

# PBIS Forum 15 Practice Brief: The Role of the Clinician in a Multi-Tiered System of Support

PBIS Leadership Forum- *Roundtable Dialogue*

December 2015

## Introduction

The clinician's role in a Multi-Tiered System of Supports (MTSS) framework is an area of growing interest and focus for educational professionals. The topic continues to require more study and research, however, it is already clear that by shifting the role of clinicians in schools there is an increase in capacity for the entire school staff to more effectively meet the social/emotional needs of all youth in the building.

For the purpose of this paper, clinicians are considered school social workers, school psychologists, school counselors, guidance deans and community mental health clinicians based in the school setting. These clinicians play an integral role in helping build, support, and sustain a MTSS framework in schools and districts.

As School Mental Health (SMH) programs and professionals become truly embedded into MTSS through the Interconnected Systems Framework (ISF) model (a proposed and developing interconnection of Positive Behavioral Interventions and Supports (PBIS) and SMH systems to improve educational outcomes for all children and youth), it is important to consider how the role of the school-based clinician will continue to evolve. The role will need to narrow in some areas and expand greatly in others to more effectively and efficiently support the needs of all youth. This paper will highlight one of many dialogues that have taken place around this important topic.

### The Role of the School-Based Clinician at All Three Tiers



## Rationale

“Almost all children attend school for some time in their lives. Consequently, school is the ideal environment for implementing universal interventions aimed at promoting protective factors associated with resilience and positive emotional development. In addition, several epidemiological studies of children’s mental health needs and services have led to the conclusion that in this country school is the de facto mental health system for children. This conclusion is based on the finding that for children who do receive any type of mental health service, over 70% receives the service from their school. This situation is further elucidated by the finding that 20% of children and youth have a clearly identified need for mental health service but only about one third of these children receive any help at all.” (Duchnowski)

To better achieve positive outcomes for all youth (both socially and academically), clinician roles need to be clearly defined, clinicians need to be adequately trained in MTSS, and clinicians need to be identified as leaders for helping build the capacity of the rest of the staff to support this important work. Transforming clinicians into social emotional leaders in buildings will be crucial to long-term success and sustainability of both MTSS and ISF.

## Support through the tiers

The questions of “What process is used in identifying which youth need ‘higher levels’ of social/emotional support?” and “Which youth receive ‘higher levels of support?’” are constantly being re-evaluated in schools. Historically, subjective concerns regarding the social/emotional needs of youth have been used to create referrals for service (formal or informal) to clinicians directly. While this may provide an organizational system and way to assess which students might require more than universal levels of support, the result has

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often led to a misidentification of appropriate youth receiving services and a misuse of clinician service time. More attention is being given today to the use of data to more effectively determine which students need and receive higher levels of support- specifically direct support from clinicians.



It is increasingly apparent how critical the use of evidence based interventions with clear entry points, tools for progress monitoring, and exit criteria are within a MTSS framework. In addition to the typical criteria that schools may consider for entry into Tier 2 (i.e. grades, attendance, referrals, etc.), many schools have begun using universal screening tools to identify which youth need Tier 2 and Tier 3 levels of support. Universal screeners have the added benefit of helping to identify youth with internalizing characteristics that are more likely to go unidentified solely through criteria such as office discipline referrals. Examples of such screening tools include the Student Risk Screening Scale (SSRS) or the Strengths and Difficulties Questionnaire (SDQ). One approach has been to screen all youth entering 9th grade from their respective feeder schools. Another approach has been to use a double gated process where teachers are asked to bring a list of the top 6-10 youth (after having considered all youth they encounter) they have the greatest concerns about regarding internalizing characteristics and externalizing characteristics alike (this is considered Gate 1). Teachers fill out a questionnaire such as the ones mentioned above regarding each of the students on his/her list (Gate 2). Youth who pass through both gates are entered directly into Tier 2 levels of support. Clear decision rules using data will provide significant benefit to students, staff, and clinicians and will be critical in the process of shifting the work that clinicians are doing to focus more specifically on the students with the highest level needs.

**“The secret of change is to focus all of your energy, not on fighting the old, but on building the new.”**

- Socrates

During this roundtable dialogue session at the PBIS National Forum in October 2015, positive outcomes were shared from examples where specific programs have been embedded in the PBIS framework (3-5 positively stated school wide expectations). These included “Compassionate Schools” in Washington State and the implementation of character education programs where data is used to track the effectiveness of explicitly teaching positive behavior by recognizing a decrease in problem behavior. Participants shared ideas about using mindfulness activities for high stakes testing, embedding restorative practices into Tier 1, and also educating teachers on the effects of trauma. There was consensus among the participants regarding the need for continued exploration of culturally relevant best practices and evidence based interventions within MTSS.

Supporting social/emotional needs of all youth through educating and training all school staff was also discussed during this dialogue. The group agreed it is essential to teach all students social/emotional skills at the universal level. All staff must understand, through ongoing professional development, that teaching social emotional skills is as important to achieving positive outcomes for our youth as teaching reading, math, science and other academics. Ideally, teachers would embed direct instruction of social/emotional skills within a strong academic curriculum. Helping teachers understand function-based thinking was also raised as an important area to consider. School staffs will greatly benefit from understanding function (the “why” of student behavior) and understanding how it is relevant at all three tiers. Keeping “function of behavior” as a focal point during conversations pertaining to student behavior (including Tier 1 in the classroom, problem solving team meetings, grade level team meetings, etc.) will not only increase the skill-set of the staff but will also

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increase the potential to effectively support youth earlier in the process. The group identified a need for easily accessible information on critical topics such as restorative practices, trauma, classroom management and other content areas as well as their potential positions within the MTSS framework.

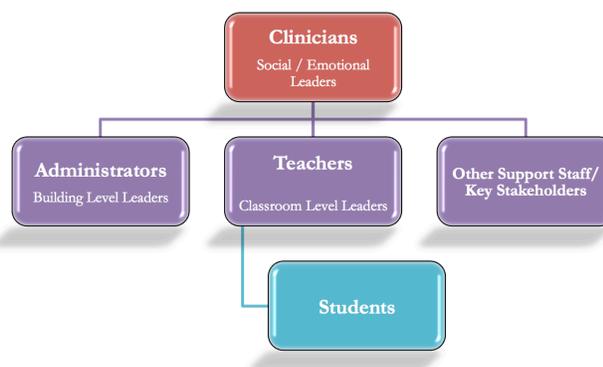
## Considerations

The authors propose using highly specialized school-based clinicians to:

- Coach and consult with school-wide systems at Tier 1
- Coach and coordinate systems, teams, and interventions at Tier 2
- Coach and facilitate individualized teams and work with individuals directly at Tier 3

This allocation of supports (and potential paradigm shift) allows clinicians to use their time more effectively and efficiently in schools/districts. Clinicians need to make connections between all three tiers and may need support understanding the importance of a needs assessment and resource mapping as tools/guides to help support school-wide systems level work. As the social-emotional leader(s) in the building, clinician(s) will need to have a level of understanding and familiarity with a variety of topics impacting the success of classrooms to be able to effectively help support the staff in these settings.

To lay the foundation for the clinicians to become the social-emotional leaders of school buildings administration need to provide support and leadership for this expanded role. The role of the clinician needs to be clearly defined (transparent) to all staff and key stakeholders. Clinicians need to be given the skills necessary to help initiate critical (and sometimes difficult) conversations and deliver crucial content and strategies to all staff around topics previously mentioned including: trauma, restorative practices, function based thinking, classroom management and other mental health diagnoses and concerns. The first step is to provide professional development to clinicians on these important topics. Next, clinicians need to be prepared with the strategies, tools, and information necessary to provide training to all staff including administration other support staff, and key stakeholders. Once a universal knowledge base has been provided, other adults in the building including classroom teachers will be armed with tools and skillsets to teach basic social/emotional skills in their own classrooms. Students receiving this foundational level of social/emotional support will be less likely to need higher levels of support provided by a clinician.



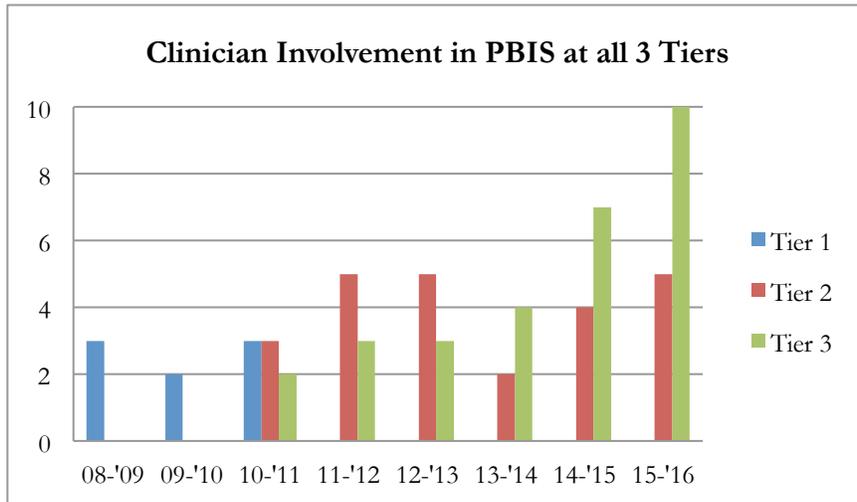
## Frequently asked questions

**Q: Does a change in the clinician role from less direct service delivery and support at Tier 1 to more coordination and facilitation at Tier 2 and Tier 3 mean that I could ultimately lose my job?**

**A:** With hundreds of youth in a school and typically only 1-3 clinicians in the building at a time, there is always going to be a tremendous amount of work to do to help support the social/emotional needs of **all** youth. Training clinicians to be social/emotional leaders in the building vs. the sole provider of social/emotional supports will help create a system where all youth will ultimately receive the exact level of support necessary to be successful. Giving teachers and other educational professionals in the building base

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level skills to deliver to youth at Tier 1 (and Tier 2) will allow clinicians to begin to step out of Tier 1 work and go deeper into the coordinating of interventions at Tier 2 and the direct facilitation of teams and interventions at Tier 3. The amount of time a clinician is working and the amount of work there is to do will



EXAMPLE FROM HUNTLEY HIGH SCHOOL DISTRICT #158, IL.  
VISUAL OF HOW CLINICIANS HAVE MOVED OVER TIME FROM PRIMARILY BEING INVOLVED AT THE TIER 1 LEVEL TO PRIMARILY BEING INVOLVED WITH TIER 2 AND TIER 3 LEVEL WORK.

essentially be the same as it has been previously, however, the focus of the work will be on the students with the highest level of needs (at Tier 3), without sacrificing supporting youth with Tier 1 or Tier 2 levels of need. The capacity will be built along the way for other professionals to help support these youth with foundational level skills. In addition, throughout this conversation about growth and change, it is imperative to keep the focus on the function of the clinician in a school, rather than the job title of that clinician to most effectively fill all roles/ functions and meet all youth needs.

**Q: Will we be asking teachers and other educational professionals to diagnose students or provide therapeutic services/supports to youth?**

**A:** No. The social/emotional support that teachers and other educational professionals will be providing will be in the area of social skill development, typically from a curriculum created or organized by the school-based clinician(s). These professionals will be providing a strong foundation of prevention to youth by teaching basic social skills. Even at the Tier 2 level, educational professionals other than clinicians can be re-teaching the social skills previously taught at Tier 1. At no point is diagnosis or the delivery of therapeutic services to youth (by others) a part of this model of support/service delivery. Rather, this model allows for clinicians (who typically come to a school with the greatest level of behavioral expertise) to effectively support youth with the highest levels of emotional needs, while supports are still being provided at the lower tiers for youth with lower level needs.

**Q: Who else in the building can provide this kind of support at Tier 1 and Tier 2? Everyone in our building has so much to do already, it doesn't feel fair/feasible to ask them to do one more thing.**

**A:** It is true that today it feels there is more for **everyone** to do in a building than there was years ago. The goal is for everyone to be as effective and efficient with time and resources as possible. In terms of providing Tier 1 levels of social/emotional support to youth, any adult in the building can help. Librarians, secretaries, custodial staff, resource officers, hall monitors, bus drivers, teacher's aides, academic interventionists, teachers, volunteers, community partners, parents/families, etc. are all good candidates for this important work. It is important to be clear that this is basic social skill development from a curriculum that a clinician can assist with creating or from critical features already present in Tier 2 level interventions (i.e. Check-In-Check-Out). It is not work that is therapeutic in nature. The overall goal is that time is saved by being more effective, efficient, and preventative earlier on in the process. If support can be provided through someone other than a clinician, attempt to use alternative providers where possible.

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**Q: How do we get our staff, administrators, clinicians and other key stakeholders to fully understand what the clinicians in our building do? There seems to be a lack of clarity on the exact role/tasks, which leads to challenges in systems and organization as well as service delivery.**

**A:** It is critical that everyone in the school is clear on what exactly each clinician does. It is not as important that the title of the clinician matches job function as it is that each function is covered by a clinician and the staff understand exactly who does what. Getting to a place of clarity will look different for each school/district. Having a basic understand of MTSS will be important so that everyone is on the same page with how supports will be provided through a response to intervention model. If clinicians and administrators can be clear on the roles and tasks that clinicians provide/fulfill, it will be easier to help the rest of the staff to see where clinicians fit in to MTSS. Clinicians can be leads in helping the staff to see the vision of the model and the potential of what it can look like to support **all** youth effectively in the building, and administrators will take an imperative role in helping the vision come to fruition.

## The future of this work/Next steps:

It is going to be critical to continue to find ways to support school-based clinicians with this important work as their role in MTSS is solidified. During this roundtable dialogue and other collaboration opportunities, it has been clearly expressed that clinicians want/need a learning community/community of practice as well as specific strategies and tools to use within buildings to help build capacity. Using ISF and MTSS as frameworks, professional development needs could be met by offering clinicians a variety of recorded modules/videos or live webinars with an accompanying workbook of specific resources and activities. These materials would ideally give clinicians a foundational level of knowledge on a variety of topics and a starting place for gaining the skills necessary to build the capacity of all staff in a universal way. These tools would ideally be accessible on the national PBIS or Midwest PBIS Network websites and would provide clinicians with basic content, guiding questions and a 'how-to' approach to working with staff via specific activates and tools. Another potential next step is partnering with universities (in a variety of ways, including) to establish learning communities or communities of practice with regularly scheduled calls and agendas where clinicians could engage in dialogues on specific areas of interest. This work is important and clinicians are asking for more resources to help navigate through this changing process. Collaboration will be a starting place to help meet these shifting needs.

**“Change is hard at first, messy in the middle and gorgeous in the end.”**

- Robin Sharma