Advancing School Mental Health in Montana: Partnership, Research, and Policy

Erin Butts, Sara Casey, and Carol Ewen

Introduction

Montana consists primarily of "frontier" areas (less than seven persons per square mile), extreme geographic isolation, and few metropolitan zones. Montana ranks first in the nation for suicide and fourth for adolescent drinking rates (Health, 2006). Research suggests that rates of emotional/behavioral problems are similar for youth located in urban and rural areas, yet youth in rural areas tend to lack access to mental health treatment (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). Montana was an early pioneer in implementing school mental health (SMH) to allow rural youth better access to mental health services (Farmer, Stangl, Burns, Costello, & Angold, 1999).

E. Butts (✉)
University of Montana Institute for Educational Research and Service, 32 campus drive #6376, Missoula, MT 59812-6376, USA

Missoula County Public Schools, 215 South 6th Street West, Missoula, MT 59801-4801, USA
e-mail: erin.butts@umontana.edu

S. Casey, M.S.Ed
Montana Office of Public Instruction, Missoula, MT 5924-0046, USA
e-mail: saracasey.work@gmail.com

C. Ewen, M.A.
Missoula County Public School District, 215 South 6th Street West, Missoula, MT 59801-4801, USA
e-mail: cewen@mcps.k12.mt.us

Nationally, SMH is one of the fastest growing professional fields for mental health workers and public school systems. Montana's SMH program Comprehensive School and Community Treatment (CSCT) is no exception. CSCT exists as an "intense service designed for youth who are in immediate danger of out-of-home placement and/or exclusion from school or community," providing a "comprehensive, planned course of outpatient treatment…to a child with a serious emotional disturbance (SED)" (Montana Department of Public Health and Human Services, 2003, p. 2.6). The evolution of CSCT provides a context to look at the interplay of partnership, research, and policy, three realms impacting the advancement of SMH practices in Montana.

In 2010, Montana's Department of Public Health and Human Services (DPHHS) and the Office of Public Instruction (OPI) employed a researcher to write a white paper on effective school mental health practices. Through this collaborative research project and the subsequent white paper (described in the following), state and local leaders began to advance the Trilateral Framework: Partnership, Research, and Policy as an effective tool for building school mental health agenda in Montana.

History of Montana's School Mental Health Services

CSCT began from a school day-treatment model provided by four Montana Regional Mental Health Centers, which originated in 1997. In day-

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Old Approaches	New Approaches
• Each school works out their own plan for involving community mental health (MH) staff • One community MH clinician is housed in a school building 1 day a week to "see" students • The clinician does not participate in school teams and operates in relative isolation • No data are used to decide on or to monitor interventions • There is no systematic evaluation, instead "intuitive" monitoring of efforts.	• District has a plan shaped by diverse stakeholders for promotion of learning, positive behavior and mental health for students, and a "shared agenda" is real in individual schools, with staff from education, mental health and other child serving systems working closely together and with youth and families for developing and continuously improving programs and services at all 3 tiers, based on community data as well as school data. • There is "symmetry" in leadership among staff from education and mental health systems in leading and facilitating activities at all three tiers • Personnel from MH agency assists school district clinicians with facilitating some Tier 2 and Tier 3 interventions including some small group interventions, function-based behavior plans and wraparound teams/plans

Fig. 1 Barrett, Eber, Weist proposed new approaches to SMH

treatment, schools provided a work space and teacher to serve up to 12 students. Regional Mental Health Centers staffed a licensed therapist and non-licensed behavior consultant in the classrooms to work with students diagnosed with a serious emotional disturbance (SED). Although students were provided educational and mental health services, the Regional Mental Health Center model denied students access to the general curriculum and consequently excluded them from their peers. Furthermore, school day-treatment was provided in major urban areas leaving rural youth with little or no access to mental health services.

In 1998, DPHHS offered Regional Mental Health Centers, a state waiver to pilot SMH services. Moving from an isolated day-treatment model to an inclusive service delivery model propelled Montana down the path to improve services for children and their families. The change in service delivery required schools and mental health workers to rethink their roles in the provision of SMH.

Barrett, Eber, and Weist (2009) argue for new approaches towards comprehensive SMH integration in their document *Development of an Interconnected Systems Framework for School Mental Health*. Montana began initial implementation of this work 10 years earlier. Figure 1 shows the contrast between old approaches to SMH practice to new approaches.

Following the waiver project, SMH was written into State Administrative Rule. "Administrative rules are agency regulations, standards or statements of applicability that implement, interpret, or set law or policy" (Hergert, 2012). The state disbanded its Regional Mental Health Center model and allowed a variety of providers to bill for Medicaid services. Consequently, SMH expanded into rural communities, increasing families' access to mental health services. Ultimately, the popularity and growth of SMH strained the state budget, requiring DPHHS to remove SMH as a billable service despite protests from the education and mental health communities. In 2002, agencies were forced to lay off staff and cut services to qualified youth, while schools were burdened with continuing services for large caseloads of youth with inadequate, untrained staff. At this point, Montana state policy failed the youth in the system, diminishing the trust and partnership between mental health agencies, other youth-serving organizations and the state. Because research and partnership were not the foundation for policy decision making, State Administrative Rule did not effectively address the needs of children and their families.

Within a year of cutting SMH, OPI explored avenues to increase access to Medicaid funds and approached DPHHS with the idea of creating a blended service model funded jointly through

education and public health dollars. In 2003, the OPI, DPHHS, and mental health agency representatives set aside differences to work collaboratively and develop a system that supported a consistent, blended funding stream for effective service delivery and consistent access to services in rural communities. Although collaborative partnerships informed state policy at this juncture, research was not yet being used to drive policy. In 2003, SMH was once again incorporated into Administrative Rule, this time named Comprehensive School and Community Treatment (CSCT).

Although partnerships were key in bringing CSCT to Montana, research was not utilized resulting in vaguely described services and no program evaluation system. The state did provide a contract template for schools to use to obtain CSCT services that addressed legal and financial issues; however, program descriptions and requirements were left up to each district. Schools lacked the expertise and support to write in service delivery provisions. Consequently, CSCT services were determined by mental health personnel and agency policy rather than evidence-based practices for school mental health delivery.

When writing the Administrative Rule for CSCT in 2003, the state provided a contract template for schools wanting to obtain CSCT services. This template addresses legal and financial concerns. Program descriptions and requirements were left up to each district, and the template was never intended to be used as a generalized tool for all Montana public schools. The generalized use of the contract is an unintended consequence and an area receiving more attention in the new Administrative Rule rewrite process today, with the expectation of more focus and attention on helping school districts better individualize their own mental health needs and expected outcomes.

Demographics

Montana's unique geographic size and demographic makeup create challenges to advancing school mental health, owing to the rural composition of many public school districts that exist across sizeable distances. When considering CSCT Administrative Rules, it is important to note the following characteristics: Montana's racial composition is 89.4 % white, 6.3 % American Indian, 2.9 % Hispanic, 0.6 % Asian, 0.4 % Black, 0.1 % Pacific Islander, and 0.6 % others (Montana Office of Public Instruction, 2011). In 2011, Montana had a total of 421public school districts encompassing 827 schools (2011).

The large number of school districts, each with an independent administration and educational philosophy, makes managing CSCT programs a significant task. Individual school buildings have administrators with varied backgrounds and philosophies on the role of mental health in schools, so programs look different from one school to the next. Additionally, recruiting and retaining professionals to work in rural areas is difficult and can put mental health agencies in a position of having to hire inexperienced staff who lack postsecondary training. Furthermore, providing clinical supervision, skill building, ongoing training opportunities, and support to staff in remote areas is trying and contributes to high employee turnover, consequently creating a wide variation in service delivery and practice.

Despite the challenges created by remote and sparsely populated areas, Montana has been successful in growing CSCT programs and placing mental health services in rural communities across the state (Fig. 2). In 2003, 13 schools and two subcontracting entities participated in CSCT services. In the 2010–2011 academic year, CSCT increased to nine subcontracting entities with a total of 256 schools and 96 school districts receiving the service. In the past 4 years, CSCT grew by 34 %, making up 32.8 % of total Medicaid mental health billing for youth (Bureau, 2011). Research should inform revision of Administrative Rules due to the financial breadth of CSCT in Montana.

Figure 2 shows CSCT contract awards by school district from the 2008 academic year (AY) to the present. From AY 2008–2009 to AY 2011–2012, the total number of school contracts for CSCT increased by 65, a 34 % rate of change. The increasing trend of mental health providers in school districts has resulted in CSCT serving

Academic Year	Schools Districts Contracting CSCT Providers	School Contracting CSCT Providers
2008-2009	80	191
2009-2010	80	194
2010-2011	84	212
2011-2012	96	256

Fig. 2 Comprehensive schools and community treatment contracts, by academic year (Bennetts, 2011)

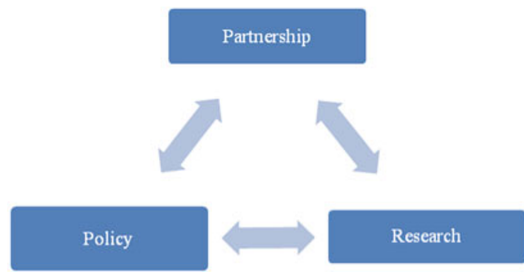

Fig. 3 Montana's trilateral framework: partnership, research, and policy

more children and represents a large portion of Montana's Medicaid billing for children's mental health services. As one of many Medicaid-supported programs, stakeholders recognize the need for research-based decisions to improve outcomes for youth and substantiate spending (Bennetts, 2011).

Montana's Trilateral Framework: Partnership, Research, and Policy

Because CSCT services had such wide variation with no data to suggest program efficacy, Montana saw the need to systematically analyze SMH provision. Montana is currently in the process of developing policy that articulates the use of evidence-based practices, family and community involvement, and quality improvement. The trilateral partnership, research, and policy model (Fig. 3) demonstrates how the three components are essential in the development of effective services for students, offering opportunities to share scarce resources and provide a continuum of supports. Montana partners and researchers involved in the spectrum of intervention to policy have found this model to be a useful and practical way of organizing statewide systems change in a productive and collaborative manner.

Underpinning the trilateral framework in Fig. 3 is the idea that to create effective mental health delivery systems, states must use collaborative partnerships and research to inform policymaking. Partnership fosters accountability and efficient use of resources and builds consensus towards implementing best practices. Each of these three realms continuously impacts each other creating a cycle where sound policy promotes strong partnerships resulting in research-informed intervention delivery and improved outcomes. Alternatively, partnerships help shape effective policy and the subsequent implementation, while research impacts policy development and informs partnerships. This model promotes diverse systems working together to break down the "siloed" approach to delivering services. Individually one part is not more important than the others; rather, all three are essential to cohesive multisystems change in individual and school-level practices.

Although CSCT services were provided in a school context, Montana recognized that the siloes between mental health systems and school systems still existed. This resulting gap from a siloed approach is not unique to Montana. Kutash, Duchnowski, and Lynn (2006) write about gaps existing between research in education and research in mental health, "with neither citing each other's work." The authors continue that "[t]here are bridges to build here" between research and implementation (p. 6). Fortunately for Montana, developing strong partnerships is part of the state's social heritage. The frontier mentality of helping one's neighbor promotes collaborative teaming and support.

Partnership

In Montana where "everybody knows most everybody," there is a high degree of collegiality

between university personnel, community professionals, and state department staff. Montana's small population and scarce resources create conditions where collaborative partnerships are vital to service provision. It was through interdisciplinary collaboration that two Montana government agencies, DPHHS and OPI, partnered to articulate a shared agenda – the desire to use research to inform policy in developing mental health programs and services in the schools. Both state systems directly impact policy and, thus, the quality of service delivery across Montana. DPHHS and the OPI leaders are increasingly making efforts to align services that will complement and build on financial and personnel resources and employ research to drive policy that promotes best practice.

Researchers Andis and colleagues (2002) discuss the importance of developing a shared agenda among professional organizations, policy leaders, and families. They write, "experience has shown that much of the misunderstanding and discord that occurs among different child-serving agencies arises from erroneous assumptions and beliefs about the mission and goals of the other agencies, and the legal and funding mandates that help drive an agency's agenda in meeting the needs of the children and young people" (p. 30).

Collaboration

Developing collaborative interdisciplinary partnerships is central to reaching Montana's ambitious goal to require and support evidence-based practice within CSCT. These partnerships create bridges for communication that engage key stakeholders in identifying and supporting best practices and increase provider buy-in for implementation, resource sharing, and efficient service delivery and outcomes.

Bronstein (2003) presents a model of interdisciplinary collaboration for social workers that aligns with Montana's notion of partnership, representing "optimum collaboration between social workers and other professionals" (p. 297). Bronstein presents five core components to interprofessional processes: (1) interdependence, (2) newly created professional activities, (3) flexibility, (4) collective ownership of goals, and (5) reflection on process. Bronstein describes interdependence as referring to:

> the occurrence of and reliance on interactions among professionals, whereby each is dependent on the other to accomplish his or her goals and tasks. To function interdependently, professionals must have a clear understanding of the distinction between their own and their collaborating professionals' roles and use them appropriately. (2003, p. 299)

Through collaborative interdisciplinary partnerships, Montana's mental health and education professionals are developing common language and a shared vision to improve expanded SMH services and outcomes. Montana recognizes that policy sets service delivery expectations and holds providers accountable. Therefore, it is important that all State Administrative Rules provide consistent expectations for all providers and professionals.

Moving Forward

In the fall of 2009 through the summer of 2010, Montana focused again on building collaborative relationships. During this time, the state began conversations about how to intentionally work together, across disciplines, as partners in advancing SMH. Montana formed an informal state level SMH workgroup with partners from the OPI, including representation from the statewide Positive Behavioral Interventions and Supports (PBIS) network (referred to as the Montana Behavior Initiative), Special Education, Health Enhancement, and partners from DPHHS, including Children's Mental Health, Medicaid, and Head Start. With guidance and active support from national SMH leaders, this group's effort resulted in the planning of the first statewide School Mental Health Conference that brought stakeholders to the table to start a conversation about mental health in the Montana public school system.

Stakeholders at the inaugural meeting held in January 2010 identified a number of recom-

Table 1 Stakeholder recommendations (January 2010) and subsequent progress (January 2010–present)

Stakeholder recommendations	Actions taken following conference
Engage champions	
Maximize roles and interdisciplinary collaboration	The SMH workgroup formalized, agreeing to meet monthly at a regular date and time to discuss school mental health in Montana and collaboratively plan subsequent conferences. Representatives from CSCT licensed mental health centers adopted regular meeting times to share best practices, concerns and experiences
	Montana's statewide Community of Practice (CoP) originated.
Social marketing to promote youth and family voice	A partnership between Youth MOVE Montana and the CoP emerged. With COP support, Youth MOVE created and published a toolkit educating adults about how to support Montana youth with mental health concerns
Integrate SMH and PBIS initiatives	A school mental health strand was reinforced at the largest educational conference in the state, the Montana Behavioral Initiative (MBI) Summer Institute
Expand university partnerships	University of Montana Institute for Educational Research and Service partners provide grant writing support, participation in CoP webinars, and provided in-kind office space to researcher
Support demonstration sites to advance practices	School districts were selected to begin connecting SMH and PBIS supported by the Interconnected Systems Framework
Pursue grant opportunities	The OPI wrote and received a grant from the Mental Health Settlement Trust to implement high-fidelity wraparound services in three turnaround school districts on the Crow, Northern Cheyenne, and Fort Peck reservations
Focus on outcome data	*Outcomes and evaluation* is identified in the white paper as one of the nine pillars for expanding school mental health (CSCT) in Montana
Conduct resource mapping activities	Planned for Fall 2012, locally in Missoula and with the systems of care statewide committee
Research rural SMH strategies	Planned for forthcoming statewide SMH conferences

mendations that propelled the work forward. The following Table 1 explains the collaboratively developed recommendations as well as the resulting actions.

It was the strengthened partnerships between stakeholders reflected in the recommendations and subsequent work identified in Table 1 that accelerated the pace of change in the time following the first conference. Furthermore, the increased communication and collaboration among stakeholders readied the field for the introduction of research-based decision making.

In 2010, the OPI employed a researcher with experience and knowledge of child and adolescent and school mental health issues and programs in the state to write a white paper on SMH. The purpose of the white paper was to research and inform the state of Montana on SMH best practices and guide DPHHS in the revision of Montana's CSCT Administrative Rules, starting in 2011. The white paper titled *Advancing School Mental Health in Montana: A Report on Changes to Administrative Rules for Comprehensive School and Community Treatment* (Butts, 2010) was submitted to the OPI in December 2010.

Research

The final white paper presents a series of evidence-based recommendations to specifically fit within the context of Montana's CSCT program and the corresponding Administrative Rules. It is a working manuscript for stakeholders and policy makers intended to guide the change process ensuring alignment with research. Figure 4 exhibits the research methodologies used to underscore the development of the research paper.

The accelerated national growth in research on improving SMH increased Montana state partners' knowledge and resources for developing new CSCT Administrative Rules. National researchers were willing to provide free resources and consistent involvement of their time to assist the state of Montana in advancing SMH. Information gathered is now foundational for rule

Fig. 4 Research methodologies to inform white paper

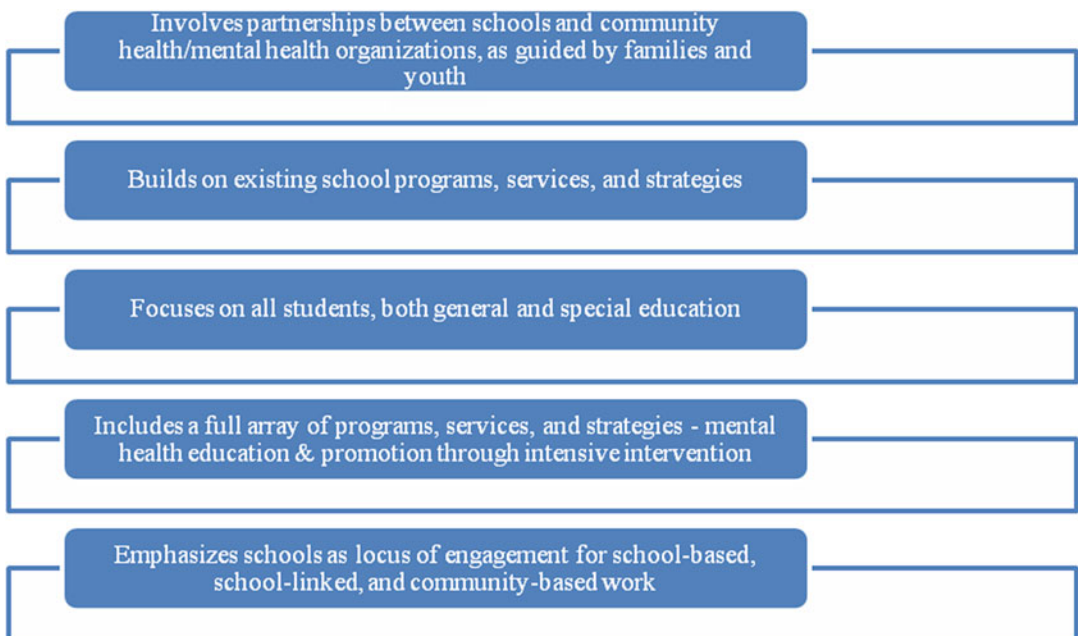

Fig. 5 Definition of school mental health (Weist & Paternite, 2006)

revision. Research outcomes included a common SMH definition (Fig. 5) and Principles for Expanded School Mental Health (ESMH) (Fig. 6), elaborated in the following.

Though there are many definitions of SMH, common themes and concepts reoccur. Weist and Paternite (2006) present a comprehensive definition incorporating key concepts. Figure 5 summarizes this definition.

Building on the above definition are systematic quality assessment and improvement (QAI) frameworks for SMH. "The failure to advance systemic quality assessment and improvement (QAI) frameworks in [School Mental Health],"

Detailed Principle	Section V Subheading
All youth and families are able to access appropriate care regardless of their ability to pay	Prevention & Early Intervention
Programs are implemented to address needs and strengthen assets for students, families, schools, and communities	Family-School-Community; Training; Evidence-Based Practice
Programs and services focus on reducing barriers to development and learning, are student and family friendly, and are based on evidence of positive impact	Outcomes & Evaluation
Students, families, teachers and other important groups are actively involved in the program's development, oversight, evaluation, and continuous improvement	Outcomes & Evaluation; Family-School-Community
Quality assessment and improvement activities continually guide and provide feedback to the program	Outcomes & Evaluation
A continuum of care is provided, including school-wide mental health promotion, early intervention and treatment	Promotion
Staff hold to high ethical standards, are committed to children, adolescents, and families, and display an energetic, flexible, responsive, and proactive style in delivering services	Evidence-Based Practice
Staff are respectful and competently address developmental, cultural, and personal differences among students, families, and staff	Supervision
Staff build and maintain strong relationships with other mental health and health providers and educators in the school, and a theme of interdisciplinary collaboration characterizes all efforts	Interdisciplinary Collaboration
Mental health programs in the school are coordinated with related programs in other community settings	Youth Leadership Opportunities

Fig. 6 Principles for expanded school mental health as applied to categories for CSCT administrative rule revision

argues Evans, Weist, and Serpell (2007), "contributes to a picture of poorly planned, implemented and evaluated services that are having superficial if any benefit" (p. 2).

Evans et al. (2007) argue that if QAI frameworks are not in place, the connection of training, practice, research, and policy into system transformation is less likely to occur. These system transformations themselves are "being called for by mental health, education, and other child serving systems" (Evans et al., 2007, p. 2).

Figure 6 reviews principles for high-quality and effective SMH programs from the University of Maryland, Center for School Mental Health (Weist et al., 2005, 2007). The first column of Fig. 6 shows the principles, and the second column shows the separate subheadings pertaining to categories of CSCT Administrative Rule revision.

Butts (2010) concluded that definitions of SMH, QAI frameworks, and research-based principles for expanded SMH all engender their own

Fig. 7 Nine pillars for expanded school mental health practice

complications but, when implemented together, promote coherent strategies for systems change and readiness. Abovementioned processes to guide the work in Montana and presented in Fig. 7 represent the core of the document and are major areas guiding practice. The nine pillars are:

In addition to synthesizing the research and presenting this framework for systems change, the white paper provides recommendations for specific actions to be taken in Montana. Recommendations are emphasized in a number of key realms related to Administrative Rules and better integrating Positive Behavior Intervention and Supports (PBIS) and SMH. Thus, the development of the white paper and associated processes helped to facilitate the development and implementation of the trilateral model for advancing SMH in Montana.

Policy

Weist and Paternite (2006) reason: "because states and local communities have significant latitude in decisions about policy and practice, the extent, type, and quality of services that are offered vary tremendously" (p. 177). The authors continue to highlight:

> The significant variability in policies and practices across child-serving systems within and between localities contributes to inertia in local and state governments in advancing reforms and improvements in these systems. Organization of state level initiatives that reform and improve child-serving systems is an important strategy to address existing variability in SMH policy and practice. (p. 177)

The white paper provided specific recommendations for advancing SMH for each of the nine pillars and also provides four individualized recommendations for the Process of Administrative Rule Changes: (1) *Include Stakeholders* (involve multiple stakeholders in CSCT Administrative Rule change process), (2) *Continue with Evaluation and Assessment of CSCT* (conduct a thorough evaluation of CSCT by implementing a quality assessment and improvement analysis), (3) *Increase the Use of Technology* (increase the use of technology for therapeutic services, professional development, and statewide collaboration), and (4) *Work Collectively* (all nine CSCT providers to begin working collectively to come up with a shared agenda, goals, and action strategies).

Policy makers and family organizations can develop and embrace a shared agenda in partner-

ship, with a "common conceptual framework that underpins a comprehensive approach to mental health services in schools: a seamless, fluid, interlinked multi-level framework that encompasses positive child and youth development, prevention, early intervention, and intensive interventions" (Andis et al., 2002, p. 31). In this regard, the white paper underscores the need for policies to support new practices that improve outcomes to Montana's children, youth, and families. Writing new CSCT rules is an opportune time to implement research to practice expectations for all CSCT licensed Mental Health Centers. However, within the rule changes, there needs to be enough flexibility for schools to have localized decision-making power. If new rules are written with such rigidity that individual schools or school districts and CSCT licensed mental health centers are unable to meet new standards, the effectiveness of CSCT will be compromised.

State officials acknowledge CSCT licensed mental health centers, and school districts can exert local control through school contracts for CSCT services. The contract has the potential to become a critical component and asset to support new research-informed CSCT Administrative Rule requirements and standards. The CSCT contract between licensed mental health centers and schools is receiving more attention during the current rule rewrite process. Policy makers are considering a more direct and supportive role in contract decision making. State officials may offer a sample contract that specifically outlines evidence-based practices. The white paper includes a sample contract from the state of West Virginia. West Virginia's sharing of resources will expedite sample contract development in Montana, consistent with a major theme in this book of working within the context of a Community of Practice, whereby states, communities, initiatives, and people share helpful resources and support one another through the foundation of collaborative relationships (Wenger, McDermott, & Snyder, 2002).

DPHHS administration upheld the research-founded tenet of having multiple stakeholders at the table when rewriting state CSCT Administrative Rules. The first CSCT Administrative Rule write in 2003 followed a typical process of political negotiation and did not reflect multiple stakeholders at the table. Following a specific recommendation in the white paper (Butts, 2010), DPHHS administration has taken ample time to put together a working group to rewrite the rules that is broader and more representative of those affected by CSCT. The following representation was specifically invited to constitute the working group to support the CSCT Administrative Rule revisions: OPI, one state agency staff in addition to a student, a parent, and up to three school staff representing school administrators and educators; DPHHS, four state agency staff representing Quality Assurance-licensure, Health Resources-acute services, Child Protection Services and Developmental Services-Children's Mental Health; Mental Health Centers, two staff representatives; and The University of Montana, one research representative and American Indian social services representation one individual.

Readiness

Holt, Armenakis, Field, and Harris (2007) looking at readiness for organizational change, and surveying more than 900 participants from public and private sectors, stated:

> Readiness for change is a multidimensional construct influenced by beliefs among employees that (a) they are capable of implementing a proposed change (i.e., change-specific efficacy), (b) the proposed change is appropriate for the organization (i.e., appropriateness), (c) the leaders are committed to the proposed change (i.e., management support), and (d) the proposed change is beneficial to organizational members (i.e., personal valence). (p. 232)

Montana state leaders exemplify best practices of effective decision making and moving towards statewide systems change. Multiple activities were set in place to assure state readiness for change. Table 2 provides a timeline of readiness activities to advance statewide CSCT rule revisions.

Table 2 Readiness activities towards statewide CSCT administrative rule revision

Timeframe	Readiness activity
December 2010	Final white paper to the OPI is submitted
January 2011	OPI, DPHHS, and IERS receive a formal presentation of the final white paper
February 2011	The OPI provided all participants at the statewide Communities of Practice a copy of the final white paper. This was the first release of the final document and an opportunity for public review of the research
March 2011	Presentation of the white paper at the statewide 2011 School Mental Health
April–May 2011	The nine CSCT licensed mental health centers met face to face with DPHHS administrators and researcher to discuss the nine pillars. CSCT licensed mental health centers invited DPPHS personnel and researcher to their Communities of Practice meeting to further discuss the nine pillars and talk about the expected Administrative Rule rewrite process.
June 2011	The Montana Behavioral Initiative (MBI) Summer Institute, Montana's adaptation of the national Positive Behavioral Intervention and Supports (PBIS) framework, implemented a SMH track to include multiple dialogues with national and statewide representatives around the forthcoming CSCT rule rewrite.
November 2010–February 2011	DPHHS and OPI hosted three Administrative Rule rewrite working group meetings with participants aware of group expectations and background information. Meetings were centered around the nine pillars with ample time for group discussion and individual feedback to DPHHS. Final notes from these meetings are used to guide CSCT Administrative Rule revision(s)
March 2012	The statewide School Mental Health Conference provided a panel discussion with the DPHHS and OPI administrators and co-facilitators of the CSCT working group to provide highlights of the CSCT rule change process with Q & A
March–May 2012	DPHHS and OPI leaders will draft and develop new Administrative Rules for CSCT based on working group member feedback within notes framed within the context of the nine pillars and host two more working group meetings to review and provide feedback on newly drafted CSCT Administrative Rules and discuss funding mechanisms for CSCT
June 2012	National SMH researcher Mark Weist and researcher Erin Butts will present full-day session at the MBI summer institute to stakeholders around the nine pillars
July 2012	Drafted CSCT Administrative Rules are expected to be ready for public comment
December 2012– Spring 2013	Anticipated time when CSCT Administrative Rules will be legally completed and key stakeholders prepared for new Administrative Rule implementation
Summer 2013	New CSCT Administrative Rules are expected to be in effect

Readiness Timeline for CSCT Administrative Rule Rewrite

It is particularly important that the CSCT licensed mental health centers have an ongoing opportunity to raise questions, get answers, and understand how the SMH research expectations will ultimately inform new CSCT Administrative Rules. For the first time in Montana, rules are being supported, discussed and written by individuals who are highly informed of what research demonstrates as best practice. This exemplary research process not only has the possibility of changing the SMH culture of research to practice across Montana for CSCT, but moreover is a pilot of how to approach future rule revisions for any state system that influences our children, youth and families.

Leaders in implementation, Fixsen, Blase, Naoom, and Wallace (2009) write that for science to influence practice in the human services fields is particularly difficult in part because "the practitioner is the intervention" (p. 532). Thus, the number of individuals serving our children, youth, and families across the nation is extensive, and getting individuals from multisystems to implement science is no small feat. Fixsen and colleagues propose six stages of implementation that include exploration, installation, initial implementation, full implementation, innovation, and sustainability. The authors believe that "the

stages are not linear as each appears to impact the others in complex ways. The stages of implementation can be thought of as components of a tight circle with two-headed arrows from each to every other component" (p. 532). Supporting this understanding of implementation, Montana expects that approaching policy with the trilateral framework firmly in place will lead to integrative and consistent service delivery.

Conclusion

There are positive SMH system changes emerging for the state of Montana guided through the implementation of the trilateral framework emphasizing interconnections among partnership, research, and policy. Montana has developed strong partnerships and collaboration across agencies and departments, identified evidence-based mental health practices to incentivize through policy and increase access to throughout the state. Results from this interconnection of partnership, research, and policy are encouraging and suggest a way to systematically improve SMH for other states. Only time will tell whether impending Administrative Rule Changes of CSCT assist in the expansion and improvement of school mental health in Montana. We look forward to continuing to tell this story as it plays out.

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