development across all tiers.

Including MHCs in Tier 2 and Tier 3 discussions ensured their timely access to school-based data for progress monitoring, provided opportunities for MHCs to share clinical data with the team, and enabled teams to plan ways to support teachers in their efforts to intentionally reinforce skills taught during Tier 2 and/or Tier 3 sessions within the classroom setting.

MHC were involved in the selection of all interventions and in determining decision rules for identifying students to include in Tier 2 or Tier 3 interventions, and to determine when students met criteria to fade or end Tier 2 or Tier 3 interventions. Progress monitoring data were entered into the schools' data management

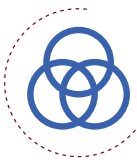
systems by both school personnel and MHCs.

For example, a student was experiencing anxiety, resulting in frequent absences, withdrawal from social interactions, and dysregulated emotions. The MHC utilized cognitive-behavioral therapy techniques with the family and the individual student. The team tracked student attendance and used school data trackers (e.g., emotional thermometers, daily progress reports, behavior data) to monitor student response to intervention. Including the MHC as part of the multi-disciplinary team led to expanded data sharing across community mental health and school agencies, allowed the MHC to access school data systems for progress monitoring, resulting in improved accountability and clearer communication by all, enhancing outcomes for students.

Professional Development to Ensure Common Language

When community mental health partners and schools integrate their systems, technical assistance is a necessity, including professional development and ongoing coaching (Eber, 2020). Opportunities for integrated professional development results in common language across providers, settings, and programming across tiers of the MTSS framework. District and community leaders can support school teams by ensuring an understanding of how each system operates, how they will function together as a single system, and what routines and procedures they should follow in shared decision-making.

Elaborating on this theme for this project, teams included both a district-employed and mental health agency-employed coach that collaborated to install



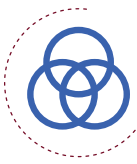
an ISF. Coaches provided guidance to teachers and school teams on how to address social, emotional, and behavioral support in the classroom; facilitate interventions; and reinforce mental health strategies. School teams provided guidance to MHCs related to school system parameters in the selection of approved interventions, available resources for progress monitoring, and the assessment of interventions. In turn, MHCs coached school teams related to their clinical skills, access to community resources, and terminology. School and mental health systems collaborated on developing family engagement strategies to support students. It is imperative that co-coaching relationships are established so that school personnel and MHCs engage in collaborative coaching. Securing buy-in from leadership across all systems prior to implementation is noted in key informant interviews as significant to the success and sustainability of the collaboration. One interview participant stated "... I would get buy in, and then I would build in opportunities for communication, relationship building and trust building between team members to create more co-coaching" as a way to ensure effective collaboration.

Specific professional development should be provided to those staff who will be facilitating interventions, and all staff should receive training in topics such as mental health literacy, suicide prevention, and substance abuse prevention. Multiple key informants indicated that the ISF ensured the development of a common language across disciplines and systems as a priority, resulting in increased understanding and empathic responses to students' needs.

Challenges

Practitioners described that an initial major hurdle schools face is moving from a philosophical mindset of a co-located, or separate system model, to an integrated model of SMH. The addition of a MHC from a community mental health agency to the school team introduces more than simply an additional chair at the table. This seemingly simple step opens up Pandora's box and introduces questions beyond scheduling parameters (e.g., school bell schedules, uninterrupted instructional blocks, clinician work hours, coordinating itinerant staff and clinicians to be on campus the same day). Professionals must work together to navigate differences in confidentiality regulations (e.g., Family Educational Rights and Privacy Act – FERPA and Health Insurance Portability and Accountability Act – HIPAA) and policies related to sharing and accessing relevant data (e.g., student school data and mental health data). Additionally, school-employed mental health professionals and community MHC must problem-solve and intentionally address differences in philosophical approaches to the selection and implementation of evidence-based interventions and practices.

Implications of the aforementioned challenges are reflected in responses from key informants, who indicated difficulties integrating community MHCs in a meaningful way into the culture of the schools in which they served. One school-based informant stated, "a lot of our staff at the time did not really understand what she (MHC) was there to do, sort of the scope of what her work was." These challenges impacted MHCs' personal perceptions of their effectiveness, specifically



related to their productivity and treatment goals. On the surface, the idea of integrating agencies seems agreeable; however, when school teams and MHCs begin to merge, a focus on teaming and coaching is required to mitigate potential barriers.

Recommended Teaming and Coaching Strategies

Based on experiences of this project, including challenges and strategies identified to overcome them, the following recommendations are offered. We first offer recommendations for District Teams, and then for School Teams.

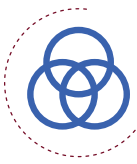
District Teaming Recommendations: District Community Leadership Teams, including identified coaches from both the school system and community mental health agency, form to build an effective MTSS to meet the social-emotional-behavioral (SEB) needs of all students.

- The District Community Leadership Team:
 - designates a continuum of interventions within schools with input from school system and community mental health agency coaches,
 - develops a protocol to select evidence-based interventions and practices, using school and community data, that will match identified student needs,
 - and establishes the service delivery infrastructure by developing a plan for funding, professional development, scheduling, and technical assistance to support the staff who will facilitate and implement the intervention protocol with fidelity.

- The community mental health agency and school district must enter into a mutually beneficial contract that allows for the integrated provision of mental health services at school. This typically requires:
 - collaboration between the school board attorney and mental health agency attorney to create a binding contract to be approved by the school board at an official school board meeting,
 - background checks and/or sharing of background screenings that have been previously conducted, and
 - the leaders from education and community agencies develop a Memorandum of Agreement (MOA) to define the roles and responsibilities of all involved parties and outline a funding plan that articulates how partners operate within the system.

School Teaming Recommendations: Practitioners emphasized the need for a strong team leading the work across all three tiers as critical to ensure integration of services and collaboration among stakeholders and team members. In this project, related to assuring consistent implementation, the research team emphasized to schools use of one primary MTSS team focused on student social, emotional, and behavioral functioning (also reviewing data to discern impacts on academic functioning). Regardless of one or multiple teams, our experiences point to these recommendations:

- School leadership teams, including school-employed mental health professionals, community MHCs, an administrator, representative educators with diverse backgrounds and areas of expertise,



and family and student members, form to develop a school MTSS implementation plan to meet the social, emotional, and behavioral needs of all students. These teaming structures integrate and align the work of all professionals, build capacity, avoid duplication of resources, and create a single system of support. Specifically, these teams:

- use their specific school data to guide the selection of interventions, or practices, from the continuum developed by the district community leadership team,
- establish decision rules for identifying students in need of interventions, intervention selection, criteria for intervention start and end dates, and progress-monitoring data source(s) to assess intervention effectiveness,
- provides ongoing monitoring of implementation fidelity and outcomes.

District Coaching Recommendations: Co-coaching relationships must be established around trust and open communication, allowing both systems to be involved in creating a district framework that facilitates supporting mental health and social, emotional, and behavioral wellbeing of all students.

- Upon school board approval of the contract and MOA, implementation logistics require communication and co-coaching at the district level to arrange issuance of name badges, sign in/out procedures, access to paper and/or electronic student information and/or shared files, initiation

of email accounts, and reporting procedures within the organizational structures.

- District and community health agency leaders co-coach across agencies to coordinate and facilitate ongoing professional development at the district and school level, including specific training in the ISF implementation domains (i.e., teaming; collaborative planning and training; family and youth engagement; selecting, implementing, and monitoring interventions; and using school-wide data for decision making).
- Agency coaches (i.e., school system and community mental health) provide ongoing technical assistance during professional development and on-site co-coaching.

School Coaching Recommendations: Co-coaching, through bi-directional communication between mental health agency and school personnel, is essential to create safe and supportive environments that facilitate sharing feedback and open dialogue around best practices for implementing interventions.

- Co-coaching as collaborative partners ensures successfully navigating logistics of shared workspace vs. confidential work space, and coordinating schedules to establish mutually agreed upon meeting plans.
- School personnel and community MHCs coordinated and facilitated the instruction and intervention plans across all three tiers in a co-coaching manner.

Case Study Example

An elementary school in Marion County, FL, demonstrated exemplary efforts in integrating an agency MHC within the school team and their work. Upon completion of all contractual and logistical arrangements, the MHC was introduced to the school team, and many real-world barriers began to emerge around logistics, communication, and roles. This case study illustrates how the school assistant principal (AP) and district coach applied problem-solving and coaching with the intentionality to remove barriers.

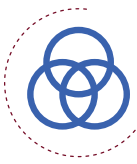
Initially, the school team continued to meet as scheduled and the MHC was provided office space to begin seeing students. The district coach and school AP worked together to ensure the team understood FERPA and HIPAA regulations, invited the MHC to the meetings, and verified she would be on campus and available to attend. Before this emphasis on strong involvement of MHCs in teams, the MHC did not attend the school team meetings, as she was unsure when/where meetings took place, was unsure of school confidentiality rules, and expressed general uncertainty around how to navigate these concerns.

Participating in the meeting revealed another barrier in that the MHC was not sure what type of information she should be prepared to share, how to effectively contribute to the meeting agenda, or what her role was on the school team. The first meeting or two resulted in discomfort for all involved parties, as the MHC felt interrogated by the school counselor and student services manager (SSM) who asked many questions about the students on the MHC's caseload.

The district coach and school AP realized the shift from a traditional co-located model of SMH to an integrated model (i.e., ISF) required more intensive coaching than was originally anticipated. The district coach and school AP stepped in to coach team members, assist with communication of roles and responsibilities, and remove these barriers.

In the traditional co-located model, the MHC was not part of the Tier 1 system and was unaware of the PBIS framework (e.g., school-wide expectations and acknowledgement system). Additionally, the MHC was often not part of the Tier 2 system, and did not have an understanding of how individual (i.e., Tier 3) sessions with students fit into the MTSS. Furthermore, school personnel were typically unaware of what the MHC was doing with students in one-on-one sessions. Although all professionals were doing their part, this model created inconsistencies within the MTSS. For example, MHC supports were not connected to the Tier 1 behavioral expectations, nor communicated to teachers and administrators, resulting in little to no ability to help generalize the intervention and/or individualized instruction to the classroom and/or school setting. Integrating the MHC into programming occurring at all tiers of the MTSS helped to promote a single system of service delivery seamlessly meeting the needs of all students.

Initially, having the MHC at the table with the school team was awkward. With collaborative coaching conducted by the district coach and school AP to facilitate effective teaming, the benefits of an ISF were apparent. For example, the AP and district coach worked together to create the meeting agenda,



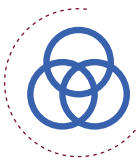
designating time on the agenda to give an overview of Tier 1 PBIS, explain the ISF, and review the common types of data reviewed (e.g., office discipline referrals, early warning system, attendance, intervention receipt forms). Collaborating on the development and implementation of meeting agendas leveled the playing field and ensured all team members had the foundational knowledge necessary to contribute.

The AP and district coach met with the school counselor and student services manager to identify their concerns related to the MHC's work. School professionals did not know what group and/or individual interventions the MHC was implementing and wanted additional information. For example, they suggested the MHC could create student folders with communication for the teacher and/or the parents. Once the MHC understood the level of communication the school team members and teachers were seeking, she worked with the school AP and district coach to create a regular system of communication that became known as the "Clinician's Corner." Additionally, prior to team meetings, the school AP and district coach prepared individual team members to present relevant details of their work at the appropriate times based on the upcoming meeting agenda. For example, the MHC was coached to share a basic update to include students being seen for intervention, types of intervention groups being conducted, students being seen for Tier 3 interventions, and how to share progress monitoring updates with the team.

The role of the MHC transformed from that of an "outsider" who conducted confidential work in isolation



to an integral part of the team, as a result of intentional coaching and communication. As indicated by key informants during interviews conducted by the study team, there was clear value added from ensuring MHCs were appropriately integrated within all tiers of the school's MTSS. As a result of this paradigm shift and integration, teachers and team members sought out the MHC for support and suggestions on how to help students generalize skills learned in Tier 2 and 3 interventions to the classroom and various school settings. The MHC felt valued and respected and began to understand how her work fit into the MTSS, and eventually inserted her expertise at the Tier 1 level to facilitate school-wide mental wellness efforts.



Educator interviews revealed the positive impact of increasing collaboration by intentional teaming and co-coaching, establishing roles and responsibilities, and open communication about services provided to students, teachers, and families. Mental health integration further improves when MHCs establish open lines of communication with teachers of students they are supporting. These strategies ensured the MHC navigated the school environment and provided services as part of the school, resulting in teachers and MHCs being more comfortable interacting with and supporting one another. One participant indicated that a primary benefit of having a MHC on campus was that they “became a trusted ally with teachers and administration and also our families.” Rather than considering the MHC as an outsider, educators indicated the best way to improve collaboration was by inviting them to team meetings and ensuring their opinion was valued.

Conclusion

The lessons learned from these two ISF implementation sites offer valuable insight into the critical ingredients of successfully integrating mental health with the school-wide PBIS framework. Practitioner interviews revealed three primary benefits of the ISF to include:

1. the identified value of a multi-tiered approach to integrating mental health clinicians (MHC) within school settings,
2. data sharing across agencies (i.e., community mental health and school system) to enhance the vertical alignment and integration of data-based decision making across tiers, and
3. integrated professional development across agencies (i.e., community mental health and school system) to ensure common language and skills across agency professionals.

Emphasis is placed on teaming and coaching from both systems to ensure effective integration. These study sites identified the following vital components of the ISF: 1) making time for collaboration in the schools at the outset of integration to shift the co-located paradigm to one of interconnectedness and 2) ongoing co-coaching, training, and technical assistance provided in a continuum of mental health interventions and databased decision-making. Researchers’ interviews with practitioners from each implementation site provide behind-the-scenes insight into challenges and successes other schools, districts, and community agencies may experience during the journey to implement ISF.

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