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Redefining the Role of Mental Health Services in Public High Schools:

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An Exploration of Mental Health Care Access in the Positive Behavior Interventions and Supports Framework

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Abstract

The demand for mental health services by young adults is exceeding the resources, resulting in an increase in system fragmentation and ineffectiveness. School mental health services have been researched and discussed with promise as a way to target adolescent and young adult populations, expand the availability of supports, and provide access to quality mental healthcare through collaborative partnerships with community mental health groups. This project investigates the relationship between public high schools and community mental health providers, exploring if and how the positive behavioral intervention and supports framework is supporting delivery of care. Successes and barriers in respect to 1) identification of need, 2) access to care, and 3) effectiveness of care are examined through the case study of one Connecticut public high school implementing positive behavioral interventions of supports. The paper concludes with a review of relevant school mental health legislation and a table of policy suggestions based on the findings of this project.

Keywords: positive behavioral intervention and supports, school mental health, interconnected systems framework

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Introduction

Background

According to a 2009 report from the National Research Council and Institute of Medicine, 13-20% of United States children suffer from a mental disorder each year. That percentage has only been increasing; for a variety of reasons, children and young adults are growing up more anxious and depressed today than ever before. The effects ripple across society, reflected in an increase in juvenile incarceration rates, a rise in adolescent suicide, and mass acts of violence to suggest a few (O'Connell, Boat, & Warner, 2009).

As a result, mental healthcare for children, adolescents, and young adults has become a pressing public health issue in the United States. The demand for care and services is exceeding the resources. While many in the public have called on elected officials to increase government funding for mental health services, the lack of a comprehensive and coordinated mental health services delivery system for youth must be addressed as well.

In this effort, many public health officials and researchers argue community mental health services should be synced and integrated with school-based services to ensure that students receive the support they need in a seamless, organized, and extensive system of care (Stroul & Friedman, 2011). Teachers and other school staff have the opportunity to make a profound difference as a *de facto* support system; of children who do not receive any type of mental health service, over 70% receive such service from their school (Barrett, Eber, & Weist, 2012). Thus, promoting the development of school mental health services has the unique and unleveled potential to reach the 53 million of our nation's youth who spend at least seven hours a day, five days a week, in our nation's public school system. As far back at 2002, President George Bush's New Freedom Commission on Mental Health had concluded, "Schools are

uniquely positioned to play a central role in improving access to child mental health services and in supporting mental health and wellness as well as academic functioning of youths," in general, "School mental health programs offer increased accessibility to students by reducing many of the barriers to seeking care in traditional settings, such as transportation, child care, and stigma." (Hoover, Weist, Kataoka, Adelsheim, & Mills, 2007, p. 1) The commission suggested enhancing the connection between community mental health and schools, their recommendation 5.2 proposing, "[advancing] evidence-based practices by using dissemination and demonstration projects and create a public-private partnership to guide their implementation."

As we ask ourselves how we can improve access to mental health services for students, while also fostering and overall healthier and more supportive school environment, the Positive Behavior Interventions and Supports framework (PBIS) has become a promising answer. PBIS is an approach schools adopt to organize behavioral interventions into an integrated system that enhances academic and social behavior outcomes for all students. Nationwide, 18,726 schools are implementing PBIS, and 100 Connecticut schools have been trained since 2005. Outcomes of PBIS include learning environments that are less reactive, aversive, dangerous, and exclusionary, and are instead more engaging, responsive, preventative, and productive. PBIS improves support for students whose behavior requires special assistance, in a system of data-based decision making, evidence-based interventions, teaching, encouraging, continuous progress monitoring, and prevention (State Education Resource Center, 2009).

Creating an interconnected systems framework that links PBIS and school mental health may allow schools to better provide services to their students. *PBIS: A Look at Connecticut* states (2011), "the PBIS model uses a systemic approach so that otherwise isolated parts of the school operate in tandem" (p. 1). This would make a school mental health delivery system,

similar to a typical PBIS student behavior intervention, much more efficient. From the initial intervention to later progress monitoring, staff at schools implementing PBIS must operate as a team and engage only in evidence-based practices when helping students with behavioral issues. Thus PBIS school staff would, theoretically, provide mental health services in the same coordinated and effective manner.

Additionally, "School-wide Positive Behavior Supports operationalizes school-based prevention from a public health perspective" (Sugai & Horner, 2006) using a three tiered approach. Schools with a PBIS approach create primary (school-wide), secondary (small group), and tertiary (individual) systems of support. The first, universal level ensures that all students and staff are taught the school expectations and are recognized for meeting those expectations. After teaching and reinforcing the school wide expectations schools see decreases in many low level student behavior issues. This decrease in student behavior incidents allows schools to free up resources to better address students who need more intensive support and ensures that no student is forgotten or passed over. Schools use data systems to identify students who need additional support. This preventative approach means students can receive support sooner and no longer have to "wait to fail". In terms of mental healthcare, this could mean an earlier diagnosis and sooner treatment of disorders. "From a public health perspective that covers the continuum from prevention to intensive intervention, a focus on [school mental health] is logical and empirically supported," reads *Advancing Education Effectiveness*, "School is the ideal environment for implementing universal interventions aimed at promoting protective factors associated with resilience and positive emotional development" (Barrett et al., 2012, p. 9).

Objective

The PBIS and school mental health relationship is a developing field in educational psychology research. “Although there is the emerging consensus for locating mental health programs in schools, the role and structure of these services are varied and the empirical base is limited” (Atkins, Hoagwood, Kutash, & Seidman, 2011, p. 1). While PBIS may have a conceptual framework similar to school mental health, there is a considerable difference between implementing a behavioral intervention and providing mental healthcare services. PBIS enables coordination and organization of support inside the school, yet for school mental health services to be effective they must also draw upon external mental health supports. Community mental health helps extend the infrastructure, availability, and expertise of support available to students.

The objective of this project is to describe the gap public high schools and community mental health providers, through analyzing if and how PBIS schools help students in need access support. My project will explore how PBIS is facilitating access to mental health care, providing insight into both the successes and barriers with respect to 1) identification of need, 2) access to care, and 3) effectiveness of care. I will reexamine models of care to better integrate improved learning and behavioral supports with access to mental health care, providing policy suggestions to help PBIS schools become better facilitators of mental health supports based on my research. Focusing on the issue of access is necessary to create a coordinated and systemic continuum between schools and public health groups. “Connecticut needs to further the development of a coordinated, comprehensive, statewide system… to address the behavioral and mental health needs of all Connecticut children,” according to the State Education Resource Center (2011, p. 45). An open and supportive relationship between PBIS and school mental health communities may further this goal.

While PBIS, as a conceptual framework, does not formally organize mental healthcare, I am interested if it facilitates access to community mental health supports *de facto.* This will help tell if mental healthcare supports can grow within the PBIS model. PBIS schools are designed to offer an array of supports to their students, which may allow for genuine collaboration and mutual support among school and community providers. Yet actual implementation of these mental health supports may be limited; as discussed in *Advancing Education Effectiveness,* "Instructionally-based interventions to treat anxiety and the effects of trauma have strong evidence for effectiveness but require considerable training, ongoing coaching, fidelity monitoring and implementation support for effective delivery" (Barrett et al., 2012, p. 4).

My project specifically looks at the PBIS and SMH (school mental health) relationship in public high schools. Of all Connecticut schools implementing PBIS, 75% are elementary schools. For a variety of reasons, from the more complex organizational structure of high schools, a larger and more diverse student body to an increased focus on academics, behavioral supports are too frequently overlooked in later secondary education. However now more than ever, behavior and mental health supports are critical in high schools and we need to work aggressively to bring this type of support there.

Methodology

I have conducted an in-depth case study of one, anonymous Connecticut public high school that implements Positive Behavior Interventions and Supports to paint a descriptive picture of what school mental health and community mental healthcare access may look like within in the PBIS framework. The high school was implementing BPIS with fidelity, however they have not yet integrated mental health supports into their system. With approval from UConn's Institutional Review Board, I administered an online, anonymous survey to school

staff. The questionnaire included questions about both social factors, such as stigmatization, and protocol, such care referral procedures. Traditional providers of student supports, such as guidance counselors, school nurses, and school psychologists, were surveyed along with administrators and teachers whom play an important role by first identifying need. The high school featured in this case study is a regional high school in Connecticut, with a student population of approximately 400. The large majority of the student population is middle-class and Caucasian. There are approximately 100 staff working at the school.

In addition to interpreting these survey responses, my research includes a study of relevant education and mental health legislation on the school's federal, state, and local level as all affect daily operations within the school and how school mental health is manifested. My policy research focuses on Part B of the IDEA Act, No Child Left Behind, Public Health Service Act's Coordinated Services for Children Youth and Families 1990 Amendment, President Obama's Safe Schools-Healthy Students Program, CT's Sandy Hook Legislation, relevant privacy laws of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA), and the school's district codes and handbooks.

Case Study

Identification of Need

Identification. When examining SMH within the PBIS framework, how well at risk students are identified is integral to success. Delivery of care begins with the identification of a student at risk and in need. Without this fundamental step, the individual will not receive the necessary attention or treatment. In the PBIS model, identification leads to a targeted intervention. The PBIS Response to Intervention framework is grounded in the idea of

differentiated instruction (SERC, 2011) meaning the support team works with the identified student in an individualized manner.

Yet identifying a student with a mental health issue differs from identifying a student with a behavioral issue. PBIS schools implement evidence-based behavior interventions after making data-driven identifications from students' discipline referral and attendance records. Yet signs of poor mental health, especially in adolescents, are much less discernible and thus require more intensive training for regular staff to be able to identify and take meaningful action upon. Respectively, the school's handbook states it will provide all pupil personnel with a written or electronic copy of the school's district Safe School Climate Plan, as well as in-service training and professional development described in Connecticut General Statute 10-220a. The statute details programs including, "health and mental health risk reduction education which includes, but need not be limited to, the prevention of risk-taking behavior in children, and the relationship of such behavior to substance abuse and pregnancy, sexually transmitted diseases, including HIV-infection and AIDS, violence, teen dating violence, domestic violence, child abuse and youth suicide," and, "school violence prevention, conflict resolution and prevention of bullying."

Yet of all staff surveyed in this case study, only 50% say they have received training in identifying students whom may need mental health support. 67% of those who claim they have received training are still concerned that some students who may need mental health supports go unidentified. This can be attributed to many factors; although Boards of Education mandate trainings, the seminars may not specifically address how at risk students can be identified. The training detailed in the above excerpt addresses mental health prevention, however not identification. Only pupil personnel who hold the initial educator, provisional educator, or professional educator certificate are required to be trained, according to the Conn. Gen. Statute.

In addition, training by itself, without coaching or follow up support is ineffective. Identifying risk factors for mental health issues is complex and teachers need more than just training to do it effectively. These all lower the effectiveness of in-service training and thus the ability of all school personnel to identify students and provide mental healthcare access to those in need.

As evidenced these case study responses, there is much room for PBIS to grow in its capacity to identify at risk students through proper mental health training. President Obama's Safe Schools, Healthy Students program includes the launch of Project Aware to train teachers and other school adults to identify and interact with in-need students, as well as ensuring they are referred to mental health services. It sets the goal of training more than 5,000 additional mental health professionals to fill the gap.

The PBIS multi-tiered framework enables schools to target students for behavioral identifications and interventions. The framework includes a focus on five systems: school wide, classroom, non-classroom, family, and student, and allows for varying levels of intensity and complexity of support in those areas. An expanded PBIS –SMH model can support school mental health and student identification in the same way. 83% of survey respondents stated they are concerned both about the mental health of students in their classroom, or that they work with everyday, as well as the mental health of students in their entire school. Although this answer may be influenced by respondents' personal beliefs, conceptually it supports the claim that larger scale, school community support is available for all students and thus there are multiple school staff members who can play a role in identifying mental health care need.

Screening. From a public health, prevention and identification perspective, school support teams are encouraged to conduct universal mental health screenings to provide early access for at risk students. Training staff to self-identify students is one approach, however

universal screenings allow identifications to be more data-driven and intensive, giving a higher rate of success. For a behavioral intervention, screenings may include student grades, attendance records, and office discipline referrals. In transitioning from behavioral support to mental healthcare, it is important that PBIS schools modify their screening procedures. A mental health screening could occur via questionnaire, asking students questions drawing from research-based symptoms of common mental health disorders. 60% of the PBIS-school staff surveyed supported universal mental health screenings in their high school, one respondent claiming they have already begun the process of implementing them. "Being proactive in this regard is a safeguard for safety and welfare of all persons within the school community," said one respondent. Yet another expressed concern that, "Adolescence is difficult enough without adding the stress of screenings which may yield inaccurate self-diagnosis."

Some schools have started to document "time out of class" for students rather than just office discipline referrals, in an effort to help capture students who frequent the nurse or guidance office and may have more internalizing symptoms. It could result in a step between just looking at office referrals, and school wide screeners. However most schools still lack efficient and effective screeners or data sources, and when they do there are policies in place that make collecting that type of student information very difficult. For example, in some states schools are not allowed to ask students to self-report behaviors such as substance abuse or sexual activity.

Access to Care

Social Factors. In addition to enabling SMH through establishing a coordinated systemic framework, PBIS shows potential in how it creates a more accepting school climate (Backenson, 2012). A more supportive atmosphere, with stronger faculty to student and peer to peer relationships, can overcome some social factors that may prevent students from receiving mental

healthcare they need. "The Interconnected Systems Framework [of PBSI and SMH] will achieve a number of economic and social benefits, such as… accessing services within the school setting will become less stigmatizing" (Barrett et al., 2012, p 16).

Acknowledging that teenagers may stigmatize mental health disorders and the process of receiving care, 67% of respondents stated that they do not believe receiving mental health care is stigmatized in their PBIS school. No responses were given when asked in what ways, if any, the school as a whole was working to reduce the stigma. When asked to list what ways, if any, they were individually working to alleviate this barrier, staff gave a variety of examples, including:

> *" As an English teacher discussing literature from Catcher in the Rye to The Rules of Survival, or even Hamlet and Macbeth, we discuss the nature of the human psyche, mental health and available resources."*
>
> *"I work with students and families by having families who have accessed mental health services be willing to discuss their experiences."*
>
> *"Open up about friends of mine who have mental health issues and are stable now… try to relate it to someone they already know, like and respect."*

Although the above are promising occurrences, they are individual experiences better indicative of personal opinions rather than an organized school-wide attempt to reduce students' cultural barrier of accessing mental healthcare. Furthermore, when asked if there are any specific barriers that might prevent a staff member from reaching out to families, 67% still indicated they have concern discussing mental health care. "A culture in which students don't easily volunteer concerns about peers," was mentioned when asked what the greatest obstacles in providing student with access to mental health, behavior, and emotional care.

While there continues to exist a notable obstacle when accessing to mental healthcare for students here, this should not undermine the success that PBIS has been it comes to prevention and promoting healthier school environments. "PBIS provides a social culture and foundation for more effective implementation of mental health promotion, early intervention and treatment, with greater likelihood measured impact for more students than separate or 'co-located' mental health delivery systems can provide" (Barrett et al., 2012, p. 16). Climates where students feel unthreatened and safe is a fundamental step to begin and reduce the stigma of accessing mental health care. "Schools across the country are already implementing PBIS, a systems approach to establishing the social culture needed for schools to achieve social and academic gains while minimizing problem behavior for all children," wrote U.S. Secretary of Education Arne Duncan in an open letter to Chief State School Officers, "PBIS is an important preventative approach that can increase the capacity of the school staff to support children with the most complex behavioral needs thus reducing the instances that require intensive interventions."

Strong primary prevention is accomplished when the host environment, the whole school community, establishes procedures that maintain clear and consistent behavioral expectations. (SERC, 2011). As a prevention-oriented system, PBIS enhances social expectations as a tool to be effective. An example of how the profiled school does so is in its strong stance against bullying, which increases the risk of mental health issues in young adults, through their Board of Education's Safe School Climate Plan. The Safe School Climate Plan is an example of PBIS in action; it complies with state law requirements and enables students to anonymously report acts of bullying to school employees and requires students and their parents/guardians to be notified annually of the process by which students may make such reports. Additionally, the protocol requires that school employees who witness acts of bullying or receive reports of bullying to

orally notify the safe school climate specialist, or another school administrator if the safe school climate specialist is unavailable, not later than one school day after the occurrence, and to file a written report no later than two school days after making the oral report. This prevents bullying and thus potential mental health issues by establishing a zero tolerance stance, and discouraging this behavior as socially unacceptable and punishable.

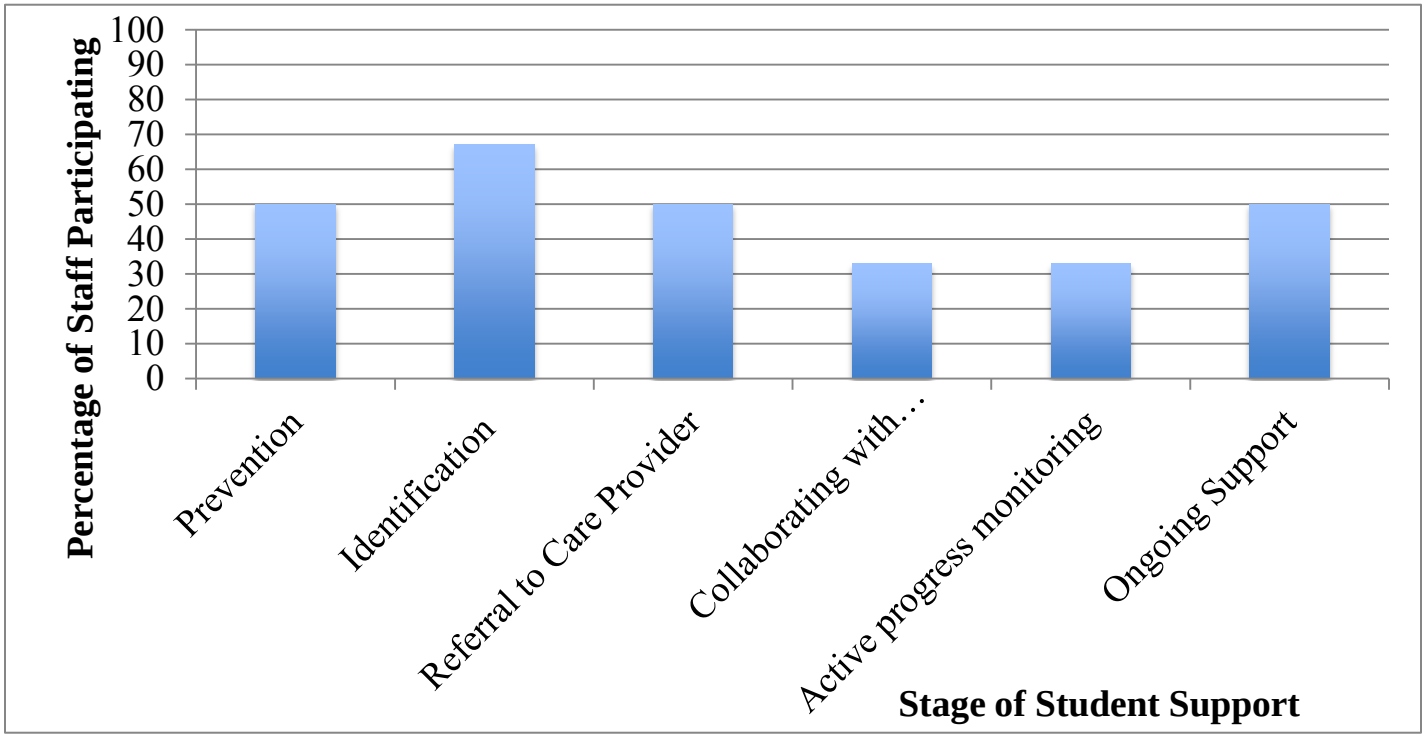
PBIS aids Bullying Prevention (BP) strategies in the way that it establishes behavioral expectations and in tandem teaches students to act respectfully. In a study conducted by Ross and Horner in 2009, 6 elementary school students who exhibited bully behavior were monitored. A baseline was established by observing the frequency of incidents of bullying during 10-minute observations over lunch recess, for which the targeted students had a combined average of 3.1 incidents of aggression. Afterwards, the school staff received training on BP and PBIS. Once BP-PBIS interventions and the "stop, walk, and talk" social reinforcement approaches were fully implemented, the mean number of poor behavioral incidents decreased dramatically to .9.

Response to Intervention. The PBIS Framework includes "formal processes for the selection and implementation of evidence-based practices" (Barrett et al., 2012). This allows interventions to be coherent, methodized, and effective, designing a continuum from identification to treatment. When looking at the mental health care delivery system within a PBIS school, the system should be organized in a similar way, with core features aligning with concepts of PBIS to ensure that students are assisted until they are secured community mental health supports. Simply securing treatment or seeing a mental health specialist in the community is not enough; students need to be monitored and supported until outcome data indicates they no longer need it.

School staff were asked questions to track the process of supporting a child in need of mental healthcare and determine if the coordinated response addresses the crucial element of access with community mental healthcare support. The responsiveness of staff to students is the first indicator; 84% of respondents stated they either feel somewhat responsible, responsible, or very responsible for responding to the mental health needs of students in their school, and that they know how to get support for students in their school with mental health needs.

All listed either the guidance or school psychologist's office as the first contact point, proving a sense of coordination. However only 67% feel as if it is their job to help students access this support. When asked to what extent they have a role in providing mental health care, involvement dropped after the identification of need, inhibiting a complete team-oriented response. See Figure 1, demonstrating the variation of staff involvement in different stages of the intervention and support of students.

Figure 1



Community Mental Health Partnerships. PBIS must have effective teams that include community mental heath providers. President Bush's New Freedom Commission on Mental Health 2007 report emphasizes, "early mental health screening, assessment, and referral to services are common practice," which is only possible with and improved and expanded school-community mental health partnership.

This is not the first time the school-community mental health connection has been explored; Part B of the IDEA (Individuals with Disabilities Education) Act "promotes interagency coordination and coordinated service delivery" among schools, community mental health providers, primary care providers, public recreation agencies and community-based organizations, even juvenile courts an child welfare agencies. "[The Interconnected Systems Framework] involves collaborating community mental health providers working closely with school employees within a multi-tiered teaming structure, actively reviewing data and coordinating the implementation, fidelity, and progress monitoring of supports delivered at multiple levels of intensity," (Barrett et al., 2012, p. 3) allowing schools to take advantage of a public health approach. Community mental health partnerships mean that school employees can facilitate the coordination of both internal and external resources, overcoming traditional challenges such as position and time limitations, lack of interdisciplinary training, non-collaborative and ineffective teaming process, fragmented processes, and no method to progress monitor nor measure fidelity.

Community mental health partnerships establish a clear and consistent relationship between school mental health workers and community agency providers. The shared agenda causes the two to collaborate, expand and improve together along the way. Yet it is unclear whether the surveyed school has a partnership with a mental health care provider in their area: 33% stated

yes, while 50% said they were not sure. Similarly, when asked if their school has community mental health supports integrated into school supports, 50% answered yes, however 17% answered no and 33% were unsure. Either way, for the answer to have such uncertainty, the partnership (if existent) must not be very strong. There may be a partnership that is only connected to sections of school staff, which can be expanded if they report back the status and outcomes related to the partnership to the rest of pupil personnel.

According to the surveyed school's handbook, the school clinic acts as the first aid and referral center, counseling students, parents, and others concerning the finding of their health examination. These health examinations are mandated by the state to be required in Grade 11 by, " a legally-qualified physician of each student's parents/guardians own choosing, or by the school medical advisor or the advisor's designee to ascertain whether a student has any physical disability or other health problem." Yet the phrase "other health problem" only vaguely alludes to mental health related issues; it is primarily up to the parents or other guardian to pursue additional mental health supports in the community. The sharing of medical records (to be exaggerated upon in the "Privacy" section) is the only evidence of school-community collaboration, while in an Interconnected Systems Framework of PBIS and SMH would create effective teams that enhance the functioning and effectiveness of all school staff. The gap between schools and community mental health is evident in the lack of cross-system problem solving.

Insurance. Some high school students face financial obstacles when attempting to secure access to mental healthcare services. The school's handbook policy states that students who meet the requirements for the free or reduced lunch program qualify for a free physical conducted by the school's medical advisor.

President Obama's Safe Schools, Healthy Students Program is putting pressure on lawmakers to ensure coverage of mental health treatment. The Affordable Care Act of 2010 requires all new, small, group, and individual plans to cover the ten essential health benefit categories, which includes mental health. The program is, "[finalizing] requirements for private health insurance plans to cover mental health services" through the Mental Health Parity and Addiction Equity Act of 2008, as well as reanalyzing Medicaid policy to ensure quality mental health coverage. Comprehensive mental health coverage, coupled by an extensive school-community mental health partnership, can help guarantee mental healthcare access despite a student's financial background.

Family. The system of care framework, a concept developed in the mid-80's after the Substance Abuse and Mental Health Services Administration (SAMHSA) launched the Children's Mental Health Initiative (CMHI) to provide federal grants to communities trying to establish more comprehensive support systems, is, "based on a philosophy that emphasizes services that are community-based, family driven, youth guided, individualized, coordinated, and culturally and linguistically competent" (Stroul & Friedman, 2011, p. 1). Although dependent on the strength of family support available, public health experts argue that family-based participation is necessary for services to be effective. Families have a clear stake in their student's mental health care, making it more likely they will take action. Systems of care where families, schools, and communities are full partners ensure availability of both traditional and non-traditional supports, and thus more opportunities to access them.

In the PBIS-SMH model, family-driven care means strong family collaboration at all tiers of the PBIS framework. Family, school, and community coordination allows for a broad variety of effective services, individualized care, and a more student access-points. How PBIS schools

engage families in behavioral interventions informs the delivery of mental health care process, determining if it can achieve a true, expanded system of care model. "The necessary and ongoing merger and collaboration between the positive behavior support (PBS) and mental health communities [provides] effective services for families and their children who have challenging behaviors," wrote Duchnowski and Kutash (2009), "While both communities have recognized the need to collaborate with families as equal decision-making partners, the process has evolved to another level with the recent promotion of family-driven care as a necessary characteristic of effective strategies" (p. 203). There still remains a lack of research about what effective family involvement looks like and how to measure it.

Family is one of the five PBIS sub-systems, designed to be utilized in a way that, "identified practices, processes, and systems for engaging and supporting family participation and ensuring family access" (SERC, 2011, p. 3). PBIS encourages the healthy involvement of parents in creating a supportive school environment, in a team-based approach that is less separated than the traditional *in loco parentis* model (Atkins et al., 2011). This family engagement can help mental healthcare access through enhanced progress monitoring and fidelity measuring. Yet as seen in this case study, there are significant barriers that prevent families from being full partners in school mental health care. Only 40% of school staff included "collaborating with student's family members" when asked to what extent they have a role in providing mental healthcare. 17% said student's parents or guardians would be one of the first contacts if they suspected a student is in need of mental health care.

Protocol certainly vary based on respondents' position in the school; when asked about specific barriers that might prevent them from reaching out to families, 50% said it is someone else's job at the school to do so. Respondents mentioned concerns that they were not adequately

trained or authorized to do so. This shows how care is centralized with those that are most qualified to have those discussions with families and students; teachers likely don't have the training necessary to do that well and such a responsibility could be overwhelming. Centralizing the concern so that families get a consistent message is important.

67% said it would depend on the situation whether they feel comfortable reaching out to a student's family if they suspected the student might need support. Even in PBIS schools, there remain social and cultural factors that inhibit healthy family-school interaction when it comes to mental health. 67% specifically answered "concern discussing mental healthcare" as a factor that would prevent them from reaching out to families. Teachers don't systemically have training and are not qualified to make diagnoses, so they are rightfully hesitant to reach out. Language barriers and privacy were also listed as concerns. This again may indicate a lack of training on mental health issues.

Effectiveness to Care

In-School Team Coordination. When looking at school mental health within the PBIS framework, the coordination of in-school teams must be analyzed to determine the effectiveness of care. PBIS and a potential school-community delivery of care system work best when led by collaborative and focused working groups; teams create symmetry among the tiered PBIS system. For team members inside the school, coordination is essential to carry out an effective response to an intervention. In-school coordination means that the proper in-school team member can direct the student to the proper community team member. Lessons learned by Barret, Eber and Weist in their 2009 study of ISF sites include, "the functioning of school teams is critical to all efforts, and are emphasized and supported strongly." Team-based leadership allows staff members to allocate their time in productive ways, establishes continuous progress monitoring,

and supports an evidence and solution guided agenda. "ISF leadership is team-based, multi-leveled, and distributed. Team-based refers to a collaborative and focused effort that takes advantage of membership that has been selected because of their motivation, collective practice expertise, ability to use implementation authority, and collaborative approach. Multi-leveled refers to coordinated and uniform knowledge, practice, and priority across the decision-making continuum" (Barrett et al., 2012, p. 22).

School staff were asked who they would be first to contact if they suspected a student needed mental health support. 67% included the school counselor or guidance officer, and 83% included the school psychologist, showing an impressive sense of coordination. All respondents said they know here to direct a student who came to them with concern about a peer. Respondents also shared about their school's specific referral system for accessing mental health, behavioral, or emotional supports, reassuring that there are guidance counselors, psychologists, and interventionists in the building who are able to point students in the right direction. As one respondent stated:

> *"I am part of the support system as a school counselor. In our school our teachers are very attentive to the students in our school, and have a good communication and relationships with the guidance team, including school psychologists. When the classroom teachers, and staff see or hear something they most always contact someone in guidance to start a process."*

Another respondent echoed the same process, stating:

> *"We are mandated reporters for instances that fall under 'reasonable suspicion' and the protocol is to inform the student intervention team, and when necessary appropriate state*

agencies... teachers are not Doctors of Psychiatry, or psychology, and we cannot diagnose students' mental health statuses."

Having a common first contact and a well-understood referral system shows faculty members working together towards the shared cause. While teachers may not be explicitly mentioned as members of the intervention teams, their role in identifying students at risk is what triggers the necessary chain of events. Yet although the school does have in-school intervention teams and a specific referral system that when accessed is effective, not all know it exists. 33% of those surveyed said their school does not have such a system.

***Ongoing Progress Monitoring*.** There is a system in the school featured in the case study that monitors student progress after a referral and during treatment, although only 33% of respondents included active progress monitoring as the extent of the role they personally have in providing mental health care. Comprehensive student progress monitoring system, while varying in frequency and intensity, can greatly influence the effectiveness of mental health treatment; progress monitoring strengthens the relationship of schools and community mental health providers by opening a dialogue about each student. In addition to allowing each individual student intervention to become more effective, progress monitoring lets interventions teams learn and improve, allowing future interventions to be evidence-based from past experiences.

Student Privacy. Communication between school support teams and community mental health providers is affected by student privacy laws, and thus so is their relationship and the overall effectiveness of care. Privacy laws established under the Family Educational Rights and Privacy Act (FERPA) and medical recordkeeping protocols of the Health Insurance Portability and Accountability Act (HIPAA) exist to protect students' personal information and history. The balance between student privacy and effective, targeted mental health interventions remains

controversial, most respondents agreeing their comfort level in reaching out to families about their student's mental health needs depends no the situation, yet it is an important question to answer.

FERPA defines educational records as any record that is generally 1) directly related to a student and 2) maintained by an educational agency or institution or by a party acting as an agency or institution. According to *FERPA and HIPAA: The Effect on Student Health Records,* "At the elementary or secondary level, a student's health records, including immunization records, maintained by an educational agency or institution subject to FERPA, as well as records maintained by a school nurse, are 'education records' subject to FERPA." IDEA and FERPA Confidentiality Provisions provided by the US Department of Education state the term education records include those records that are:

> *"(i) made or maintained by a physician, psychiatrist, psychologist, or other recognized professional or paraprofessional acting in his or her professional capacity or assisting in a professional capacity;*
>
> *(ii) made, maintained or used only in connection with treatment of the student; and*
>
> *(iii) disclosed only to individuals providing the treatment."*

The schools' district handbook lists maintaining school health records as the responsibility of the school nurse, although it is the responsibility of the school guidance and psychologist office to address mental health care access for students. The above definition still leaves a gray area when it comes to students' mental health records, which culturally may be considered more personal and not within the traditional definition of health or medical treatment.

HIPAA defines health care providers as, "institutional providers of health or medical services, such as hospitals, as well as non-institutional providers such as physicians, dentists, and

other practitioners" which may be expanded to include school mental health providers along with community mental health providers. "As a covered entity, the school much comply with the HIPAA Administrative Simplification Rules for Transactions and Code Sets and Identifiers with respect to transactions," according to the U.S. Department of Health and Human Services and the U.S. Department of Education (2008), "However many schools, even those that are HIPAA covered entities are not required to comply with the HIPAA Privacy Rule because the only health records maintained by the school as 'education records' or 'treatment records' of eligible students under FERPA, both of which are excluded from coverage under the HIPAA privacy rule" (p. 2).

President Bush's New Freedom Commission Goals and Recommendations of 2002 include, "6.2. Develop and Implement Integrated electronic health record and personal health information system" to facilitate team-communication, and make the community-school relationship more relevant and direct. Although the electronification of medical records over recent years has been controversial, the strong majority of 83% of staff respondents confirmed they believe that school support staff, such as nurses, counselors, and psychologists should have access to student's mental health records. There is the valid concern that students and their families may want to maintain a level of privacy, and medical records would be available only with the proper authorization. One respondent explains, "We work very closely with students and families to stress the importance of sharing information with all parties involved. We have a high percentage of families willing to work with us and outside agencies in collaborating in planning for a student."

Concerns over student privacy arise not only when it comes to the sharing of treatment records, but also when discussing the supporting and opposing arguments of universal mental

health screenings. Although universal screenings, as discussed earlier, can provide early access to mental health supports by ensuring virtually all at risk students are identified, universal screenings may be seen as invasive and for some, are unnecessary intrusions.

Conclusion

The Future of the PBIS-SMH Relationship

Learning how mental health services operate within this school's PBIS framework sheds light onto the potential for the SMH-PBIS relationship to develop. As school support teams work to provide their students with more effective interventions, if and how PBIS schools can facilitate access to community mental health partners must be investigated. The PBIS conceptual framework empirically supports a school mental health program, with research-based interventions, cross-system leadership, tiered structuring, and a supportive atmosphere, that establishes a high likelihood of success. As evidenced by the findings of this case study, most of the school's success in providing access to mental health services came from its in-school coordination, largely attributed to teaming structures pre-established by PBIS, which allowed support staff to conduct wholesome response to interventions. Social factors, also a core feature of PBIS safe climate school systems, play an important role in reducing the stigma of receiving mental health services.

Although PBIS may inherently promote the adoption of strong school mental health services, there are still areas in which school mental health can grow particularly in school's relationship with community mental health providers. Although there is evidence of success after referring students to community providers, outside psychologists, specialists, or therapists, the interagency collaboration necessary to create a continuum is fundamentally missing. The variety of resources and expertise within the entire community is not being fully taken advantage of, and

thus the coordinated intervention is not developed to the point of full treatment. The task of strengthening the school-community relationship may be beyond the task of PBIS, however must be undertaken to achieve the maximum level of quality of adolescent mental health care.

School Mental Health Legislation

What mental health services look like in any school, whether or not they have adopted the PBIS framework, is affected by relevant legislation on the federal, state, and local level. Part B of the 2004 Individuals with Disabilities Education Act (IDEA) added requirements for the qualifications of special education teachers, endorsed supplementary aids and services, and encouraged whole-school approaches, such as PBIS and early intervention strategies, by providing incentives. The act charges state-level officials with the task of, "[assisting] local educational agencies in providing positive behavioral interventions and supports and appropriate mental health services." The No Child Left Behind Act of 2001 (NCLB) acknowledges that the academic success of students is affected by outside factors, and that adolescents' social and emotional lives cannot be ignored in education policy. For example, NCLB Subpart 14 "Grants to Improve the Mental Health of Children" specifically authorizes the U.S. Department of Education to, "award grants to, or enter contacts or cooperative agreements with State educational agencies, local educational agencies, or Indian tribes, for the purpose of increasing student access to quality mental health care by developing innovative programs to link local school systems with the local mental health system."

School mental health policy has been affected on the state level by Connecticut Public Law 13-3: An Act Concerning Gun Violence Prevention and Children's Safety. The Act, in response to the tragic shooting at Sandy Hook Elementary School, is two fold, addressing gun control and adolescent mental health. In addition to providing in service training for teachers,

administrators, and pupil personnel on health and mental health risk reduction education, the act called for major advancements in youth behavioral health care such as requiring the Connecticut State Department of Education to provide assistance to school district behavioral intervention specialists in both public and private schools and calling on the Commissioner of Children and Families to implement a "regional behavioral health consultation program for primary care providers who service children" by January 1st, 2014.

The Sandy Hook legislation also launched the Task Force to Study the Provision of Behavioral Health Services for Young Adults. The goal of the Task Force was to review behavioral health services for the young adult population and make recommendations for further legislative action. Concerned that a mental health system might not be equally accessibly to all young adults, much of the task force's conclusions focused on school mental health as a way to increase availability of supports. The Task Force's main findings included the inadequate identification early on in young adults, poor workforce capacity and specialty training, system fragmentation, poor coordination of care and accountability at the individual case level, and ultimately, "local educational authorities in need of enhanced capacity for behavioral health interventions for students at risk, and for services located in school settings."

Policy Suggestions

See Table 1, a table of policy suggestions based on lessons learned from this case study and policy review to help school mental health continue to develop with PBIS and the Interconnected Systems Framework, as well as for young adult access to mental health services to grow as a whole.

Table 1

Category	**Problem**	**Potential Solution**
Identification of Need	Inadequate Training	- require that all school

		staff, who are in contact with students day to day, undergo adolescent mental health identification training as part of professional development; - publish and share a list of mental health related disease symptoms that is readily available; - encourage school staff who may have a slight concern to report it to a more qualified contact, such as a guidance counselor or school psychologist, to conduct a more in-depth review.
Identification of Need	Lack of a data-driven approach	- encourage disciplinarians to use discipline records to identify students with repeated instances of risk-taking, disruptive, or abnormal behavior, share these records with the school psychologist office, who may conduct a psychologist evaluation in lieu, or in addition to, a suspension; - analyze questionnaires from universal screening surveys to identify trends and flag students with a high risk and likelihood of mental health issues; - review medical records of at-risk students, to determine if past trends of risky behavior may indicate future concerns.
Identification of Need	Fear that children in need may go unidentified	- support the adoption of tiered approaches, such as PBIS, as a way to facilitate interventions both universal and individualized, while keeping the organizational

		context of the school in mind; - mandate that schools perform mental health screenings of all students; - require that physicians screen all patients in the adolescent to teen age group for behavioral issues.
Access to Care	Negative social factors	- sponsor activities and programs that help lower the stigma of receiving mental health, such as peer-to-peer support groups; - include mental health education, as well as mental health risk reduction, in mandatory health classes; - encourage the adoption of PBIS, stressing the role it plays in creating safer, more supportive school climates and healthier student-teacher relationships.
Access to Care	Poor Insurance Coverage	- "expand State appropriations for Access MH CT to include young adults up to 25 years old, making Access MH CT available for children, adolescents, and young adults ages 0-25 years old." (Task Force to Study the Provision of Behavioral Health Services for Young Adults); - include mental health coverage in school insurance plans; - use in-school supports to help students with insufficient health insurance receive quality

		care; - establish clear definitions of mental health care for insurers; - facilitate co-management models between behavioral health providers with primary care physicians regardless of insurance type.
Access to Care	Poor collaboration with families	- encourage strategic family engagement through specialized outreach programs; - include families in the district-team model, potentially partnering with organizations such as the PTA (Parent-Teacher Association) - update families regularly of concerning behavior at school; - when necessary, respectfully request information about student's behavior at home; - recognize that interventions must be socially, developmentally and culturally appropriate to each student's family .

Access to Care	Nonexistent Community Health Partnership	- apply a public health approach to health services both in school and community; - require that mental health providers in the area work with school officials through the adaption of a district-team model, which promotes collaboration; - suggest community mental health professionals evaluate the school's mental health system and provide suggestions to make it more effective; - encourage interagency communication by establishing clear contact points for each involved agency; - create a formalized protocol of referring or reporting in-need students to community mental health providers; - encourage leadership in this area through grants, such as the federal Safe Schools, Health Students program, that support innovative community outreach programs; - include local law enforcement agencies, mental health/substance abuse service systems, welfare agencies, trauma networks, and other community support groups in the dialogue, cutting across public and private entities.
Access to Care	Lack of a formal process for responding to interventions	- ensure that school staff are aware of the process for reporting at-risk students;

		- verify that each school staff members is aware of his or her role in any response to intervention; - assure that teachers understand their responsibility to report students; - expand the role of school nurses to collaborating with school psychologists and guidance counselors, creating school-based health centers that include mental health services.
Access to Care	Poor Resources	- increase funding to allow for the hiring of more school psychologists, and guidance counselors, lowering the ratio of student to guidance counselor or psychologist; - increase funding for mental health training of all school professionals, allowing them to multitask; - reward mental health programs through grants, or state appropriations; - requite that the State Department of Education provides technical assistance.
Effectiveness of Care	System Fragmentation, school-community incoordination	- create an open dialogue between school support teams and community mental health providers, through the creation of a district-team model working group; - require that each school has an appointed safe school climate specialist, who acts as a liaison to community mental health professionals; - support the co-location of

		services.
Effectiveness of Care	No Ongoing Progress Monitoring	- establish a system to monitor the progress of students after they are referred to community mental health providers, possibly as a "progress report" monthly or more often depending on the severity; - establish open communication between school staff, families, and medical professionals to monitor students comprehensively.
Effectiveness of Care	Privacy Conflicts	- encourage the electronification of mental health records; - educate health care providers on HIPAA and FERPA laws, specifically addressing communication between clinical providers and school staff; - clarify or update HIPAA and FERPA to allow for enhanced communication, specifically when a mental health issue is time-sensitive; - ensure that students grant both school staff and community providers the proper privacy authorization .

Final Remarks

As echoed by Daniel F. Connor, co-chair of the Task Force Issues Plan for Dealing with Mental Health Issues, "There exists a substantial public mental health burden in Connecticut for children, adolescents, young adults, and their families with early onset psychiatric and mental health disorders." Although it is a problem with significant consequences for the young adult

population, it certainly is one that can be faced through creative problem solving and leadership from multiple communities, all of whom share a common investment in our nation's youth. Supporting the expansion and growth of mental health services within schools is more than just a promising way to reach all students in need, enhancing quality of care and increasing access from diagnosis to recovery; it is a proven answer. A long-term solution that focuses on structure, to fix current system fragmentation, can be found in an interconnected systems framework between PBIS and SMH.

The State of Connecticut has broke ground through passing historic legislation in the wake of the Sandy Hook Tragedy, yet there is still room for student behavioral supports to develop and for its potential to be reached. The Mental Health in Schools Act of 2013, proposed by Congresswoman Grace Napolitano for California's 32nd congressional district, seeks to amend the Public Health Service Act to extend projects related to school-based comprehensive mental health programs, encourage schools to adopt programs such as PBIS, and assist both schools and communities in applying a public health approach on the national level. GovTrack.us gives the bill a 0% chance of being enacted. In a society where we train teachers how to handle active shooter situations, rather than comprehensive mental health education, there is no way to describe this crisis other than a national epidemic. For the future health of our nation, it is time to invest both time and resources in the evidence-based solution of positive behavioral intervention and supports and school mental health.

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Report of Results

1. Do you work at a school that implements Positive Behavior Intervention and Supports (PBIS)?

#	Answer		%
1	Yes		83%
2	No		17%
3	Not Sure		0%
	Total		100%

2. Are you concerned about the mental health of students in your classroom, or that you work with everyday?

#	Answer		%
1	Yes		83%
2	No		17%
	Total		100%

3. Are you concerned about the mental health of students in your entire school?

#	Answer		%
1	Yes		83%
2	No		17%
	Total		100%

4. Generally speaking, should educators and school faculty be concerned about the mental health of their students?

#	Answer		%
1	Yes		100%
2	No		0%
	Total		100%

5. To what degree do you feel responsible for responding to the mental health of students in your school?

#	Answer		%
1	Not at all responsible		0%
2	Not responsible		17%
3	Somewhat responsible		17%
4	Responsible		50%
5	Very responsible		17%
	Total		100%

6. Do you believe government officials should prioritize mental health on their policy-making agenda?

#	Answer		%
1	Yes		67%
2	No		33%

	Total		100%

7. Do you believe this emphasis on mental health care should be integrated into the public school system?

#	Answer		%
1	Yes		67%
2	No		33%
	Total		100%

8. Do you believe mental health support should be available in public schools?

#	Answer		%
1	Yes		83%
2	No		17%
	Total		100%

9. Do you believe receiving mental health care is stigmatized in your school?

#	Answer		%
1	Yes		33%
2	No		67%
	Total		100%

10. In what ways, if any, if your school working to reduce this stigma?

Text Response, N/A

11. Are you individually working to reduce the stigma of mental health?

#	Answer		%
1	Yes (If so, please explain in the text box below)		67%
2	No		33%
	Total		100%

12. Have you received training in identifying students whom may need mental health support?

#	Answer		%
1	Yes		50%
2	No		50%
	Total		100%

13. Do you feel confident in your ability to identify students in your classes or in your school who might need additional mental health support?

#	Answer		%
1	Yes		33%
2	No		67%
	Total		100%

14. Are you concerned that some students who may need mental health supports may go unidentified in your school and/or classes?

#	Answer		%
1	Yes		67%

2	No		33%
	Total		100%

15. Do you know how to get support for students in your school with mental health needs?

#	Answer		%
1	Yes		83%
2	No		17%
	Total		100%

16. Do you feel it is your job to help students access support?

#	Answer		%
1	Yes		67%
2	No		33%
	Total		100%

17. Does your school have a specific referral system for accessing mental health, behavioral, or emotional supports?

#	Answer		%
1	Yes		67%
2	No		33%
	Total		100%

18. If Yes, do you know how to access it? Do you think it is effective?

Text Response, N/A

19. Who would you be first to contact if you suspect a student is in need of mental health care? (Check all that apply)

#	Answer		%
1	Principal		17%
2	School Counselor		67%
3	School Psychologist		83%
4	School Nurse		0%
5	A Teacher		0%
6	Student's parents/guardians		17%
7	Other		33%

20. Does your school have a system in place for students to refer other students for mental health, behavior, or emotional supports?

#	Answer		%
1	Yes		17%
2	No		67%
3	Not Sure		17%
	Total		100%

21. If Yes, have students been taught how to use this referral system?

#	Answer		%
1	Yes		0%
2	No		100%
	Total		100%

22. Would you know where to direct a student who came to you with a concern about a peer?

#	Answer		%
1	Yes		100%
2	No		0%
	Total		100%

23. Is the present student referral system (if existent) effective?

#	Answer		%
1	Yes		17%
2	No		17%
3	N/A		67%
	Total		100%

24. Does your school offer a variety of mental health, behavioral, and emotional support programs?

#	Answer		%
1	Yes		17%
2	No		83%
	Total		100%

25. Are mental health, emotional, and behavioral supports for students a budgeting priority at your school?

#	Answer		%
1	Yes		0%
2	No		100%
	Total		100%

26. Does your school have community mental health supports integrated into school supports?

#	Answer		%
1	Yes		50%
2	No		17%
3	Not Sure		33%
	Total		100%

27. Does your school have a partnership with a local mental health care provider in the area?

#	Answer		%
1	Yes		33%
2	No		17%
3	Not Sure		50%
	Total		100%

28. To what extend do you have a role in providing mental health care?

N/A

29. Is there a system at your school that monitors student progress after a referral and/or during treatment?

#	Answer		%
1	Yes		50%
2	No		17%
3	Not Sure		33%

	Total		100%

30. What are the greatest obstacles in providing students with access to mental health, behavior, and emotional care? (Check all that apply)

#	Answer		%
1	Lack of Time, intruding on the academic curriculum and schedule		75%
2	Lack of Money and funding for support staff		25%
3	Lack of a comprehensive support infrastructure (referral systems, programs, interventions, progress monitoring, etc.)		50%
4	Inadequate training on identification of students who may need support		75%
5	Inadequate training on referral system		75%
6	Please List Any Others		25%

31. Do you believe support staff (nurses, counselors, psychologists) should have access to students' mental health records? Why or Why Not? (Please explain in the text box below your multiple choice answer)

#	Answer		%
1	Yes		83%
2	No		17%
	Total		100%

32. Some public health experts are advocating for universal mental health screenings in schools, such as a student survey to help identify students who may need support. Would you support this?

#	Answer		%
1	Yes		60%
2	No		40%
	Total		100%