Responding to Escalating Student Behavioral Health Needs: A Comparative Case Study of Multi-Tiered System of Support Team Functioning

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RESPONDING TO ESCALATING STUDENT BEHAVIORAL HEALTH NEEDS: A COMPARATIVE CASE STUDY OF MULTI-TIERED SYSTEM OF SUPPORT TEAM FUNCTIONING

A Dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Education

by

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2023
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I HEREBY RECOMMEND THAT THE DISSERTATION PREPARED UNDER MY
SUPERVISION BY Randi Bargo-Smith ENTITLED Responding to Escalating Student
Behavioral Health Needs: A Comparative Case Study of Multi-Tiered System of Support Team
Functioning BE ACCEPTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
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ABSTRACT


The state of youth behavioral health in the United States was a public health crisis before the overwhelming challenges presented by the coronavirus disease 19 (COVID-19) pandemic, and now, the situation is even more dire. The impacts of youth behavioral health challenges are pervasive and long-lasting for youth, their families, and the entire community. It is critical to identify innovative ways that youth behavioral health is being addressed in schools and understand how comprehensive school mental health systems including multi-tiered system of support teams are functioning. This comparative case study investigated the functioning of two high school multi-tiered system of support teams in the context of responding to students with behavioral health needs. This study was investigated through the lens of Bronfenbrenner’s Bioecological Model of Human Development with a focus on the student, school, and community level. Individual interviews were conducted with nine MTSS team members from two Midwest high schools. One team utilized a traditional school behavioral health model, and the other school had a school navigator. The data were analyzed and organized into 27 different codes, five of which were represented in all participant interviews and were representative of the broader themes: Structure, Division of Labor, Behavioral Health Resources, Barriers, and Student Needs. Structure, division of labor, data and evaluation were identified as key challenges for the functioning of MTSS teams. The utilization of universal behavioral health screening and
knowledge of behavioral health resources for students were two of the most critical differences in team functioning. While there were differences that were meaningful to the functioning of the teams, there were more similarities than differences in their functioning. Opportunities to support student mental health, expand the development of comprehensive student behavioral health systems, and further support education professionals in practice and through future research opportunities were identified.

*Keywords* behavioral health, youth, mental health, MTSS, public school, school navigation, school improvement, early intervention, RtI, PBIS, school-based mental health, team functioning
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Chapter 1: Introduction

A Centers for Disease Control and Prevention (CDC) analysis found a terrifying 76% increase in youth suicide for ages 15-19 from 2007-2017 (Curtin & Heron, 2019). The suicide rate statistics for youth ages 10-14 are even more dire as they almost tripled from 2007 to 2017 (Curtin & Heron, 2019). The skyrocketing youth suicide rates illuminate the fact that youth mental wellness must become a priority. Furthermore, during the COVID-19 Pandemic, behavioral health emergency room visits for 12–17-year-old adolescents increased by 31% and 1 in 4 young adults considered suicide (Curtin & Heron, 2019). In a nationwide survey of a representative sample of adolescents, Merikangas et al. (2010) found that 1 in every 4-5 children in the United States meets the criteria for a mental disorder. It is estimated that approximately 20-40% of youth need behavioral health services while a much lower number of families are actually seeking and utilizing behavioral health services (Becker et al., 2015). It is estimated that as many as 50% of youth in need of behavioral health services do not receive them (Merikangas et al., 2010). Because of the severe impact that youth behavioral health disorders have on children, families, and the community, in addition to the estimated annual cost of 247 billion dollars, it is evident that the state of youth behavioral health is a public health crisis in the United States (Perou et al., 2013). We cannot rely primarily on the outdated approaches that have been in place and continue to build more of the same services, because these systems and approaches continue to fail many of our youth and families (von der Embse, 2018; Mental Health America, 2
School-age children in the United States spend about one thousand waking hours per year in school and over thirteen thousand hours in school from kindergarten to high school graduation. This is a tremendous opportunity to impact youth behavioral health in a positive way and to provide access and linkage to the appropriate level of behavioral health services for youth and families who are struggling. It is imperative that support, skill-building, and referrals to community resources be provided where youth spend so much of their time (Mental Health America, 2020). Schools are uniquely positioned to make an impact for youth, families, and their communities by implementing comprehensive behavioral health systems that provide services to promote school climate, social and emotional learning, behavioral health, and well-being (FREDLA, n.d.).

In addition to the challenges students are facing, schools and teachers are struggling too. Research shows the reality that the faculty and staff of each school create the quality of the experience and outcomes for students (Dufour & Marzano, 2011). Researchers have found that teachers overwhelmingly supported providing behavioral health services in schools, however, the two biggest barriers that they identified were lack of training and lack of time (Reinke et al., 2011; Walter et al., 2006). The tremendous gap between research and practice in school behavioral health is evident (Reinke et al., 2011; Ringeisen et al., 2003; Walker, 2004; von der Embse, 2018). Illustrating this, only 34% of teachers surveyed reported that they felt they had the knowledge and skills necessary to support the behavioral health needs of students, while 89% of those teachers indicated that they believed that it was the role of the school to address these student needs (Reinke et al., 2011). These findings speak to the discrepancy between teachers’ motivation to support the behavioral health needs of students and how well-equipped school staff
feels to do so. The stark contrast between the value teachers place on their role to support
students’ behavioral health and their preparation to do so underscores the need for training,
consultation, and innovation in the practice of school behavioral health.

As highlighted, students and schools are both struggling, but the community behavioral
health system has also experienced significant long-term and persistent challenges throughout
the evolution of the system over the past forty years. Knitzer (1982) documented program and
policy concerns in the United States that resulted in families and children not receiving the
services they needed and youth behavioral health needs not being met. They made the case that
public agencies should be held responsible for serving youth with the most serious behavioral
health needs (Knitzer, 1982). The reality was that the primary behavioral health service available
to these youth was often the most restrictive and expensive option: care delivered in an inpatient
hospital setting (Knitzer, 1982). Unfortunately, for many children and families, accessing less
restrictive behavioral health resources remains a challenge even in 2023.

The system of care philosophy was proposed to address youth behavioral health in a more
effective and impactful manner (Knitzer, 1982). In 1984, the federal Child and Adolescent
Service System Program was created by the National Institute on Mental Health in an effort to
support states and communities to implement systems of care (Stroul, 2002). The program was
later led by the Substance Abuse and Mental Health Services Administration’s Center for Mental
Health Services (Stroul, 2002). The goal of the system of care philosophy was to reform the
youth behavioral health system and the definition and implementation has continually evolved
since its inception. The key values include youth and family driven care, serving children in their
homes and communities, strengths-based and culturally relevant services while emphasizing the
importance of comprehensive services, individualized care in the least restrictive environment,
collaboration between agencies, and strong care coordination (Hill & Gresham, 2014; Pumariega et al., 2003; Stroul et al., 2021). Due to the overtaxed behavioral health system and high cost of delivering youth services, some experts have suggested the integration of prevention and health promotion into the system by taking a public health approach (Stroul et al., 2021). As noted by Cooper et al. (2008), the country should be striving to move to a public health approach to youth behavioral health services and should focus on a balance of treatment services, prevention, and early intervention (Iachini et al., 2013). This approach includes universal behavioral health promotion and prevention, universal screening, early identification and a pyramid depicting approximately 80% of children needing basic or no behavioral health services, 15% of children needing intermediate behavioral health services and supports, and 2-5% requiring intensive behavioral health services and supports (Pires, 2010).

This pyramid of children and service needs is comparable to the multi-tiered system of support framework that many schools implement. Because of their access to children and families, schools can play an integral part in the implementation of a public health approach to addressing youth behavioral health (von der Embse, 2018; Stroul et al., 2021). Schools should not just be the facilitator or delivery location of services, but they should be an integral part of the team that is creating the plans to meet the needs of at-risk youth and youth with behavioral health diagnoses (Cooper et al., 2008). Furthermore, the convergence of education and behavioral health is critical and collaborative planning, funding, outcomes, and evaluation between schools and community behavioral health is imperative to success (Cooper et al., 2008).

The behavioral health workforce shortage is another factor that supports the need for collaboration between systems and utilizing diverse behavioral health professionals in addition to master’s level therapists to meet the behavioral health needs of students. Behavioral health
workforce shortages across the United States were a concern prior to the COVID-19 Pandemic and have now escalated to unprecedented levels as demand for services continue to rise (Hernandez & Lampl, 2021). For example, based on projections prior to the COVID-19 Pandemic, by 2030, Ohio is estimated to have a shortage in behavioral health counselors, marriage and family therapists, psychologists, psychiatrists, physicians, and social workers (Hernandez & Lampl, 2021). In 2016, years before behavioral health needs escalated during the pandemic, projections estimated that by the year 2025 there could be a nationwide shortage of up to 15,400 psychiatrists, 57,490 clinical, counseling, and school psychologists, 48,540 social workers, 26,930 behavioral health counselors, and 78,050 school counselors in the United States (U.S. Department of Health and Human Services et al., 2016). These dismal projections underscore the need for creativity and partnership to meet student behavioral health needs with the current workforce.

Part of a comprehensive school behavioral health system is facilitating access for families and children to services across the Institute of Medicine’s Continuum of Care (Springer & Phillips, 2007). It is likely that most people with common behavioral health disorders began to experience these struggles in childhood, so this underscores the importance of transitioning from a treatment approach to a prevention and early intervention focus (Merikangas et al., 2010; von der Embse, 2018). The fragmentation of the youth serving systems, including behavioral health services in schools, is devastating for students and families, schools, and the community behavioral health system (Adelman, 2010). We know that it is essential to prioritize practices that engage youth and families as involvement in services is related to a reduction in symptoms and improvements in functioning (Becker et al., 2015). Because the continuum of youth services
is often already available and being provided by behavioral health experts in the community, it is imperative that more effort is made to take a holistic approach to youth behavioral health.

The school and the community behavioral health system should be partnering to facilitate the best outcomes for youth and their families. This is critical, because schools are tasked with doing the impossible: engaging in problem-solving, identifying solutions, and implementing plans to meet the diverse needs of every single student they serve. This responsibility doesn’t end with meeting student academic needs, but also includes social and emotional needs, behavioral needs, and more. The recommended framework for accomplishing this momentous task has evolved across the United States from a focus on implementing Response to Intervention, an academic tiered system, in combination with Positive Behavior Intervention Support (PBIS), a preventative framework, to the most inclusive approach, Multi-Tiered System of Support (MTSS) (Kern et al., 2022; Miller, 2015; Samuels, 2016). The MTSS framework represents the merger of academic and behavioral systems of support. The connection between academic challenges and emotional and behavioral concerns is well-documented in the literature (Kern, et al., 2022). MTSS is a problem-solving framework that is focused on the use of data, removal of barriers to growth and success, and the use of evidence-based practices to support the success of the whole child. The framework includes three tiers of intervention from tier 1 universal, to tier 2 targeted group intervention, and tier 3 intensive individual intervention. This framework is designed to facilitate early intervention and to be a collaborative, responsive, team-based process to meet the diverse academic, behavioral, and social-emotional needs of all students. The MTSS framework includes six key principles: students are capable of grade-level learning with appropriate support, a foundational focus on proactivity and prevention, the utilization of evidence-based practices, data-driven decision making and procedures, level of support
determination based on individual student need, and school-wide implementation with collaboration from stakeholders (Harlacher et al., 2014). Sailor et al. (2021) described MTSS as a rising star in educational innovation and explained that the integration of tiered intervention for academic, behavior, social and emotional learning have poised MTSS to be a transformative practice in schools in the United States. Schools are responsible for facilitating student access to behavioral health services because they are tasked with removing barriers to student learning and providing effective learning environments (Slade, 2003). Strong MTSS teams are an essential component of successful comprehensive behavioral health service in schools and they are key to early identification and prevention of severe and long-term behavioral health problems (Kern et al., 2022; von der Embse, 2018). Universal screening for behavioral health concerns is a critical prevention strategy that increases efficiency and enhances team decision-making (von der Embse, 2018). Because MTSS is the framework designed to meet the diverse needs of all students, we must ask, “How is this working for our students with behavioral health challenges?” The first step to answering that question is to investigate how the MTSS team is functioning in the context of responding to students with behavioral health needs.

As shown, we understand that students, schools, and community behavioral health providers are experiencing tremendous difficulty in navigating the collective goal of meeting student behavioral health needs. Because there are still significant challenges in meeting student behavioral health needs, new models of school-based behavioral health must be explored. School navigation is a unique model that schools and community behavioral health providers have implemented to strengthen the connection between the school and the community mental health system. The school navigator is fully embedded as a part of the school staff and their primary role is to collaborate with school staff, engage in early intervention including conducting student
behavioral health screenings, and to partner with the student and family to connect them to the most appropriate services available in the community. This is different than the traditional treatment approach to school behavioral health with an embedded behavioral health counselor that provides individual therapy and case management for referred students. Therefore, the purpose of this comparative case study is to gain an understanding of the functioning of a midwestern high school’s MTSS team with a school navigator and the functioning of a midwestern high school’s MTSS team without a school navigator in the context of responding to students with behavioral health needs being referred to or identified by the team. Because we know that the MTSS team is responsible for implementing the tiered system of support to meet the needs of all students in the school building from universal to the most intensive, including those with behavioral health challenges, it is imperative that we understand how this critical team functions. We know that students and families, schools, and community behavioral health providers are facing overwhelming challenges in their efforts to decrease student behavioral health concerns and increase student resilience. However, we also know that the MTSS team is a fundamental and critical piece of the school behavioral health services puzzle (Kern et al., 2022; von der Embse, 2018). Strong collaboration between the school and the community behavioral health system is mutually beneficial for all parties involved: the student and family, school, and community behavioral health provider (Cappella et al, 2008; Kern et al., 2022; Ringeisen et al., 2003). Because the innovative school navigator role is designed to facilitate a strong partnership and merging of the school and the entire continuum of youth behavioral health supports in the community, it is crucial to investigate the functioning of MTSS teams with and without this role.
Chapter 2: Literature Review

To understand the diversity of approaches to addressing student behavioral health in schools, the literature review begins by introducing the traditional school behavioral health model and the school navigator model. After the exploration of the models, existing findings around team functioning of interdisciplinary and school teams are presented. Next, gaps in the team functioning literature are highlighted with emphasis on the critical nature of these gaps. The theoretical framework that guided this work, Bronfenbrenner’s Bioecological Model of Human Development, is introduced and the topic of this research study is presented.

Existing School Behavioral Health Model

In order to understand the challenges and opportunities to more effectively serve students and families, it is imperative to examine the elements of the typical school behavioral health model. The traditional school behavioral health model includes a combination of case management and individual counseling. This combination of services in schools is expensive to provide and demonstrates a limited impact (Ringeisen et al., 2003). This approach is not efficient or effective enough to meet the needs of the large number of students or diverse range of needs students experience (Mental Health America, 2020; Ringeisen et al., 2003; von der Embse, 2018). The major pitfalls of this approach include only having the capacity to serve a small number of students, services being dependent on the payer and being primarily accessible only for students who have Medicaid coverage, lacking trauma-informed services, dependence on
therapy and overlooking more beneficial services, and the inadequate involvement from the student’s family (Atkins et al., 2021; Ringeisen et al., 2003).

Unfortunately, confusion and conflict are often the result of larger conversations and plans about formalizing behavioral health services in schools in the United States because there are numerous differing agendas that are attempting to guide policy, practice, research, and training (Adelman & Tayler, 2010). Most schools do not have enough resources to meet the needs of the growing number of students who are experiencing behavioral health challenges. Because of the allocation of funding and resources devoted to behavioral health in schools, the well-intentioned efforts of school staff to meet the complex needs of students are insufficient, fragmented, and programs often operate in isolation and without the necessary stakeholders (Adelman & Tayler, 2010; Weist et al., 2012). Slade (2003) suggests that most schools in the United States are not prepared to adequately address youth behavioral health concerns or to refer to the appropriate treatment and concluded that reforms are desperately needed. It is imperative to intentionally plan school behavioral health care to ensure that value is added to the services that already exist in the community instead of simply adding additional resources (Slade, 2002).

Recent initiatives across the country highlight the importance of behavioral health in schools, particularly with a focus on social and emotional learning (The Whole Child Initiative & Comprehensive School Health Approach). The Whole School, Whole Community, Whole Child model has become a focus for schools that represents the combination of the former two leading models, The Whole Child Initiative and The Comprehensive School Health Approach (Lewallen et al., 2015). This is a socioecological approach with a focus on the entire school drawing resources and influences from the whole community to meet the needs of the whole child (Lewallen et al., 2015). Behavioral health services are most cost-effective and resources are best
utilized when schools and communities are working together to meet the needs of kids and families (Lewallen et al., 2015). The translation of behavioral health research into practice in schools and the implementation of effective school-based services will require strong collaboration between behavioral health professionals and education professionals (Cappella et al., 2008; Kern et al., 2022; Ringeisen et al., 2003).

**School Navigator Model**

To respond to the struggles faced by students, schools, and community behavioral health systems, the school navigator model was developed (Atkins et al., 2021). The school navigator model prioritizes early intervention and strong connections between the school, community, and family (Atkins et al., 2021). The school navigator approach to meeting student behavioral health needs integrates the school and community behavioral health approaches. School navigators are behavioral health professionals that sometimes hold a clinical license, but they aren’t required to have a counseling or social work license. The primary roles and responsibilities of the school navigator include performing student behavioral health screenings and assessments, coordinating student level of care and treatment, providing student and family case management support, performing group student and staff interventions, providing individual and family treatment, providing school staff outreach and support, crisis response, and participating in professional development (Bowdre et al., 2021). Because of their integration with the school team and the funding model, school navigators can devote the necessary time to fully participate as a member of the school MTSS team (Atkins et al., 2021). This model is the bridge between the school MTSS framework and the community behavioral health system of care approach. The school navigator model is consistent with the goals of both approaches and is built on the foundation of prioritizing early intervention and strong connections between the school, community, and
family. In the school navigator model, school navigators are the linkage between all of the student’s ecosystems. School navigators are the thread that connect the student, the family, the school, and the community together.

**Team Functioning**

Navigating student behavioral health challenges requires the collaborative teamwork of students, families, school professionals and community behavioral health professionals. Accomplishing the collective goal of meeting student needs through the collaborative efforts of these individuals requires effective team functioning. Literature documenting the functioning of multi-disciplinary teams varies in approach, models, functioning indicators and theories. Common team functioning theories are rooted in system’s models including McGrath’s Team Interaction Process that examines team composition, team activities impacting functioning, and team performance and cohesiveness rated by external individuals and categorized as inputs, processes, and outputs (Erickson et al., 2015; Kutash et al., 2014). More recently, approaches have shifted to models focusing on the core characteristics of high-performing teams (Erickson et al., 2015). To understand the specific key elements of team functioning in schools, it is important to explore the broader scope of what researchers have found about the functioning of interdisciplinary teams, mental health teams, and school teams.

**Team Functioning in Schools**

Since the literature specific to school teams is limited, we can learn from team functioning in disciplines including business, healthcare, management, and psychology. Factors found to impact team meeting effectiveness in these disciplines include meeting structure, shared purpose, facilitator effectiveness, use of data, and interpersonal factors (Johnson et al., 2020).
Additionally, it is important to explore the functioning of interdisciplinary teams. School teams are inherently multidisciplinary as the individual team members have diverse training, skillsets, and areas of expertise. When it comes to school-based teams addressing student behavioral health, this becomes even more relevant as they include community-based professionals or facilitate linkage to community-based behavioral health services. This is important to consider because the inclusion of behavioral health providers from community agencies as part of school mental health teams is increasing (Weist et al., 2012). Researchers investigating the functioning of interdisciplinary teams have found mixed results, but essential characteristics for team functioning that have been identified include a clear vision, processes and procedures, division of labor based on roles, team cohesion, trust, communication, and leadership (Grumbach & Bodenheimer, 2004; Jones et al., 2020; McGuier et al., 2022; Nancarrow et al., 2013;). When looking at research specific to interdisciplinary team functioning in community-based children’s mental health services, Kutash et al. (2014) found that teams functioned better when they had stronger teamwork, informal communication, integrated family members with lived experience as equal teammates, and had positive organizational culture (Kutash et al., 2014).

It is difficult to generalize team functioning research findings from other fields to education settings because the roles, responsibilities, challenges, demands, schedule, and culture in education are unique. Teaming in schools is important because we know that interdisciplinary teams in education can result in improved communication, alignment of goals, reduction of duplicate services, increased support and empowerment, and decreased burnout (Erickson et al., 2015; Somech, 2005). Similarities in team attitudes values and beliefs can impact team functioning including team effectiveness, team performance, and team satisfaction (Emmerik & Brenninkmeijer, 2009). However, there are certainly challenges with teaming in schools. For
example, school psychologists identified challenges including the amount of time discussing interventions, limited participation by parents and teachers, and inadequate follow-up (Huebner & Gould, 1991). We know that aspects of school team functioning including structure, communication, and focus can impact productivity, efficiency, decision-making, and effectiveness of school teams (Erickson et al., 2015). However, structure has been identified as a key challenge for school teams despite researchers finding that higher functioning teams excelled in focus and structure but tended to score lower in communication (Erickson et al., 2015).

Researchers have identified four characteristics of school and community teams that enhance team functioning and collaboration (Iachini et al., 2013). The characteristics include clear team purpose, diverse team composition, having a designated leader, and established processes and procedures (Iachini et al., 2013). The concept of data usage as an essential part of team work is missing in the majority of school teams (Iachini et al., 2013). The inconsistency in school approaches to teaming and lack of systematic data-driven decision-making underscores the need to focus on the functioning of school-based teams (Iachini, 2013).

**Gaps in School Mental Health Team Functioning Literature**

In response to identified gaps in school behavioral health programming, pilot studies have been conducted to investigate team models for addressing student behavioral health challenges in schools (Raviv et al., 2022). There is anecdotal evidence supporting multi-disciplinary school mental health teams, but there is limited research demonstrating the impact of these teams on student outcomes or on the level of behavioral health service provision in schools (Reaves et al., 2022). To further complicate this scarcity of research, there isn’t consensus regarding who should participate on these teams and what the team’s primary areas of focus should be (Reaves et al., 2022). It is challenging to measure the effectiveness of school mental
health teams because their teamwork is often not measured and the measurement of success for implemented intervention is often individualized, making success difficult to define and measure on a large scale. Confidentiality, limited resources, competing priorities, lack of training, time demands, and position constraints are recognized as challenges for school mental health teams (Weist et al., 2012). Furthermore, the structures and processes of these teams are not well-documented or defined and we don't have robust evidence to demonstrate that they improve service delivery or student outcomes (Reaves et al., 2022). These same challenges exist regarding the best practice of community partnership on school mental health teams. Researchers have not investigated the impact of community partner participation on student outcomes or service delivery (Reaves et al., 2022). Reaves et al. (2022) conducted a secondary data analysis using data provided by the National Center for School Mental Health and found that 46% of schools included community providers as participants on their school mental health team, schools with more disciplines represented on their team reported higher rates of services at each intervention tier, and teams with greater multi-disciplinarity were more likely to report having tier 2 services available for students.

Exploring the functioning of teams addressing student behavioral health in greater depth and specifically, MTSS teams, is essential because these are the teams that are tasked with developing and implementing the framework of tiered interventions and supports to meet the needs of the most vulnerable and struggling students. We need to understand how school MTSS teams function in the context of responding to student behavioral health referrals in order to know what is working and identify opportunities to facilitate increased efficiency and improved outcomes for students. The key characteristics of interdisciplinary team functioning in schools
and other fields identified in the research informed the development of the interview questions for this research study.

**Theoretical Framework**

Students do not live in a vacuum. They are surrounded by people and systems that influence and impact their experiences and construction of reality. In order to understand the functioning of the team intended to support students, we must view our analysis through the lens of systems that have such a profound impact on the student experience: the student and family, school, and community. Developmental psychologist and researcher Urie Bronfenbrenner’s work is key to this exploration due to his groundbreaking work in the field of child development and his recognition of the impact of environmental and societal factors on child development. Bronfenbrenner struggled with how researchers studied child development with such a narrow focus, so he created the ecology of human development field to weave all of the critical aspects of human development together (Brendtro, 2006). Bronfenbrenner was ahead of his time with his conceptualization of the whole child including the context, processes, and interactions that have such a profound impact on their development. Bronfenbrenner strongly advocated for the power that adults had to positively impact children’s development and summed up his thoughts by stating, “Every child needs at least one adult who is irrationally crazy about him or her” (Brendtro, 2006, p.163). He strongly believed that children thrive with the development of strong bonds and a sense of belonging (Brendtro, 2006). Bronfenbrenner (1979) defined development as the “lasting change in the way in which a person perceives and deals with his environment,” (p. 3). Bronfenbrenner’s (1979) Ecological Systems Theory focuses on the interaction between a child and their environment.
Bronfenbrenner’s theory has evolved in the more than forty years since its’ inception and in 1994, with the recognition of the importance of the child at the center of the model, it became the Bioecological Model of Human Development (Bronfenbrenner, 2005). Themes that have remained central throughout Bronfenbrenner’s child development work include context, social and historical, the active person, and understanding that you cannot study an individual’s development in isolation (Darling, 2007). Bronfenbrenner’s model describes how a child’s development is influenced by their inherent qualities and the environment in which they are directly and indirectly part of (Chachar et al., 2021). The Bioecological Model of Human Development states that people are products of four primary elements: processes, person, context, and time (Bronfenbrenner & Morris, 2006). Processes describe the interactions that a child has with objects and people. The person refers to the characteristics of the child such as personality, appearance, and IQ. The context refers to the circles of influence around the child (Brendtro, 2006). The microsystem is the most influential system of interaction and includes the child’s immediate environment (Swick & Williams, 2006). The microsystem would include those people and systems closest to the child such as their family, school, and peers. Bronfenbrenner explained that a child’s behavior is reflective of the interactions with their closest circles of influence, and he opposed assessments and processes that viewed the child as the problem (Brendtro, 2006). The next system in the child’s world is the mesosystem and this system encompasses interactions between two of the microsystems (Chen & Rivera-Vernazza, 2022; Swick & Williams, 2006). The exosystem includes structures and systems that the child is indirectly influenced by such as their caregiver’s workplace, neighborhood, and mass media (Swick & Williams, 2006). The macrosystem describes the larger systems that have a powerful impact on shaping youth development such as cultural beliefs and values, socioeconomic status,
ethnicity, and political system (Chachar et al., 2021; Swick & Williams, 2006). Lastly, time is represented by the chronosystem which encompasses dynamic changes that influence development. The chronosystem can include what is viewed as typical or out of the ordinary such as historical events, caregiver divorce, or obtaining a driver’s license (Swick & Williams, 2006). Figure 1 is a visual representation of the Bioecological Model of Human Development (California Department of Education, 2019).

Figure 1
Bronfenbrenner's Model of Human Development

The Bioecological Model of Human Development suggests that if we alter the way that we do things in certain settings, we can produce a change in behavior and development in people who interact with that environment (Bronfenbrenner, 1979). Viewing this study through the lens of Bronfenbrenner’s Bioecological Model of Human Development there are opportunities to positively impact the development of children. By changing the way we address behavioral
health, we can change the interactions with influential people in the child’s microsystem and increase the collaboration and positive interactions between microsystems that encompass a child’s mesosystem as defined by Bronfenbrenner (1979). Marraccini et al. (2022) described how schools have roles in all four of the context ecosystems in supporting student development: creating safe spaces for learning and growth in the microsystem, building school-family-community partnerships in the mesosystem, belonging to a safe community to implement supports as a part of the macrosystem, and being shaped by an understanding of the community norms and the level of inclusion of diverse students and mental health needs as a part of the exosystem.

Darling (2007) suggested that the key aspect of Bronfenbrenner’s work is the recognition of the importance of patterns and the interrelationship between the determinants of development to a child’s development. This is key in this study as the investigation of team functioning will help us to understand the relationships between the parties in students’ microsystems that are functioning as part of the MTSS team. Because school, family, and community behavioral health services are all part of a youth’s microsystem and interactions between each of these entities are part of their mesosystem, altering the collaboration and communication between these three entities could have a tremendous impact on the development and behavior of the child in addition to the implementation of the appropriate interventions. Bronfenbrenner (1979) theorized that the microsystems in a child’s mesosystem are interconnected and influence each other. He explained that it would be an ideal scenario if a child’s family, school, and peer group worked together in harmony to support the child and reinforce the same values (Brendtro, 2006). Because the school navigator as a part of the MTSS team should facilitate increased collaboration and communication by utilizing the community-based system of care philosophies,
this model could increase the positive interactions between the school, the child’s behavioral health services within the community, and their family. Additionally, this increased collaboration could assist the team in focusing on the same goals, speaking the same language, and functioning in harmony as described by Bronfenbrenner. Thus, the inclusion of this role on the school and family team, by design, could affect change in a child’s development and behavior in addition to any change that could be attributed to the actual behavioral health interventions, services, and resources that youth and families are linked to. I will be using this framework as a lens to view the three levels involved in school behavioral health: student and family level, school level, and community level.

**Present Study**

For too long, school systems and community behavioral health systems have been functioning independently and this approach hasn’t resulted in the desired level of improvement for students, families, schools, or the community behavioral health system. The school and the community behavioral health system have toiled alone through the challenges of meeting the needs of struggling youth and families and the biggest travesty is the youth that were failed by these systems and did not receive the intervention, services, or treatment that they desperately needed. Research has demonstrated that students and families are suffering from the fragmentation of youth behavioral health services (Adelman, 2010) and that the approach of providing case management and individual counseling in schools is not sufficient, results in limited impact, and is expensive to maintain (Ringeisen et al., 2003). We also know that school-based behavioral health services are imperative and that schools are uniquely positioned to conduct universal screenings, early intervention, and prevent students from experiencing long-term and severe behavioral health problems (Cooper et al., 2008; Merikangas et al., 2010; von
Bronfenbrenner’s Bioecological Model of Human Development says that if we change the interaction by strengthening the relationship and collaboration between entities that are part of the key ecosystems in children’s lives, we can influence a child’s behavior and development (Bronfenbrenner, 1979). We know that students’ families, schools, and community including services and resources are key elements of a youth’s ecosystem. Bronfenbrenner (1979) theorized that by increasing collaboration between each of these microsystem members, we can alter the development of the youth. When we consider behavioral health of students, we know that their family, school, and available community resources are pivotal and can significantly influence their development. We know that many youth-serving systems have an established history of functioning separately as if in silos. The inclusion of a school navigator as a part of the MTSS team demonstrates the merging of the school and community behavioral health system and a partnership between entities in a youth’s microsystem. MTSS teams and their implementation of tiered intervention using universal screening, data-driven decision making, and evidence-based practices are key to meeting student behavioral health needs (Harlacher et al., 2014; Kern et al., 2022; Sailor et al., 2021; von der Embse, 2018). There is a dearth of research on team functioning in schools and we must understand how this critical team functions with and without the inclusion of a school navigator.

The topic of this research is the team functioning of two high school MTSS teams responding to student behavioral health needs. For purposes of this case study, the following three dimensions were examined; child and family, school, and community behavioral health system. One of the participating high schools has a school navigator that is a member of the MTSS team, and the other high school does not have a school navigator.
I understand that this study won’t answer all of the questions and fill in all of the research gaps. I did not interview students or explore the family perspective in this study. Student and family perspectives are obviously a key puzzle piece to understanding and meeting youth behavioral health needs. However, before we can understand the student experience and the impact of teams, services, and school resources on the student, we must understand what is happening with the MTSS teams and how they are functioning. This is key because we know that the multi-tiered system of support in place at the school and ultimately, the MTSS team, is tasked with responding and providing support options and interventions to students with the most serious challenges impacting their school success, including behavioral health challenges.

**Research Questions**

My objective was to gain rich insight into the experience and functioning of the MTSS teams from the school administrators, school psychologists, school counselors, school navigators, teachers, and additional members on the MTSS teams. I described the cases in rich detail and found emergent themes based on the analysis of the data. This case study was investigated through the lens of Bronfenbrenner’s Bioecological Model of Human Development and this theory guided the development of the research questions. The case study was designed to explore two cases, public high schools, and interview data was analyzed to answer the following research questions:

1. How are students' behavioral health challenges manifesting in the context of MTSS referrals? (Student Level)

2. How does the MTSS team identify students and design collaborative behavioral health interventions? (School level)
3. How does the school team facilitate linkages to community behavioral health services for students with behavioral health struggles? (Community Level
Chapter 3: Research Methods

Design

This comparative case study investigated the functioning of the MTSS team at two demographically and geographically similar high schools in the Midwest United States. Case study methodology was selected to gain a deep understanding of the complex context in which the phenomenon was occurring (Gillam, 2010). Case study was a well-matched methodology for this study as it should be used when how and why questions need to be answered and understanding the context is essential to the selected phenomenon (Baxter & Jack, 2008; Yin, 2014). I sought to gain a holistic and complex picture of the functioning of an MTSS team with a school navigator and without a school navigator through this case study (Marshall & Rossman, 2016). A comparative case study design was selected in order to gain a deep understanding of the two specific cases in real-life settings (Creswell, 2018; Yin, 2014). The unit of analysis was the individual school buildings, and each case was bounded by the time and place of one school building at the time of the data collection (Creswell, 2018). As Creswell and Poth (2018) emphasized, case study methodology allows researchers to focus on one issue and examine a case in great detail to illustrate the selected issue. Data was collected from individual semi-structured interviews with members of the MTSS teams with context provided by the School Navigator Toolkit and district MTSS policies. To prioritize the confidentiality of study participants, I did not reveal the position titles of participants or link their position titles with
quotes when presenting their statements. Participants are identified by their team membership and an individual interview identifier (A, B, C, D, or E).

**Positionality**

**Research Topics & Questions**

My research interest was inspired by my experience as an educator and a member and leader of several different MTSS teams at the junior high and high school level. I pursued a career in school counseling and school administration because I care about helping kids thrive and I am passionate about impacting my community in positive way. I am particularly interested in investigating the functioning of MTSS teams in the context of student behavioral health concerns because I have experienced a multitude of challenges and successes participating on MTSS teams. I have struggled to identify and meet student needs, struggled to remove barriers to student learning, and struggled with the overwhelming and never-ending to-do list on an educator’s plate. I have experienced challenges in determining how to intervene and locate appropriate resources and have experienced the defeating feeling that there were far more students that needed intervention than my team could possibly serve. I was interested in this research topic because it is important: important for students, important for families, important for educators, important for behavioral health service providers, and important for the future of the entire community. My own experience has fueled my passion for this research topic, and I understand that this could be a source of potential bias. However, I believe my experience in the field of education was a strength for engaging in this research. I truly understand that every educator’s experience and how their MTSS team functions is unique and I was thrilled to have the opportunity to learn from the educators that participated in this study.
Philosophical Paradigm, Epistemology, Ontology, & Axiology

The philosophical paradigm that guided this study was the social constructivist paradigm acknowledged by Creswell and Poth (2018). My worldview closely aligns with this philosophical paradigm and the belief that meaning is created through an individual's experience and interactions with others. I believe that a person’s identity, lived experience, and interactions with others strongly influences how they experience and make meaning of the world around them. This paradigm is supported by the theoretical framework of this study, Bronfenbrenner’s Bioecological Model (Bronfenbrenner, 1979). I sought to understand the world in which I work (Creswell & Poth, 2018) and I hope the insight and knowledge gained from this study, while not generalizable to other schools, will contribute to further research and implementation of more impactful mental health interventions through the MTSS team for youth and families in schools.

I have an extensive human services background having engaged in roles including school counselor, school administrator, and a youth services director in the community mental health field. I have a passion for making a positive impact on people and the world around me. I have witnessed the intense struggles that youth with untreated or inadequately addressed mental health challenges face in the school setting and the impact that has on families. I have also witnessed the inadequate response of the most common models of responding to mental health concerns in schools today. I strongly believe that qualitative research has the power to change the world and is best used when variables cannot be easily measured (Creswell & Poth, 2018). I appreciate that the participants and the researchers can be on the same level and people can be empowered to share their experiences.

My epistemological beliefs are aligned with social constructivism as I believe that knowledge is personal, subjective and unique (Al-Saadi, 2014) and that reality is co-constructed
by both the researcher and those that are being studied (Creswell & Poth, 2018). This epistemological orientation lends itself to the research process essential for a quality case study. My ontological beliefs, as defined by Al-Saadi (2014), closely align with the social constructivist framework. Having worked in human services, I support the concept that meaning is constructed through each person's individual lived experiences and interactions with others and that multiple realities exist (Creswell & Poth, 2018). My axiological beliefs honor individuals’ values and experiences and this is consistent with the case study process that was selected to gain a holistic view of the case (Creswell & Poth, 2018). Social Constructivism also aligns with my methodological beliefs and the qualitative case study approach. The need to utilize inductive methods of analysis searching for emergent ideas guided my selection of the methodology and selected sources of data (Creswell & Poth, 2018).

**Researcher-as-Instrument**

I served as the instrument in this case study which could have contributed to bias in the analysis of this study. This could be a concern given my experience functioning on MTSS teams as a school counselor and administrator in public schools and my work as a director in a county behavioral health authority. I strived to mitigate the effects of any potential bias through member checking and reflective journaling.

**School Context**

The identified cases are two public suburban high schools located in the Midwest United States. One high school has implemented the school navigator model to facilitate linkage to community behavioral health services to meet the needs of students referred to the district’s MTSS team. The school navigator position is funded by an outside agency. This team will be
referred to as Team Navigator (Team Nav). The second high school does not have a school navigator, but implemented the more traditional school behavioral health model. This team will be referred to as Team Traditional (Team Trad). They have a licensed social worker from a behavioral health agency that is housed in the school building. This position isn’t funded, so they rely on the clinician being able to bill enough student insurance providers to support the continuance of the position. Because the social worker needs to have a certain number of insurance billable hours, they primarily work with students that become clients of the behavioral health provider to receive case management or individual therapy reimbursed or partially reimbursed by Medicaid or commercial insurance. The social worker does not participate as a part of the school MTSS team unless it involves a student that is already their client, because this time would not be billable to insurance.

Purposeful sampling was used to identify the participants as the two high schools’ MTSS teams. The teams weren’t necessarily specifically titled MTSS and they used a school-determined title, but the teams selected were both tasked with implementing tiers of support, utilizing and collecting data, facilitating removal of barriers, and using evidence-based practices to support the success of students that are identified to be struggling in a way that is impeding their school success. The cases and participants were selected due to the implementation of the school navigator model and participating on the MTSS team and a demographically similar school district that doesn’t have a school navigator. These cases were uniquely positioned to inform an understanding of the phenomenon in question, how an MTSS team functions differently with a school navigator on the team when tasked with meeting youth behavioral health needs, and thus were selected for this reason (Creswell & Poth, 2018). I was able to gain
additional contextual information by reviewing the School Navigator Toolkit, district MTSS policies, and the Developing a Curriculum (DACUM) School Navigator Job Analysis report.

High School Nav is a public suburban school with a total district enrollment of approximately 5,000 students and an enrollment of around 900 students in one of the high school buildings. The student composition of the high school includes approximately 20% students with disabilities, 13% economically disadvantaged, and 87% white, 2% black, 2% Asian or pacific islander, 5% Hispanic, and 34% multi-racial. District Nav has a graduation rate of approximately 97%, an attendance rate of approximately 94%, and spends about $12,000 per student.

High School Trad is a public suburban high school with a total district enrollment of approximately 6,000 students and a building enrollment of 1,800 students in the high school building. The student composition of the high school includes approximately 7% students with disabilities, 7% economically disadvantaged, 89% white, 2% black, 4% Asian or pacific islander, 2% Hispanic, and 3% multi-racial. District Trad has a graduation rate of approximately 99%, an attendance rate of approximately 95%, and spends almost $9,000 per student.

Participants

All the members of the two schools’ MTSS teams were invited to participate in an individual semi-structured interview. The list of team members to be invited was provided by a team member from each of the two teams. The participants invited included individuals in the roles of school counselor, school psychologist, school administrator, school navigator, and district student services representatives. Nineteen individuals were invited to participate in the interviews and a total of nine individuals consented to participation and engaged in the interview process. Five members of the MTSS Team Trad that included a school navigator participated and
four participants of the MTSS Team Trad that didn’t include a school navigator participated. The composition of the teams identified by interview participants included variations of building-level administrators, school counselors, school psychologists, and behavioral health professionals. The primary differences in team composition as described by participants include that Team Nav included a school psychologist and Team Trad did not include a school psychologist; Team Nav included a school navigator while Team Trad included a mental health clinician assigned to their building, but only for discussions about specific students that the clinician already works with; and Team Nav and Team Trad both included or consulted with a district-level behavioral health expert as needed.

Figure 2

Position Details Comparison
Demographics of Participants

A total of nine participants engaged in individual interviews for this study. Five individuals from Team Nav participated and four individuals from Team Trad participated. One interviewee was a school administrator, however participation in this study from school leadership was notably limited. Study participants at the building-level included school counselors, school psychologists, and behavioral health professionals.

For participants from Team Nav, the average years in their current position was 12 years, average years in education was 13.2 years, and years participating in MTSS or formerly RTI and PBIS work was 12 years. For participants from Team Trad, the average years in their current position was 8.5 years, average years in education was 16.25 years, and years participating in MTSS or formerly RTI and PBIS work was 8.75 years.

Table 1

Experience and Education

<table>
<thead>
<tr>
<th>Experience</th>
<th>Team Nav</th>
<th>Team Trad</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience in Current Position</td>
<td>12 years</td>
<td>8.5 years</td>
</tr>
<tr>
<td>Experience in Education</td>
<td>13.2 years</td>
<td>16.25 years</td>
</tr>
<tr>
<td>MTSS/PBIS/RTI Experience</td>
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<td>8.75 years</td>
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<td>-------------------------</td>
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<td>Education Level</td>
<td>2 Master's with EdS., 2 Master's, 1 Bachelor's</td>
<td>4 Master's</td>
</tr>
</tbody>
</table>

**Data Sources**

Several existing data sources were reviewed to provide context for this study.

**School Navigator Toolkit**

The School Navigator Toolkit was created by the Mental Health and Recovery Board of Union County and funded by the Ohio Department of Mental Health and Addiction Services with support from Miami University. This toolkit documents the background, workflow and implementation, framework, recommended trainings, and a quick start guide to implementing the school navigator model in a community.

**Developing a Curriculum School Navigator Research Chart**

The Ohio State University Center on Education and Training for Employment produced Developing a Curriculum (DACUM) School Navigator Research Chart. The DACUM School Navigator Research Chart was created to identify the major duties and tasks of a school navigator using subject matter experts to inform the creation of the document.
School MTSS Policies

The school building policies related to the implementation of their MTSS frameworks were examined. This review included policies developed by both of the individual schools participating in this study.

Individual Interviews

The questions for the individual semi-structured interviews were informed by a review of team functioning, MTSS, and the Bioecological Model of Development literature. The questions were developed to gather data to inform this study’s research questions and ensure to address the student and family, school, and community levels.

Demographic Questions.

1. How many years have you been working in this position?
2. How many years have you been working in an education setting?
3. What is your highest level of education?
4. How many years have you participated as part of a multi-tiered system of support team (formerly RtI, PBIS, etc.)?

Interview Questions.

1. Describe the composition of your team. (School)
2. Discuss the shared vision of your team. (School)
3. Describe the team members’ understanding of their individual role? (School)
4. What is your individual role on this team? (School)
5. Are there any additional roles that would make this team function more effectively? (School)

6. What essential skill sets are represented on your team? Are there any missing? (School)

7. What does collaboration between your team members look like? (School / Community)

8. Discuss communication between team members. (School / Community)

9. Describe the workflow of your team. (School / Community)

10. How are students referred to your team? (Students)

11. How often do you take new referrals? (Students)

12. Describe any universal screening processes that result in referrals to the team. (Students)

13. What are the behavioral health challenges that lead to referrals to your team? (Students)

14. What does your evaluation process look like for a referred student? (Students)

15. How do you determine what interventions are appropriate for students to create an intervention plan? (Students)

16. How is data used to inform your decision-making process and intervention plan? (School)

17. What behavioral health resources outside of the school does your team use and refer students to? (Community)

18. How would you describe your team’s relationship with community partner organizations? (Community)

19. How does your team measure the success of implemented interventions? (School)

20. How does your Team Tradrack outcome data? (School)

21. How does your team meet the needs of your students? What could be done to improve this? (School)
Procedure

For both districts, individual, semi-structured interviews were conducted with consenting school staff members that were a part of the MTSS team including administrators, school psychologists, school counselors, and school navigators. My goal was to engage in face-to-face interviews with eight to fifteen school staff members including at least four staff members from each high school. This target number was identified with the goal of achieving data saturation. The invitation to participate in the individual interview was extended to all members of the MTSS team at both high schools. I created open-ended interview questions to allow participants to determine what information is most important and how much they wanted to share with me based on their experience. As explained by Creswell and Poth (2018), qualitative researchers serve as instruments in data collection and tend to design their own instruments instead of using questionnaires or surveys already created by other researchers. Team members were selected based on their expertise and experience as a part of the MTSS team and were given the opportunity to consent or decline participation after the opportunity to read about and discuss the risks and expectations of participation. School staff members were informed that they could opt out of participating in the study at any time. The participant informed consent script included a definition of behavioral health to ensure that participants understood that questions being asked encompassed both mental health and substance use challenges. Individual interviews were conducted with participants, recorded, and transcribed. Confidentiality was maintained by assigning each participating staff member a letter and removing their identifying information prior to engaging in the data coding process. Participants engaged in member-checking through confirmation of their transcription and had the opportunity to revise or add any additional
information. I wrote reflective journals for each interview conducted to document my observations and thoughts.

**Trustworthiness**

To establish trustworthiness of the study, I strived to meet the expectations of credibility, transferability, dependability, and confirmability as described by Guba and Lincoln (1989). To establish credibility, the match between the participants’ views and my presentation, member checking was implemented (Guba & Lincoln, 1989; Nowell et al., 2017; Stake, 1995). Following transcription of the individual interviews, the transcript of the interview was sent to each participant for their review. Participants had the opportunity to verify that the transcript of their interview accurately reflected what they intended to communicate, and they were provided the opportunity to share any additional information. Credibility was established using thick description to decrease the possibility of translation errors between participants interview responses and my interpretation of their responses (Creswell & Poth, 2018). To establish transferability as presented by Guba and Lincoln (1989), I provided thick descriptions of the findings. I included thick descriptions of the interviews in order to provide context, capture thoughts and emotions communicated, provided interpretations of what was stated and presented the information in a way that readers experience the feeling that they could have been present to experience the interviews (Ponterotto, 2006). I worked to ensure that readers could examine the process to establish confidence in the dependability of the study, as defined by Guba and Lincoln (1989), by keeping a journal of notes throughout the research process. Confirmability, or ensuring that the conclusions are informed by the data, was established by the criteria of credibility, transferability, and dependability being met as described (Nowell et al., 2017).
Data Analysis

I conducted a holistic analysis to create a detailed description of the cases and used an inductive method of data analysis to identify emergent themes when analyzing the data (Creswell & Poth, 2018). To ensure confidentiality, I de-identified the data in the interview transcriptions prior to analyzing the data. I engaged in thematic analysis as defined by Nowell et al. (2017). I utilized Microsoft Excel throughout the data analysis process. During phase one of the data analysis, I focused on immersing myself in and familiarizing myself with the data which included documenting thoughts, interpretations, questions, and ideas during the collection process (Nowell et al., 2017). Following the data collection, I transcribed the interviews and repeatedly reviewed and read through the collected data in a manner that allowed me to become immersed in the pursuit of patterns and meaning (Nowell et al., 2017). After that, during phase two, I generated and assigned initial codes using the knowledge from being immersed in the data and continually revisiting the data (Nowell et al., 2017). After assigning codes, I revisited the codes and data and determined there were some codes that could be collapsed and combined. During phase three of data analysis, I focused on searching for themes and I organized the existing coded data into five broader themes (Nowell et al., 2017). I used an inductive, data-driven approach in which the themes generated were existing codes and were informed by the data and not by pre-existing themes. Identifying the case themes was essential to creating a rich description of the cases and these themes were reported based on the system level that they inform, student and family, school level, and community level. As defined by Nowell et al. (2017), phase four of the data analysis included reviewing and refining the themes to make sure they were accurate, specific enough to be distinct and broad enough to encompass ideas captured in the data. The fifth phase of data analysis encompassed a final review of the finalized themes,
and ensuring they captured the data accurately and were comprehensive and clear (Nowell et al., 2017). For the final phase, phase six of the data analysis, I produced a written report and revealed the themes in a manner aimed to help readers to understand what the themes reveal about the topic (Nowell et al., 2017)
Chapter 4: Results

Identified Themes

Consistent and pervasive themes emerged from analyzing the participant interview data. The emerging data was coded into 27 different codes, five of which were represented in 100% of the interviews and were representative of the broader themes: Structure, Division of Labor, Behavioral Health Resources, Barriers, and Student Needs. The 27 existing codes were organized under these five broader themes. Structure was the most frequently discussed topic and was mentioned a total of 37 times across all 9 interviews. Table two lists the 27 codes and total code counts grouped by themes and broken down by times coded per team and percentage of participants that referenced the code across both teams.
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<th>Team Trad Percentage</th>
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</tr>
</tbody>
</table>
Structure, Division of Labor, Roundtable Discussion, Barriers, and Student Needs were in the top 10 referenced codes for both Team Nav and Team Trad. Whereas each team had an additional five codes that didn’t make the other team’s top ten codes. Codes included in Team Nav’s top ten included Behavioral Health Resources, Data, Adult Identification of Needs, Team Cohesion, and Proximity. Table three includes both teams’ top 10 codes, total number coded, and the number of interviews that referenced each code. Codes included in Team Trad’s top 10 included Academic, School Connectedness, Evaluation, Administrator Involvement, and School Counselor Workload.

Table 3

Top Ten Codes

<table>
<thead>
<tr>
<th>Team Nav Top Codes</th>
<th>Team Trad Top Codes</th>
<th>Total</th>
<th># of Interviews Referenced (n=5)</th>
<th>Total</th>
<th># of Interviews Referenced (n=4)</th>
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<td>16</td>
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Table four describes the top ten codes in common between the two teams including the number of times coded per team and the percentage of interviews that referenced this code.

**Table 4**

*Top 10 Codes in Common Between Teams*

<table>
<thead>
<tr>
<th>Code</th>
<th>Team Nav</th>
<th>Team Trad</th>
<th>Team Nav Percentage of Interviews</th>
<th>Team Trad Percentage of Interviews</th>
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</table>

Table five describes the top ten code disparities between the two teams including the number of times coded per team and the percentage of interviews that referenced this code.
Table 5

Top 10 Code Disparities Between Teams

<table>
<thead>
<tr>
<th>Code</th>
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<th>Team Trad</th>
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<th>Team Trad Percentage of Interviews</th>
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Research Question 1: How are students' behavioral health challenges manifesting in the context of MTSS referrals? (Student Level)

In research question one, I focused on the student at the center of Bronfenbrenner’s Bioecological Model of Human Development. I wanted to understand the MTSS teams’ perspectives on how they are seeing students’ behavioral health challenges manifesting in the context of MTSS referrals. Table six describes the codes related to research question one, number of times coded, and the percentage coded across both teams.
Table 6

*Code similarities and differences related to research question one: How are students’ behavioral health challenges manifesting in the context of MTSS referrals?*

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</tbody>
</table>

**Similarities**

**Student Needs.**

Study participants from both teams discussed the wide variety and diverse presentation of the challenges that students being referred to the MTSS team face. Student Needs were mentioned a total of 22 times and in 100% of the interviews. Members of Team Nav referred to Student Needs 13 times across all five interviews while members of Team Trad discussed Student Needs 9 times across all four interviews. Student Needs were discussed by both teams and focused on the expression of need through changes in student behavior, anxiety, decreases in academic performance and attendance, and both teams specifically mentioned high acuity student cases.

Study participants from both MTSS teams discussed student needs in terms of changes in student behavior. Changes in behavior were described as indicators to school staff that a student may be struggling and might need behavioral health services. Specific examples of changes in behavior cited by study participants included avoidance and withdrawal and students not taking...
care of themselves. Team Nav Participant A said, “seeing a change in behavior so not going to class and not taking care of themselves.” Specific to avoidance behavior, Team Trad Participant C stated:

I think one of the biggest ones that we look at tend to come out in avoidance, whether that is school avoidance itself and so those students are also an attendance problem, avoidance in that they can’t make it through an entire school day without spending part of their day somewhere else, struggling to stay in class, and work avoidance. I think those always indicate to us there’s something bigger going on. But I often feel like what we’re dealing with is either task or school avoidance.

Members of both Team Nav and Team Trad discussed the prevalence of student anxiety and how this is presenting in students referred to the team. Related specifically to anxiety, Team Nav Participant C said, “A lot of it is anxiety in the classroom,” and Team Trad Participant B talked about “behavior as a coping skill to deal with stress and anxiety.”

Members of both teams discussed students’ decrease in academic performance and presence including difficulty completing work and truancy resulting in a referral to the team and a need for behavioral health support. Team Trad Participant D shared “Kid is not engaging, in class work is not being done in a timely fashion, if at all, there is no attempt to do any schoolwork.” Team Nav Participant C discussed students describing the challenges themselves saying “I can’t get my work done…. Because I can’t even get out of bed.”

The MTSS team involvement in high acuity student cases including severe and persistent suicidality and violence or threats was also discussed by members of both teams. High acuity student situations referenced by both teams were primarily related to suicidality while a member
of Team Trad discussed the increase in self-harm and a member of Team Nav discussed involvement with students that have made threats of violence. Team Nav Participant D said:

My level of involvement is typically with very high acuity situations….when it results in community based mental health referrals, you know, or higher order mental health in behavioral health referrals. The behaviors that are driving that are usually severe and pervasive suicidality or things that would fall under the realm of threat assessment where we have a murder list or we have a young person that’s searching how to create pipe bombs or how to hide a body…things like that.

Team Trad Participant B shared:

There’s been quite an uptick of students with self-injury…You know, we see a lot of suicidal ideations. Severe ones are not as common, but it’s still, you know, a handful that we are referring out for severe suicidal ideation.

Study participants from both teams emphasized how critical identifying student needs are to the functioning of the MTSS team. Participants noted that student behavioral health needs are manifesting to the MTSS team in the form of student behavior change, anxiety, academic challenges, and high acuity behavioral health needs. There was consistency in the emphasis and discussion of student needs across all interviews and both teams.

**Increase in Behavioral Health Needs.**

Several participants from both teams discussed the increase in youth behavioral health needs following the COVID-19 Pandemic. The Increase in Behavioral Health Needs was coded five times by five different participants. This was mentioned by 60% of Team Nav members and
50% of the members of Team Trad. The consistent message from team members described how they have observed a tremendous increase in student behavioral health needs unlike anything they have seen despite being in the education field for years. Study participants from both teams talked about how the increase in number of students experiencing behavioral health challenges has increased the demands on their teams. Team Nav Participant B noted that:

I think there’s a lot of students because it’s definitely the mental health, like, it is a mental health crisis right now. I mean we’re seeing from even when I started 14 years ago, the amount of mental health, anxiety, depression, all of that, has pretty much skyrocketed. So yeah, it’s a lot.

Team members discussed ways in which the teams have responded to meet the increasing needs of students and families. Team Trad Participant D said:

This was during the pandemic and so the goal was to really monitor progress and access to learning. That grew then into more of a consistent follow through and follow up with behaviors, attendance, some social and emotional challenges that the kids have. All of those were in place before, but it really felt more like we’re just monitoring grades and finding out who’s not doing well in class. So, I think the social emotional pieces grabbed a little bit more of an urgency, and I think the school district has done a few more things to try to make people available that would focus solely on those aspects of the student’s life.

The consistent message from the members of both teams that discussed the increase in student behavioral health needs was that the increase in these needs is monumental and that
school districts and MTSS teams have responded by adjusting the work they do to meet the needs of students and families.

**Adult Identification of Needs.**

Every single participant from both teams emphasized how critical adult identification of student needs were to their team process. Adult Identification of Needs was coded a total of 25 times. Team Nav referenced this code 17 times across all interviews and Team Trad mentioned this code 8 times across all interviews. Participants discussed the recognition of specific students struggling and being referred to the team for behavioral health concerns by administrators, counselors, parents, and mostly, teachers. Emphasis from participants on both teams was placed on the amount of time teachers spend with students, how well they know their students, and those two factors being translated into the ability to identify students with behavioral health needs. Team Nav Participant E said “It comes from the teachers. You know, teachers are the front line of work with kids, so when they’re seeing things, that’s coming to us” and “I think we’re good at identifying.” Team Trad Participant A said, “I would say most of it starts with a teacher referral…They’re the ones who see them every day.”

While the consistent emphasis was on teachers identifying student needs, participants also discussed administrators, parents, and other school staff’s role in identifying student behavioral health needs. Team Nav Participant C noted “They can be referred by teachers. A lot of times the principal, the admin, will refer them…especially if they’ve gotten in trouble.” Team Nav Participant A shared, “Each guidance counselor has a portion of the alphabet, so they bring up kids that they have concerns about” and “I feel like our guidance counselors have a good idea of their student population.” Team Trad Participant A said, “Of course, we have parents that
sometimes ask us to talk to their student, talk to their child.” Team Trad Participant C noted, “It’s mostly going to be word of mouth” and Team Trad Participant D said, “Pretty much everybody in the building has said, ‘Hey, if you got a concern, tell somebody.’” Team Nav Participant A stated:

Lucky, I think in our building, whenever we do screening or SOS type stuff, the kids that flag from that are kids usually that we’re pretty aware of. So, I think that’s a good sign. There’s not many kids that (we) are like, oh, we didn’t know about this.

The clear message from participants highlighted how essential the role of adults identifying student needs was to the functioning of the MTSS team in high school.

**Differences**

**Academic.**

Academic performance was referenced 20 times across both teams, but while both teams mentioned academics in some capacity, Team Trad referenced academics three times as much as Team Nav even though Team Trad had less interview participants. Team Nav referenced academics five times across 40% of participant interviews and Team Trad discussed academics 15 times across 100% of participant interviews. There was certainly a difference in emphasis on academics between the two teams. It is helpful to understand that a contributing factor to this difference is likely the structure of their teams. Members of Team Nav shared that they take a bifurcated approach to MTSS teaming and have two separate teams: an academic team and a behavioral health team. The behavioral health MTSS team is the Team Trad that participated in this study. Conversely, Team Trad utilized one Team to address academic and behavioral health
challenges, but the team communicated a much stronger focus on and diversity of interventions for academic challenges than behavioral health.

However, the overall message from both teams related to academics included the importance of reducing barriers to academic success, changes in student academic performance, and academic performance as a primary data point and indicator of success for school districts. The primary difference seemed to be that Team Trad viewed academic performance as one of, if not the primary, entry point for students to the MTSS team, whereas, that didn’t seem to be the case with Team Nav.

Team Nav Participant D discussed academics in stating:

So, if we have like a young person that’s not really involved in school and they’re credit deficient or their grades are poor or they just, you know, they haven’t met competency for state testing or their (academic) screening data looks pretty crummy, they have a history of not doing well on end of course or end of year state assessments, that trips a lot of triggers for us in terms of risk.

Team Trad Participant B discussed the importance of academics in identifying students for their team by stating, “Typically, students are identified first through academics. You know, we notice that their grades are slipping, and that’s usually an indicator that something’s going on” and “So, when we pull the quarter 1, 2, 3 grades for D’s and F’s, we kind of quickly can identify areas of concerns.” Team Trad Participant C emphasized the team’s use of classroom performance data stating, “Like, why aren’t they passing math, you know, has this always been a chronic issue? So, I think we rely very heavily on the classroom performance and attendance piece a lot.” While Team Nav discussed academic challenges as a data piece that contributed to
analysis of student needs, Team Trad tended to present academic challenges as the primary indicator of student need that would get them referred to the MTSS team.

**Family Challenges.**

Members of both teams discussed challenges in the home and how the struggles that families are experiencing impact students’ behavioral health and wellness. This was coded a total 13 times across six interviews. While the message was consistent from participants, there was a much greater emphasis on Family Challenges by Team Nav with this coded 10 times across 100% of interviews, whereas, this was only coded 3 times across 50% of interviews for Team Trad. Obstacles with consent to services and how lack of family engagement with services for students affects the students and the functioning of their teams was discussed primarily by Team Nav. Team Nav Participant A shared:

> Some of these families are students that we've been trying to get into services for a long time and there's more of a we'll handle it at home type attitude. You know, they're thankful for the school and support, but as much as we ask and refer and refer, some families just don't want to be involved. So, a lot of times it's for the same families we're referring again.

The teams discussed what they see, the impact that they observe, and noted the recognition that families often need support too and schools have very limited control when trying to impact many examples of family challenges. The overwhelming message from both teams related to family challenges was a recognition of the limited power MTSS teams have to impact family challenges that are impacting students and their behavioral health. The inability to control or change some of the family challenges that greatly impact student behavioral health and
wellness was a shared concern by both teams. Team Nav Participant D discussed, specifically, the ability of the school to change family challenges when stating:

I can’t…we can’t…we can’t really change necessarily the home that a young person lives in. We can’t change how often or how little they take their medication or how often or how little they go to do the therapeutic services depending upon the parent or caregivers’ level of engagement and interest in the entire process.

Team Trad Participant D explicitly discussed the challenges of addressing issues occurring in the home by saying:

Drug use, family drug use, socioeconomic issues that contribute to more challenges and potential neglect or abuse at home…tough for us as the school to measure, because where do you get involved as the school and how far can you get into that house?

Several participants discussed that most of the families they work with need support and services in addition to the student. Team Nav Participant A said, “I feel like families need support as well, not just a student.” Team Trad Participant D discussed struggles families face stating:

Occasionally, there’s been a split in the family, there’s been a loss in the family, there’s been an eviction from the house. Those things are a little bit more regular now than what they used to be two or three years ago.

The consistent message regarding Family Challenges shared by both teams included the recognition that often families need support in addition to students and that the school team has limited ability to control for or influence the family challenges impacting the student. A
consistent message across Team Nav was related to challenges and obstacles in obtaining consent for behavioral health treatment services beyond assessment and engagement of families in their child’s treatment.

**Student Involvement.**

Student involvement with the MTSS team was referenced six times by four of the nine education professionals that participated in the study. The message delivered from teams was consistent, however, there was a great discrepancy in the percentage of participants from each team that discussed this. Student Involvement was discussed in 20% of Team Nav interviews in comparison to 75% of Team Trad interviews. Beyond including the student in their own services or bringing them in for some questions, neither team currently involved students in the MTSS team work nor were they aware that the team existed to support them or the student body. Team Trad Participant A discussed how they’d like to learn from engaging with the students:

Part of me would love to ask the students just to see maybe those kids that do slip through the cracks because they keep their grades up and they’re quiet in class and they don’t really ever give off that red flag of I need help, but maybe they do. I would love to hear from that kid to see what they think of how, how we could help them more.

Team Trad Participant B shared:

I think it would be super helpful to have the student involved in the actual meeting. At times, we’ve pulled students in, but if students don’t know that this team exists and it’s there to support them, it kind of defeats the purpose.
Team Nav Participant E shared that “Kids self-report a lot more than they used to. You know, I think back on all of the years that I’ve been here doing this, I feel like kids self-report a lot more than they did in the past.” It was clear that there was a recognition of the awareness students possess to bring behavioral health concerns forward and that increasing the involvement and awareness of this team for students was very important for those participants that discussed how this could impact the functioning of the team.

**Research Question 2: How does the MTSS team identify students and design collaborative behavioral health interventions? (School level)**

For research question two, I focused on the school team as a microsystem as defined by Bronfenbrenner’s Bioecological Model of Human Development. I wanted to understand the MTSS teams’ perspectives on how they identify students and design behavioral health interventions for students that they serve. Table seven describes the codes related to research question two, number of times coded, and the percentage coded across both teams.

**Table 7**

*Code similarities and differences related to research question two: How does the MTSS team identify students and design collaborative behavioral health interventions?*

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<thead>
<tr>
<th>Code</th>
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</table>
Roundtable Discussion.

The concept of the team process essentially being roundtable discussion including keeping a list of students and talking about their needs each meeting was pervasive amongst both teams. It was clear that this was the process that both teams utilized, and team members didn’t feel that they had a solid process or workflow. Roundtable Discussion was coded 25 times across 100% of participant interviews. Team Nav discussed this 16 times while Team Trad referenced Roundtable Discussion 9 times. Team Nav Participant A stated, “Our workflow is usually just reviewing kids, what kids are connected and what aren’t, what parents have not responded.” Team Nav Participant B echoed those thoughts in stating, “I mean we kind of don’t know if there’s like a workflow necessarily because we’re meeting to discuss” and “We’re talking about them, you know, how can we help them. That kind of thing.” Team Nav Participant B also further emphasized the idea of Roundtable Discussion stating, “It’s more of just a group that meets to try to discuss and brainstorm” and “Right now it feels like, you know, we’re a team that talks a lot and we don’t have a lot of plans.”
The concept of Roundtable Discussion was further emphasized by Team Trad Participant C stating, “The meetings, sort of you know, we kind of go over all of the students, what their needs are, what’s been done” and “We kind of just say who else should we be talking about? And we put them on our list and then talk about them and run through some ideas.”

Structure.

The concept of informal team structure was consistent and pervasive amongst both teams and all nine study participants. This was the most coded concept across all nine interviews and was the most prominent code in Team Trad’s interviews. Structure was coded a total of 37 times: 20 times by Team Nav and 17 times by Team Trad. The concepts of informal structure discussed by participants included expressing the need for a framework and a more standardized process. Participants explained that the informal and people dependent process that is currently in place presents challenges for sustainability and consistency of the work across buildings in the district.

Team Nav Participant A stated, “It’s a pretty kind of casual process.” Team Nav Participant E emphasized the informal structure stating, “I feel like this is where I feel like we are not super structured in that way. I don’t think we really ever have been. I feel like it’s a very organic thing.” Team Trad Participant D also emphasized the informal structure in saying:

I hate to say it this way because it sounds so unofficial, but it really is on a hunch. I heard this kid talking about this or some other kids told me he was having this problem, and that’s usually what’s going to land you on the list.

Team Nav Participant B discussed the need for more structure and a more standardized process, “I really think it could be and should be a multi-tiered process that is a little bit more
regimented. You know we are kind of this loose group that's just trying to put band aids on.”

Team Nav Participant D discussed how critical it is for the Team Trad focus on systemizing the work they are doing to ensure sustainability. This participant discussed how the lack of formalization and structure around this process could become problematic and why this is an area of focus for the team with the goal of systemizing their process stating:

I would say this is the case for like any work, it really boils down to workflow and process, right? Like, making things systematic. So, we have a lot of people dependent things going on here where if I took those individuals out of the mix, that aspect of the system would probably collapse which is not good. We don't want to be super people dependent. It's good to have great people, but we don't want to be people dependent. We want to be system and framework dependent and so really, for us, the next legs of the work is going to be focused on how do we systematize the things that we're doing, how do we standardize it, how do we, you know, essentially do a few things very, very well, so that even if we had people leave or, you know, changes in leadership or changes in personnel, the systems and structures would persist and continue to stand.

Team Trad Participant C supported the same ideas regarding the people dependent processes stating, “All of it kind of lives and dies by that team.” Both teams explicitly discussed how their informal structure created a people dependent process that certainly presented challenges to sustainability of the work the team engages in for students. Members of both teams expressed a desire to formalize the work and discussed how a more systematic structure for both the team process and interventions for students could improve the functioning of their MTSS team.
Division of Labor.

The Division of Labor was in the top five most discussed codes and was present across all participant interviews. This was coded a total of 30 times across 100% of interviews. Team Nav discussed this 14 times and Team Trad discussed Division of Labor 17 times. Points of emphasis included conversations around the need for equity in the workload and division of duties based on strengths and expertise.

Team Trad Participant C stated:

If there was more workflow, more equity in that process, that could help. Having teacher representatives at the meetings I think would be great and again, even something like an intervention specialist as part of the team, I think just as someone who, again, is sort of an expert in or maybe like a subject matter expert in in the areas that we’re lacking as far as academic interventions, attendance interventions and things of that nature I think would be very helpful. I think a larger team, more equity in the responsibility and having it be a really uniform process throughout the district as well.

Team Nav Participant A shared, “A lot of times in this office we’re just putting out fires, so whatever the current emergency in that moment, we’ll deal with. As much as you’d like to follow up regularly with a student, it’s difficult to do so. Which is frustrating.”

Team Nav Participant B discussed the situations in which people in different positions tend to take the lead role:

I would say for like the school psychologist; it would be more of with students around IEP’s [individualized education plans] like what are those specific disabilities. Guidance
counselors, a lot of times we know family history, we know educational history. We work with them and tend to do a lot of these things. We tend to see a lot. So, we kind of know all that background. NAME OMITTED's coming in from the administrative background, so are there any other issues that have been going on discipline wise? What have they seen in the hall? If NAME OMITTED school navigator sees them, what is the counseling piece of it or are they receiving other outside services that?

Team Trad Participant B reinforced this idea stating:

I think it varies based on which student you’re talking about. If it is an academic type question, it will be more myself and the assistant administrator. If it’s more mental health or substance abuse, that is when we start relying on our mental health coordinator to step in, provide resources or services for that student.

_School Counselor Workload._

School Counselor Workload was coded a total of 15 times across 60% of Team Nav interviews and 75% of Team Trad interviews. The consistent and pervasive theme was that the bulk of the work conducted by the MTSS team weighed heavily on the team members that are school counselors. There was a strong sense of ownership and responsibility for students on their caseload conveyed and a clear message that school counselors took on most of the pre-work and post-meeting to-do list and a recognition of the intense time demands that they face. Team Trad Participant C discussed the school counselor taking on the bulk of the workload stating:

I think that's the other area that we are kind of lacking that workflow. The meetings, sort of you know, we kind of go over all of the students, what their needs are, what's been
done, but then I do feel like 85 to 90% of the work then is given to the counselor. As far as that communication, follow up, implementing ideas, that falls a lot onto the counselor, some on the administrator if they tend to have like a good, positive relationship with the student. But I do think that's an area that we're lacking because it does kind of most of it comes down to one person.

Team Nav Participant E further emphasized the role of the school counselor when describing the workflow coming down to one person for each student, the counselor, stating:

The workflow comes back to the person, the counselor, that is in charge of that family. So, each one of the three of us would have our own caseload of whoever's on that list. Like, we're sort of the point person for getting things off the ground in terms of whatever the team has decided needs to happen.

Team Trad Participant C further supported this concept stating, “I think communication and kind of tracking that student does fall a lot on the counselor.” The reality that the workload and most of the responsibility for the pre-work and post-meeting work including communication, implementation of interventions, working with students and families, and tracking of data being placed on the school counselor was a strong and pervasive code emphasized by both teams.

Evaluation.

The absence of progress monitoring and evaluation was pervasive and consistent across both teams and evaluation was discussed in each of the nine interviews. This was coded a total of 22 times, 11 times across each of the two teams, and across 100% of all participants. The ubiquitous message that participants conveyed was that evaluation was a missing, but necessary
next step for their team, the challenge of measuring the success of interventions implemented, and the need to formalize the evaluation process. Both teams consistently discussed the primary evaluation measure essentially being when the team felt that the student could be removed from the team’s list. Members of both teams shared that they didn’t really feel like they had a true evaluation process and that they didn’t engage in measuring the success of the interventions that they implemented. Both teams emphasized how important an evaluation process and progress monitoring were to the functioning of their team and that it was an opportunity to improve their team functioning. Team Nav Participant A discussed this stating, “I don’t know if we’ve got to that point yet. I mean…Obviously, if they like graduate from services they no longer need supports but, I don’t think we have a direct way of measuring interventions.” Team Nav Participant E also supported this stating, “I don’t know if we’re good in that area. I feel like we have a process of getting them to where we want them to be or getting them involved in services, but I don’t know that we evaluate how effective any of that’s been.” Team Trad Participant A shared similar thoughts, “I would say this is probably something we could improve upon. Mostly because, I say mostly because if it’s a student that I don’t really know, we don’t really have like a formal evaluation.” Team Trad Participant B also stated, “I don’t think that we have a great evaluation process” and stated that “It’s just very anecdotal evaluations.” Team Trad Participant C’s comments were consistent with the other participants explaining, “I would say that’s another thing we’re definitely lacking in that we don’t have a strong evaluation process at all. We kind of just say who else should we be talking about, and we put them on our list.” This participant also discussed the challenges of identifying and measuring interventions stating, “That’s one of the areas that’s the hardest is that we are kind of grasping at straws sometimes to look at what’s specifically an intervention. And then, I think measuring that intervention is difficult too.” Team
Nav Participant D shared that they are analyzing general outcome measures for students, but spoke to the opportunities to move forward stating, “So that’s kind of like where the rubber hits the road right now. We do these interventions, but we’re not actively monitoring student progress.”

**Communication.**

Informal and formal communication occurring often and through multiple modes of communication was described as a key strength between team members from members of both teams. Communication was coded 17 times across 100% of Team Nav interviews and 75% of Team Trad interviews. It was evident from both teams that consistent, open, and communication through multiple platforms between MTSS team members was a critical and valued component of their team functioning.

Team Nav Participant B discussed communication with colleagues stating, “We constantly see each other, emails, text messages” and “We’re constantly talking to each other.” Team Nav Participant D described it as “an incredibly high level of communication with one another in this work.” Team Trad Participant C supported the other statements stating, “We’re in close communication as all the counselors are in close communication on a daily basis with the administrators that are on the team.”

**Whole Child Focus.**

Both teams emphasized their team’s focus on the child holistically as compared to a focus on just academics or solely behavioral health. This concept was coded a total of 15 times across 80% of Team Nav interviews and 100% of Team Trad interviews. This was a concept that both
teams emphasized as a key foundation for their team functioning and shared purpose. Team Nav Participant B shared, “It’s an overall childcare as far as looking at their overall self” and stated:

The goal, ultimately, is to try to get these students help to try to get them to be successful not only in school, but as a soon to be functioning adult with their mental health. That is always the goal. That is what we’re trying to do.

Team Nav Participant C echoed these sentiments, “Our goal is to keep everybody safe, to keep everybody healthy,” and “To get students to be as successful as they can while they’re in the school setting.” Team Trad Participant C discussed the vision of the team with a holistic approach, “To keep anyone from slipping through the cracks,” and that this work was focused on “students who are at risk in some area, whether that be academic or social emotional.” Team Nav Participant D discussed the goal of “ensuring that we’re providing the best possible care for these young persons” and working for them to have “this felt sense of safety,” “sense of belonging,” and “feeling the best they can be and that we’re doing everything we can to make sure that those things happen.”

While the message was consistent about the Whole Child Focus for both teams, it’s unclear how the separation of the academic and behavioral health MTSS teams impacts the ability to truly be whole child focused. It was evident that Team Nav still focused on supporting academic success and acknowledged that to be a primary goal, but it’s possible that the team experiences communication or alignment challenges as a part of the siloed nature of the bifurcated team approach. It seemed like the whole-child focus certainly meant something different to each team member and whole-child focus likely falls on a continuum. Both teams perceived and communicated that they took a whole-child approach, but the analysis of the data
certainly felt like Team Nav focused much more on behavioral health and Team Trad leaned much more to the academic side of the work.

**Individualized Support.**

The importance of Individualized Support was consistent throughout the individual interviews with both teams. Individualized Support was coded 18 times across 80% of Team Nav Interviews and 100% of Team Trad interviews. The message delivered by both teams was consistent in emphasizing the importance of personalizing the approach and intervention to the individual student and their needs and circumstance. Team Nav Participant D summed this up saying, “How does the team meet the needs of students? That completely depends upon the kid,” Team Nav Participant E emphasized this stating, “We are very student driven. Obviously, that’s the whole goal of it,” and Team Trad Participant B said, “It’s individualized to the student and their needs.”

While the value of individualized support and intervention was communicated, the lack of interventions available within the walls of the school was consistently communicated as an opportunity for improvement in team functioning by both teams. The team members described consistently being able to connect students and families with behavioral health resources available in the community, but struggling with options for behavioral health interventions they could implement with students at school. Team Nav Participant B emphasized this:

I think this is another thing that's kind of missing is the implementation piece. We're talking about a lot of these things. I don't know that we're in a standard tiered model. You know, so we are talking about these things, but we don't necessarily implement which is I think the biggest issue. What we need to be doing is actually implementing things into the
classroom, implementing things for the students like, we get them hooked up with outside resources, but I think it needs to be more of a tiered level.

Team Trad Participant A shared concerns about limited intervention option:

As far as choosing the correct intervention, I mean it can be anything from just a weekly check-in to, you know, at the high school level you don’t really get like a daily signing your agenda. We don’t really do that much stuff here.

Members of both teams shared a recognition of the need for increased expertise regarding student behavioral health interventions and the need for more options to support students. The challenge with identifying appropriate interventions and the missing intervention expertise was described by Team Trad Participant C:

I think having a person, whether that’s the mental health person or even another education person, who could share more expertise in the areas of actual interventions to put in place. I think that’s where we get the most stuck with helping these kids move forward.

**Time Constraints.**

The challenge of not having enough time, particularly time with students in which they wouldn’t be losing academic time and time for teachers within their schedule to engage in the MTSS team process when they don’t have students was discussed across both teams. Time Constraints was coded 9 times across 80% of Team Nav interviews and 50% of Team Trad interviews. The message was clear that time available for students and professionals to engage in this work is a major challenge for the functioning of these teams. When discussing opportunities for improvement and wanting to do more, Team Nav Participant B stated:
You know, a student, an individual student plan to implement and we don’t really collect
data. It's just…That would be very hard because that would be such a large undertaking
that it would probably need more than just us and more time and someone more specific
who could actually focus strictly on that.

Team Nav Participant C discussed the challenges of busyness, “We get the job done, but
we’re all super busy. This year has been really busy for us.” Team Nav Participant D discussed
the team having a great understanding of roles and responsibilities, but recognized time as the
challenge in saying, “The only dialogue you’ll see often times in terms of like responsibilities is
whether or not someone has the bandwidth or the capacity to take on something additional.”
When discussing the impact teacher perspective could make for the team, Team Nav Participant
D talked about why this isn’t currently happening stating, “Unfortunately, it becomes a matter of
scheduling and when time is available.” When discussing challenges of time to work with at-risk
students, Team Trad Participant D shared:

Time is always I think the one thing that a high school student is going to be challenged
by, because the day is so rigid in terms of when are you supposed to be in first period and
when are you supposed to be in second period and so extending those times with the
teacher or taking away time from another teacher creates a lot more conflicts and high
school teachers tend to be pretty guarded as far as the amount of time that they do get
with an individual student. So, the... a lot of the solutions could be managed with a little
extra time here and there, but you have to really be careful to balance that.
Differences

Team Cohesion.

Specific to the MTSS team implementation of interventions, it was evident that team cohesion was an essential component of their functioning. While the message communicated from both teams was consistent in the tremendous value of team cohesion and how critical team cohesion was to their functioning, Team Nav referenced this code 24 times while Team Trad mentioned the code 7 times. Team Nav discussed team cohesion in 100% of interviews while Team Trad discussed team cohesion in 75% of interviews. While there was a difference in emphasis the value and communication of importance remained consistent across both teams. The primary elements of team cohesion were shared by both teams and included pursuing shared goals, the recognition and value of diverse skillsets and expertise, and providing support for one another.

Team Nav Participant E discussed the team cohesion in the pursuit of a common goal stating:

I feel like that’s kind of been our vision is to try to pull the people together, these individual people who are all interacting with those students, together and build a game plan so that everyone’s doing and moving us, moving the student and family toward the same thing.

Team Trad Participant C further supported the idea of shared goals explaining, “We kind of are always coming together, making sure we have close tabs on those students, and coming together for more thoughts on how we can help those students.”
Members of both teams emphasized how key the representation and sharing of diverse skills and knowledge was to their team functioning. Members of both teams expressed how the diversity of team skills and expertise represented on their team allowed them to support students better than any of them could individually. Participants talked about the different perspectives and expertise that individual team members contributed to the functioning of their team and how they often collaborated on individual student situations outside of regular meeting times. Team Nav Participant B shared, “We also collaborate individually, often. Even with the counselors, amongst each other, we bounce ideas off of each other. Like, ‘Hey, I have this student, this situation. Have you dealt with this? How do we move forward?’” The strength of the diversity of skills of the team was reinforced by Team Trad Participant A stating, “I think everybody, each one of those team members kind of bring something different to the table.”

Members of Both Team Nav and Team Trad discussed how critical supporting fellow team members is to the functioning of their teams. It was evident from both teams that the support from their team members was key to their ability to engage in this difficult work. Team Nav Participant C discussed the support team members provide for each other when stating, “We’re really respectful and just try to be a part of the team and plus give each other support, which is really key.” Team Trad Participant A discussed how critical support for each other is to feeling valued as a team member stating:

I mean the people that I work with, we communicate well. We talk a lot. I’ve been other places where that doesn’t happen all the time. So, I think I can appreciate, like really feeling a part of the team. And, when I give input, that it is valued, and people trust like he’s done his job to really get to know this kid and to really try to understand what this kid’s going through. I do feel like I’m a piece of, a part of, this team and it’s valuable.
Behavioral Health Screening.

Behavioral Health Screening was the most significant difference between the two teams. Team Nav referenced behavioral health screening 10 times across 100% of interviews and Team Trad mentioned it 4 times across 75% of interviews. Both teams discussed behavioral health screenings, but the emphasis and the message delivered by each of the teams was very different. Team Nav engaged students in universal behavioral health screenings and Team Trad didn’t use any universal screening instruments with students. Team Nav discussed both universal screening measures and brief screenings for students that are referred to the school navigator to identify needs before being connected to treatment and/or community resources. Team Nav Participant A discussed universal screening:

We’re all part of the SOS stuff with freshmen or when we do mental health screeners throughout the year, which I don’t know how many we’ve done this year. But, sitting down reviewing that and cross-checking kids that are flagged on the screeners versus kids we already know that are in supports to see if there’s anyone that we need to help connect.

Team Nav Participant D shared “Traditionally, the building has screened students and then use that risk screening data to identify which young persons are at risk and require a follow up screening, you know, for basic mental health needs, things like that.” Team Nav Participant B discussed the screening, brief intervention, and referral to treatment process “that makes determinations about whether they get into services.”

Members of Team Trad were consistent in sharing that they didn’t conduct universal behavioral health screenings with students. Team Trad Interview A stated, “I don’t know if we
have like an official screening” and Team Trad Interview C emphasized that saying, “We don’t have any universal screenings that will result in referrals to the team. We don’t use that.”

Data.

Data was a consistent code referenced 26 times across 100% of both teams’ interviews, however, the emphasis on this code between the two teams was certainly different. Team Nav referenced this code 18 times and Team Trad mentioned it eight times. The primary difference was that Team Nav discussed collecting and utilizing student behavioral health screening data and Team Trad didn’t. The participants’ message regarding the use of data, acknowledging a lack of and need for more formal data processes, the primary data collection being a running log of students, and the need to collect outcome data was very consistent between the two teams. Members of both teams discussed the use of the following data points; anecdotal, academic, attendance, and discipline. When discussing the use of anecdotal data points in combination with school performance and attendance data, Team Nav Participant A stated:

We’ll look at things like school attendance, teacher feedback, but it’s not…When I think of data I think of like numbers and that type of stuff. A lot of it is anecdotal, like, “What are parents saying? What are teachers saying?”

Team Trad Participant B said, “We usually check grades, attendance, and then anything we can add.” Team Nav Participant A said, “that kind of data…attendance, discipline, referrals, and then obviously any screenings that we do like with SOS and that type of stuff.” It was clear that beyond screening data that Team Nav collected to determine student need, neither of the teams were collecting additional behavioral health specific data or monitoring the progress of interventions beyond these measures and anecdotal team analysis of progress.
Both teams discussed their informal data tracking as a running log or spreadsheet of students and interventions until they no longer needed to be on the list. Both teams described the measure of success being when the student no longer needed to be on their list, but they described the determination as a subjective determination by the team. Team Trad Participant A shared, “The biggest way is we have a running log of every kid on the intervention piece.” Team Nav Participant A said, “We keep a spreadsheet, or we enter it into our student data system as to what supports they’re receiving.” Team Trad Participant B said, “We have that running document that says, you know, this is what’s going on.”

Both teams shared a consistent message of limited data collection. Both teams recognized that their team didn’t collect an abundance of data around youth behavioral health, particularly recognizing the lack of outcome data for interventions. Team Trad Participant D summarized the lack of data stating, “Mostly grades and discipline referrals is about the only data that we’re going to have.” Team Nav Participant E discussed data challenges sharing:

I would say that is a downfall probably of it. Other than, it’s probably more anecdotal of us coming back together in those biweekly meetings like, you know, do we have them connected to services? Are we seeing like, what are grades looking like? What’s attendance looking like? Or you know, how are we functioning in class?

Team Nav was the only team that discussed the use of student screening data, but both teams explicitly emphasized the need for improvement in collecting student outcome data and measuring the success of the interventions that they implement. Team Nav Participant D discussed success in collecting higher order, more global outcome data for the student data to monitor improvement such as suicide screening data but acknowledged the need to focus on
student level data and outcome monitoring. This participant shared, “That’s kind of like where the rubber hits the road right now. We do these interventions, but we’re not actively monitoring student progress.”

**Teacher Involvement.**

The missing puzzle piece of teacher involvement in the work of the MTSS team beyond just making a referral to the team, was clearly a critical factor for the participants in this study and negatively impacted the functioning of their teams. Teacher Involvement was coded a total of 19 times, seven out of the nine participants discussed this, and the resounding message was that teachers spend the most time with students and know them better than most school staff members. Participants were confident that teacher participation on the MTSS team would result in improved team functioning and better outcomes for students. However, challenges that prevent full participation on the MTSS team included scheduling, time constraints, and the number of students each teacher serves. While the message was consistent from both teams, the emphasis placed on Teacher Involvement was quite different with this being coded 13 times across 100% of Team Nav interviews and 6 times in 50% of Team Trad interviews.

Team Nav Participant D stated:

> I think it would be good, and scheduling is always the great equalizer in all of this work, I think it would be good if we had some teacher representation on that team and I imagine if you ask those, you know, the rest of the team members, they would probably say the same thing just to bring that perspective to the table. And quite frankly, unfortunately, it becomes a matter of scheduling and when time is available…At the end of the day, I think we really need to have some teacher representation on that team.
Team Trad Participant C was discussing opportunities for team improvement and said, “I think if we had, I think it would be great and potentially more effective, if we had like a teacher representative actually be a part of these meetings.” Several participants also noted the ability of a teacher to support students in a way that minimizes the impact of the behavioral health challenges that students face in the school setting. Team Trad Participant A said:

Kids can be different from classroom to classroom. So, if they have a great relationship with one teacher, we’re never going to hear from that teacher. They’re going to do well in that class. The teacher pushes the right buttons to motivate them and that kind of thing, as opposed to, you know, they might not have a great relationship with their very next class, so that teacher sees something totally different.

The overwhelming message from both teams regarding Teacher Involvement was that active and consistent teacher participation in the work of the MTSS team could result in more effective functioning of the team and result in improved student outcomes if the barriers could be overcome.

**Administrator Involvement.**

Administrator Involvement was coded 16 times across both teams; however, it was present in only 60% of Team Nav interviews compared to 100% of Team Trad interviews. Team Nav mentioned this code 6 times while Team Trad discussed it 10 times. Both teams discussed the support of administration and a level of participation, however, it appeared that the administrator involvement with the MTSS Team Trad was greater than that of Team Nav. However, it both situations, it seemed that the other team members definitely carried the responsibility of the majority of the team work and were responsible for keeping the
administrators informed. Team Trad Participant D shared, “The principal heads up the team, but I think for the most part, they expect that we are going to be aware of every, every facet of it and put them in the loop when they need to be.” In contrast, a member of Team Nav shared that a school psychologist led their team and facilitated the meetings. Team Trad Participant B discussed communication with the administrator stating:

I stay in constant communication with my administrator, in particular about students, so he knows what I am doing so that we’re on the same page. If there is something I’d like to try, I run it past him first to make sure he’s on board and then we move forward with that plan.

School Connectedness.

Prioritizing school connectedness for students including staff building relationships with students was a key theme throughout conversations with both teams. This concept was coded 23 times across six participant interviews. While it was coded 10 times across Team Nav interviews it was only referenced by 40% of participants whereas it was coded 13 times in Team Trad interviews across 100% of participants. Team Nav explicitly discussed the concept of school connectedness. Team Nav Participant D emphasized how important this goal is for their team stating:

I mean, at the end of the day, we want kids to feel like they have this felt sense of safety, a sense of belonging with their broader school community and typically, that they can be the best that they can be because you know, if we do those things right, everything else kind of falls into place. Especially with what we know around school connectedness and how young persons are engaged within their school community.
Whereas Team Trad tended to focus solely on the relationship building aspect of school connectedness between staff and students. Members of both teams explicitly discussed how critical positive relationships with school staff is to student success and the work of their teams, specifically students having at least one trusted adult that they can go to.

Team Nav Participant A discussed the importance of school connectedness to the team’s work stating:

I feel like a lot of it is just trying to get these kids the support that they need. On the same hand is having a trusted adult they can talk to and go to whether it’s their guidance counselor or we all love NAME OMITTED, because she works so well with students and families. A lot of these kids don’t have that…a lot of them do too.

It was evident that this is the heart of the work that these teams engage in; truly caring for the students that they serve. Team Trad Participant B also highlighted how critical it is for school staff to build relationships with students involved in their MTSS work:

You know, we know our students that are on this list. They’re not just random names given to us, so getting to know these students, building rapport with them, and investing in them. That’s a big part of meeting their needs. It’s just being that positive adult in their life.

**Figure it Out Mentality.**

The Figure it Out Mentality was coded a total of ten times across five of the interviews and was present within both teams. The message was consistent, however the emphasis on this concept was not. The Figure it Out Mentality was coded 8 times across 80% of Team Nav
interviews and only 2 times across 25% of Team Trad interviews. The participants described the challenges of determining appropriate mental health interventions that were not black and white and the team doing the best they can to support the student with the people and resources they have. Team Nav Participant A describes the challenge of determining behavioral health interventions for students stating:

   It’s a team decision, especially with mental health. It’s so hard to have, like cut and dry. Like when I give an academic test, I can get a score and be like, okay, this warrants a certain amount of stuff. But with mental health, it varies person to person. So, a lot of times, it is a team decision determining what kind of supports the student might need.

   Team Trad Participant B echoed these thoughts about doing the best they can with the resources they have by sharing. “For your most severe cases, you, it’s just a case-by-case situation. You got to look at what’s best for the needs of that student.” When talking about doing what you can with what you have and how it would be ideal to involve more community partners, Team Nav Participant B shared:

   We just are kind of in this bubble of like okay we hit the ground running, we go, we go, we got testing, we got this, we’ve got that. So, it can be really hard, you know, and it’s not the community’s fault and it’s not our fault. It’s no one’s fault. It’s just, we get in this bubble of okay, take care of this right now.
Research Question 3: How does the school team facilitate linkages to community behavioral health services for students with behavioral health struggles? (Community Level)

For research question three, I focused on the microsystem as defined by Bronfenbrenner’s Bioecological Model of Human Development. I wanted to understand the MTSS teams’ perspectives on the connections between the school and community systems and how the team functioned to facilitate linkages to community behavioral health services. Table eight describes the codes related to research question three, number of times coded, and the percentage coded across both teams.

**Table 8**

*Code similarities and differences related to research question three: How does the school team facilitate linkages to community behavioral health services for students with behavioral health struggles?*

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**Similarities**

**Barriers.**

Barriers were commonly discussed by participants across both teams. This code was referenced 22 times across 100% of participants: 13 times by Team Nav and 9 times by Team Trad. The common barriers discussed by both teams included the team composition, time, and
team processes. When speaking about team composition and missing team involvement, both teams discussed the barriers to teacher involvement as an integral part of the team. Team Nav Participant A stated, “It’s also difficult because there’s a large population. In order to kind of have eyes on every student, you’d need to involve a ton of teachers.” Members of Team Nav also discussed the need to engage parents more in the MTSS process. Team Nav Participant C shared, “What we could do better is…I think get parents on board. I think that’s a tough one for all of us to do.” Team Nav Participant E discussed the need to formalize the work to better engage both teachers and parents in the MTSS process. Team Trad Participant C discussed the need for the inclusion of someone on their team that could bring more behavioral health intervention knowledge to the group. This participant stated:

What is a tier 2? If they’re to the point, we’re already at a tier 2. What is tier 3? What is something really concrete that we can do and measure? Having some type of someone in a skillset of that area, I think would definitely make it more effective and it’s something we’re lacking.

The challenge of time in regard to the functioning of the MTSS teams was emphasized by participants on both of the teams. The teams talked about the limited time available with students and the limited flexible time high school students have in their schedules. Team Trad Participant A said, “I feel like there’s always kids that you’re going to miss just because these kids are different and we have over 2,000 kids in this building.” Team Trad Participant D shared, “Time is always I think the one thing that a high school student is going to be challenged by, because the day is so rigid” and “A lot of the solutions could be managed with a little extra time here and there.” The participant further stated:
It’s difficult to take a kid that’s an at-risk student and isn’t going to do a lot of work at school as a general rule, and then with all the positive and good intentions say, hey, can you stay after school?

The challenge of time was also discussed in relation to the limited time that staff have to devote to this work given the other duties that they are charged with. Team Nav Participant B said, “I think Where we fall short is, there can be a large list with a lot of kids and not enough time and all the other requirements we’re dealing with.” Team Nav Participant D shared, “Scheduling is always the great equalizer in all of this work.”

Team processes were discussed by participants of both teams as a barrier to optimal team functioning. The key consistent team processes discussed was challenges with the implementation of true tiered intervention and formal workflow versus people-dependent processes.

Team Trad Participant C discussed the missing implementation of tiers of support stating the need for, “More expertise in the areas of actual interventions to put in place. I think that’s where we get the most stuck with helping these kids move forward.” Team Trad Participant D shared that, “High schools are not designed for RTI at all.” Team Nav Participant D stated:

It really boils down to workflow and process, right? Like, making things systematic. So, we have a lot of people dependent things going on here where if I took those individuals out of the mix, that aspect of the system would probably collapse which is not good. We don’t want to be super people dependent. It's good to have great people, but we don't want to be people dependent. We want to be system and framework dependent and so really, for us, the next legs of the work is going to be focused on how do we systematize the
things that we're doing, how do we standardize it, how do we, you know, essentially do a few things very, very well, so that even if we had people leave or, you know, changes in leadership or changes in personnel, the systems and structures would persist and continue to stand?”

**Community Relationships.**

Community relationships were discussed a total of 11 times across all of the interviews. This was coded 7 times for Team Nav and 4 times for Team Trad. The message communicated within this code was interesting because both ends of the community relationship spectrum, from strong to struggling, were presented by members of both teams. However, the primary message was consistent within this code that both school teams struggled with feeling disconnected from many of the community resources and partners and acknowledged that it was by no fault of either party, but it remained a challenge. However, members of both teams also discussed how critical and important the community partnerships and relationships were to the work of the MTSS team.

Team Nav Participant D discussed the strength and success of community partnerships:

Phenomenal. Like we could not do the work that we do without our community partners. It’s impossible for schools to do this work alone, so to have partnerships with our Mental Health and Recovery Board and BH provider NAME OMITTED and even our prevention agency, Agency NAME OMITTED, they make everything much, much, much, much more manageable and easier for us to actually and engage in this work. Schools can’t do it alone, so we’re very thankful for our partners.
Team Trad Participant D discussed the strength of community partnership specific to one of their team members saying:

I think there are members of our team that have very position relationships with community organizations. I personally do not have in-depth ones. I think it’s a phone call away….Without using employee names, that is our linkage to our community.

The majority of feedback from participants discussed the feeling of disconnection from community partners, but a willingness and openness to work with any available resources. Team Trad Participant C said, “You know it’s interesting, we don’t have a lot…we don’t have a lot of community partnerships.” Team Nav Participant B stated:

We always say this, like we would love to get involved with more community, but we just are kind of in this bubble of like okay we hit the ground running, we go, we go, we got testing, we got this, we’ve got that. So, it can be really hard, you know, and it’s not the community’s fault and it’s not our fault. It’s no one’s fault.

Members of both teams discussed the difference between connection to resources available within the school building compared to those community resources available outside of the school building. Team Trad Participant A shared:

I would say we’re very close with the agency that’s in the building. As far as outside, it’s a little more difficult I think. I don’t feel as if we communicate all the time with those.

Team Nav Participant B said, “I think we feel a little disconnected from the community,” and stated, “It’s just easier to have someone in your building that you can talk to and to bounce ideas off of.”
Differences

Behavioral Health Resources.

Behavioral Health Resources was coded 31 times across 100% of all interviews conducted. However, Team Nav mentioned Behavioral Health Resources 24 times, whereas, Team Trad only discussed it 7 times, so the emphasis on behavioral health resources certainly varied between the two teams. The primary discussion around behavioral health resources from both teams was treatment services available within the school provided by the community behavioral health provider. For Team Nav this was referrals to school navigation and for Team Trad this was referrals to the behavioral health therapist. For Team Trad, this is the only resource that they discussed. However, Team Nav shared their knowledge of many more resources and referral pathways. It is unclear whether this stark contrast is because Team Trad doesn’t have as many options available or if they are just not aware of the diversity of services available to their students. Resources that were discussed by Team Nav that were not discussed by Team Trad included crisis lines, screenings, service coordination, and wraparound team meetings.

Both teams certainly focused on referrals to the behavioral health professional located in their school building. Team Nav Participant A shared, “We rely heavily on the school navigation component” and Team Nav Participant B shared, “We’re going to refer them to counseling.” Team Trad Participant A stated, “We have an outside agency that is here in our building,” and Team Trad Participant C discussed the memorandum of understanding with the counseling agency to “provide therapists in our building.” This participant said, “I will say that the mental health therapy is probably the biggest outside agency with work with and refer students to.”
Beyond referrals to therapy, Team Nav discussed much more diversity in student behavioral health resources, referrals, and intervention that their team works to get students connected to. Team Nav Participant A, “Most of it revolves around service coordination, school navigation, SBIRT, and then we need to just have an advisor or mentor at school.” Team Nav Participant D shared their typical behavioral health referral pathways:

There's two biggies. One is our school navigation program, which is our, you know, tri-braided partnership between ourselves and LOCAL AGENCY NAME OMITTED and AGENCY NAME OMITTED as our community-based provider. So that that's one avenue for behavioral health that we'll refer to. The other, and this is a more recent one, just because the programs exist more recently. Really, OhioRISE has been our other platform that we've referred students to for services and typically, that's an intense referral. That's a young person that has like systemic and multimodal needs that they need to have address beyond just behavioral health that if they do have behavioral health needs, they're usually very severe.

Team Nav Participant E also discussed behavioral health crisis line resources for families and additional community-based resources including wraparound and local counseling resources. One participant from Team Nav discussed treatment services happening in the school-setting provided by school personnel. This was unique and was not a concept that was presented by Team Trad. Additionally, multiple members of Team Nav discussed the service coordination process and the MTSS team’s role in understanding the behavioral health needs of the student and connecting them to the appropriate level of service. Team Nav Participant D discussed behavioral health resources within the school stating:
We've got two avenues where we roll with when it comes to student intervention. One is just getting you involved in school stuff and the other is therapeutic services and that's if it's with like our school psychologist that's going to come through like EBP NAME OMITTED and she has her own...like she's going to work through her data to determine like, this is my jumping off point for this young person during intake and getting to know them and what other assessment information lives out there.

Related to services happening within the school, this participant discussed the service coordination mechanism and the ability of this team and process to get students connected to behavioral health screening and working to understand the needs of the student.

**Access.**

Access was coded 14 times including 8 times from participants on Team Nav and 6 times from participants on Team Trad. The primary difference in the emphasis on access was that this code was discussed by 60% of Team Nav and 100% of Team Trad. The message communicated by both teams around access was consistent in the importance of accepting referrals at any time, having a process for behavioral health assessment, and shared struggles with access to resources that aren’t located in the school. Both teams shared that accepting referrals from anyone at any time was critical to their team functioning. Both teams discussed that anyone could bring up a concern about any student at any time and the team would respond accordingly. Team Trad Participant B shared, “You can take referrals at any time” and “Referrals can come from any one person or from any direction.” Team Nav Participant D said:

There is no gatekeeping or time locking of referrals. It is as easy as, hey, I’ve got a kid I’m really worried about. I’m going to pick up the phone and make a call. And that’s that.
Both teams discussed the process for students to access behavioral health assessments, however, possibly because the school navigator was part of the MTSS team, Team Nav discussed more of the specifics about the process whereas Team Trad participants spoke in more general terms about a referral to an assessment. Team Nav Participant D shared:

That’s a young person we’re going to want to get connected with their school navigator to see if there’s further pervasive mental health needs that exist there. And as we’re, as prescreening comes in, it potentially kicks off other forms of assessment after that. And then beyond that, it really boils down to either a diagnostic assessment if there’s a referral to treatment, even in some instances, if the needs are so pervasive that they’re impacting multiple dimensions of a young person’s life here at school, maybe an evaluation for special education services.

Whereas, Team Trad Participant A stated:

We have an outside agency that is here in our building, so we have two counselors that come in here. They’re here every day. They actually, when they have a waitlist, which is often, they have a couple places that they also recommend or refer.

Both teams discussed that despite doing their best to stay connected with resources outside of the school, it can be challenging to do and that this can impact access to services for students. Team Nav Participant E said:

I feel like if we had like a source person who knew everything outside of here, because sometimes I feel like even though you’ve been doing this job for a long time, people
change, departments change, different things that are offered change, and different ways to access things change.

Team Trad Participant A emphasized this challenge stating, “As far as outside, it’s a little more difficult I think. I don’t feel as if we communicate all the time with those.”

**Proximity.**

Proximity was coded 20 times across 100% of participants on both teams. However, Team Nav emphasized how important this was to their team functioning at a greater level with this being coded 14 times in comparison to 6 times for Team Trad. The participants from both teams emphasized that their most utilized behavioral health resources were those available to students and located in the school building. Participants cited the ability to collaborate with providers and monitor the service when it is located in the school as one of the primary contributing factors. Both teams referenced feeling more disconnected from services outside of the building.

Team Trad Participant B emphasized their preference for using behavioral health resources in the school building stating:

I like that resource, in particular, because we can, you know, talk with them if there’s a release and that kind of gives us that holistic team approach to help students be successful. But, I kind of stick with the resources that are available here, because then I can kind of keep an eye on those resources.

Team Nav Participant B discussed feeling more separated from services in the community stating, “The other community stuff…sometimes, I think we feel a little disconnected
from community.” A participant from Team Nav shared concerns about the need for more diverse options of behavioral health resources being provided in the school setting. This participant discussed the concern of conducting behavioral health screenings and identifying needs, but not having the diversity of services to meet those needs. Team Nav Participant A shared:

I will say sometimes there is a little bit of frustration on more of the guidance counselor/building side of it, because a lot of times I feel like we do a ton of screeners and we can flag kids, but sometimes, it’s like, where are the resources to support these kids that need help? Especially within the building.
Chapter 5: Discussion

There is a scarcity of research around the composition of school mental health teams and we don’t know enough about how school mental health teams function in real-life contexts (Reaves et al., 2021). This study aimed to target this gap in the research by gaining an in-depth understanding of the functioning of the two MTSS teams that participated in this study in the midst the real-life challenges and complexities of the difficult work they do in public high schools. I aimed to identify the differences in MTSS team functioning with and without a school navigator when the team is addressing student behavioral health needs. This study provides valuable information about what the functioning of MTSS teams can look like in a school including how the students’ behavioral health challenges are manifesting, how the team identifies students and designs behavioral health interventions, and how teams collaborate and facilitate linkage to behavioral health services within the community for students with behavioral health struggles.

Research Question 1: How are students’ behavioral health challenges manifesting in the context of MTSS referrals?

As presented in the results of this study, Identifying Student Needs was critical to the functioning of the MTSS teams. Team Nav and Team Trad both shared that student behavioral health needs are manifesting to the MTSS team in the form of student behavior change, anxiety, academic challenges, and high acuity behavioral health needs. These findings illuminate the
reality of MTSS teams experiencing increases in youth behavioral health needs emerging in schools. This experience is supported by the national estimates of 20-40% of youth needing behavioral health services and more than half of those youth not receiving them (Becker et al., 2015; & Merikanagas et al., 2010). Furthermore, both teams described students presenting to the MTSS teams with high acuity behavioral health needs and this is supported by the Center for Disease Control and Prevention’s findings of an incredibly concerning 76% increase in youth suicide for high school students from 2007-2017 (Curtin & Heron, 2019). Related to an Increase in Behavioral Health Needs, both teams emphasized the increase in these needs being monumental and shared that the school districts and MTSS teams have responded by adjusting the work they do to meet the needs of students and families.

The importance of school staff members identifying behavioral health needs of students was consistently emphasized across all the interview participants. Adult identification of needs was critical to the functioning of both MTSS teams with particular emphasis placed on how well the teachers and school counselors know their students and the needs of those students. While adult identification of student need can be an important strategy, researchers have found that universal behavioral health screening for students allows for earlier identification of behavioral health challenges (Dowdy et al., 2015; Moore et al., 2022; Weist et. al, 2018). I found that only the MTSS team with the school navigator utilized universal screening and even that team still highly prioritized adult identification of student needs. While Team Nav engaged in universal screening of students, Team Trad relied on adult identification of student challenges as the primary pathway for student referrals. While students exhibiting changes in behavior and experiencing higher acuity behavioral health situations might be clear for adults to identify due to externalizing behaviors, evidence suggest that students with anxiety will often present in a less
observable manner that makes an approach void of universal screening particularly problematic (Weist et al., 2018). The emphasis on academic performance was tremendously different between the two teams. While Team Nav tended to focus on academic challenges as one data point that contributed to their analysis of student need, Team Trad presented academic performance as the primary indicator that the MTSS team utilized to determine student need and resulted in the most referrals to their team. The primary focus on academic changes and indicators is concerning due to the escalating needs of student behavioral health and the importance of utilizing a more preventative and proactive approach to student behavioral health needs (Dowdy et al., 2015; Moore et al., 2022 West et al., 2018).

While previous studies have found that youth and family involvement in services results in improvements in functioning and symptom reduction (Becker et al., 2015; Garbacz et al., 2016; Splett et al., 2017), my findings demonstrate that in the real-life school context, the MTSS teams had very limited involvement from students and experienced challenges engaging families to obtain consent for behavioral health treatment. The consistent message from study participants was that students were not currently engaged with the MTSS team work, but participants felt that student involvement would improve the functioning of their team. It could be possible to engage students at different levels including involvement in their individual connection to behavioral health services, providing insight about student needs and their experience, or more broadly through involvement in planning and implementing mental health promotion activities (Atkinson et al., 2019). While both teams acknowledged that families need support in addition to students, they expressed concerns about the limited impact the MTSS team can have on the challenges families are experiencing. Family challenges cited by participants included socioeconomic struggles, housing instability, and adult substance use concerns. Team Nav also discussed
challenges with obtaining consent for behavioral health treatment and challenges with families’
levels of engagement in their child’s behavioral health services. This is concerning given that we
know family involvement results in behavioral health symptom reduction and improved
behavioral health outcomes for young people (Becker et al., 2015; Garbacz et al., 2016; Herman
et al., 2011; Splett et al., 2017)

In summary, student behavioral health needs are increasing in schools and are presenting
most often to the MTSS teams involved in this study in the form of student behavior changes,
anxiety, and high acuity behavioral health situations. The team that included a school navigator
engaged in universal behavioral health screening to identify students that were at-risk for
behavioral health challenges or needed intervention. While both teams relied on adult
identification of student needs, this was the only referral source utilized by Team Trad. Team
Nav utilized a more diverse data set while Team Trad relied heavily on academic data to identify
need. In current practice, neither team included strong involvement from students or families in
the work of the MTSS team. Both teams acknowledged the tremendous number of families that
need support in addition to services for their child and the challenges the team faced in trying to
overcome this. Team Nav shared the additional challenge of obtaining consent from parents for
student behavioral health services and difficulty engaging families as a part of those treatment
services.

**Research Question 2: How does the MTSS team identify students and design collaborative
behavioral health interventions?**

In order to interweave the typically siloed systems of school and community mental
health, it is necessary to make changes to how school staff and mental health clinicians function
(Dowdy et al., 2015; Mellin et al., 2010; Weist et al., 2018). According to Weist et al. (2018), to
truly create an integrated behavioral health system in schools, it is imperative for community mental health clinicians to be active on MTSS teams and all available behavioral health interventions should become part of one integrated system. The findings of this study suggest that structure, division of labor, data and evaluation are key challenges for the functioning of MTSS teams in the context of these two public high schools. This study demonstrates several differences in the functioning of an MTSS team when it includes a community-based mental health professional (school navigator) fully integrated into the team. However, I found that the informal structure of the MTSS teams was consistent amongst both teams. Participants on both teams expressed a desire to formalize the work and felt a more systematic structure would improve their team functioning. The consistent message about the team process included roundtable discussion involving managing a running list of students and discussing their needs. The roundtable discussion team process is concerning given that school psychologists have cited the amount of time in meetings spent just discussing interventions as a team functioning challenge (Huebner & Gould, 1991). Previous researchers studying school teams that address student behavioral health needs found that the domain with the lowest mean score for their teams was structure followed by focus and communication when rated by participants (Erickson et al., 2015). This study supports that finding with participants’ perceptions of communication being one of the key strengths of their team functioning and structure being one of the primary challenges.

Four characteristics of school and community teams that researchers have identified that enhance team functioning and collaboration include clear team purpose, diverse team composition, having a designated leader, and established processes and procedures (Iachini et al., 2013). This study supported the need for established processes and procedures as both teams
communicated a very informal process and the challenges of a roundtable discussion meeting organization. I found that there is a need to formalize leadership for these teams. Participating teams discussed administrator involvement, however, Team Trad emphasized this concept at a greater level. It was clear that involvement from administration was much greater on Team Trad than Team Nav, but that it was more of an oversight and management level than the direct work. The team leader of Team Nav was not in a formal building leadership position but was universally described as the leader of the MTSS team work. Previous researchers found that teams that were higher functioning, excelled in structure and focus and struggled more with communication (Erickson et al., 2015). I found the opposite for the teams participating in this study as they perceived communication as a primary strength and structure as a key challenge. The message delivered by both teams around team communication emphasized how critical consistent communication between team members is to the functioning of their team.

Team Nav and Team Trad delivered a consistent message regarding the division of labor. They expressed the need for more equity in the workload and the importance of division of duties based on the strengths and expertise of their individual teammates. Even though the use of teams to solve challenges in schools is common practice, they often operate inefficiently and ineffectively, leave school staff dissatisfied, and result in student outcomes not substantially improved (Erickson et al., 2015; Johnson et al., 2020; Splett et al., 2017). Members of both teams discussed the challenge of the tremendous school counselor workload. Systemic issues contribute to these challenges including student to provider ratios far exceeding the recommendations from national professional organizations including the American School Counselor Association, National Association of School Psychologists, and School Social Work Association of America (Weist et al., 2012). Participants from both teams shared that the bulk of
the workload, responsibility for communication and the meeting follow-up work is placed on the student’s school counselor. We know that the translation of behavioral health research into practice in schools requires collaboration between behavioral health professionals and educators (Cappella et al., 2008; Kern et al., 2022; Ringeisen et al., 2003). The division of labor on these teams could be impacted by a stronger presence of behavioral health professionals on both teams and most importantly, on Team Trad that didn’t include any community-based behavioral health professionals. Another essential finding of this study includes an understanding of the tremendous workload placed on school counselors and the pressure they feel as a part of the MTSS teams. Because the outcomes of this work are as consequential as the behavioral health and wellbeing of students, it is concerning that so much of the responsibility is placed on one position instead of a more equitable and shared responsibility. This is key as we know that teams in schools that involve stakeholders beyond school employees can address a more diverse array of student behavioral health needs than those that only include school personnel (Splett et al., 2017; Weist et al., 2012). Strong leadership could be an important component to developing additional community partnerships to invite more stakeholders to the table. Additional community partners might include community behavioral health agencies and service organizations that can provide support for factors such as economic stability that are social determinants of health. While participants shared that community partnerships could be expanded, the findings of this study emphasized the lack of formal leadership involvement in the MTSS teams. Both participating teams communicated some level of building administrator involvement, but it was clear that the leaders of the teams weren’t always in an official leadership capacity. The overwhelming nature and pressure of the responsibility to meet students’ needs communicated by team members participating in this study and the lack of
structure could be influenced by a greater investment of time, energy, and responsibility from school administrators in the MTSS process. Previous research suggests that MTSS teams should be taking a public health approach that balances prevention, early intervention and treatment services (Cooper et al., 2008; Iachini et al., 2013; Merikangas et al., 2010; von der Embse, 2018). A more structured and intentional approach to balancing services across the full continuum of care could inherently involve the full team at a greater level and support a more equitable division of labor.

The message from participants on both teams regarding teacher involvement was consistent in that teacher involvement was a key missing puzzle piece in the functioning of their teams and would improve the functioning of their team. However, Team Nav emphasized this at a much greater level than Team Trad. The lack of teacher involvement in the MTSS teams involved in this study is concerning given that previous research findings indicating that teachers want to support the behavioral health needs of students, but don’t feel capable and confident in their skills and knowledge to effectively do so (Reinke et al., 2011; Walter et al., 2006). Excluding teachers from the MTSS process decreases opportunities to learn about behavioral health services and eliminates opportunities to increase their level of comfort with addressing these skills and needs. This could be impacted by the rigid time constraints on teachers’ schedules. Because of the lack of flexibility in teachers’ schedules, it was impossible for teachers at both schools to meaningfully engage in the MTSS team functions.

While the division of labor and team composition was a challenge, team cohesion was clearly critical to the functioning of both teams even though the emphasis from the teams was different. This concept was emphasized more than three times as much across participants from Team Nav in comparison to participants on Team Trad. The teams consistently emphasized
Individualized Support by discussing how critical personalizing their approach and intervention to the student, their needs, and circumstances was to the functioning of their team. This concept of team cohesion supports the findings from Emmerik and Brenninkmeijer (2009) noting that team similarities in attitudes, values, and beliefs were important for team functioning indicators including team effectiveness, team in-role performance. It was clear that the teams shared a common purpose and felt a strong sense of support from their teammates.

The MTSS team members’ strong connection with their teammates was a strength of both teams. It is not surprising that they desired this sense of connection for their students and emphasized that a focus on school connectedness was a critical component of their team functioning. Team Nav explicitly discussed the concept of school connectedness while Team Trad primarily focused on the goal of school staff building strong relationships with students. This focus area is critical given the power of school connectedness as one of the strongest protective factors against emotional distress and substance use for young people (CDC, 2009). Both teams felt that their teams were functioning with a Whole Child Focus but given the bifurcated approach of Team Nav and the overwhelming emphasis on academics from Team Trad, it’s unclear if each team had a different definition of Whole Child Focus.

In order to understand the needs of individual students, data was acknowledged as a critical part of team functioning. The primary message from both teams was a lack of and a need for more formalized data processes and the need to collect outcome data to analyze the effectiveness of student interventions. However, there was a much stronger emphasis on data usage and diversity of data as a critical component of team functioning from Team Nav than Team Trad. This is critical because we know the lack of effective and efficient use of data and the absence of progress monitoring of implemented student interventions was evident from both
teams. In order to function effectively, teams should be using data to drive decision-making for students in addition to having a process to determine the use of evidence-based programs and practices (Harlacher et al., 2014; Kern et al., 2022; Sailor et al., 2021; von der Embse, 2018; Weist et al., 2018). These teams didn’t consistently communicate knowledge around a broader framework or a process to evaluate selected evidence-based interventions or monitor the progress of interventions that they implemented for students. Beyond the challenges of seeing the big picture framework, they communicated an urgent desire for more knowledge around interventions and implementation strategies to best support their students. The concept of a figure it out mentality was present across both teams but was emphasized at a much greater level across Team Nav participants. The message was consistently related to the challenges the MTSS teams face when determining appropriate behavioral health interventions. Participants discussed doing the best they could with the resources they had. This study demonstrated the figure it out mentality that school teams utilize to meet student needs when they don’t have the formal structure and mapped out tiered system of interventions for students even though we know that these are key concepts to move to a preventative public health approach (Cooper et al., 2008; Iachini et al., 2013; Merikangas et al., 2010; von der Embse, 2018). The primary focus of both teams when discussing evaluation was on the absence of progress monitoring and evaluation of MTSS interventions. Participants from both teams acknowledged that evaluation should be a critical component of their team functioning and should be something they are working toward. Continuous progress monitoring of implemented behavioral health interventions can decrease the effect of educator’s implicit bias on the work they are engaging in for students (DeBoer et al., 2022).
The differences were significant between the teams regarding the concept of behavioral health screening. Team Nav engaged in universal student behavioral health screening and Team Trad didn’t use any screening measures. We know that behavioral health screening is critical to early identification and early intervention for student behavioral health (Dowdy et al., 2015; Harlacher et al., 2014; Kern et al., 2022; Moore et al., 2022; Sailor et al., 2021; von der Embse, 2018; Weist et al., 2018). The concept of screening for behavioral health needs is especially critical for young persons who internalize the behavioral health challenges they are experiencing, because adult identification of need would not be an effective strategy to recognize the students’ needs (Weist et al., 2018). We also know that universal screening presents the opportunity for all students to have access to early intervention if it is needed and creates a more proactive and less reactive service delivery model (Dowdy et al., 2015; Moore et al., 2022). While we know that behavioral health screening results in earlier identification of student behavioral health challenges, without effective team functioning, screening students for behavioral health needs alone might not improve or expand the services available to them (Iachini, 2013; Splett, 2017; Weist et al., 2018; Weist, 2022). While I found that one of the two teams utilized behavioral health screening to facilitate early intervention, challenges with team functioning including structure, division of labor, data and evaluation were clearly communicated by both teams participating in this study. The findings of this research demonstrate that when we study what is happening and how teams are functioning in the context of public high schools, there is still more work to be done in the areas of developing a strong model for implementation of the public health framework and increasing the behavioral health and tiered intervention knowledge of educators.
To summarize, structure, division of labor, data and evaluation emerged as challenges for the functioning of the two high school MTSS teams. The urgent need to formalize the team process, add structure to the MTSS work, and increase the diversity of interventions available for student behavioral health needs was clear. Data usage and progress monitoring of implemented student interventions was acknowledged as an area for growth by both teams. While team cohesion was viewed as a strength for both teams and a key component of MTSS team functioning, there is an opportunity to impact team functioning by addressing team composition and team leadership needs. The approach to identifying student behavioral health needs was a notable difference between the two teams. Team Nav engaged in a more preventative approach utilizing universal behavioral health screening for students and Team Trad took a more reactive approach relying only on school staff to recognize a need for intervention.

**Research Question 3: How does the school team facilitate linkages to community behavioral health services for students with behavioral health struggles?**

Both teams participating in this study emphasized that community relationships were key to the functioning of their teams. The primary message delivered by both teams was that school teams struggled with feeling disconnected from many of the community resources. However, both teams communicated the importance of community partnerships and relationships developed to the functioning of their MTSS team. They praised the strength of their existing community partnerships while also presenting this as an opportunity for improvement. While Team Nav seemed to have a more diverse set of community partnerships, both teams primarily viewed one person on their team as their strongest connection to the community. This is important, because we know that in order to implement a comprehensive school mental health system that is modeled on the public health approach, school staff and community behavioral...
health professionals are going to have to change the way that they collaborate (Dowdy et al., 2015; Mellin et al., 2010; Weist et al., 2018). Strong partnerships between schools and community behavioral health systems will be necessary if schools are going to successfully translate behavioral health research into practice in their buildings (Cappella et al., 2008; Kern et al., 2022; Ringeisen et al., 2003).

Behavioral health resources were discussed across all participant interviews; however, Team Nav referenced this more than three times as much as Team Trad. Team Nav demonstrated a much greater knowledge of the diversity of behavioral health resources available in the community for their students. Researchers have found that diverse team composition and specifically community providers as part of the school mental health team added value to the team and increased the availability of services to students (Reeves et al., 2021; Splett et al., 2017). This finding was supported by my research as Team Nav demonstrated a much greater knowledge of behavioral health resources available for students across the behavioral health continuum, whereas, individual therapy was the only behavioral health resource that was explicitly discussed by Team Trad. The benefits of school teams including behavioral health professionals on service implementation and outcomes for student behavioral health have not been rigorously studied and has been implemented based on theory and anecdotal experiences (Reaves et al., 2021; Walker, 2018). This research illustrates that there were benefits to Team Nav by including a school navigator as a part of their team in comparison to Team Trad whose team composition did not include a behavioral health professional.

Researchers have found that the availability and growth of tier 2 interventions was one of the greatest benefits of schools utilizing an interdisciplinary team to address young persons’ behavioral health needs (Reaves et al., 2021). Tier 2 includes targeted student interventions that
can be facilitated individually but are commonly facilitated in a group setting. Examples of evidence-based tier 2 interventions include check in and check out (Filter, 2019) and Cognitive Behavioral Intervention for Trauma in Schools (Jaycox et al., 2012). This study illustrated a greater diversity of knowledge around student behavioral health services and services available to students for the team that included a school navigator. However, both teams communicated challenges with minimal tier 2 resources being available in their school. Even the team that functionated with a school navigator communicated that tier 1 (universal) and tier 3 (intensive) services were more available than tier 2 services. This study reinforced the need for stronger tier 2 services in schools as we know there should be a continuum of Tier 2 interventions to respond to the diversity of challenges students face (Weist et al., 2018). This underscores the urgent need to move to a more preventative and proactive approach that includes a structured system of tiered student supports (Dowdy et al., 2015; Iachini et al., 2013; Moore et al., 2022; von der Embse, 2018) as desired by both teams that participated in this study.

Effective and fully integrated evidence-based treatment in schools allows for earlier identification of students, a higher chance of those students receiving the needed treatment and provides the necessary treatment in a more natural setting as compared to a behavioral health facility (Cooper et al., 2008; Iachini et al., 2013; Merikangas et al., 2010; von der Embse, 2018; Weist et al., 2022). These findings support the critical need to provide more diverse treatment in the school setting versus relying only on one community behavioral health referral source. Previous research tells us that a common school behavioral health model includes having a clinician co-located in the school district, but essentially, that provider functions independently and separately from the school mental health initiatives (Dowdy et al., 2015). We know that when implemented in schools, this co-located behavioral health model is a reactive approach that
often necessitates students having more intense challenges before a referral is made and results in less improvement in student outcomes as compared to integrated approaches (Dowdy et al., 2015; von der Embse, 2018; Weist et al., 2022). The findings of this study demonstrate that this model is being utilized in practice and reinforced previous researchers’ findings because Team Trad did not demonstrate the utilization of a preventative approach and was not implementing any universal behavioral health screening for students. The reactive nature of this approach was further demonstrated through the full dependance on school staff members’ identification of student needs to recognize students in need of interventions. Furthermore, the reactive nature of this co-located model was further emphasized because the behavioral health professional co-located in the school was not an active participant on the MTSS team. Additionally, Team Trad demonstrated a much more limited knowledge of the available student behavioral health resources.

The two teams demonstrated a different level of knowledge about the behavioral health services available for students, however, both teams acknowledged that they were most likely to connect students to the behavioral health counselor that provided services located in their school building. The teams discussed accepting referrals at any time, a process for behavioral health assessment, and challenges with access to services located in the community. This study found that proximity was a key concept for both teams. They identified their most utilized behavioral health resources as those resources that were available to students and delivered while at school. Both teams cited the ability to monitor the services and collaborate with the provider as the primary factors for prioritizing connecting students to resources located in the school building. Team Nav and Team Trad communicated their reliance on behavioral health resources that were physically located in their schools and the importance of proximity of these services. We know
that schools have continually relied on external referrals to mental health providers to meet the needs of students because we are lacking the intensity of cross-system collaboration, systems and structures, and shared knowledge to successfully create an intentionally and fully integrated approach to youth mental health needs (Weist et al., 2018). We also know that if school teams can meaningfully engage a diversity of stakeholders on their team, it is likely to result in increased service availability for students with behavioral health needs (Splett et al., 2017). Relying on only one provider and primarily a single service within the school is concerning given the urgency of moving to a preventative public health approach that includes services for students across the full Institute of Medicine’s Continuum of Care from prevention to treatment and recovery supports (Springer & Phillips, 2007). This demonstrates an urgent need to either expand the diversity of services provided in schools or to identify opportunities to successfully break down silos and increase the level of collaboration between schools and community providers. The comfort levels of professionals and families, an understanding of the behavioral health services being provided in the community, and clarity around the outcomes of those services are critical components to improvement.

To successfully create a comprehensive school-based mental health system, community behavioral health clinicians need to learn about navigating the education culture and environment and gain an understanding of the MTSS structure, while educators need to learn and understand the intricacies of student mental health challenges that are typically handled by mental health staff (Dowdy et al., 2015; Mellin et al., 2010; Weist et al., 2018). The critical component of sharing of knowledge and expertise between the education professionals and school navigator was demonstrated by members of Team Nav. This study demonstrated how this team is successfully sharing their diverse expertise between the community behavioral health
representative (school navigator) and educators. Team Nav communicated that this avenue for professional growth is impacting the functioning of their MTSS team. The increased knowledge that could have resulted from the interdisciplinary MTSS team design was demonstrated by Team Nav’s knowledge of numerous behavioral health supports for students and how to access them within the community system of care.

Because of the challenges schools face in implementing evidence-based practices with fidelity to the models and the need for flexibility in implementation, there is movement toward modular strategies that distill the evidence-based approaches down to the active kernels that create change for students with specific tier 3 needs (Weist et al., 2018). This concept was demonstrated by Team Nav that utilized this approach with an evidence-based tier 3 intervention implemented by educators and the school navigator. A modularized approach was not referenced in any way by Team Trad. In order to develop a comprehensive school behavioral health system, teams must facilitate access for students and families to services across the Institute of Medicine’s Continuum of Care (Springer & Phillips, 2007). Team Trad demonstrated a much more limited knowledge of behavioral health services available when compared to Team Nav. This knowledge could help us to understand some of the challenges, the diversity of school readiness for implementation of comprehensive school mental health systems, and the need for more comprehensive supports for schools and MTSS teams working toward implementation.

We know that effective collaboration between schools and the community behavioral health system is beneficial for the school, behavioral health providers, students and families (Cappella et al, 2008; Kern et al., 2022; Ringeisen et al., 2003). Resources are best utilized, and behavioral health services are more cost-effective when these partnerships are strong and a team approach to student behavioral health is implemented (Lewallen et al., 2015). The findings of
this study provide a nuanced picture of the landscape of community partnerships between schools and community behavioral health providers and the impact on the functioning of the two MTSS teams participating in this study. These findings demonstrate the value of these partnerships but underscore an urgent need to enhance them and engage in identifying potential solutions for the challenges these MTSS teams are experiencing. The findings support the need to further the work toward a more integrated school mental health approach.

The MTSS teams acknowledged the value they placed on their existing community partnerships, but also recognized this as an area that could be further developed to improve their team functioning and student outcomes. The MTSS team that included a school navigator demonstrated a much greater knowledge about the diversity of behavioral health services available to students. Concerns about behavioral health workforce were expressed by Team Nav discussing treatment and Team Trad discussing waitlists. This reinforced research illuminating the unprecedented level of behavioral health workforce shortages following the COVID-19 pandemic and certainly impacts the MTSS team functioning (Hernandez & Lampl, 2021).

Implications for Theory

Bronfenbrenner’s work and the concepts included in his Bioecological Model of Human Development support the need for a comprehensive, consistent and integrated model of school behavioral health (Bronfenbrenner, 1979). Bronfenbrenner discusses the connection between all the people and systems included in a youth’s macrosystem and explains how a child’s development can be impacted in an extraordinary way when their school, family, and peers reinforce the same values and work together in harmony (Brendtro, 2006). The functioning of the MTSS teams, as described by participants in this study, indicate that there is opportunity for improvement by developing a more comprehensive approach to meeting student behavioral
health needs, implementing a more structured model of interventions from universal to intensive, and increasing teacher, family and student participation in this process. To successfully accomplish this harmony across the entities in a child’s microsystem, stronger universal intervention can support the sense of harmony from peers, stronger family involvement and student involvement are needed across the full tiered system and the school needs to facilitate and support the consistency of all of this through the development of a clear and intentional approach to meeting student needs.

Bronfenbrenner’s Bioecological Model for Human Development demonstrates the power of the connection and interaction in the macrosystem between the parties that collectively make a young person’s microsystem (Bronfenbrenner, 1979; Bronfenbrenner, 2006). My findings are connected to this model due to the parties involved in the development of a young person’s protective skills and the impact they have on a child’s behavioral health. The MTSS teams can be a powerful combination of these parties including family, school, behavioral health providers, and natural supports to be a unifying force for a consistent approach to the growth and development of the young person. The power of the macrosystem to be an essential influence on the development of a young person is dampened when the parties involved are limited and opportunities to expand MTSS team composition were demonstrated in this study. The impact for students could be magnified through the expansion of these teams and the development of a stronger established partnership between teachers, families and community behavioral health providers as part of student’s microsystem. By strengthening the relationships between these essential parties, the teams would be strengthening the young person’s macrosystem and the ability to impact their development at a greater level.
Creating a foundation of prevention services and universal intervention for students facilitates connection to early intervention for students that begin to struggle. Maraccini et al. (2022) describes that schools play a role at most of the student ecosystem levels that encompass the Bioecological Model of Human Development including the duty to create a safe learning and growing space for students while building school-family-community partnerships. School MTSS teams play a tremendous role in a school’s ability to accomplish these goals and the functioning of these teams ultimately determines their level of success. The teams participating in this study described how essential building community partnerships was to the functioning of their team, but the many challenges that persist despite the best efforts from the teams and community partners. The teams shared their desire to have a more structured tiered system of supports. Tier 1 interventions for all students are a critical component to creating safe spaces for students to learn and grow. My findings demonstrate that schools could be more successful in accomplishing the creation of a safe learning space and the development of student behavioral health and wellness with a more systematic and structured approach to comprehensively understanding and meeting students’ needs.

Bronfenbrenner’s Bioecological Model for Human Development emphasizes the critical role that young people play in their own development (Bronfenbrenner, 2006). My findings have implications for this given that students are not involved in the MTSS processes at either of the two school buildings. Being at the center of the model, a young person’s ability to interact with the systems that are critical to their own development and influencing outcomes as important as their behavioral health and wellness could greatly impact the process. The young person’s involvement in this process could inform an understanding of their experience, provide
perspective, introduce new and innovative ideas, and impact their ownership of their own knowledge, skill development, and treatment.

**Implications for Practice**

To achieve the best outcomes for students and families, educators urgently need to focus on systems and structures for student behavioral health that are built on a broader model that integrates student behavioral health into the umbrella of all they do to support student success. The model, processes, and services available must be clearly communicated to staff, families, students and community behavioral health providers. All of these parties play an integral role in supporting improved behavioral health outcomes for students. We must empower education leaders to take ownership over serving youth with behavioral health needs. They need support in developing the knowledge and skills necessary to implement prevention, early intervention and treatment services and to support their staff to feel more confident and competent in supporting student behavioral health. In practice, school and district administrators could identify opportunities to free up administrator time to prioritize leadership for this team. Leaders could look at the possibility of re-aligning job descriptions to have one key administrator leading their MTSS team and making it a priority. It is imperative that educational leaders spearhead the implementation of MTSS systems and structures embedded in an evidence-based model like the Interconnected Systems Framework (ISF) (Barrett et al., 2017; Splett et al., 2017). ISF is a newer framework that has demonstrated success in helping schools to integrate Positive Behavioral Interventions and Supports (PBIS) and school mental health into an integrated MTSS system that address the full spectrum and diversity of student needs including students with internalizing behavioral health problems (West et al., 2018).
To support the ability to implement a more comprehensive model, there is an urgent need to address the limited professional development time available for educators. Education leaders must seek out education and professional development opportunities for educators and partner community behavioral health staff to fill our educator’s toolboxes with strategies to address the mental health challenges that students are experiencing on the school bus, in the cafeteria, and in the classroom every day. We know that teachers want to support youth behavioral health needs and the level of need demands that they do so. However, many of our teachers do not have the knowledge or skills to successfully support youth behavioral health needs. Teachers are clearly experts in teaching skills, so with the knowledge to teach skills that impact behavioral health challenges, the increase in student skill development would be tremendous. It is essential that we work to increase educators’ involvement in behavioral health intervention and increase training for school professionals, particularly school counselors, school social workers, and school psychologists, in evidence-based interventions. This increased training can happen at the practice level but should also be considered for integration into pre-service professionals’ coursework at the university level. Furthermore, energy would be well-spent in identifying opportunities for professional development in a sustainable way for educators.

To support the expansion of behavioral health knowledge and resources, we must encourage schools to develop stronger and more integrated partnerships between schools and community mental health providers with the opportunities to capitalize on their diverse areas of expertise. This study builds upon the research that identifies the value added to school MTSS teams when community behavioral health providers are integrated and fully participating on these teams. The study also reinforces the concept that siloed work by youth-serving system is still a very present barrier to student outcomes. There are opportunities for educators to teach
behavioral health professionals to navigate school systems and MTSS structures and for community behavioral health professionals to teach educators about youth behavioral health needs and strategies to use in the classroom. School districts must identify opportunities to address the missing puzzle piece of teacher involvement in MTSS teamwork and opportunities to increase family and student involvement.

Even if additional partnerships are built and team members are added, it is critical to address the concerns around equity in workload and increased building-level leadership to MTSS teams. This study illuminated concerns about the bulk of the workload for serving students with behavioral health needs being placed on the shoulders of school counselors. The weight of these student needs is a lot to carry with limited support and shared workload. Outcomes for students could be increased through a more well-designed shared workload leveraging the expertise of a multi-disciplinary team. Intentional processes, data systems, and progress monitoring for implemented interventions are critical to ensuring improvement in outcomes for students. The roundtable discussion meeting process lacks efficiency, limits the number of students that can be served, and relies on anecdotal reports of student improvement. The expansion of behavioral health services available within the school setting must be a priority, particularly tier 2 group interventions in schools. Schools can make this happen through the implementation of evidence-based group interventions. An example of this implementation includes Cognitive Behavioral Intervention for Trauma in Schools (Jaycox et al., 2012) that relies on screening positive for trauma indicators. The intervention teaches students and families skills to improve the challenges they are experiencing.
Implications for Future Research

Given the scarcity of research regarding team functioning of school teams addressing youth behavioral health and the level of urgency warranted, the development of a model specific to the nuances of MTSS teams and student behavioral health in schools should be prioritized. Schools need the support of researchers to understand how MTSS teams should be structured and function to address student behavioral health most effectively. School leaders need to feel confident that the structure and functioning of their MTSS team will impact student outcomes in a positive way. School professionals and community behavioral health professionals that are working in the trenches with students and families often do not have the available time to engage in research. Researchers could support school staff engaging in this work through further developing a comprehensive model, such as ISF (Barrett et al., 2017; Splett et al., 2017), and providing a roadmap and technical implementation for implementation for schools.

Future research could analyze MTSS team data collection processes and progress monitoring for students with behavioral health needs and the impact on student outcomes. This research could help school professionals to understand the most efficient and effective data collection process and progress monitoring for interventions. There are opportunities to identify more efficient and effective data procedures than the informal processes and non-existent progress monitoring being utilized as demonstrated by both teams participating in this study. Given the challenges of creating an integrated mental health system, models for collaboration and instruments to measure team functioning are critically needed to understand whether these teams are effective and to understand what strategies would improve the functioning of teams addressing student behavioral health needs (Mellin et al., 2010).
Furthermore, researchers urgently need to engage in studies to determine the most efficient and effective combination of youth-serving professionals to meet student behavioral health needs. According to Mellin (2018), most of the literature regarding teaming efforts between schools, community mental health, and families to meet the needs of youth behavioral health are essentially program descriptions and fail to identify the concepts critical to functioning of these teams. Existing research recognizes the strengths and challenges of different approaches, but schools would benefit from researchers identifying the optimal team configuration and behavioral health services to demonstrate the best outcomes for students. If researchers developed a model that was supported by the evidence for improved student outcomes, this would decrease a lot of uncertainty around the funding and implementation decisions schools are tasked and support them in improving student and family outcomes.

While it was clear that the Team Nav was much more knowledgeable about the diversity of behavioral health services available to students in their community, a member of this team still stated that their team would benefit from an outside person that was an expert in services in the community. Because Team Nav has an integrated behavioral health expert and demonstrating their knowledge of the diversity of resources was a strength they possessed, we must consider what the root of this challenges is. Does integrating a behavioral health professional into the school staff decrease the ability of that behavioral health professional to be an expert in the community behavioral health continuum? Is the student caseload too large to devote this time? Or will the people doing the difficult work just always feel they need more expertise in this area? We need more information to understand why this continues to be a concern for Team Nav despite the increased knowledge they demonstrated. Researchers could help us to understand if this is specific to this team or occurs for many school teams and what the root challenge is. Team
Trad expressed this same concern regarding interventions. How could behavioral health intervention and service expertise be added into school teams in the most effective way? Would more comprehensive care coordination or comprehensive community health centers in schools with integrated behavioral health care make a larger impact? Further research could support a greater understanding of these challenges.

Additionally, the limited participation by school administrators in this study despite the nearly 50% percent participation rate from the full roster of members of the MTSS teams is interesting. This factor warrants further investigation. This could be an opportunity for further research as this might help us to learn about the culture of leadership within schools, the pressure that building-level administrators face, the demanding workload of school administrators, the opportunity for behavioral health professional development for administrators, or the level of ownership that building level administrators feel for the process and outcomes of the MTSS work related to behavioral health needs.

Limitations

This research contributes to filling the literature gap by describing the functioning of school MTSS teams in the context of two public high school settings. However, there are study limitations to consider. First, there are several limitations related to the study sample including the use of purposeful sampling. The small sample size of only two high school teams from one geographical area is a limitation. The fact that both high schools are located in the same state and are subject to the same requirements is a limitation given that the functioning of the teams could look different with different state-level expectations. It is important to understand that the results are meaningful in these specific contexts but cannot be generalized to other school settings. The nearly $3,000 discrepancy in the two schools’ spending per student could present a limitation in
the comparability of resources. In addition, the study was limited by the participants that consented to participation and that resulted in a lack of diversity in positions represented and limited representation from school administration.

There are limitations with the data analysis in this study. Although I immersed myself in the data and followed a process that included multiple iterations and refining of the data to identify emergent themes and codes, I was the only individual involved in the coding process. As such, I was limited by my perspective that is inherently influenced by my perceptions of participants’ statements, my construction of reality, and my experience as an educator and community-based behavioral health professional. Because my professional experience and background is similar to that of the participants, bias could have been introduced into the analysis despite my best efforts to limit this.

**Conclusion**

This study aimed to investigate the team functioning of two high school MTSS teams addressing the behavioral health needs of students. One of the teams participating in this case study included a school navigator while the other team did not. I anticipated the functioning between the two teams would be vastly different given the inclusion of the school navigator role on Team Nav. While there were differences that were meaningful and significant to the functioning of the teams, I was surprised to find far more similarities emerged than differences in the functioning of the two teams. However, the differences in functioning that emerged between the two teams were critical factors that influence the outcomes for students with behavioral health challenges. The most significant differences in team functioning included the utilization of universal behavioral health screening for students, knowledge of behavioral health resources for
students, and the emphasis placed on collecting and utilizing student data to inform decision-making.

After immersing myself in literature, engaging in conversations with education professionals, and analyzing the data, I feel confident that despite the incredibly hard work and best intentions of educators and community-based behavioral health professionals, MTSS teams will not function efficiently or obtain the highest level of student outcomes without evidence-based structures and systems guiding the implementation of multitiered systems of support, a fully integrated school mental health system, comprehensive screening, data collection, and progress monitoring, and the necessary education and skills training for educators and community behavioral health professionals to implement the system effectively.

It was clear that the MTSS team members that participated in this study care tremendously about students and the families they serve and are working incredibly hard to meet the behavioral health needs of their students. However, the gap between research and practice in school mental health was further emphasized and supported through this study (Reinke et al., 2011; Ringeisen et al., 2003; von der Embse, 2018; Walker, 2004). Contributing factors include educators’ partially filled behavioral health strategies toolbox, historically siloed nature of this work, and missing team structure and big-picture roadmap is making their job incredibly taxing and impacting the behavioral health outcomes for students. For MTSS structures and implementation to effectively prevent, intervene early, and treat students with behavioral health needs, systems need to be intentionally and comprehensively designed and implemented with the necessary levels of cross-system collaboration and partnership.

The teams that participated in this study are functioning with a very informal structure, are at different levels of integrated and interconnected student mental health systems, and don’t
have the tools or staff availability they need to create the necessary systems integration at the level that would produce the level of outcomes they want for students and students need. We know that all universal, targeted, and intensive intervention are critical components of meeting students’ needs. Tier 1 supports create a more predictable and safe learning environment, tier 2 supports improve the structure, instruction, targeted intervention and feedback for students that are at risk for or are experiencing mild concerns need a higher level of intervention, and tier 3 supports allow for individualized and evidence-based assessment and intensive intervention for academic, behavioral and emotional student needs (Reaves et al., 2021 & West et al., 2018). It was evident in this study that the team that included a community-based behavioral health professional possessed a greater level of behavioral health knowledge and knowledge of the diversity of resources available to students in the community. In order to move from independent student supports to a more integrated and connected approach, improvement is needed in the systems and structures to support practice, further research is needed to guide efficient and effective use of interventions, and policy improvements are needed to support scaling and sustaining (Weist et al., 2018). The team functioning of these MTSS teams would vastly improve, hard-working professionals would face fewer barriers, and students with behavioral health needs would experience greater outcomes if schools were supported in developing, implementing, and sustaining a more integrated and comprehensive system that included structured processes for MTSS teams and tiered student behavioral health prevention and intervention.
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