Advancing Education Effectiveness:

Interconnecting School Mental Health and School-Wide PBIS

Volume 2: An Implementation Guide

By: Lucille Eber
Susan Barrett
Kelly Perales
Jennifer Jeffrey-Pearsall
Katie Pohlman
Robert Putnam
Joni Splett
Mark D. Weist

CENTER ON PBIS Positive Behavioral Interventions & Supports

Advancing Education Effectiveness: Interconnecting School Mental Health and School-Wide PBIS

Volume 2: An Implementation Guide

AUTHORS

Lucille Eber
Susan Barrett
Kelly Perales
Jennifer Jeffrey-Pearsall
Katie Pohlman
Robert Putnam
Joni Splett
Mark D. Weist

CENTER ON PBIS Positive Behavioral Interventions & Supports

Recommended Reference

Eber, L., Barrett, S., Perales, K., Jeffrey-Pearsall, J., Pohlman, K., Putnam, R, Splett, J., & Weist, M.D.(2019). *Advancing Education Effectiveness: Interconnecting School Mental Health and School-Wide PBIS, Volume 2: An Implementation Guide*. Center for Positive Behavior Interventions and Supports (funded by the Office of Special Education Programs, U.S. Department of Education). Eugene, Oregon: University of Oregon Press.

First published 2020
by University of Oregon
1235 University of Oregon, Eugene, Oregon 97403-1235

This monograph was supported in part from funds provided by the Center on Positive Behavioral Interventions and Supports cooperative grant supported by the Office of Special Education Programs (OSEP) of the U.S. Department of Education (H326S180001). Dr. Renee Bradley served as the project officer. The views expressed herein do not necessarily represent the positions or policies of the U.S. Department of Education. No official endorsement by the U.S. Department of Education of any product, commodity, or enterprise mentioned in this document is intended or should be inferred..

Typset in Adobe Garamond Pro and Museo Slab
by Robin Spoerl.

Acknowledgments

Thank you to all contributing authors from Advancing Education Effectiveness: Interconnecting School Mental Health and School-Wide Positive Behavior Support. The second volume would not exist without the foundation of the work.

Sincere appreciation is also expressed to the many researching and implementing partners over the past decade continuing to define an integrated system. Without the dedication, experiences, and data you have contributed the explicitness of this Implementation Guide would not be possible. In addition to all state, regional, school and community partners, we would like to individually acknowledge the following for their contributions in Volume 2.

Ali Hearn, Midwest PBIS Network
Patti Hershfeldt, Center for Social Behavior Supports
Sheri Luecking, Midwest PBIS Network
Natalie Romer, University of South Florida
Kim Yanek, Center for Social Behavior Supports

We would also like to thank our Internal Evaluation Review Panel for providing thoughtful feedback around this Implementation Guide prior to publication:

Lucas Anderson, Placer County Office of Education, CA
McKenzie Harrington-Bacote, Laconia School District, Laconia, NH
Nanci Johnson, Missouri School-wide Positive Behavior Support
Tina Lawson, Pennsylvania Training & Technical Assistance Network
Carrie Novotny-Buss, Millard Public Schools, Omaha, NE
Justyn Poulos, Washington Office of Superintendent of Public Instruction - Center for the Improvement of Student Learning
Florence Protopapas, David Douglas School District, Portland, OR
Kim Traverso, Connecticut State Department of Education - Office of Student Supports

Table of Contents

Preface

In the 1990s and 2000s, I was fortunate to be deeply involved in improving mental health services for children and adolescents through education-mental health system partnerships. This included helping to found the Center for School Mental Health Assistance, now the National Center for School Mental Health (NCSMH),[1] and in its 24th year of federal funding from the Health Resources and Services Administration. I am grateful to have had this experience with the NCSMH, and for its continued positive impacts in advancing more comprehensive school mental health (SMH) programs in all states in the United States (U.S.).

As the SMH movement was advancing in the late 1990s and early 2000s, I was engaged in research, policy and technical assistance/coaching through the center, and helping to build programs and improve practices in schools in Baltimore and other locations in Maryland. During this time, while I knew of Positive Behavioral Interventions and Supports (PBIS), I viewed it as a separate and different initiative, and had little to no interaction with PBIS staff and leaders, even though this framework was present in many of our schools (for a more recent example of this *parallel play*, see Splett et al., 2014).

Fortunately, national leaders in PBIS, Lucille Eber and Susan Barrett reached out to me in 2007 emphasizing that the two initiatives, SMH and PBIS should be working together. I found their arguments compelling, and we began to explore ways to build complementarity. This led to the development and dissemination of a white paper in 2009, followed by a convening of leaders identified by national centers for SMH and PBIS and in 2013, a monograph on an Interconnected Systems Framework (ISF) for PBIS and SMH was published (Barrett, Eber, & Weist, 2013). Each chapter of the monograph is written by leaders involved in PBIS and SMH. Practical guidance is provided on dimensions of interconnected work including the enhancement of teams and integration of mental health clinicians into them; data-based decision making; implementing and refining evidence-based practices (EBPs); school building, district and state approaches and connecting them together; and resources to build supportive policies and capacity. Reflecting a free and user-friendly resource for the field, the monograph has been viewed/downloaded more than 50,000 times.

The ISF is being implemented in more than 30 states around the U.S. and is being explored in other countries (e.g., Australia, Iceland, the Netherlands, New Zealand). This growth is related to its significant advantages of promoting depth and quality in schools' multi-tiered systems of support (MTSS), economies of scale, and synergy in programming that reduces barriers to student learning and improves their social, emotional, behavioral and academic functioning

(see below*). For the past six years, a national ISF workgroup has tracked progress and interacted with sites to provide guidance, learn about challenges and successes, and hear recommendations from the field.

Around two years ago, there seemed to be clear consensus on the need for a second version of the monograph (Barrett et al., 2013), with emphasis on pragmatic guidance and effective examples of implementation, and we are pleased to present this Volume 2 to you now. The purpose of this updated version of the ISF monograph is to help teams considering, just starting to, and/or already implementing the approach to deepen and improve the quality of the work based on guidance and practical examples reflecting our past six years of experience.

After providing relevant background and a compelling rationale for the ISF, relevant to all school districts in the U.S., this monograph provides step-by-step guidance for districts and partner schools to move this agenda forward systematically. Building from the prior monograph (Barrett et al., 2013) and validated key messages (*a single system approach, mental health is for all, access is not enough,* and *the MTSS is foundational to successful school mental health*), comprehensive guidance is provided on all relevant processes (e.g., district-school collaboration, diverse stakeholder involvement, teaming, screening, data use, installing EBPs, etc.). The monograph includes experiences from sites implementing the ISF from around the country, guides all phases of this work from exploration to full implementation and sustainability, and includes a range of valuable tools and resources, all from the vantage point of school districts and partner schools working closely together, ideally supported by state leaders and advances in policy.

There are a number of reasons why the ISF is gaining momentum in the U.S. In addition to advantages presented above, two other reasons are: 1) There is evidence that mental health challenges among children and youth are worsening (Torio et al., 2015), and limitations of traditional, single-system approaches are increasingly recognized (Lever et al., 2003; Splett,et al., 2013). Children, youth and families are suffering and there is an urgent need to move away from status quo approaches toward genuine cross-system collaboration, broadening the range of resources and support and improving the reach and depth of programs. 2) Research documents that well-done interventions in one realm of student functioning can affect that realm and other realms. For example, in studies on children and youth, effective academic intervention has been found to improve school performance, and also improve emotional/behavioral (EB) functioning (Mulcahy et al., 2017). Relatedly, well-done counseling may improve EB functioning and also improve school performance (Suldo et al., 2014). **This interconnectedness of processes in people should be reflected in interconnectedness in our systems.**

We are fortunate to be involved in the first randomized controlled trial on the ISF - *Interconnecting PBIS and school mental health to improve school safety: A randomized trial,* funded by the National Institute of Justice (#2015-CK-BX-0018, 2016-2020), as part of President

Obama's *Now is the Time Initiative*[2] to promote school safety and student success. The study involves 24 elementary schools with 12 in Charleston, South Carolina, and 12 in Marion, Florida, with 8 schools (4 per district) implementing the ISF, 8 schools implementing PBIS alone, and 8 schools implementing PBIS plus SMH (i.e., parallel play). Following a two-year intervention versus comparison period and one year of follow-up, major analyses are now underway. We are encouraged by preliminary findings indicating positive impacts for ISF schools compared to other conditions in team functioning and decision making; receipt of services by students with elevated needs; reduced inequity in service receipt for children of color; and teacher-rated improvements in social, emotional and behavioral functioning (with academic impacts being explored).*

In closing, we convey our significant appreciation to the Office of Special Education Programs, U.S. Department of Education (and project officer, Renee Bradley) and the Center for Positive Behavioral Interventions and Supports for the foundational support and wise guidance provided in furthering the work and impact of the Interconnected Systems Framework for SMH and PBIS.

Mark D. Weist, PhD
Professor, University of South Carolina
November 15, 2019

CHAPTER ONE

Introduction: Setting the Stage for an Interconnected System of Education and Mental Health

The Interconnected Systems Framework (ISF) is a structure and process to establish a single system of delivery across education and mental health, with active family and youth engagement. The deliberate integration of mental health and other community partners into the multi-tiered Positive Behavior Interventions and Support (PBIS) system in schools is intended to ensure education and mental health structures interact in the most efficient and effective manner. The overall purpose of such an integrated system is to create a school culture and climate that promotes wellness (i.e., social, emotional, behavioral, academic, mental health promotion) of the whole child and addresses the needs of all students, especially those at-risk for or with mental health challenges. The ISF structure is focused on the system features needed to ensure evidence-based practices are delivered with accuracy and greater accountability to evaluate student growth overtime including formative and summative assessment.

History of the Interconnected Systems Framework (ISF) in Schools

Conceptual work on the ISF originated in 2007 through purposeful collaboration between national leaders of PBIS and expanded School Mental Health (SMH) programs, who recognized the parallel functioning and associated missed opportunities from separately functioning frameworks. This led to a white paper, *Development of an Interconnected Systems Framework for School Mental Health* (Barrett, Eber, & Weist, 2009) and increased discussion among leaders and staff from diverse youth-serving disciplines, with emphasis on education and mental health systems. The impetus was a keen awareness among PBIS and SMH leaders of the need to directly align structures to establish more comprehensive and effective systems of behavioral/mental health in schools. This was driven by the prevalence of underserved emotional, mental health, and behavioral needs of our children and the recognition of the value in applying organization, intervention and prevention sciences to address the situation. The need to ensure a multi-tiered, prevention-based methodology for supporting the mental health of all students was established.

The synergy created from the original workgroup and concept paper led to the development of the first monograph, *Advancing Education Effectiveness: Interconnecting School*

Mental Health and School-Wide Positive Behavior Support (Barrett, Eber, & Weist, 2013). This publication was developed through a focused collaboration among practitioners and researchers from the fields of PBIS and SMH and outlined the rationale, and approach for an ISF, building from the success of the effective system features of the PBIS framework. It included descriptions from efforts in states and districts to date, clarifying essential features for using the framework to expand and improve mental health in schools. The chapters of the monograph, each coauthored by a PBIS and a SMH researcher/leader, described the structured use of district and school-based teams using relevant data to design, deliver and refine an expanded continuum of evidence-based practices.

Since 2013, work in the field of ISF, influenced by prevention and implementation science, has grown and now includes multiple examples of application across the country. Collaborations with and among the various sites over the past eleven years have contributed to a growing knowledge base on how to integrate these systems (Weist et al., 2018; Splett et al., 2017). This knowledge includes the development of planning tools, fidelity measures, and curriculum for supporting state, regional and local collaborations. From 2016-2019, the development of the ISF was guided by a National ISF Targeted Work Group led by the National Technical Assistance Center on PBIS. Participants included a host of field-based leaders who participated in regular webinars, highlighting knowledge development and experiences from state, regional, and local implementers. Further, field-based knowledge development has grown from national and international training events and conferences, and has been documented in professional publications.

Since the publication of the first ISF monograph, there has been a period of mutual growth and learning during which the implementation of the ISF across sites, guided by the ISF Targeted Work Group, has refined practices/tools/processes. These iterative improvements have increased the knowledge, effectiveness and efficiency of the ISF as implementation has expanded, often with the support of state and federal education and mental health grants. This enhanced knowledge base has informed the content of this second iteration of the monograph, *Advancing Education Effectiveness: Interconnecting School Mental Health and School-Wide Positive Behavior Support, Volume 2: An Implementation Guide*. The purpose of Volume 2 of the ISF Monograph series is to provide updated information and technical guidelines for the implementation of an interconnected system of PBIS and mental health that have emerged over the past six years. This volume is intended for state, district or building leadership at any stage of implementation.

The remainder of Chapter 1 will focus on the broader societal context leading to the development of the original monograph in 2013 and the continued relevance and need for the development of an interconnected system today. Additionally, the remainder of Chapter 1 will provide an expanded description of the purpose and structure of Volume 2.

Societal Context / Contextual Variables Impacting Child Development

As described in the introduction of Chapter 1, in 2007 national leaders in PBIS and SMH recognized a need to come together to develop a comprehensive and aligned framework to best support the often unmet social, emotional, and mental health needs of children and youth, using schools as a primary source of influence on child outcomes. At that time, the U.S. Surgeon General reported that 20% of children and youth were in need of mental health interventions, but only a third of those in need received support (Centers for Disease Control and Prevention, 2013). Of those that received support, 70% accessed support through the school setting, leading many to declare schools as the de facto mental health setting for children (Kutash, Duchnowski, & Green, 2011; Jacob & Coustasse, 2008). However, researchers have documented a lack of adequate evidence for intervention strategies used to address mental health needs in schools (Barrett et al., 2013; Kutash, Duchnowski, & Lynn, 2006; Weisz, Jensen-Doss, & Hawley, 2006). Additionally, a report from the National Research Council and Institute of Medicine (2009) put forth a national call-to-action to place a high priority on the behavioral, emotional, and mental health needs of young people in our country – and this call continues today. Clearly, the need to support children and youth behavior/mental health has been identified as a national issue, making it a priority for all.

Current Mental Health Wellbeing of America's Youth

Clear identification of the current prevalence and trends in children's mental health is difficult for a number of reasons. Variances in methodology for gathering data, various sources of information (e.g., medical providers, families/caregivers, community agency personnel) and even changes in and interpretations of diagnostic criteria make it difficult to determine exact prevalence and trends (Holbrook, et al., 2017). However, multiple studies indicate that there is a continuing increase in both the prevalence and severity of mental disorders in children and adolescents (Hellebuyck, et al., 2019).

Since the original call to action in 2007 and publication of the first ISF monograph in 2013, various agencies have reported a substantially larger prevalence of adolescents experiencing some type of mental disorder. National Alliance on Mental Illness (NAMI) (2017) reported 20%, Substance Abuse and Mental Health Service Administration (SAMHSA) 40% (2018) and The National Institute of Mental Health (2019) closer to 50%. Thus, it is apparent that many children and youth exhibit a need for mental health services/intervention and yet an estimated 50% receive no treatment or education about mental health (NAMI, 2017). According to the results of the *2018 National Survey on Drug Use and Health,* school settings are where the majority of youth receive supports (Kazak et al. 2010, SAMSHA, 2018). Additionally, the complexities of our society have increased; further proliferating the needs

of our children. For example, Twenge et al., (2010) found increases in more serious social/emotional/behavioral problems among current youth as compared to previous generations. This increase in more severe social/emotional/behavioral problems speaks to a broader set of stressors placing children's overall wellbeing at higher risk, and the need to establish comprehensive nurturing environments to mitigate these risk factors (Biglan, 2015).

Depression in Children and Adolescents

Recent studies indicate between 9.4 % (NAMI, 2017) and 13.3% (SAMSHA, 2018) of youth aged 12-17 experienced at least one major depressive episode (MDE) in the years surveyed. Of the 3.2 million children and youth who reported having a MDE, 60.1 % did not receive treatment (SAMSHA, 2018). Historically, the rate of treatment completion, even when treatment is delivered, is extremely low (Martini, Hilt, & Marx et al., 2012). It is estimated that 20% of children experience depression at some point during adolescence, while only half are identified and diagnosed before reaching adulthood (Zuckerbrot, et al., 2018).

Children with depression are 3.93 times more likely to use substances, 3.85 times more likely to exhibit antisocial behavior, 5.79 times more likely to engage in early sexual behavior, and 3.46 times more likely to have an eating disorder (Boles, Biglan, & Smolkowski, 2006). The prevalence of depression being undiagnosed or untreated in adolescents reached a point where, in 2018, the American Academy of Pediatrics and the U.S. Preventative Services Task Force endorsed universal screening for depression through primary care systems in children age 12 and over as detailed in the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) , (Zuckerbrot, et al., 2018).

Suicide in America

In addition to increase in rates of depression, there is an increase in rates of suicide and suicide ideation. There has been a 2.2% increase in the suicide rate among youth ages 15-24 years old between 2011 and 2016 (Drapeau & McIntosh, 2018). Currently, suicide is the second leading cause of death for children 15-24 years old (Heron, 2019). According to NAMI (2017) 90% of youth who died by suicide had an underlying mental illness. With such a high prevalence of depression and suicide among children and youth, and with schools continuing to be the de facto setting for service delivery, it is imperative to support educators to increase awareness around preventative measures, symptoms, and responses to possible threats of depression of suicide.

Impact of Trauma

Many children and youth in our schools experience life events or emotional states that inhibit access to learning and compromise their overall wellbeing (Santiago, Raviv, & Jaycox, 2018). According to data collected through the National Survey of Children's Health, almost half of children and youth (46%) in the U.S. (ages birth to 17) have experienced one or more traumatic events in their lives with and between

18-20% of children experiencing two or more traumatic events (Child and Adolescent Health Measurement Initiative, 2017). These stressful or traumatic life events are referred to as Adverse Childhood Experiences (ACEs) and are associated with a higher risk for adverse physical and mental health outcomes including alcoholism, smoking, drug use, depression, diabetes, suicide, heart disease, stroke, and obesity and also adverse academic outcomes (Sacks, Murphey, & Moore, 2014; Felitti, Anda, & Nordenberg, 1998). The prevalence of ACEs increases with a child's age and, as the number of ACEs increases, so do the risks for negative outcomes (Felitti, Anda, & Nordenberg, 1998; Santiago, Raviv, & Jaycox, 2018). Similar to depression and suicide, it is imperative that educators are supported to understand the experiences in their students' lives that may constitute a traumatic event, recognize possible symptoms of trauma, and respond accordingly.

Substance Use and Abuse

Substance misuse in the household is one ACE that has been intensified by the current opioid epidemic in the United States (Derefinko, et al., 2019). Opioid use in the United States has become a public health crisis, with the United States having the highest rate of opioid use in the world, outpacing many other countries by five to six times (National Institute on Drug Abuse, 2017). Opioid use is most prevalent in larger metropolitan areas where educational attainment and income occur at higher rates (Mack, Jones, & Ballesteror, 2017). Adolescents are especially vulnerable to opioid use, as evidenced by 7.9% of children ages 12-17 reporting the use of prescription drugs for non-medical purposes (Center for Disease Control, 2018). One-half of opioid-related deaths in the United States occur among men and women between the ages of 25 and 44, ages when many in the United States become parents and/or have school-age children. Children living in a home with a parent using opioids are more likely to experience a parental overdose, chronic stress, added household responsibilities, and unmet mental health needs and children living with an addicted parent are at higher risk for physical, academic, and social-emotional problems (Solis, Shadur, & Burns, 2012).

Role of Technology

Finally, compared to prior generations, technology plays a more central role in children's lives. Children now have rapid access to greater amounts of information (i.e., cable television, internet, social media) on a continuous basis with readily available devices (e.g., cell phones), requiring them to process and filter more information at a faster pace than ever before. One of the social implications of technology for our children includes an increase in electronic aggression, or "any type of harassment or bullying (teasing, telling lies, making fun of someone, making rude or mean comments, spreading rumors, or making threatening or aggressive comments)" that occurs through a variety of devices with access to social media (David-Ferdon & Hertz, 2009). Electronic (cyber) aggression has emerged as a public health problem and can serve as another stressor in a child's life with 15% of high school

students reporting having been cyber-bullied (Musu, et al., 2019). Being a target of electronic aggression has been associated with a higher risk for misusing alcohol or substances, receiving a school detention or suspension, skipping school, experiencing in-person victimization or emotional distress, and feeling unsafe at school (Ybarra, et al., 2007).

Despite the 1999 National Research Council's and Institute of Medicine's (2009) call-to-action for schools to invest in prevention and mental health promotion, schools and community agencies continue to struggle to establish efficient and effective systems of support for the children and youth they serve. The ISF provides systems with a structure and guidelines to use the public health prevention framework to implement practices and interventions across universal, secondary, and tertiary tiers of support that create nurturing environments (Weist et al., 2018).

Our schools continue to serve children, families, and communities with complex needs. Schools cannot do this work alone. As such, forming partnerships between schools and communities strengthen our preparedness and ability to educate the whole child by establishing: (a) comprehensive systems to mitigate the stressors experienced by young people in our society; (b) a continuum of evidence-based prevention and intervention strategies to support quality of life for all; and (c) a focus on the promotion of mental wellbeing for all (Biglan, 2015; Weist et al., 2018).

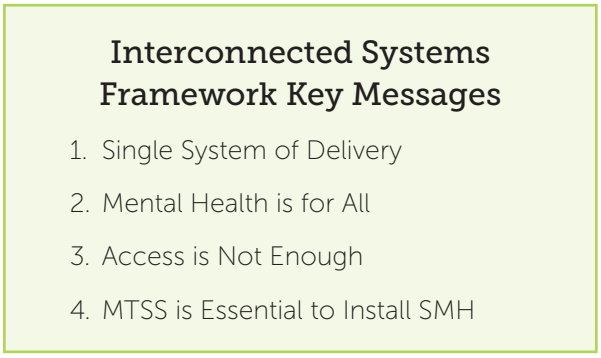
Context for Development of Volume 2 of the ISF Monograph Series

Since publication in 2013, the monograph outlining the ISF (Barrett et al., 2013) has gained increasing interest from educators and mental health providers in the field. The ongoing work of the ISF Targeted Work Group has supported field-based implementers to coalesce around the issues of installing and implementing a single system for the delivery of comprehensive behavioral health services at the local, regional, and state levels. National leaders have continued to support knowledge development sites as they move through the process of merging systems. Experiences with training, technical assistance, and networking have helped to develop and refine tools, curricula, publications, and other resources to assist local sites in moving forward with interconnecting their PBIS and mental health systems. To date, there are representatives from twenty-one states who have participated in some capacity with the ISF Targeted Work Group. Among these, nineteen school districts and over forty-two schools have contributed to the growth of knowledge development sites, by sharing their collective experiences and lessons learned from application of tools and resources within local contexts.

During this process, key leaders from education and mental health have continued to build strong collaborative relationships, further articulating core features and key messages used to guide states, districts, and school teams through alignment and action planning. To further support and clarify the alignment process,

leaders of the National PBIS and SMH Centers coalesced around ensuring consistent messages to the field and put forth four key messages of the ISF (Figure 1.1) to provide further guidance for implementation (Weist et al., 2016). These key messages are described in Chapter 2 and further illustrated throughout this monograph including tools and resources for working through the actualization of these messages.

Figure 1.1: Key Messages of the ISF



It is important to acknowledge that this work is conducted within the context of best practices in implementation science (Fixsen, Naoom, Blasé, Friedman, and Wallace, 2005), with an understanding that systems change is a multi-year process. This multi-year process follows a progression of stages of implementation that include: Exploration, Installation, Initial Implementation, and Full Implementation (Fixsen, et al., 2005). The generic stages of implementation are defined in Table 1.1, and are further articulated and applied to the ISF in Chapter 2 and throughout this monograph.

Table 1.1. Stages of Implementation and Operational Descriptions

Implementation Stage	Description
Exploration/ Adoption	During this stage, a team is assessing the needs of the district and community and selecting evidence- based practice(s) to meet the identified needs while also assessing the readiness to implement (e.g. financial, political, resources).
Installation	The installation stage is about acquiring or repurposing resources to support the implementation of new practice or program. Resources include staffing, training, funding, evaluation systems, and coaching.
Initial Implementation	This is referred to as the 'fragile' or 'awkward' stage of implementation when staff are beginning to implement changes. District continues to shift resources to support staff.
Full Implementation	When practices become the norm, and are integrated into policy and procedure. Practitioners are implementing with proficiency, leadership is supporting implementation needs, and stakeholders have adapted to innovation.

Purpose and Structure of Volume 2 of the ISF Monograph Series

This volume is intended to be used by those interested in meeting child behavior/mental health needs in school, with an emphasis on developing an efficient system and process for integrating mental health promotion in schools. More specifically, this resource is designed as a "how to" manual for state, district, school personnel who are working to deliberately integrate community partners into an expanded multi-tiered system of social-emotional-behavioral support in schools to better meet the needs of all students. Content within each chapter is linked to relevant resources and tools that support the implementation of the ISF. Chapter 2 provides an expanded description of the Interconnected Systems Framework (ISF), and how the framework was developed, including a description of key messages and stages of implementation. Remaining chapters are organized by phases of implementation with specific implementation guidelines organized and illustrated for use by state, district or school-based teams. Chapter 3 describes the exploration process, specific to an ISF, and considerations for adoption by state, regions and districts. Chapter 4 moves beyond exploration and adoption to articulate the installation steps for District and Community leaders and includes an Installation Guide of tools and activities. Chapter 5 guides coaches and local leaders through the steps for installation of an ISF within a school, and is also supported by an Installation Guide that includes templates, tools, and examples of the various steps identified from knowledge development sites. Chapter 6 provides a description and examples of full implementation with a focus on continuous improvement and sustainability.

CHAPTER TWO

Defining Interconnected Systems Framework (ISF): Origins, Critical Features and Key Messages

The Interconnected Systems Framework (ISF) was introduced in Chapter 1 as a framework developed by national leaders in the fields of Positive Behavioral Interventions and Supports (PBIS) and School Mental Health (SMH) to advance effective systems of behavioral/mental health in schools. Recognizing the shared vision and value of both PBIS and SMH, the interconnected approach is a deliberate process intended to leverage the strengths inherent in each approach while also addressing the limitations of each. To assist in understanding the ISF process and structure, this chapter begins by briefly reviewing the contributions made from PBIS and SMH and describing how schools and communities can benefit from the combined assets of both while addressing the combined weaknesses inherent in both fields. An overview of the ISF is provided, including descriptions of the four key messages that exemplify the process. Additionally, the application of implementation science is explained as an organizing structure to guide movement through the phases of implementation with a focus on intentional planning for sustainability throughout implementation.

Origins of the Interconnected Systems Framework (ISF)

The PBIS Framework

PBIS is a framework for enhancing the adoption and implementation of a continuum of evidence-based, behavioral interventions to improve academic and behavioral outcomes for all students (Sugai et al., 2000). PBIS establishes four interactive elements (a) outcomes, (b) systems, (c) data, and (d) practices as the base for implementation. Systems are the structures (e.g., teaming, coaching, training, data systems, etc.) that are needed to ensure accurate and sustainable use of evidence-based practices (McIntosh, Horner, & Sugai, 2009). Teams use data to support the selection and implementation of practices matched to students' needs. Data are also used to progress monitor whether interventions are having the intended effect so that adjustments can be made if needed, thereby, ensuring desired outcomes are achieved. Practices are the evidence-based interventions that address students' needs to meet these identified outcomes. These interactive elements of PBIS provide the foundation for the ISF with emphasis on the

implementation of an expanded continuum of supports to meet the needs of all students, especially those with or at-risk of mental health challenges (Barrett et al., 2013).

PBIS was introduced into policy with the reauthorization of the Individuals with Disabilities Act (1997) and districts across the country have accessed technical assistance and resources through the Office of Special Education Programs (OSEP)'s National Center on PBIS[3] to support local implementation efforts. Currently being implemented in over 26,000 schools nationwide, PBIS has been associated with reductions in discipline referrals and out-of-school suspensions (Anderson & Kincaid, 2005; Bradshaw et al., 2009). Improvements in social/emotional functioning, school climate and academic performance have also been linked to PBIS implementation in schools (Bradshaw et al., 2009; McIntosh et al., 2006). Exemplifying the public health model, PBIS uses a continuous improvement process to meet the changing needs of a population including (a) building the needed skills of school personnel, (b) implementing interventions as intended, (c) providing ongoing coaching to support school and district personnel as they implement evidence-based practices, (d) assuring the fit of evidence-based practices to the needs of individuals and groups being served, (e) promoting collaboration among systems leaders, and (f) assuring appropriate implementation supports for evidence-based practices (Horner & Sugai, 2015).

As a multi-tiered system of support, PBIS emphasizes prevention and promotion of social-emotional-behavioral wellness at Tier 1; targeted intervention for students identified as at-risk at Tier 2; and intensive, individual interventions for students identified as needing high levels of support at Tier 3. Although effective outcomes are well documented, PBIS implementation has experienced slower installation at Tier 2 and even more challenges at Tier 3 as schools struggle to establish the systems and the expertise for students with higher level needs. Furthermore, PBIS has historically had an emphasis on externalizing behaviors while often overlooking more internalizing concerns, such as depression, anxiety and the impacts of trauma (Weist et al, 2018).

School Mental Health (SMH)

The field of SMH emerged during the mid-1990s as a vision of schools being a place where all students, especially those with mental health challenges, could receive comprehensive services (Dryfoos, 1994). In part, this was in response to the evidence that children who were identified with mental health concerns were not being offered needed services. SMH providers established locations within schools to facilitate the provision of mental health services to students. Over the past several decades, SMH models pioneered the inclusion of community mental health providers into schools and have been associated with increased access to care, enhanced preventive services, and reduced stigma of treatment (Elias, Gager, & Leon, 1997; Catron, Harris, & Weiss, 1998; Nabors & Reynolds, 2000). In more recent years, the National

Center for School Mental Health has partnered with the National Quality Initiative (NQI) and the School Based Health Alliance (SBHA) with the task of gathering national mental health census information to advance a data-driven mental health team process in districts and schools. One resource developed through this work is an online database[4] with tools and resources to support building a more comprehensive continuum of mental health supports for students within schools (Connors et al., 2016).

While SMH efforts have resulted in services being moved to "where students are", mental health providers still tend to operate separately from other professionals in the school system (e.g., teachers and administration); thus, services to students may be reactive versus preventative and occur without active participation of other professionals working in schools (Barrett et al., 2013). The lack of structured teaming processes in SMH implementation, as well as, inconsistent use of evidence-based practices and the lack of systemic progress monitoring (Evans & Weist, 2004; Kutash, Duchnowski & Lynn, 2006; Mellin et al., 2010) were identified as weaknesses to be addressed in the development of the ISF approach and process (Barrett, et al, 2013).

An Overview of the Interconnected Systems Framework (ISF)

The ISF is an implementation framework that creates and guides the deliberate merge of education and mental health systems and staff (Barrett, et al., 2013). The ISF was developed because, despite the strengths of PBIS and SMH, school and community systems continue to struggle to meet the mental health needs of children and adolescents, and schools often lacked a comprehensive, proactive universal approach to support mental health wellness in children and youth. The ISF draws on the strengths while addressing the limitations of both PBIS and SMH through the strategic linkage of SMH practices within the framework of PBIS, producing a single system of delivery for behavior/mental health supports. The result is an integrated structure and process for education and mental health leaders to interact more effectively and efficiently.

A desired outcome of the merge into a single system is to expand the availability and effectiveness of a full continuum of evidenced-based interventions to promote the success and well-being of all students. This includes students who have been historically underrepresented in mental health services, such as African American males (Alang, 2019; Bain, 2014). Examples within an expanded continuum include social/emotional/behavior curriculum for all students at Tier 1; trauma informed practices at either Tier 1, 2 and/or 3; small group or individual cognitive-behavioral based interventions for anxiety; function-based behavior support plans; and highly individualized wraparound plans. The interconnected multi-tiered approach to prevention and intervention establishes conditions where more students can access supports without requiring labels, diagnoses, or insurance plans. This includes the positioning of mental health and other community partners into an integrated structure of social/emotional/behavioral instruction and support within the school,

to improve educational outcomes for ALL, with a specific focus on those with, or at-risk of, developing mental health challenges (Barrett et al., 2013). Traditionally, educators have referred students with mental health needs to a separate set of staff (i.e., school- or community-employed mental health providers) when they have felt unable to provide effective support. An interconnected system places the mental health providers on the school-based multi-tiered teams where school staff and community representatives work together to design interventions that are likely to produce outcomes for the presenting problems.

The ISF should be viewed as a process of integration and enhancement rather than the initiation of a new system or program. For this reason, implementing an ISF should not be viewed as a separate initiative within a school system. Many schools and districts have a multi-tiered system of PBIS that can be enhanced with the integration of support from mental health and other community partners. In fact, integration of all related social/emotional/behavioral initiatives (e.g., bullying-prevention, restorative practices, social/emotional learning curricula, skills-training groups, etc.) can be accomplished through the ISF implementation process outlined in this monograph.

Key Messages

As referenced in Chapter 1, national leaders in the fields of PBIS and SMH have coalesced around four key messages, which describe an interconnected system: 1) A single system of delivery; 2) mental health is for all; 3) access is not enough; and 4) MTSS is essential to install an ISF (Weist, et al., 2016). The following section describes each message and provides examples of what will be different in an interconnected system versus the traditionally separate structures for PBIS and mental health in schools.

Message 1: A single system of delivery.

A *single system of delivery* is one in which education and mental health systems are integrated across tiers of support, with multi-disciplinary teams using data to implement one continuum of evidence based behavioral/mental health practices. This is initiated by a state, regional, or district level executive leadership team with the authority to make decisions for change within both the education and community mental health systems targeted for integration. The executive leadership team addresses the policy, funding, and work force issues that impact the integration of personnel as they move into a blended structure at the school level. Team membership at all levels should be representative of education, community mental health, students, and families, as well as, other community stakeholders.

This integrated team structure is different than typical district or school leadership teams that are comprised primarily of educators reviewing data and making decisions regarding the types of interventions and supports students need. In traditional systems, decisions typically involve matching education/school-based interventions with student need. When students exhibit a higher level of need or present with symptoms outside the school team's exper-

tise (e.g., depression or anxiety), the school team makes a referral to a school or community-based mental health provider, often co-located within the school. The school or community-based mental health providers are often not part of the problem-solving team initiating the referral and responsibility for selection and monitoring of interventions shifts to a separate set of professionals. By contrast, in a single system of delivery, the school- and/or community-based mental health specialists are part of the school teams at each tier of decision making, and work together with school personnel to explore possible interventions and decide collectively who will deliver the selected intervention(s) at each tier of support. Referrals across teams within a school are replaced by a single Request for Assistance processed through one set of teams and referrals are reserved for when a student has medical or other needs outside the abilities of the merged teams of school and mental health providers.

Message 2: Mental health is for all.

This message assumes the value in recognizing mental health wellness as a protective factor and a variable that can be addressed within a single system of delivery across a continuum of supports. Mental health wellbeing is associated with healthy emotional, cognitive, and behavioral functioning, which contributes to school success (Lester & Cross, 2015). Within a mental health *for all* approach, student social, emotional, and behavioral health is addressed with the same level of attention and concern as cognitive development and academic achievement. This results in social-emotional-behavioral skills being taught by all staff, across all settings, with all students, and embedded in all curricula.

In a non-integrated approach, schools may be addressing the teaching of behavioral expectations separately from a curriculum intended to address social/emotional learning. For example, a school implementing PBIS may be using a teaching matrix to guide the instruction of desired student behaviors across each setting for each expectation (e.g., *pick up trash in the cafeteria* as an example of Being Responsible) and the school may also have adopted a social/emotional curriculum which is taught separately. Within an integrated system, data informs the selection of valued social/emotional skills which are aligned with and included in the school's Tier 1 teaching matrix. This allows the curriculum to articulate not only the specific desired student behaviors, but also the valued pro-social skills for that setting or routine (e.g., *include others when you see they are sitting alone in the cafeteria* as an example of Being Respectful). Relevant data are used to ensure the school's core social-emotional-behavioral competencies are the focus at each of the tiers, with a match between the skills targeted for instruction and the level of particular need in the school building. For example, if a large number of students are reporting stress and anxiety, then it may be more efficient and effective to include instruction around coping skills for all students through the Tier 1 curriculum. This may be accomplished by defining and anchoring coping skills to school-wide expectations in a teaching matrix and/or using a separate program focused on coping skills that is reviewed

for alignment with school-wide expectations and other social emotional practices/programs.

Message 3: Access is not enough.

Historically, SMH programs have focused on counting the number of students referred to mental health providers, considering the number of students receiving a service as a measure of effectiveness.* However, simply gaining access to SMH programs is an insufficient metric of effectiveness and systems need to move from access to outcomes as their determining measurement of impact. A major feature of successful PBIS implementation over the past 20 years is careful monitoring of the effectiveness of interventions over time through student outcomes and fidelity of the delivery. It will be essential to apply this

rigorous progress monitoring approach to all interventions delivered within a comprehensive system of behavior/mental health support, regardless of who is delivering the intervention.

Within an integrated system, psychosocial measures and school record data (e.g., student attendance, assignment completion, behavior, disciplinary referrals) are used to both (a) identify needs so students gain access to necessary supports and (b) monitor student progress toward goals within each tier of the multi-tiered framework. Using data, practices are matched to presenting problems and monitored for both fidelity and outcomes. When interventions do not achieve desired outcomes, teams make appropriate adjustments such as improving the fidelity of the intervention, adding components to the intervention or selecting a new intervention.

Within an ISF, teams are explicit about defining intervention features, including specific techniques, dosage, and frequency. This may be different for mental health interventions delivered through separate structures that might have traditionally been described in more generic terms (e.g. "student will receive cognitive behavioral therapy to address traumatic stress symptoms"). Teams working within the ISF describe interventions specifically and include measurable goals and action steps to implement the interventions selected to address the presenting problem. For example, the student "will learn when and how to use the deep-breathing technique when experiencing distress about entering morning math class in order to (a) reduce visits to the nurse from two times per day to one time per week: and, (b) improve attendance at school in the morning from 50% to 80% within two months." Skills acquired during sessions with mental health staff are supported by ALL staff and linked to Tier 1 instruction in the classroom to promote generalizability across settings. In the above example, teachers are aware of which students are working on coping and problem-solving skills so that they can easily prompt, reinforce, and correct these skills throughout the school day as part of core instruction at Tier 1. Chapter 5 provides examples of intervention progress monitoring strategies that link across tiers.

* It should be noted that the National Center for School Mental Health standards (Connors et al., 2016) now directly promotes student outcomes for measuring the impact of SMH.

Message 4: MTSS is essential to install SMH.

The ISF uses the features of MTSS as successfully applied through PBIS implementation over the past two decades. The core features of an MTSS include (a) coordinate implementation with a representative leadership team, (b) use data to guide all team decisions, (c) establish formal processes for team-based selection and implementation of evidence-based practices across tiers, (d) ensure early access through use of comprehensive screening, (e) establish a rigorous progress-monitoring system for both fidelity and effectiveness of all interventions, and (f) invest in team based professional development and ongoing coaching at both the systems and practices level (Sugai & Horner, 2009).

Using the MTSS core features, the ISF approach intentionally includes components and adaptations to emphasize and integrate mental health. This is accomplished through the inclusion of a broader range of partners, a wider scope of data, and an expansion of interventions to address internalizing mental health issues such as anxiety, depression, and trauma. Applying the MTSS features systematically to the expanded continuum of interventions is a deliberate and defining aspect of the ISF process. The following section provides a brief description of how each MTSS feature is positioned within the ISF. These descriptions are expanded and illustrated through the steps for installation and initial implementation of an interconnected system that are detailed in Chapters 4 (at the District/Community level) and Chapter 5 (at the school level).

MTSS Features

1. Leadership Teams
2. Use of Data
3. Team Selection Process
4. Early Access
5. Measure Fidelity & Outcomes
6. Team-based Coaching

MTSS Features within the ISF

An integrated team process.

Integrated teaming structures within districts and schools are expanded to be representative of all stakeholders including families, students, community mental health providers, and other invested community partners. The purpose of one set of integrated teams is to ensure that school- and community-based leaders and providers (e.g., teachers, school social workers/counselors, community mental health clinicians) share decision-making to increase efficiency and effectiveness. Also, teams with a wider array of stakeholders, including students and families, will be better positioned to address the shared goals within their school-community, providing a foundation for a nurturing environment that promotes positive social, emotional, and behavioral health for all students and the adults that support them.

An expanded use of data.

Interconnected teams make decisions about how to improve student well-being using school

data (e.g., attendance, grades, discipline data) as well as community data (e.g., poverty, homelessness, domestic violence, substance use). From prevention through intensive, individual interventions, the teams will review relevant school and community data in order to determine the approaches needed to most efficiently meet the needs of all students. For example, a community with increasing rates of incarceration for opioid use may want to invest in prevention-based instruction at Tier 1 that is linked to the health curriculum and specific professional development and coaching (e.g., supports and services available for families) for staff who are facilitating Tier 3 Wraparound interventions.

Team-based selection of all evidence based practices.

Within an MTSS, teams use formal processes for selecting a continuum of evidence-based practices based on likelihood of desired impact on identified needs. An integrated framework expands this formal process for selection of evidence-based practices to include the use of both school and community data in this process and to purposefully include all clinical services/interventions in the team selection process. This may be a change for school personnel who may not be experienced in the use of community data to select school-based interventions. This may also be a change for community mental health clinicians who may not be used to selecting their mental health interventions through a team process that includes educators.

Using comprehensive screening for early identification.

PBIS implementers may be using office discipline referral data, as well as, attendance and grades to identify students at-risk of school failure. Over the past decade, an increasing number of schools have begun a formal screening beyond these data points to better identify students at the first sign of need. In the ISF, districts are encouraged to adopt a structured and comprehensive universal screening for uncovering internalizing, as well as, externalizing needs of children and youth within a community. Rather than having a separate screening process for mental health needs, an integrated screening process includes early indication of anxiety, depression, impact from a traumatic life experience, substance misuse, as well as, conduct problems.

An important component of comprehensive universal screening is that all adults who work with children and youth, including teachers and other school staff, understand mental health challenges, how to recognize them, and what to do if they are concerned. Therefore, a related feature to ensuring early access is the availability of one clear and simple process for teachers, families, and students to request assistance with behavioral/mental health needs. This will likely be a change in the way of work for schools that have typically used separate referral pathways for needs viewed as behavioral verses needs perceived as mental health issues. Creating one pathway for access to interventions, regard-

less of who may be facilitating the intervention, is a critical step in the installation of an ISF.

Tracking fidelity and impact.

Often schools implementing PBIS track fidelity and outcomes for behavioral interventions across tiers while interventions delivered by mental health clinicians may be monitored separately, differently and, in many cases, with less rigor. In an integrated system, interventions for anxiety, depression, trauma, and substance abuse are monitored for fidelity as well as outcomes, following the same standards and rigor as applied to reading and behavior interventions. School-based teams benefit from having clinicians on the team as they provide additional expertise and are able to explicitly describe and help design a broader array of behavioral/mental health interventions. An integrated team is better positioned to identify the most efficient method for assessing fidelity and the effectiveness of each intervention. For example, when delivering a Tier II intervention designed to reduce trauma-induced behaviors (e.g., fight, flight or freeze responses), the team would discuss the critical features of the intervention per relevant research and design a fidelity checklist for clinicians to use as a self-assessment of the accuracy of their intervention delivery. Monitoring the effectiveness of the intervention can be supported by a classroom-based daily progress report that captures data of student skill fluency in natural settings. (Specifics of these progress monitoring routines are described in Chapters 4 and 5.)

Professional development: Training, coaching, and performance feedback.

School-and community-employed mental health staff traditionally receive different professional development based on their job role. For example, teachers typically have not had access to information about mental health conditions such as anxiety and depression, and mental health clinicians working in schools are not typically versed in Tier 1 or lower level Tier 2 interventions associated with PBIS. Although coaching to build fluency with skills has become common in typical PBIS implementation, coaching to fluency in delivery of interventions delivered by clinicians in co-located systems is less common. In an interconnected system, education and mental health staff receive professional development around the expanded continuum of behavioral/mental health interventions with the ongoing coaching and technical assistance needed to implement interventions accurately. Additionally, blended professional development on team operating procedures, data-informed decision-making, and related MTSS skills is provided for all staff in an interconnected system.

Applying the Stages of Implementation for Successful and Sustainable Systems

As previously discussed, PBIS utilizes the logic of implementation science which calls for recognition of the current status of where stakeholders are in the process of change with an eye towards what comes next (Fixsen, et al., 2005). Aligning and integrating school mental health

within the PBIS framework follows the same logic. However, applying the stages of implementation of innovations, like the ISF, is not a linear process, but rather a process that is iterative in nature and involves continuous quality improvement (Fixsen et al., 2009). Education and mental health systems are dynamic and often include challenges associated with frequent changes in staff, policies, and priorities. The remaining chapters provide guidance for ongoing analysis of system structures and data resources that allow leaders to make decisions about alignment and integration, possibly eliminating the need to create new structures.

The remaining chapters of this monograph are organized around the stages of implementation necessary for successful and sustainable systems change. Readers can progress through this monograph based on the current status of their system, choosing to focus on specific action steps linked to the priorities in their state/region, district, or school. Table 2.1 summarizes the stages of implementation and provides operational definitions and ISF illustrations. This visual is intended to help implementers of the ISF process consider readiness for an integrated approach (Exploration/Adoption), resources and structures necessary to support implementation (Installation), initial implementation steps following training (Initial Implementation), and integration and fluency with the innovation among the majority of stakeholders (Full Implementation). Planning for sustainability is part of initial and on-going dialogue and action planning. Table 2.1 also includes tools for support that will be described with access to each tool in the upcoming chapters.

Table 2.1: Stages of Implementation with ISF Illustration (adapted from Fixsen et al., 2005)

Exploration/Adoption

During this stage, a team assesses the needs of the district and explores and selects evidence based practice(s) to meet the identified needs while also assessing the readiness to implement (e.g. financial, political, resources).

ISF Illustration	Tools for Support
Leadership team reviews current PBIS implementation and SMH efforts to determine needs and fit for an ISF. After fit is determined, team conducts assessment of readiness to implement.	• District Systems Fidelity Inventory (DSFI) • PBIS Implementation Blueprint • NIRN Hexagon Tool

Installation

During this stage, a team allocates or repurposes resources to support the implementation of new initiatives, practices or programs. Resources include staffing, training, funding, evaluation systems, and coaching.

ISF Illustration	Tools for Support
The leadership team is expanded by establishing community partnerships. The expanded team creates a shared vision and identifies team operating procedures (e.g. schedule, action planning process). The expanded leadership team will also conduct resource mapping, establish a professional development plan, and define an evaluation plan.	• ISF Leadership Installation Guide

Initial Implementation

This is referred to as the 'fragile' or 'awkward' stage of implementation when staff are beginning to implement changes.

ISF Illustration	Tools for Support
Enhancing the core features of multi-tiered system of support (MTSS) begins. This includes a plan for: professional development on the ISF; implementation of features; and, monitoring the continuum of evidence based interventions, including those used to support mental health needs.	• Tiered Fidelity Inventory – Action Planning Companion Guide • ISF Implementation Inventory

Full Implementation

When practices become the norm and are integrated into policy and procedure. Practitioners are implementing with proficiency, leadership is supporting implementation needs, and stakeholders have adapted to innovation.

ISF Illustration	Tools for Support
Sites are implementing with fidelity and outcome data is demonstrating improvements.	• ISF Implementation Inventory

CHAPTER THREE

Exploration and Adoption

Pursuing multiple innovations to improve student outcomes is a common practice within education and other child-serving organizations. The impetus for adding initiatives or changing program/curricula direction, often as part of system transformation, may result from new leadership entering the system; a newly recognized need within the community (e.g., response to community opioid crisis); a natural disaster such as a hurricane, fire, school shooting; or a large scale national trauma such as 9/11 (Weist et al., 2002). Additionally, securing a new grant or funding source may spur state and local school systems to adopt new initiatives or programs. When approaching change through an implementation lens, it is important to consider ways to align and integrate new initiatives/programs with existing initiatives. Implementing a new initiative/program separately from existing initiatives/programs may lead to an inefficient use of resources, an overburden on educators, and inconsistent, fragmented approaches to common issues (see Technical Guide for Alignment,[5] National Technical Assistance Center on Positive Behavior Interventions and Support, 2017).

Recently, the mounting evidence about the unmet mental health needs of children and youth (Merikangas et al., 2010) has prompted schools and communities to explore a more effective way of preventing and responding to student behavioral/mental health needs. Recognizing the potential problems associated with duplication and splintering of efforts, increased attention is being focused on integrating school and community resources into a single system of delivery (Eber, Weist, & Barrett, 2013). An additional stimulus for exploring the benefits of interconnecting behavioral/mental health and education systems is the recent influx of state and federal funds and priorities to increase the presence of mental health clinicians in schools in response to school safety and related concerns about ensuring mental health support for all students. This includes a range of programs under President Obama's Now is the Time initiative, Remarks on Gun Violence, including Project Prevent, Project Aware, Safe Schools/Healthy Students, and School Climate Transformation grants (Obama, 2013). Organizations are increasingly recognizing that, although more clinically trained staff are needed, it is not sufficient to merely add staff without changing system structures to ensure effectiveness.

Regardless of the motivation for change, it is essential that organizations invest in an exploration process to ensure (a) the proposed new approach or initiative is a good fit with identified needs, and (b) that the structures are in place to support implementation efforts that

will produce a measurable impact. This chapter describes the exploration process with regards to the ISF at a state or district level. The assessment of current partnerships, related initiatives, and the potential impact of such a change within schools and communities are addressed through this process. Supportive resources and tools are described and a state and district case example of exploration and adoption of an ISF are included.

The ISF Exploration Process

The purpose of the exploration phase, as defined by Fixsen et al., (2005), is to assess the match between innovation and consumer need. During this phase, key leaders convene to evaluate needs and examine current systems, practices, and resources to ensure the innovation can fit the unique context of the organizations/community being served and whether implementation is feasible. When exploring the interconnecting of mental health and PBIS, key leaders in the school and community organization(s) are brought together to consider the potential benefit of applying an ISF to improve shared goals. During exploration, these leaders will invest in learning more about each other's current approaches and how the adoption of an ISF would impact existing agreements and routines within and among the various partner agencies.

The exploration process is team driven and involves the following steps (a) establish an exploration team, (b) examine current partnerships, (c) assess the impact of existing initiatives or programs (d) develop a shared understanding of the ISF, and (e) determine benefit and decide to adopt or not. Although all entities should address these steps during exploration they may occur in a different order, and with varying degrees of intensity, depending on local context that may impact the transformation process. For example, the exploration process of an ISF with a state education agency (SEA) or local education agency (LEA) where the PBIS framework for organizing evidence-based interventions is in place may look different than the exploration process in systems where the PBIS framework is not in place. Table 3.1 provides examples of coaching questions that may be helpful as a facilitator guides leaders through the exploration process.

Table 3.1: Exploration Steps and Examples of Guiding Questions

Steps	Coaching Questions
• Establish an exploration team	• Do you have an existing district leadership team?
• Examining current partnerships	• Do you have family or community partners on your team?
• Assessing related initiatives	• What existing agreements do you have with community partners?
• Establish shared understanding of the ISF	• What is current status of MTSS structures/implementation?
• Determine benefit and decide to adopt or not	

Step 1: Establish an Exploration Team

The exploration process begins with critical leaders, typically from education, reaching out to similar leaders from mental health and other child-serving agencies, to form an executive level exploration team. It should be noted that this process could be initiated by another system, such as the mental health system. Team members are typically key opinion leaders with knowledge about the current status of behavioral and mental health initiatives being used within their organization(s) and the larger organizational structures that influence implementation efforts (e.g., key policies, budget priorities). This exploration team might be a subset of a larger multi-disciplinary team assigned to determine need, examine resources, assess stakeholder buy-in, and determine if adoption of an interconnected system is feasible and desired. At a local level, a school board, superintendent, leaders from a mental health or other youth-serving system, or mayor's office would likely designate the composition of this group. This may be in response to a recent or high-profile data point such as increased suicide attempts or completions, spikes in unemployment, or increased gang activity. As the team discusses and deliberates the potential of moving to a single system of delivery within schools, new members may be added to better reflect the partnering organizations or other critical leaders necessary for a comprehensive community approach.

As the exploration team moves forward, it may be useful to include a person knowledgeable about the ISF and the MTSS features inherent in the PBIS framework that guides the ISF. This person could be a local leader, a PBIS Coach, or someone from outside the school or community system. Some groups have found it helpful to have an outside facilitator to support the team as they move through the exploration phase and into adopting a new course of action. For example, in Milton, PA, school district leaders reviewed their Pennsylvania Youth Survey (PAYS) (2018) data and noticed increases in suicidal ideation, feelings of depression, use of substances, and reports of bullying and harassment. In response to these findings, they reached out to the McDowell Institute for Teacher Excellence in Positive Behavior Support to access facilitators with experience in systems change efforts specific to youth mental health at the community level. The facilitators helped the team explore how an expanded system of delivery, within their existing PBIS framework, could help them address the issue(s) of concern, ideally documented with measurable data. The remaining sections in this chapter highlight several tools and resources to assist teams in exploring the potential benefits of using the ISF approach.

Step 2: Examining Current Partnerships

Exploring an ISF approach involves discussions about the impact of a shift to a single system of delivery for the potential partners, with a range of relevant dimensions including policy and financing, and reviewing and adjusting job descriptions for key staff. An essential step in this process is to examine the existing partnerships and facilitate conversations about

what would be different, including allocation of resources and potential organizational barriers that would need to be addressed. For example, education systems are likely to have some level of existing partnerships with outside agencies and organizations addressing the mental health needs of families and student in the community. There may be a state level children's cabinet or, at the county level, a community behavioral health team. These teams typically include partners from various child-serving systems such as education, social services, behavioral/mental health, and justice. Often, some of the organizations may already have formal processes in place that include contracts or working agreements. However, the existing team may not be engaged in conversations about organizational change and may not have the authority required to change operations to manage the increased needs of the community. Notably, when these groups come together, for example, to pursue a federal grant, there is often a level of collaboration already established that may help to propel the initiative forward.

As the exploration team examines the status of these existing partnerships, it may be helpful to meet with school teams and partner agencies that are providing supports to learn first-hand how these arrangements and service contracts are functioning and the extent to which the current partnerships are demonstrating a positive impact for youth. Interview sessions with stakeholders and "listening tours" with educators, students, community partners, and families/caregivers can provide an important view of how the overall system is performing across all levels of operation. For example, a district or school that has used the previously mentioned (Chapter 2) SHAPE system (Connors, et al., 2016) to assess the status of their current SMH program(s) might use the results to further examine existing partnerships, and other features of the current mental health system that may be impacted by a change to a single system of delivery. The exploration team can use results from this assessment to inform recommendations for improvement and suggestions for identifying schools that may be ready to improve or expand current efforts.

Reviewing existing service contracts.

If the system has current contracts, working agreements, or Memorandum(s) of Understanding (MOUs), the exploration team will need to study specific arrangements and language within the contractual agreements to identify what may be different if PBIS and mental health systems are integrated. For example, some schools may not have external community providers who come into their school but may have a system for referring children and youth to community agencies. Others may have contracts with mental health clinicians who provide interventions to a caseload of students in a co-located model. This information helps the exploration team to identify how the current system defines and funds roles and functions of clinical staff in schools, perhaps revealing strengths and possible barriers to blending the service delivery of school and community employed clinicians. This process can help the team identify potential improvements that could result from moving to an integrated system where mental health

providers contribute to system development and progress monitoring of all interventions by participating in school-based teams. For example, an existing partnership agreement may include funding to support additional behavioral health staff to be placed at school sites with the commitment from schools to provide office space. However, if the agreement does not explicitly state the role of the staff as part of the system, the team will need to explore how to fund participation on teams across the tiers. Another important dimension to consider is whether MOUs specify funding to the behavioral/mental health system for clinician placement in schools. Such funding is foundational to effective partnerships (e.g., the clinician is an active member on the PBIS team, and involved in Tier 1 and Tier 2 programming), as without it, clinicians may retract to a co-located model related to fee-for-service pressure (Weist, Paternite, Wheatley-Rowe, & Gall, 2009).

Step 3: Assessing Related Initiatives

To explore the need and desire to interconnect systems, the exploration team needs to understand all existing initiatives related to social, emotional, and behavioral health both in the school and community. This usually begins with educators (ideally in collaboration with mental health system partners) developing an inventory of efforts currently in place within the school system and then expanding the list to include related efforts underway in the broader community. Part of this assessment involves identifying the extent to which fidelity and impact are being measured to determine whether or not the initiatives are having the desired effects. A preliminary review of this inventory can reveal strengths and opportunities for improvement through a transition to an integrated system. Questions that can be addressed through this dialogue include (a) are current interventions being evaluated with enough rigor to know if the resource allocation is producing measurable student outcomes? and, (b) are vulnerable student populations (e.g., students of color and students with disabilities) experiencing benefits from current efforts? As the potential impact of interconnecting all mental health and education initiatives is explored, the team may begin to address the feasibility of interconnecting related initiatives more specifically. For example, can social-emotional competencies be taught directly to students in the classroom through Tier 1 implementation of PBIS? Is bully-prevention instruction clearly embedded in the PBIS Tier 1 curriculum to ensure clarity and efficiency for teachers?

A Key Question

Are current interventions being evaluated with enough rigor to know if the resource allocation is producing measurable student outcomes?

The assessment of current initiatives often includes asking the team to consider moving away from the notion that "more is better" and focus on a smaller number of initiatives that prioritize a direct impact on agreed upon needs. A tool that can be used to guide the team's review

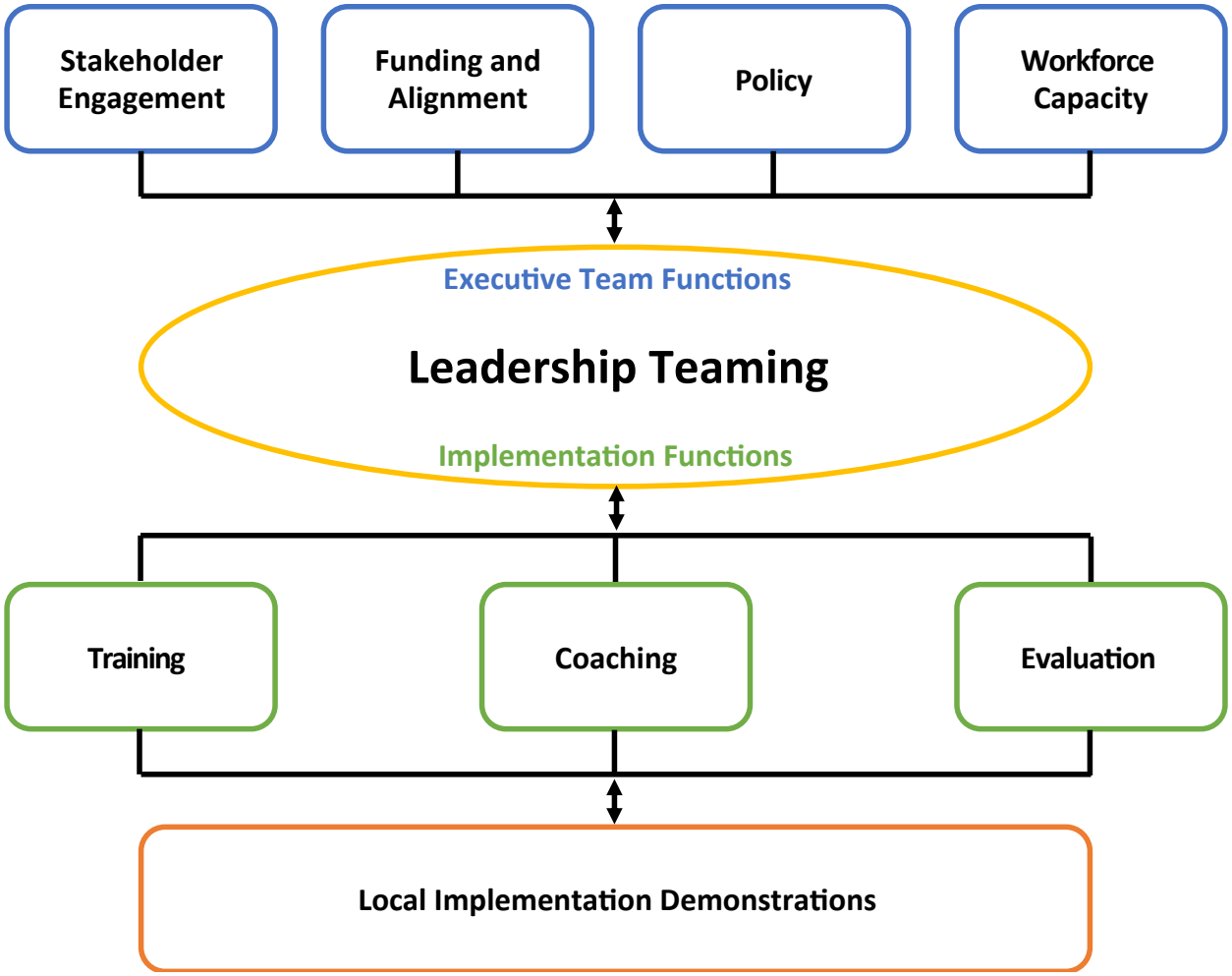
of current behavioral/mental health initiatives is the Technical Guide for Alignment[6] (National Technical Assistance Center on Positive Behavior Interventions and Support, 2017). The purpose of the technical guide is to provide a structured alignment process with concrete steps to assist leaders as they examine current practices across educational and other youth-serving units and systems (e.g., instruction, special education, mental health, justice). It guides teams to consider the extent to which current practices are implemented with fidelity and produce meaningful academic and social/emotional/behavioral outcomes, with a focus on the support systems needed to select, install, and implement new practices. The exploration team can use the Alignment Worksheet in Appendix B of the previously mentioned Technical Guide to complete the crosswalk process described above, and uncover areas of concern that can be addressed through applying the ISF to connect all school and community initiatives related to mental health/behavior. The Alignment Worksheet directs the team to list similar initiatives and answer a series of questions related to lead division/organization, the population served, research base, and evaluation. The team may learn that there are no fidelity measures or it may find that each organization uses its own data system to track fidelity and impact. These findings will be significant as the leadership team moves through exploration, and possible adoption, of an ISF. This analysis of initiatives can be used later to guide an action plan with specific recommendations for efficiency, sustainability, and more significant impact. As the team considers using an innovation like the ISF to build an integrated model, the team will need more information and a deeper understanding of what an ISF will involve.

Step 4: Establish Shared Understanding of the ISF

At this point, the team has focused on examining the current system and conducting an internal review by sharing data, listening to stakeholders, and analyzing current partner agreements. The team has considered areas of strength, areas for improvement, and has had conversations to determine if the system is ready to move to a single system for supporting behavioral/mental health through schools. The team also needs to ensure that all partners have a shared understanding of an interconnected system of PBIS and mental health in schools, including the implementation process and effort required to establish a standard way of work among educators and their community partners. Often teams place value on the innovation without considering the capacity of the system to undertake the innovation. It is wise to invest time discussing how the change fits with existing initiatives, existing policy, and how professional learning is consistent with adult learning research. One approach to developing a shared understanding of the ISF is to increase fluency with implementation science by studying the *PBIS Implementation Blueprint* (Center on PBIS, Oct 2015). This Blueprint provides foundational content and descriptions of the key elements of PBIS implementation as depicted in Figure 3.1. The National Technical Assistance Center's *PBIS*

District Systems Fidelity Inventory (DSFI)[7] (OSEP Center on PBIS, 2019) to assess the current status of PBIS within the district. (For state-level teams, a PBIS State Systems Fidelity Inventory (SSFI)[8] (Center on PBIS, 2019) is also available.)

Figure 3.1: PBIS Implementation Elements



Building fluency with the PBIS framework.

The PBIS framework was selected as the foundation of the ISF as PBIS is an established large scale implementation effort with well documented effects (Horner, Sugai, & Fixsen, 2017). The critical elements of this successful framework are described in the The PBIS Implementation Blueprint and can be used to guide the exploration team through a deeper understanding of the elements associated with sustainable implementation. We recommend that the key leaders engaged in the exploration use the *PBIS Implementation Blueprint* as a guide to obtain a

consistent interpretation of what they would be working toward, and to ensure full comprehension of the framework for possible adoption. To accomplish this, the exploration team may want to begin developing a glossary of terms anchored to the critical elements outlined in the *PBIS Implementation Blueprint* to organize their dialogue for decision-making about potential benefit and adoption.

The heart of the framework is the *leadership team*. Within an ISF, this is a multi-agency leadership team fully inclusive of key stakeholder groups with authority to make the organizational change (Splett et.al., 2017). Through facilitated dialogue, the exploration team can become familiar with the critical elements essential to the functioning of the PBIS framework and how these features are defined within an ISF. The executive functions, highlighted in blue in Figure 3.1, include *stakeholder engagement, funding and alignment, policy, and workforce capacity.* The task for the exploration team is to pursue a full understanding of how these critical elements of the PBIS framework are further defined with the integration of mental health within this framework. For example, *stakeholder engagement* involves actively involving all partners in shared goal setting and policy development to support a new way of work. When integrating mental health through an ISF, stakeholders will go beyond school boards, families, and politicians, and include representation from community mental health providers and mental health advocacy groups. It will be essential, to establish goals and policies, and to engage a wide range of stakeholders (e.g., teachers, youth, family members) in sharing perceptions and disseminating information.

The *funding and alignment* aspect of adopting an ISF will involve a review of current financing of all behavioral and mental health efforts with a dialogue about what would need to change to interconnect the staff and services of education and community agencies. Will the targeted agencies be willing to engage in this process including the development of a 3-5 year budget to install and initially implement the interconnected system in a designated number of demonstration schools, with additional school sites being added in increments? The shared funding plan typically involves reallocation of existing resources to allow more flexibility and will need to move from short-term funding streams to stable institutional funding streams to support long-term investment and sustainability of a merged system. Within an ISF, the exploration team seeks to understand how all participants, including educators and community-based agency leaders, will be involved in reviewing existing funding and service contracts to identify possible reallocation of resources and/or different sources of financial support.

The exploration team will also have to consider that an ISF will need to become part of the *organizational policy* in both the school and community organization. This will involve an executive leadership team investing in mapping existing initiatives and making recommendations and decisions regarding the alignment of all related behavioral/mental health initiatives/programs. For example, trauma-informed practices and restorative justice practices would

need to be integrated across the tiers of support. Interventions delivered by community-employed clinicians would also be blended across tiers and monitored by teams with the same rigor as those provided by school personnel. Current approaches or initiatives that are not compatible with the framework may need to be discontinued.

Workforce capacity is the *PBIS Implementation Blueprint* element that guides decisions around personnel, roles of staff, and allocation of time. Within an ISF, this will include dialogue around the changing roles of clinicians. For example, what will it entail to have a community-based mental health provider on a Tier 1 team? How is that clinician's role defined on the team and how do they work with existing school clinicians in this role? How could the role of school counselors, school psychologists, school social workers and other staff with behavioral expertise (e.g., special educators) change within an ISF where all interventions are selected and monitored through one set of behavioral/mental health teams in schools?

The critical elements outlined in green in Figure 3.1 are the state and district-level implementation elements that are directly related to building capacity through accurate and consistent support of the school sites as they prepare to put the ISF into practice. The implementation features the exploration team needs to develop an understanding of are: *training, coaching, evaluation and performance feedback*. The leadership team should discuss what is involved in building the capacity of school and agency personnel to work together in teams across tiers of support and with specific evidence-based interventions that are guided by rigorous evaluation of fidelity and outcomes.

Within an ISF, the team should have discussions about the need for an integrated professional development plan and the possible impact on existing district and agency efforts. For example, the executive team will need to make sure school and community mental health personnel are brought together for training events to ensure all partners become fluent with the teaming functions and implementation of behavioral/mental health across all tiers. Staff from both education and mental health should be included in a plan for developing internal training capacity. In addition, the executive/exploration team should discuss the importance of coaching support as part of the overall professional development plan as this feature is essential to building capacity for accurate implementation in the school sites (Gunderson et al, 2018). Some of the considerations within an ISF include whether they will use existing PBIS coaches and expand their roles to make sure they are aligned with an integrated behavioral/mental health approach. It is recommended that the mental health agencies also identify personnel who will partner with the school-based coaches to ensure consistency within the single system of delivery.

The exploration dialogue of the *evaluation and performance feedback* element includes assessing current school-based data systems, evaluation schedules, reporting process on both fidelity and outcome data, and established feedback loops between the site-based teams and the district team. Within an ISF, this dialogue

will include discussions around extending this comprehensive evaluation system to include the use of mental health screening tools, community data, and an expanded evaluation plan that includes mental health indicators.

As previously mentioned, the facilitator of this dialogue should be a person versed in implementation science, the PBIS framework, and how the ISF is uniquely defined when expanding PBIS to include a broader continuum of mental health supports integrated into the schools. This broad array of skills may require 2 people working in partnership as a facilitator of the exploration dialogue. Individuals facilitating this process should engage the exploration team in dialogue around the description of each element and be able to provide examples of what it looks like within an ISF. For example, *workforce capacity* within an ISF includes dialogue around how the roles of clinicians will change as they become active team members on system teams across tiers. As information is uncovered during the process of exploration, leaders will be required to synthesize new information quickly, and transfer knowledge and translate key findings to other stakeholder groups. This knowledge translation process will be critical to securing buy in and support for investing in a new way of work (Kamasak, Yavuz, & Atluntus, 2016).

Additional resources.

Additional resources that describe and illustrate the ISF[9] are available to support the efforts of the exploration team. These resources describe and illustrate the ISF and include publications, recorded webinars, presentation materials, and implementation tools. For example, a 2017 ISF brief, *Aligning and Integrating Mental Health and PBIS*,[10] (Perales et al., 2017) describes the ISF as an alignment process, with concrete examples that may help the exploration team process including establishing communication across stakeholder groups. Recorded webinars that may be useful for exploration include: a basic overview of an ISF; potential stakeholder engagement; and potential barriers such as funding and confidentiality. The exploration team can view recorded webinars[11] to provide a more comprehensive understanding of how the ISF process is different and how leaders within the organization(s) are key to the success of integration.

Step 5: Determine Benefit and Decide to Adopt or Not

The exploration team has examined current partnerships, assessed the structure and impact of existing initiatives/programs, and developed a shared understanding of an ISF and related tools. Once this work is completed, they are ready to determine benefit and decide to adopt or not. If the exploration team determines there is a high degree of compatibility and shared values, they will be in a position to move forward and coalesce around a shared vision. They can then begin a discussion about adoption and the level of formality needed to move forward with connecting and expanding their behavioral/mental health efforts through a single system.

The adoption process involves making recommendations to and securing buy-in from broader stakeholder groups including executive leaders in education, mental health and other

youth-serving systems; as well as, school-based teams, practitioners, consumers, and advocates. As previously mentioned, the exploration leaders should be able to summarize and transfer their key findings of the benefits and required actions needed to representatives of these groups. The team will likely report a list of findings with recommendations to an entity that will decide next steps. For example, this may involve an official procedure where the exploration team reviews findings with the school board for approval. Although this level of formality may not be needed in all systems, there may need to be some process of approval for moving forward that involves critical education and community leaders.

During the adoption process, the exploration team transforms into a multi-agency leadership team representative of executive-level leadership in education, mental health, and other partnership stakeholder agencies. Once the decision to adopt is reached, this team then reviews and determines the process needed to move from exploration/adoption to installation. Based on the recommendations and supporting information gathered through the exploration process, the expanded leadership team will engage in key decision points that actualize the commitment to move forward, including the determination of resources. Another potential decision point is the need to pursue any organizational policy changes that would be needed to allow the work to proceed through integrated teams at the school level. For example, MOUs and possibly job descriptions of clinicians may need to be addressed to support the new way of work through the ISF.

As mental health organizations shift how they operate within schools, they may need guidance during the exploration/adoption, installation, and initial implementation phases. A Mental Health Agency Checklist[12] has been developed to address the potential changes that clinicians and leadership will make as they move towards a single system of service delivery. This tool identifies key areas, such as shared decision making and team based problem solving, which will be supported by identified coaches from the provider agency. Leaders from the mental health agency can complete this checklist quarterly throughout the installation process in order to ensure the organization fully supports an integrated approach.

The expanded district/community leadership team identifies and articulates the initial scale of installation, typically focused on demonstration sites, and develops a plan for moving system-wide. For example, a state level leadership team may decide to install the ISF in 3-4 districts that are implementing PBIS and want to address more significant mental health needs within their structures. Alternately, a state may decide to install an ISF as an expanded version of PBIS, including local mental health partners, in districts who have not yet installed PBIS. A cadre of state-level PBIS trainers and coordinators, supported by one or more federal grants could be allocated to support these installation efforts in demonstration districts. At a district level, the leadership team may choose to have 3-5 schools, supported by one community mental health agency serve as their demonstration sites with coaching support from both the district and the mental health agency.

Adoption Decisions

1. Resource allocation
2. Policy changes
3. MOUs
4. Demonstration sites
5. Coaching
6. Communication

Initial implementation at demonstration sites is closely monitored and supported. The experiences and lessons learned will inform any necessary changes to training and coaching plans, evaluation tools, and procedures. Essential to this iterative process is an ongoing feedback loop between demonstration sites, coaches, and the district leadership team. The initial scale of adoption will inform coaching and training needs. Further, the leadership team will define partnerships and MOUs when the decision is made to adopt an ISF. The initial action plan developed by the team at the time of adoption should be focused on 1-3 years of goals with action steps for at least one year. Overall, the team should create a timeline for the next 3-5 years, with overall investment in an ISF extending beyond 10 years.

Chapter 4 describes installation steps that may include the expansion of the Leadership Team, including the identification of additional partners and stakeholders. As stakeholders are identified and communication and collaboration procedures are developed, teams can potentially identify more/different resources to support the installation of an integrated system. The executive functions of funding, policy, systems alignment, and workforce capacity will need continuous focus as they are critical to ensuring initial and sustainable capacity to support implementation. Chapter 4 continues from installation of key system structures to initial implementation at the District/Community Level. Initial implementation includes defining professional development, coaching, and evaluation structures necessary to support an expanded behavioral/mental health system in schools. This includes further discussion of an action plan that ensures that the implementation drivers (e.g., professional development, coaching, evaluation, performance feedback, behavioral/mental health expertise) are installed and revised as needed.

The following section provides a case study to illustrate how a state agency engaged in the process of exploring options for implementing comprehensive behavioral/mental health support for students across the state. Following the state example is a local district/community example to describe how the process unfolds in a symmetrical process. Throughout the remainder of this monograph, other examples are provided to illustrate how state, regional, district, and local school systems have progressed through the various stages of implementation during their journey with the ISF.

A State's Journey through Exploring and Adopting the ISF

In the first monograph (Barrett, Eber, & Weist, 2013), early adopters of the ISF were featured at the school, district, and state level.

Pennsylvania was one of the states highlighted as an exemplar in the exploration/adoption and installation of an ISF. The organic process in Pennsylvania continues to be representative of what exploration/adoption may look like at a state level.

In the mid-2000s, a diverse group of stakeholders in Pennsylvania came together to discuss shared priorities related to behavioral health. The group included family advocates; behavioral health providers; educators from early childhood, school age, and higher education; leaders in health, human services, and justice; and managed care organizations. Some of the participants had previously collaborated on projects and had a shared commitment to improving the behavioral health and wellness for children, youth, and families. This shared commitment was due in part to feedback from families, educators, and behavioral health providers that outcomes for children were either inadequate or not being monitored for impact and fidelity. Also, one of the original issues the group coalesced around was the number of students who were placed out of their homeschool into more restrictive educational or mental health placements. These issues led the group to begin exploring the status of existing efforts to improve the behavioral, social, emotional and mental health outcomes for students. The team found that the educational and mental health initiatives and systems were not effective in meeting student needs due to limited collaboration, overlap in services, and lack of focus on fidelity and outcomes of services.

Leaders in the Department of Education (DOE) were familiar with PBIS and aware of some movement toward better integrating school mental health. As a result, the Department of Education began to explore various innovations that would advance their shared commitment to improving behavioral health and wellness for children, youth, and families. PBIS was among the innovations explored by the team of multi-system stakeholders. Concerns were expressed that PBIS application would emphasize a focus on the education system only and not other child-serving systems. The group wanted to ensure cross-system collaboration that would impact children, youth, and families across the life domains of home, school, and community. This led to the exploration of an ISF, which appealed to the group because of the effectiveness of the PBIS framework and the possibility to expand upon the framework to include mental health support and other providers and interventions. Their exploration process led to a shared understanding of the ISF and a team decision to form a Community of Practice (Lave & Wenger, 1991) to guide and support the adoption and installation process of an ISF.

Community of Practice

As defined by the IDEA Partnership (2014), is a group of professionals who care deeply about a common issue and decide to work together voluntarily to improve practice related to that issue.

The Pennsylvania Community of Practice (CoP) on School Based Behavioral Health was established in 2007. Convened through the Bureau of Special Education, the CoP includes

the State Departments of Education, Health, and Human Services. In addition, advocacy groups, behavioral health providers, managed care organizations, universities, and other private groups participated in the CoP. This affiliated network has braided funding and resources, including designated employees of various agencies, who carry out the goals and objectives of the group. Operating with a Systems of Care Philosophy (Stroul, Blau, & Friedman, 2010), shared decision making and input from all members is valued equally. Moving forward from their decision to adopt an ISF as their way of work, the CoP developed an action plan that would address their shared priorities.

During the exploration/adoption phase, the Pennsylvania CoP developed a shared understanding of their new way of working together and began the process of establishing their executive leadership team. This team is made up of organizational leaders with authority to leverage resources, including the allocation of staff for an implementation team for state-wide scale-up of PBIS, nested within an ISF. The leadership team used the *PBIS Implementer's Blueprint* to organize the agenda of their meetings. Working through a sub-committee structure, the group focuses on visibility, political support, policy, funding, and personnel readiness. The leadership team also established a three-year action plan that outlined the priorities of the CoP. The goals outlined in the action plan included: 1) install the PBIS framework in both early childhood and school settings (i.e., Program-wide and School-wide PBIS); 2) align and integrate PBIS and Systems of Care to form a single sys-

Pennsylvania's CoP on School Based Behavioral Health – Core Statement (2007)

We are: a community of cross sector stakeholders that share a commitment to the advancement of early childhood, school age and adult behavioral health and wellness within the Commonwealth of Pennsylvania.

We support: at present, children, youth, families, schools, and community partners through development of comprehensive early childhood and school-based behavioral health support systems.

We do this in order to: overcome the non-academic barriers to learning for children and youth so that all can successfully transition into adulthood.

We focus on: 1) promoting implementation and sustainability of evidenced based multi-tiered systems of supports; 2) promoting integration of evidence based programming into decision-making frameworks; and 3) fostering and leveraging articulated and robust school - community partnerships.

We will be successful when: children, youth, families, educational entities and community agencies have access to services, supports, training, technical assistance, and collaborative opportunities that ensure academic and emotional/social success for all.

Statement adopted 1/15/2013 State Leadership Team (revised from early version)

tem for social, emotional, behavioral health for all children, youth, and families; 3) provide professional development to school employed staff, and; 4) develop a continuum of practices linked to both mental health literacy and suicide prevention strategies.

District Exploration and Adoption

Leaders in the Scranton (PA) School District, featured in the first volume of this monograph series (Barrett et al., 2013), began exploring options to better meet the rising need for mental health supports for students in 2008. As part of their exploration process, district leaders made outreach to county leaders who had oversight of the mental health system to establish an exploration team. This newly formed stakeholder group began to explore current partnerships and service delivery. They discovered that multiple mental health providers came into the schools to work individually with identified students in a narrowly defined way. For example, some students received support from a clinician for a specific amount of time (e.g., one hour per week). Other students received support from a practitioner (Bachelor Degree) on skill instruction or behavior redirection for a set time frame (e.g., ten hours per week) based on presenting problem. There was little communication or collaboration with school staff and desired outcomes were not achieved.

The group began to explore options that included expanding school-based partial hospitalizations or opening an alternative school. The district knew they wanted the new model to provide mental health support and also knew that they did not want the new model to result in an increase in restrictive placements. County leaders encouraged the adoption and installation of PBIS by the district. Simultaneously, they committed to bring together a group of stakeholders to use an integrated model to maximize impact, rather than continuing to try to meet all student needs through individualized support. Based on their acquired understanding of an integrated system, the team decided to adopt the ISF as the framework to guide the work.

Once an ISF was adopted, the exploration team was modified into an executive leadership team and began defining systems to support a new way of work. The managed care organization, in partnership with county stakeholders, educators, and mental health providers began developing an ISF, as their new way to ensure more comprehensive mental health services to children, youth, and families/caregivers within schools, the home, and community. The Scranton School District was one of the first to partner with the managed care organization to install the new model, using the PBIS framework to promote improved school climate and culture and focus on prevention, and early intervention. The mental health agency, recognizing the added value in working through a fully integrated system, agreed to have clinicians participate in the school teaming model to improve communication and collaboration with the schools. This new partnership allowed all involved to better support students, families and caregivers identified as needing higher levels of intervention and support. Together, by operating through an ISF, they were able to produce improved outcomes for their students including reductions in highly restrictive placements.

While the change was occurring at the LEA level in the Scranton School District, a similar change was happening at the state level that created conditions conducive for school districts and regional education agencies to move forward with more integrated approaches for planning comprehensive supports. As stated above, for this work to occur at the local level, there had to be a change in policy and funding structures from the state department of human services. In this instance, leaders at the local and regional level were able to leverage support because similar conversations were happening at the state level around the notion of better supporting the social, emotional, and behavioral health of all children, youth, and families. What emerged has been a now longstanding commitment to school behavioral health within Pennsylvania.

CHAPTER FOUR

Installing an Interconnected System at the District/Community Level

Ideally, adopting and installing an interconnected system involves layered implementation from the state, to the local level with state systems modeling and supporting district level structures. Districts then organize the partnerships and administrative components needed to guide and ensure effective integration at each school building. Many states also use regional or county structures for providing support to districts engaged in the integration of PBIS and mental health. As described in previous chapters, state, district and school teams benefit from this symmetry across organizational levels as consistent policy, funding, systems alignment, and workforce structures support a solid foundation for sustainable change. Because the unit of implementation of an ISF is most transformative at the local level, the remainder of this monograph will detail the installation process at the district/community and school levels. Implementers who have a role at the regional or state level can extrapolate the concepts presented for district/community leaders and apply the logic and the tools within their systems.

This chapter describes the process of integrating PBIS, mental health, and related social-emotional-behavioral initiatives at the district/community level. Coaches and leaders are guided through the installation of interconnected features the following five steps: (a) develop a district/community executive leadership team; (b) assess the current status of mental health and PBIS systems in the district/community; (c) reach team consensus on a mission statement; (d) establish team procedures and routines; and (e) establish action planning to support demonstration sites. This chapter also includes an ISF District Leadership Installation Guide[13] which is designed for use by facilitators and coaches who are supporting district/community leaders to customize the integration of PBIS and school mental health to fit the unique context and culture of their community. Description of features, installation steps, guiding questions and an action plan template are included in the Installation Guide.

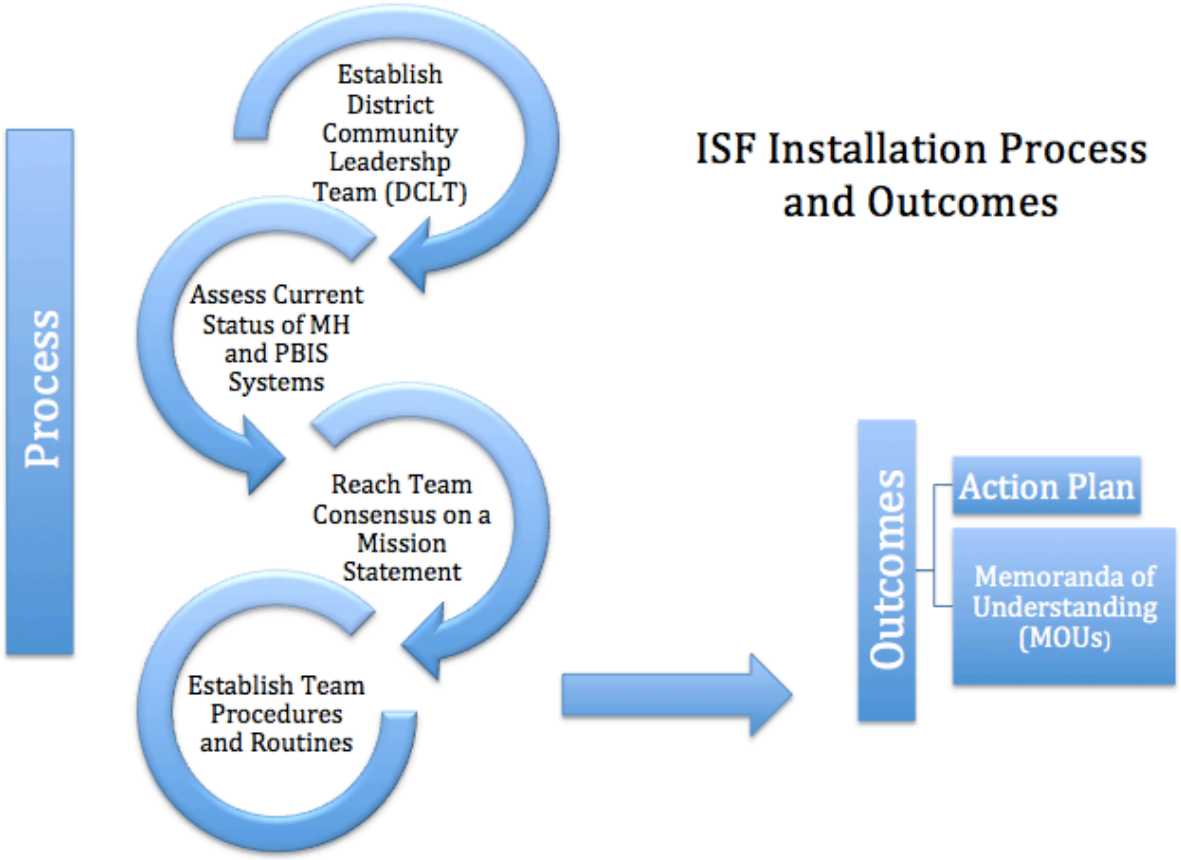
Installation

The purpose of the installation phase is to allocate or reallocate resources to initiate innovation. People who have the authority to allocate resources are identified, awareness activities are taking place and analysis of roles, functions and overall organizational structure is carefully examined.

The installation process leads to a comprehensive action plan, outlining the activities for the integration of district/community effort into an interconnected system of behavior/mental health. These actions will typically include a new or revised Memorandum of Understanding (MOU) that defines the roles and functions of the parties involved, and a funding plan that articulates how partners operate within the system. The action plan considers organizational structures that influence the way the child/youth-serving agencies, school systems, and other key stakeholders work together to promote a culture of wellness. Figure 4.1 illustrates the steps of the installation process and the intended outcomes that can be accomplished using the Installation Guide.

This chapter also provides explicit descriptions of the installation process, including tools and examples that can support teams in developing an action plan. The action plan should include strategies that build on the strengths of the community, its schools, and other child/youth- serving systems.

Figure 4.1: The ISF Installation Process



The ISF Installation Process

Step 1: Establish a District/Community Executive Leadership Team

As described in Chapter 2, the development of an interconnected system of behavioral/mental health in schools should be initiated and led by executive-level leadership from education, mental health, and other partnering agencies. Adopting a truly integrated way of working involves organizational change, requiring active leadership from those with authority to change policy, braid funding streams and re-position personnel and procedures at the school level. Including family members and community partners expand the focus and provides a more significant opportunity to incorporate local culture thus ensuring decisions that reflect a relative context.

Moving from the exploration team described in Chapter 3 to an established district/community leadership team involves setting up formal structures for (a) meeting regularly with key stakeholders, (b) continuously assessing the extent to which systems are efficient and effective, and (c) allocating or repositioning resources as needed to achieve maximum impact on student outcomes. The development of an integrated leadership structure should reflect the local context by building on existing strengths. For example, many districts have an executive-level team that supports their PBIS implementation; a viable strategy is to expand this team to include community partners and family/youth representatives. Other districts may have an interagency partner who provides mental health services to school age children, and recognizes limitations of conventional co-located models (e.g., only Tier 3 services for some students on some days) and are moving toward an integrated system of delivery. Districts just getting started with PBIS, can prioritize mental health integration from the onset and include family representatives and community partners as they form their first executive leadership team.

Executive-level leadership, including cabinet-level leaders, family, and community members, will need to be engaged in the team as significant changes in organizational practices (e.g., re-position staff, change job descriptions, review policy, and re-allocate funding) are con-

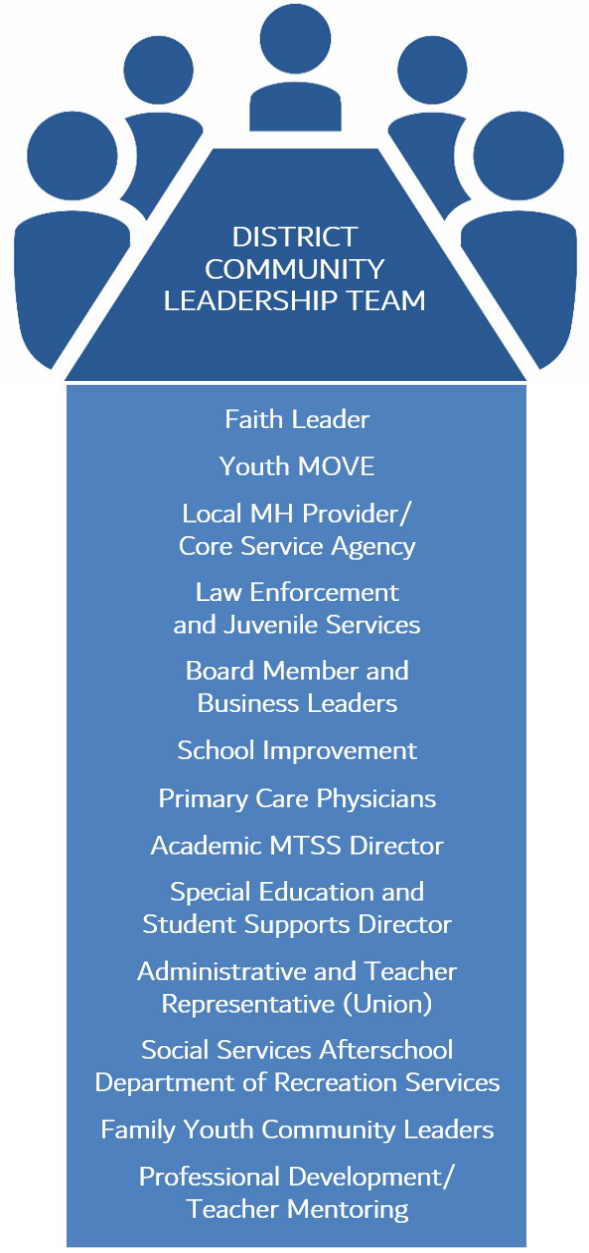
Initiating the Dialogue for Change

In Buncombe County, North Carolina, district leaders recognized they had multiple community stakeholders supporting various initiatives and grants across schools in their district. Following individual outreach to providers, they invited a group of stakeholders to meet with them to begin aligning and integrating their work for greater efficiency and effectiveness. Stakeholders involved in these initial discussions, and eventually, the District Community Leadership Team, included mental health providers, juvenile justice, the local managed care organization, the United Way, and other community groups. Moving to a workgroup structure helped facilitate collaborative efforts around agreed upon areas of focus including family engagement and evaluation.

sidered. Developing teams should consider including school board members and other key community leaders who can influence a broader community commitment to reducing stigma and investing resources that support a school-based health and wellness agenda. Although executive level administrators are essential to guide decisions that impact installation, other key stakeholders are also critical to complete the installation process. Building level leaders, program directors, clinical staff, family members, and youth leaders are also needed. Teams should actively seek family and youth membership by ensuring adequate resources (e.g., compensation, training) are designated to support their participation as leaders. Figure 4.2, although not exhaustive, includes stakeholders who should be considered for representation in the developing team.

Once the core team is established, the group can begin to work through the other installation steps. The initial focus will be on studying the existing organizational structures that impact schools' abilities to adopt an interconnected structure which include: policy, funding, and workforce capacity. This review of the current status will guide the executive team in considering changes to how they create a culture of wellness and prevention for all students and staff, while also responding with targeted and intensive mental health supports to identified students. The team will also consider the logistics of engaging with the first cohort of school sites to learn about the implementation process and continuously refining district-level support. As the team progresses through these steps, members can be added to reflect changing needs and priorities.

Figure 4.1: District Community Leadership Team



Step 2: Assess the Current Status of Mental Health and PBIS Systems in the District

As the district/community leadership team engages in their assessment of existing systems, they may create smaller workgroups to gather more information and share findings with the full team as they move toward action steps. The goal is to establish a shared understanding of (a) the current status of mental health programs and services in schools, (b) the existing relationships between the district and the community mental health system, and (c) the current implementation of the MTSS features discussed in Chapter 2.

Districts and schools can be in various stages of mental health and PBIS implementation and partnerships to begin implementation of an ISF. For example, all schools in a district may be implementing PBIS with fidelity at different tiers, or there could be no schools with PBIS implementation at any tier within the district. Similarly, districts may have MOUs that designate mental health agency clinicians to caseloads of identified students in schools; other districts may have no actual interaction with community agencies but recognize unmet student needs that prompt them to investigate partnering with community providers. All described scenarios and any combination of the situations provide an opportunity for using the steps described in this chapter, customizing to fit the community context and adopting and installing an ISF.

Regardless of the starting point, the leadership team can determine the current level of implementation by considering the following actions: (a) assess existing system structures, (b) review the status of current initiatives related to behavior/mental health, (c) conduct a staff utilization review, and (d) review existing school and community data. These team-based assessments can help the district community leadership team to identify 3-5 priorities that will determine the initial tasks in the action plan. The following section provides a brief description of the processes and resources for these assessment activities.

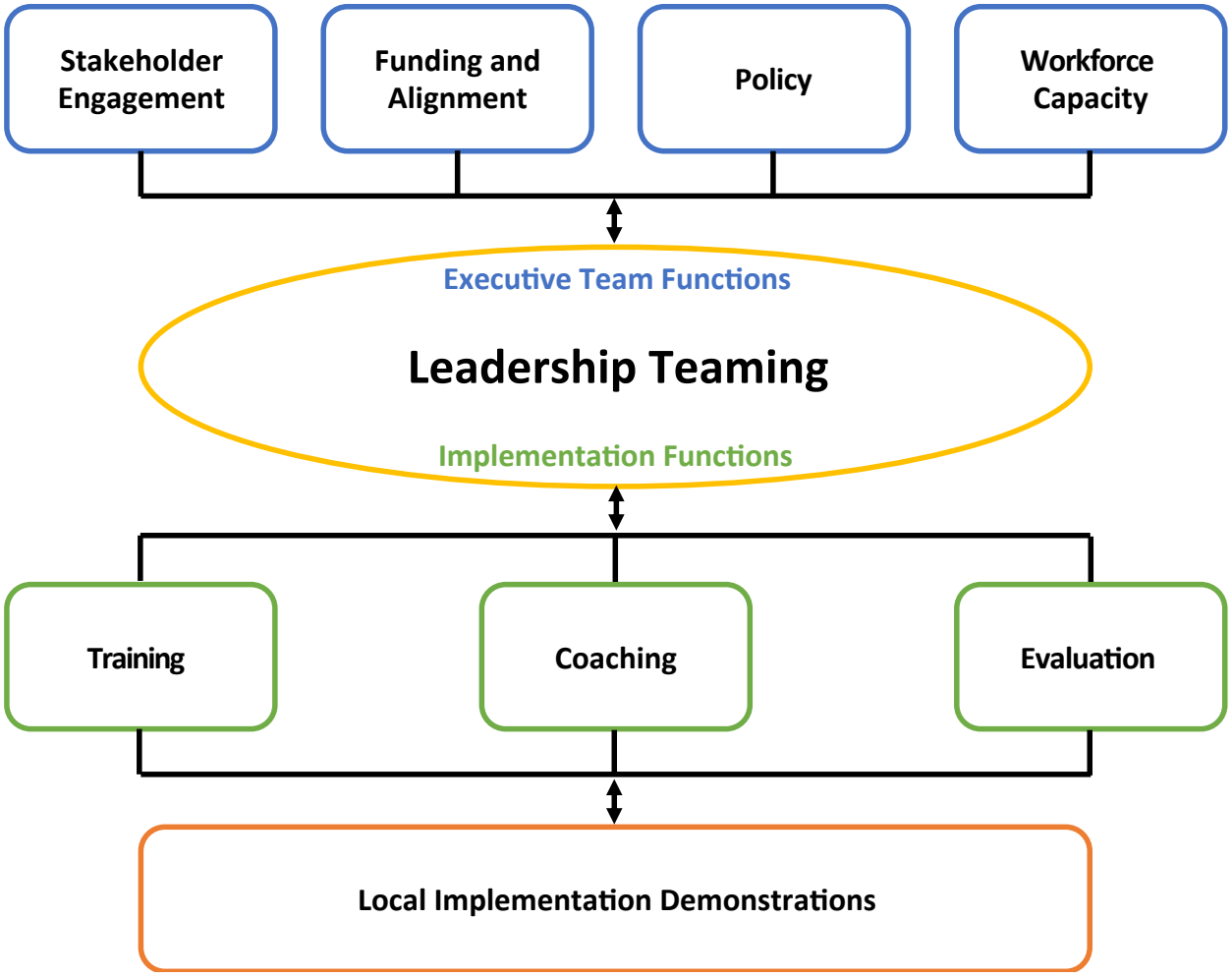
Step 2a: Assessing current system structures using the PBIS Implementation Blueprint Self-Assessment.

As described in Chapter 3, the *PBIS Implementation Blueprint*[14] (Center on PBIS, Oct 2015) is designed to further understanding of the structural framework for operating an effective multi-tiered system of support. The exploration team was encouraged to use PBIS Implementation Blueprint to reflect on how their current system works and what specific organizational changes may be needed to move to a single system of behavioral/mental health in schools. Following the decision to adopt the ISF, the district/community leadership team can use the National Technical Assistance Center's *PBIS District Systems Fidelity Inventory (DSFI)*[15] (OSEP Center on PBIS, 2019) to assess the current status of PBIS within the district. (For state-level teams, a PBIS State Systems Fidelity Inventory (SSFI)[16] (Center on PBIS, 2019) is also available.) Self-assessment results inform action planning with attention to building organizational capacity to sustain and enhance a multi-tiered system of support. This self-assess-

ment tool can guide the newly formed executive leadership group to create a common language and establish agreements to support an integrated PBIS/mental health approach. Assessing the elements of PBIS implementation will help the team (a) build fluency with core features of PBIS, (b) build consensus by discussing and rating the implementation status of the current system, (c) explain how to better integrate and align efforts, and (d) prioritize enhancement activities for the action plan. The team may consider using a facilitator who is fluent with the PBIS framework and systems change to lead them through a discussion of the items on the self-assessment tool. The facilitator, whether district employed or secured from outside the community, should have experience working with teams and applying the core features of the framework at both the school and district level.

Figure 4.3 illustrates the elements in the *DSFI* which are organized around two **structural** and seven **task** components. The two structural elements in the *PBIS Implementation Blueprint* and the *DSFI* are the *leadership team*

Figure 4.3: PBIS Implementation Elements



and *local implementation demonstration sites*. An ISF requires a well-functioning executive team, representing both the education and mental health systems, as this strong leadership structure is needed to support all other functions. Initial small-scale installation through demonstration sites allows for ongoing refinement, ensuring success while strengthening local capacity. The seven task elements address executive functions (see the blue boxes in Figure 4.3) and implementation functions (indicated in green). The self-assessment process involves the members reflecting on the current status of these nine elements of a comprehensive system with the logical starting point being the leadership teaming element. The assessment process guides the group to reach consensus on membership and routines for the district/community leadership team, including a structured meeting protocol with minutes, reporting schedules, and decision-making procedures.

This assessment process involves team members reaching consensus on a score for each item, using the descriptions of each rating for each item. As described in the administration guidelines for this tool, the team members should focus on the descriptions rather than the numerical scores as the major purpose of this self-assessment is to guide action planning. The following brief descriptions of the functional elements illustrate the blending of mental health with PBIS, and are intended to serve as guidance for the facilitator and clarification for the team members who may be new to an interconnected system.

Executive functions.

The items related to executive functions are designed to improve a comprehensive system-wide approach and include *stakeholder engagement, funding and alignment, policy, and workforce capacity.* Stakeholder engagement focuses on support for an interconnected approach that involves active participation among community members, families and students. Engaging stakeholders in dissemination of marketing resources will help promote visibility and develop consistent messages for agreed-upon priorities such as reducing mental health stigma. The items related to funding can guide the team to build a blended, flexible and sustainable funding stream that allows clinicians to participate in systems planning, moving beyond the restrictions of a fee-for-service delivery model. Flexible funding that is independent of diagnosis and insurance plans can expedite delivery of interventions, especially at Tiers 1/2.

The *policy* assessment items can help the team examine the extent to which current policies support an integrated system and highlight where changes to policies could eliminate potential barriers to integration. For example, agencies have different policies concerning confidentiality that are based on interpretation of the laws that govern student records in education (Family Educational Rights and Privacy Act [FERPA], 1974) and client records in mental health (Health Insurance Portability and Accountability Act [HIPAA], 2004). Because educational and mental health records are often viewed as separate, teams may incorrectly assume they are not able to share information

about students supported in an integrated system. The team will need to agree on a standard policy to address how data will be shared to ensure students are linked to appropriate interventions and have their rights protected. These decisions should be articulated within the MOU and shared with families and other stakeholders. Additional dialogue around policy items will assist the team in achieving equal priority for academic achievement and social-emotional-behavioral health. Policy change to reflect the need for mental health informed responses rather than exclusionary responses to mental health needs are also prioritized through the assessment items. New or revised policies will need to be clearly articulated and communicated to stakeholder groups. Items on the self-assessment related to alignment will assist the team to develop protocols for selecting evidence-based practices and streamlining the number of initiatives.

Workforce capacity items prompt the team to address job descriptions of agency and school personnel to allow changes that may be needed for implementation of an interconnected system. Roles that may need modification include those for administrators, coaches, and both school employed clinicians (i.e. school counselors and school psychologists) as well as community employed clinicians. The executive-level team will need to discuss qualifications and skills, allocation of time, identified job activities, and how both education and agency personnel will be supervised and evaluated. For example, job descriptions of school-based and community-based clinicians may need to be modified to clarify their active participation on specific teams, and expectations for the use of data and interventions they will deliver. The Staff Utilization section below (Step 2c) will provide further detail on assessing current staff resources and needs.

Implementation functions.

The implementation elements (training, coaching, evaluation, performance feedback, content expertise) are designed to promote accurate use of evidence-based practices. For example, the function of the social-emotional-behavioral expertise element ensures that personnel with skills in social-emotional instruction and behavioral/mental health interventions are available across the tiers. The assessment items for training will help the leadership team identify and refine school level readiness criteria, develop professional development with a clear scope and sequence including opportunities for teams to participate in peer networks, and identify how to build local training capacity. Teams should identify gaps among personnel groups. For example, staff trained as clinicians may be lacking knowledge and experience about how interventions can be effectively integrated into classrooms; teaching staff may be lacking knowledge and information about specific mental health interventions for conditions such as depression or anxiety. Leadership should provide opportunities for all staff to build their knowledge and expertise with the full continuum of available behavioral/mental health interventions.

The items related to *coaching* will help the team determine adequate coaching supports based on phases of implementation and needs indicated by data. The team is encouraged to

develop a comprehensive professional development plan that allows for differentiated supports provided by district/community coaching. Identified coaching personnel from both education and mental health partner agencies will need to be positioned with adequate time for the designated coaching activities. A strong focus on building coaching capacity will help support, sustain and enhance the effort.

The assessment items for *evaluation and performance feedback* target the need for systems that let school teams easily track daily occurring student data (e.g., out-of-class time, discipline referral patterns, daily progress reports) and provide disaggregated reports across sub-groups. The ability for data systems to allow school teams to effectively review screening, attendance, behavior, academic, and other community demographic data is essential. As data systems for daily use are examined, the team should consider how all interventions facilitated by both school and community employed clinicians will be tracked and monitored by teams through the same data system. Additional items assess the extent to which outcome data and accomplishments are disseminated, acknowledged, and celebrated with the school and community on a regular (quarterly) basis. Also, district community leaders should establish expectations, support, and recognition for regular and accurate use of such data routines at the school-level.

Through this self-assessment process, the leadership team will begin to develop an action plan that will move them towards a single system of behavioral/mental health in schools. More details for developing an action plan will be described later in this chapter. The facilitator and coach will need to continuously refer to the items in the *DSFI* to secure agreements around the new approach, especially as additional staff and leaders from education and community agencies join the effort.

Step 2b: Conduct a review of current initiatives.

During the exploration phase, the team conducted a preliminary review of fidelity and outcome measures of all existing social-emotional-behavioral initiatives. This information will be used as the team begins to examine initiatives with a focus on the documented impact of each initiative as well as the potential overlap of effort. This information allows the team to identify opportunities to align or eliminate related initiatives as they begin the integration into a single system of behavioral/mental health support. The focus is on effectiveness and efficiency, embracing the concept that 'more is not necessarily better.' The team should consider investing in a small number of evidence-based practices that are matched explicitly to the needs of their community and have the potential of impacting the numbers of students with identified needs. The leadership team should establish a formal internal review process that will allow the team to examine the extent to which current initiatives are (a) implemented with fidelity, (b) having an impact, and (c) matched to their specific community need. It is suggested that this continuous improvement process become an established routine to occur quarterly and/or before adding new initiatives.

The team, to provide an overall picture of existing social-emotional-behavioral related initiatives or programs available to the broader community, can use the *ISF Initiative Inventory*[17] template to organize a review of current efforts that can be potentially streamline for efficiency. The template guides the team can to list the initiatives currently available across the school community and assess each initiative with regards to the following features: (a) effectiveness, relevance, and fidelity; (b) funding and resource allocation; and (c) areas of redundancy. Executive team members with organizational and budgetary authority should conduct this process for all the initiatives related to behavior/mental health from both the school district and participating agencies. Each partner agency should seek input from stakeholders to ensure detailed knowledge of the core features of the initiative and an understanding of how the initiative is implemented. A facilitator or coach can guide the district/community leaders through the information and facilitate decision making towards an efficient, aligned system.

Table 4.1 provides an example of a completed ISF Initiative Inventory template example represents the efforts of a district/community team engaged in interconnecting their behavioral/mental health systems. In this example, items indicated in red were 'flagged' for action by the team. For example, the team recognized that PBIS and programs that were labeled as social-emotional instruction had similar outcomes. Therefore, they decided to integrate these two initiatives by redesigning the training and coaching to position teachers to deliver the social-emotional skill lessons within the classroom by embedding the skills into their PBIS behavioral matrix across settings. The leadership team also recognized a lack of evidence of impact for a professional development activity they described as 'mental health awareness.' The facilitator guided the team to a strategy for determining how teachers apply the practice through a survey to be used pre- and post-training. An additional area of note by the team was the separate, one-hour overview of suicide prevention being provided to all staff. It was determined to be insufficient based on youth report data indicating increases in both suicidal ideation and attempts. The team decided to move from a general mental health overview, where they did not see an impact, to a more specific and comprehensive approach to suicide prevention, using evidence-based strategies for professional development, including ongoing coaching and support for teachers and staff. More on the process for selecting evidence-based practices will be reviewed later in this chapter.

Table 4.1: ISF Initiative Inventory Example

Name of Initiative	Connection to Mission	Personnel Involved	Expected outcome	Evidence of Outcomes thus Far	Financial commitment and source of funding	Fidelity Measure	Professional development, Coaching and performance feedback
PBIS	School climate and culture	All Staff	Reduction in suspensions, ODRs, restrictive placements	Improved suspension, ODR and restrictive placements	District Coach FTE, Stipends for building coaches, & professional development	Tiered Fidelity Inventory	Quarterly coaching for building coaches; PD for new staff; On-going PD and coaching for all staff
Social Emotional Behavioral Skills Curriculum	School climate and culture through social and emotional learning	School counselors and social workers	Improved skills for students in grades K-5	Reduction in ODRs from last school year	Purchasing curriculum plans for each grade level and PD for integrating into academic content	Self-report of counselor or social worker	None
Wellness	Increasing awareness of the whole child	All Staff	Increased awareness of mental health issues	Unknown	Paying for materials for each teacher	None	1 hour PD for staff
Bullying Prevention: Stop, Walk, Talk	Aligns with PBIS framework	All elementary staff	Increased awareness of interactions and respect for self and others	SWIS data shows reduction in ODRs for bullying behavior	Substitutes for PD time	Part of fidelity check for PBIS – TFI	Teachers receive ongoing PD, coaching and TA from the district and building coaches
Suicide Prevention	Increasing awareness of whole child	All high school staff	Increase awareness	Increase in suicide ideation and attempts	Substitutes for PD time	None	8 hours of PD for all staff

It is recommended that teams develop a schedule (e.g., quarterly, twice annually) for ongoing review of related initiatives. Routine use of the ISF Initiative Inventory template, especially when considering new initiatives, will allow the team to proactively plan for alignment and integration of all related social-emotional-behavioral efforts. This data-based approach for making decisions about their continuum of evidence-based practices will ensure the district/community can effectively meet the needs of all students within their community. With finite resources of people, time, and funding, prioritizing effective and efficient initiatives with demonstrated student outcomes is critical.

Step 2c: Conduct a staff utilization review.

A critical feature of an interconnected system is the availability of staff that can effectively design and deliver interventions across the continuum. In most schools and districts, non-teaching staff (e.g., counselors, psychologists, social workers) are providing social-emotional-behavioral interventions. There may also be community employed clinicians or other professionals (e.g., mentors, case managers, behavior specialists) who deliver interventions within schools. To determine how staff resources should be allocated within a merged system, the team should assess the current workforce capacity by identifying roles, responsibilities, and time allocation of all staff. The *Changing Role of Staff: District Level Discussion Guide*[18] was developed to facilitate discussions with the various staff groups and includes items specific to the role of administrators/instructional staff, as well as, school and community employed clinicians.

A recent study by Kelly and Whitmore (2017) provides an example of a staff utilization review that examined the time social workers in multiple school districts engaged in various activities. Researchers applied a time study tool to gather and analyze data related to activities performed by school social workers. Researchers tracked social worker self-reported activities per fifteen-minute intervals, indicating direct support to general education, special education, or a mix of students or families. Categories of activities included: direct services with a student, crisis response, material preparation, compliance documentation, assessment, and compliance meetings. Initial findings indicated that school social workers spent approximately two hours per day in direct service tasks with every hour of direct service being matched by nearly two hours of indirect service (e.g., crisis intervention, documentation or assessments, and time spent is meetings). Of concern to the participants in the study was the realization that social worker indirect service time was not accounted for in district-level decision-making about caseload numbers and staff allocation. These initial findings emphasize the importance of assessing the current functioning of clinical staff to identify possible changes for better efficiency and effectiveness.

To assess the current workforce capacity and compare to the overall behavioral/mental health needs of students, the district/community leaders will need to establish a process to analyze current utilization of staff resources. Based on the study mentioned above, (Kelly & Whitmore, 2017), a modified *Time Study Template*[19] to gather and analyze data on clinician time is provided in the installation guide. The team could apply a similar process by identifying a timeframe (e.g., a specific week, select days within a month) and having all clinicians track how their time was spent. Modification of activity and population served categories may be needed to match the performed responsibilities in the district/community.

Once the summary of clinician time is completed, the district/community leaders can further assess the current status and desired future for utilizing workforce capacity and resources. For example, the team may want to consider allocating time for clinicians to consult at Tier

1, coordinate and facilitate interventions at Tiers 2 and 3, as well as participate on the systems teams. If clinicians are spending 10-15 hours per week supporting the implementation of Tier 1, leadership may want to prioritize strategizes to build the capacity of all staff to support the implementation of Tier 1, thus freeing up clinician time for supporting and providing individualized interventions.

Step 2d: Review existing school and community data.

It is recommended that the district/community leadership team initiate a comprehensive review of available school and community data to assess the needs of the whole student population. District leaders may already have a process to review attendance, grades, suspensions, expulsions, students placed in restrictive settings, and universal screening data. This information should be combined with available community data, including demographic information, suicide ideation/attempts, hospitalizations, child welfare contacts, juvenile justice interactions, and other related data points. In addition to school-level data and community demographic data, this review should include other community-level indicators of risk and protective factors, including family and youth perspective data, which may be gathered from surveys and focus groups. Specific community needs may be further indicated by local occurrences such as an opioid crisis, spikes in unemployment, school/community violence, or a natural disaster. This broader data review, combined with the information gathered during the DSFI self-assessment, initiative inventory, and staff utilization audit can inform the team's priorities, and guide next steps.

Step 3: Reaching Team Consensus on a Mission Statement

As district and community leaders begin to coalesce around agreed upon priorities, they will need consensus on a shared mission that is valued by all stakeholder groups. A mission statement (a) defines the purpose of the team, (b) establishes goals for work, and (c) creates a shared vision that can be communicated with stakeholders including teachers, students, and families. Some of the previous steps (e.g., reviewing data and discussing shared priorities) have provided a foundation for creating the mission statement so formalizing a shared vision with goals should be a natural progression of solidifying the team.

A proposed strategy is to conduct a crosswalk of all organization mission statements, comparing the current mission statements to the messages in the ISF approach. As the team identifies similar goals and objectives, they can determine if there is an existing mission statement that meets the purpose and goals of integrated work or if a new mission statement would better define the vision. An example of creating a new mission statement is from the Elgin Area School District U-46, a large urban district in Illinois, which formed a Community Alliance with over 30 different community agencies. They developed a mission statement that defined their purpose and established an identity for the group. Their statement emphasizes the use of data as a shared priority for their action planning to promote wellness.

U-46 Mission

The mission of the U-46 School and Community Alliance is to create, integrate, and leverage existing and new school/community partnerships that develop a full continuum of systematic interventions based on data. It encompasses three intervention tiers:

- Systems for promoting healthy development and preventing problems
- Systems for responding to problems as soon after onset as is feasible
- Systems for providing intensive care

Step 4: Establish District/Community Leadership Team Procedures and Routines

After looking at district and community data and establishing a mission statement, the next vital part of the installation of an ISF is to establish procedures and routines that operationalize the core features of a multi-tiered system of support (MTSS) at both the district and school levels. This part includes defining procedures for teams to (a) choose and install a universal screener, (b) select interventions, (c) monitor fidelity, and (d) monitor outcomes. As the routines and procedures are agreed upon, the team will develop an integrated action plan that is linked to the implementation elements of the *PBIS Implementation Blueprint* and *DSFI* (i.e., training, coaching, evaluation and performance feedback, and behavioral/mental health expertise).

The district/community leaders may decide to adopt a typical meeting agenda to establish a consistent process that increases the likelihood that all team meetings, both at the district/community and school level run effectively. It is recommended that the district/community leadership team start with a few selected schools to serve as demonstration sites for the district, allowing them to test the procedures and routines. As successes and challenges are identified, changes can be made, thus engaging in continuous quality improvement. The following sections describe each of the four procedures to be designed by the district/community leadership team for installation at both the district level and in the pilot demonstration schools.

Core Features of MTSS

1. Effective teams
2. Data-based decision making
3. Formal processes for the selection and implementation of evidence-based practices (EBP)
4. Early access through the use of comprehensive screening
5. Rigorous progress-monitoring for fidelity and effectiveness
6. Professional Development and ongoing coaching

Step 4a: Selecting and installing a universal screener.

Early access and comprehensive screening have been present for physical health, such as vision and hearing, for many years. Academic screening in the core curriculum, such as reading and math, have become part of the norm in more recent years. Screening for social-emotional-behavioral concerns has not been common practice. Even when schools screen, the tendency is to screen only for acting out problem behavior and not for internalizing concerns, such as anxiety and depression (Weist et al., 2018). Comprehensive screening within an integrated system expands the lens to identify students with both externalizing and internalizing behavior needs.

It is recommended that the executive leadership select the screener to be used district-wide. When choosing a screener, leadership should ensure that the tool identifies both internalizing and externalizing behavioral concerns of students. As many screening tools are available, teams should engage in a selection process that compares the following critical features across tools (a) evidence of each tool, (b) resources (e.g., staff time, technology, cost) needed to implement, (c) fit with other district initiatives and priorities, and (d) readiness and capacity to implement. There are both cost and no-cost options available. The fit for the district needs and capacity is imperative. *The Systematic Screening Tools: Universal Behavior Screeners*[20] document is a resource to support teams in beginning the search and the Screening Resources[21] document provides additional resources to learn more about individual screeners.

After selecting a universal screener, the leadership team should establish routines and procedures for consistent communication with relevant stakeholders, including families, students, and teachers. Additionally, procedures for when and how the screening will be conducted should also be established at the district/community level for consistent implementation at the school level. For example, will screening occur two or three times per school year? For secondary schools, decisions will need to include which teachers will complete the screener (e.g., homeroom teacher, second-period teacher, English teacher), and how the necessary technology supports will be installed. The Universal Screener Timeline[22] provided in the ISF District Installation Guide offers an example of what it might look like from starting exploration to fully implementing a universal screener.

Screening data must be analyzed quickly and used for decision making at the school and district/community level. Therefore, the district/community leadership team will also need to determine roles and responsibilities for collecting, managing, analyzing, and sharing data. Personnel with the skills to provide supports should be available to assist school teams in determining which students with indicated risk need which level of intervention as not all students who screen positive will require individualized interventions. Decisions about how to provide additional clinical evaluations for some students will be needed. Additionally, the leadership team should consider how screening results can be

used in combination with other school-community data to identify students for additional supports. For example, they may decide to pair the screening data with other data available through their district's data management system to guide decision-making at the school level. For example, a procedure may be needed to quickly calculate the indicator of risk of the screening data triangulated with existing early warning system data that typically includes attendance, grades, and discipline referral/suspension data. The use of an early warning system including an example will be discussed more in Chapter 5. These systems must be in place before the administration of a screener given the inherent time-sensitive nature of the assessment outcomes.

An essential task of the district/community leadership team is to ensure every school has a response plan, including personnel trained in providing additional assessments to adequately address the needs of children and youth who are experiencing elevated emotional distress. Schools must have interventions in place before implementing the screener so they will be prepared to respond to students identified as needing more support. The team should ensure their continuum of interventions, supported by both school and community clinicians, can address internalizing, as well as, externalizing needs identified by the screening data. *The Best Practices in Universal Screening for Social, Emotional, and Behavioral Outcomes: An Implementation Guide*[23] (Romer et al., 2019) is an additional resource that summarizes current research and provides recommendations for both selecting and installing a universal screener.

Step 4b: Establish the request for a ssistance process.

The first use of universal screening often leads to an increasing identification of students needing additional supports. School teams will need to be prepared to respond quickly to the identified needs of students and response across the district needs to be streamlined within a single system. This level of response could be a significant change for schools and community agencies that previously had separate or undefined procedures for receiving intervention. To ensure a rapid response within a single streamlined system, district/community leadership needs to provide school teams with a protocol for connecting students to full continuum of social-emotional-behavioral interventions. This will potentially be a shift from making referrals to a co-located mental health team as now all requests for assistance will be handled through a team that processes and monitors all interventions delivered by both school and community clinicians. Referrals to outside providers would only be for medical issues or complex family needs that are beyond the capacity of the newly defined single system of delivery. This could be a significant shift in operating procedures for both school and community personnel. Providing professional development and on-going coaching from the district level will ensure fidelity of implementation and sustainable systems.

To ensure the effectiveness of an integrated teaming structure that includes school and community personnel and redefined roles, the district/community leadership should consider guidelines for school teams to manage request for

assistance. The guidelines will establish parameters to ensure consistency while also providing flexibility to meet the differing needs of individual schools. One example requirement might be that all schools have a designated coordinator, such as a Tier 2 team leader, who manages requests for assistance regularly between team meetings to ensure and monitor rapid placement of students into higher-level interventions. Another requirement could be that all school teams have established entrance and exit criteria for all interventions. Flexibility for schools may be in who participates on the team that monitors Tier 2 interventions and what their l criteria for entrance and exiting are.

Step 4c: Selection process for evidence-based practices.

The executive leadership team should establish a formal process for selecting interventions for installation across all schools. They will be responsible for deploying resources (e.g., funding, staff to facilitate interventions, coaching supports) and will need to carefully determine how the overall system will be impacted if another initiative is added to the menu of available interventions. The team may want to consider using the *Hexagon Tool*[24] (Metz & Louison, 2019) to help make decisions about new interventions being considered for district-wide installation. The Hexagon Tool guides dialogue and decision-making for selecting potential interventions by organizing information about (a) need, (b) fit within current initiatives, (c) evidence of effectiveness, (d) capacity to implement, (e) usability, and (f) resources and supports. This tool allows the team to assess the fit between the proposed intervention, prioritized need, mission, and assess the implementation readiness and resources necessary to install, sustain, and expand the intervention to all students The process supports an informed decision on whether to adopt a specific intervention.

Another tool teams may use when considering the installation of a specific behavioral/mental health intervention, is the *Consumer Guide to Selecting Evidenced Based Mental Health Services*[25] within a PBIS model (Putnam et al., 2013). This Guide includes a checklist and case examples to assist teams in selecting interventions that match data and presenting problems while ensuring that staff has the skills needed to implement the intervention. Specific recommendations for assisting the team to consider how to match the developmental, linguistic, and cultural characteristics of the student population are also included.

A district/community leadership team in Pennsylvania established a hybrid *Protocol to Identify Mental Health EBPs within the PBIS Framework*[26] that used a combination of the Hexagon Tool and the Consumer Guide (Runge et al., 2017). They developed an efficient one-page worksheet with 12 guiding questions for coaches to use to guide teams through decisions for selecting new interventions. Specifically, they had each team member evaluate the interventions being considered using the 12 guiding questions. Then the coach facilitated a consensus-building dialogue to help the team determine which intervention would be added to their continuum.

Step 4d: Process to monitor fidelity of interventions.

Once district/community leadership has decided to launch a new intervention, the team has the task of determining how to accurately assess the extent to which the intervention is being implemented with fidelity. This information will be needed to help leadership deploy training and coaching resources more effectively. Choosing fidelity measurement tools and processes is an essential step in developing an evaluation plan (described in Step 5, later in this chapter). The team will be considering how fidelity tools fit with other measures and processes already in place. The following questions from the previously described *Consumer Guide to Selecting Evidenced Based Mental Health Services*[27] within a PBIS model (Putnam et al., 2013) can assist in determining how to measure fidelity as part of the installation of a new intervention:

1. When and how often will the teams assess implementation fidelity?
2. What tool will the teams use to assess implementation fidelity?
3. For this intervention, what is an acceptable level of implementation fidelity?
4. What will the district/community leadership team do if implementation fidelity is below this acceptable level?

Since not all evidenced-based interventions have a validated fidelity measure, the team may consider investing in the development of a fidelity tool or process for an intervention they are considering for adoption. The team will develop a fidelity tool that would identify core components/critical features of the selected intervention(s) and the recommended dosage and frequency. Additional fidelity tools for measuring the overall accuracy of the behavioral/mental health system and the interconnectedness of PBIS and mental health at the school level will be discussed in Chapter 5.

Step 4e: Process to monitor outcomes of interventions.

In addition to ensuring that all school level teams follow a consistent process to monitor fidelity, the leadership team has a role in ensuring these teams monitor outcomes of each intervention. As part of the evaluation plan, the district/community leaders will establish expectations for schools to adhere to the evaluation protocol for all interventions, regardless of who delivers them. These expectations include (a) identifying entrance criteria into an intervention, (b) progress monitoring during the intervention, and (c) criteria for exiting an intervention. These criteria will include data used to make general decisions about rules for access to interventions (e.g., three visits to the nurse or two minor discipline referrals is entrance criteria for a Tier 2 intervention). Coaches will support school teams to routinely engage in a problem-solving process as they progress monitor outcomes for all students. Impact of interventions at the building levels should be aggregated and reported to leadership at least annually to inform district-level action planning over time.

In summary, the role of district/community leadership is to establish consistent routines and procedures that ensure adherence to the core features of MTSS. This plan will involve a series

of action steps for (a) selecting and installing a universal screener, (b) selecting interventions, (c) monitoring fidelity, and (d) monitoring outcomes. The next section describes the team's action plan for the integration of PBIS, school mental health and related social-emotional-behavioral initiatives. The action planning process to ensure the systems are in place to support use of data and installation of practices, is linked to the implementation elements of the *PBIS Implementation Blueprint* (i.e., training, coaching, evaluation, and performance feedback, and social-emotional- behavior expertise).

Step 5: Develop Action Planning to Support Demonstration Sites

Thus far, the team has spent time reviewing data, assessing the current status, and identifying action steps for integrating efforts using the MTSS framework. Although determining action items is ongoing during Steps 1-4, we describe the action planning process as Step 5, resulting in a comprehensive multi-year action plan. District/community leaders are encouraged to project action-planning for at least a three-five year span as they consider sustainable change over ten years.

In addition to addressing the executive functions of the integrated system (e.g., stakeholder engagement, policy, and systems alignment, funding, and workforce capacity) the action plan addresses several critical components related to implementation. These implementation components include an evaluation plan and a professional development plan outlining the steps for training and coaching which are designed to build capacity by increasing the number of staff with social-emotional-behavior expertise and the established systems to support effective implementation over time. Other key components include a method for the selection of demonstration sites with defined readiness and commitment factors. Finalizing the MOU is also a key component for the 3-5-year action plan. The MOU outlines the resource commitment of all organizations involved and articulates how they will work in an integrated way.

As mentioned above, the ISF District Leadership Installation Guide is organized as an action plan template the team can use to organize their activities, and includes an example of a multi-year action plan using this template. The team may also decide to use a format for planning that is directly linked to an existing district improvement or strategic plan. Regardless of which template the team uses, agreements

Action Plan Components

1. Evaluation
   a. Fidelity
   b. Outcomes
2. Professional Development
   a. Training
   b. Coaching
3. Demo Sites
   a. Selection
   b. Readiness
4. MOU
   a. Resource Commitment
   b. Roles of Staff

to support the action item must be supported through the MOU document.

Step 5a: Develop an evaluation plan.

The evaluation plan provides the process and protocol for collecting and analyzing information for decision-making at the district as well as the school level. Drawing from the Evaluation Blueprint for School-wide Positive Behavior Support (Algozzine et. al., 2010), the district team will develop an evaluation plan that describes what activities are being implemented, the extent to which the activities are having a positive impact on students and the extent to which the effort is worthy of replicating and scaling. District leaders will develop evaluation plan organized around the following categories: **context** (e.g., goals and objectives), **inputs** (e.g., training and coaching supports, budget allocation), **fidelity and impact** of implementation related to the social–emotional-behavior of the students. The team will also develop evaluation questions that address **replication, sustainability and continuous improvement** activities. More specifically, the ISF District Leadership Installation Guide includes a resource Designing an Evaluation Plan[28] with sample evaluation questions, data sources and suggested data collection schedule. The goal for the team is to develop an evaluation plan that organizes activities across the six broad categories and documents (a) the goals and objectives of the initiative, (b) documentation method(s) to track training, coaching, and technical assistance activities, (c) fidelity measures that assess adherence to the critical features of the initiative, (d) capacity measures that examine the organizations ability to sustain and expand the effort, (e) outcome measures that assess the extent to which there is a positive impact on students, staff, families, and communities, and (f) replication, sustaining and scaling factors that contribute to ongoing improvements of the overall effort.

In developing an action plan for integrating PBIS and related social-emotional-behavioral efforts, tools currently being used by various initiatives will need to be examined, and decisions about streamlining evaluation efforts may be required. Functions being met by current tools will need to be considered, and some tools may need to be replaced or eliminated, and tools specifically designed to measure the integration of efforts may need to be added to the plan. As previously discussed, screening tools that identify students with both internalizing and externalizing needs will need to be selected as well as the logistics for installing them at the school level. Each community will have unique features that affect the scope, areas of focus and format of the evaluation effort. Evaluators will customize the evaluation plan to meet the needs of their specific community.

While sensitive to the concerns of schools completing multiple tools, national ISF leaders recognized the need to have a tool to evaluate an ISF. The *ISF Implementation Inventory*[29](Splett, Perales, & Weist, 2019) is a fidelity tool developed through early experiences and lessons learned with knowledge development sites. This fidelity tool is used at the building level to assess implementation at all three tiers and develop an action plan. Notably, the authors completed a national validation study and found the tool to

be psychometrically strong, with reliable scores at each tier, and high usability ratings (Splett et al., under review). As districts are getting started with the installation and initial implementation, it is recommended that they use the ISF Implementation Inventory with pilot schools for the first three years to guide integration efforts and provide feedback for replication and sustainability across the district. With facilitation support by coaches, it should be completed at baseline, during installation, and in the spring of each school year. As the ISF interconnects PBIS and school mental health, the ISF Implementation Inventory also requires assessing the implementation of PBIS implementation to ensure the behavioral prevention and intervention strategies employed in all tiers of PBIS are installed and interconnected with school mental health. Thus, schools should also complete a measure of PBIS implementation fidelity such as the SWPBIS Tiered Fidelity Inventory. Once the ISF Implementation Inventory is completed, an electronic report card is generated that highlights areas for strength and improvement for each school with comparisons to prior administrations to measure growth over time. A district report card can also be generated aggregating results for all schools completing the tool. Teams can use this information for action planning at the school and district levels. This information will also provide the leadership team with data on the implementation progress of the domains over time.

Step 5b: Develop a professional development plan for training and coaching.

Once the district/community team has established the evaluation plan and identified the measures school team would use to track progress and fidelity, they will need to develop a plan to provide training and coaching support to all school and community staff who participate on teams. The training and coaching plan will include steps for building local capacity by increasing the number of staff with social-emotional-behavioral expertise and ensuring personnel has an understanding of their roles within the interconnected system. All staff from both school and community agency settings should understand the integrated approach and the process for how the school and agencies are working toward a single system of behavioral/mental health support.

Coaching is a set of responsibilities, actions, and activities that bridge training and implementation through supportive facilitation and provision of appropriate resources; and coaching is associated with more successful district implementation (George et.al., 2018). While coaching to support district-wide improvements has become more prevalent in education over the past 15 years, this has not been the case in mental health systems where a clinical supervision model is more typical. The supervision approach in mental health involves supporting clinicians with their assessment, treatment planning, and clinical intervention processes. Ensuring compliance with documentation, billing, and agency policies is also a normal part of supervision in

mental health agencies. District/community leaders will need to discuss how the role and function of a coach are different from those of a supervisor within mental health as they develop the professional development plan for moving to an integrated model.

As seen in the sample Data Informed Professional Development and Coaching Monthly Calendar,[30] the district/community leadership will provide ongoing coaching from both district and community-based agencies will be necessary for building capacity. The designated coaching personnel will need to be active participants at the executive leadership level and also provide support to the school level teams, assisting in the collaborative planning and development of cross-training. At the school level, coaches will play a significant role in supporting teams to use the new protocols established by the district/community leadership. At the advanced tiers, coaches will ensure that community and school employed staff responsible for implementing interventions receive appropriate professional development and coaching regarding each intervention.

Step 5c: Selecting demonstration schools.

As the *PBIS Implementation Blueprint* describes, it is recommended that the executive leadership select a few schools to closely monitor and support as the newly defined integrated system is installed. Demonstration schools will allow district/community leaders to respond and adjust procedures and protocols as needed based upon challenges and lessons learned. For larger districts, more formal procedures and criteria for selection of demonstration schools may be needed. Decision rules, including readiness and commitment criteria, are used to select demonstration schools for initial implementation. The team may choose demonstration schools based on local priorities (e.g., a high percentage of students who have experienced trauma, a high school with a prevalence of suicidal ideation, etc.). Other selection factors might include a highly motivated building administrator, who has buy-in from staff and families; or a decision to start at the elementary level when there are only a few elementary schools within the district. The district/community leadership team should communicate with stakeholders about decisions for how and why schools are selected and the process of adding schools. Additionally, ongoing updates to keep all stakeholders informed about the impact of the initiative will also be needed.

Step 5d: Finalizing a memorandum of understanding (MOU).

The need for revision or development of a MOU was introduced at the beginning of this chapter. The roles and responsibilities of all involved school and mental health staff in the newly merged system should be written in the MOU. For districts and mental health organizations with existing relationships and MOUs, a review of the current MOU will be critical to assess what changes may be required to achieve a single delivery system with shared decision-making through the integrated teams. For example, an existing MOU in a co-located mental health service delivery may include an expectation that school staff identifies and refers students to the mental health clinician. In an integrated approach, the MOU would outline

how the clinician, as part of the team, would work together to review data and identify students needing targeted or individual intervention. Team-based system tasks for community clinicians in an integrated system may include sharing community data, shared problem-solving, and selecting interventions through a team process. Additional tasks that may need to be addressed in the agreement may be all clinicians engaging in team-based progress monitoring of all interventions for both fidelity and outcomes.

As these essential discussions begin, perceived barriers of confidentiality, funding, and other policy implications often emerge. It is critical that all of these items are reviewed and decisions reflecting input from the team are written into the MOU. To guide these conversations, teams may want to use the, Developing the MOU[31] document that outlines the elements typically included in MOUs between organizations. The district/community leadership team can review each element and use the guiding questions provided to articulate how they will design the MOU to support a single system of delivery.

Conclusion

In summary, it is critical to have a district and community leadership team guiding and supporting the implementation of an integrated system at the school level. This leadership team must include members who have the authority to reallocate resources and pursue changes in funding and policy as needed. This level of support will leverage the strengths of the current system and work to build capacity within the school community for sustainable change. As the leaders continue to coalesce around these critical elements of installation and implementation, work at the school level can begin. The next chapter focuses on installation at the school level.

CHAPTER FIVE

Installation and Initial Implementation of an Interconnected System at the School Level

In Chapter 4, the essential functions of an executive-level district/community leadership team to address the deliberate integration of PBIS, mental health and related social-emotional-behavioral initiatives are described. Installation tasks led by this team include assessing the current status of PBIS and mental health systems, data and practices; confirming a shared mission and establishing structures to support school-based personnel as they blend their efforts into a single system. This installation process allows the district to make informed and strategic decisions about the procedures and protocols needed to move toward an integrated system. Leaders and coaches, using their integrated action plan, will be positioned to guide the installation tasks for school level implementers.

This chapter outlines the steps for installation and initial implementation at the school level, paralleling the process described for district/community leaders in Chapter 4. Coaches can use the *ISF School Installation Guide*[32] to support teams through the following steps (a) establish a single set of teams to address the social-emotional-behavioral needs of their students, (b) assess the current systems, data and practices, (c) establish school level routines and procedures of a Multi-Tiered System of Support (MTSS), and (d) develop an action plan for installing and implementing the interconnected system for aligned social-emotional-behavioral efforts. Guiding questions and activities accompany each step in the School Installation Guide and allow teams to reflect and discuss current efforts and identify areas for enhancement and alignment. As will be described, the installation steps at the school level align and build on the decisions already made at the district/community level. Recognizing that schools will be at various levels of both PBIS and school mental health implementation, the Installation Guide is structured to allow coaches and teams to consider the existing structures and unique characteristics of a school and community. For example, some schools within a district may be implementing PBIS with fidelity and have working agreements with mental health partners, while other schools may not have reached fidelity with PBIS and/or have no mental health partnerships. District/community leadership will need to determine how to organize schools into professional learning cohorts so training and supports can be customized to match specific needs.

School ISF Installation and Initial Implementation Process

Step 1: Establish a Single Set of Teams

Teaming is an essential systems element for implementing multi-tiered frameworks such as PBIS, Response to Intervention (RtI), and the ISF (Barrett et al., 2013; Brown-Chidsey & Steege, 2010 Nellis, 2012). Most schools have teams of faculty and staff that meet to collaborate around academic curriculum, behavior, and safety. Sometimes schools have multiple personnel and/or teams that focus on mental health, trauma, or social-emotional health. The first task is to align and integrate personnel and stakeholders, including family and youth representation, into one set of multi-tiered teams that address all social-emotional-behavioral efforts through a unified system. These teams should include persons with expertise in the multi-tiered framework of PBIS and persons with experience implementing behavioral/mental health interventions across tiers. School-employed and community-employed clinicians who provide support to students in the school should be active members of the multi-tiered teams so the interventions they provide to students and families can be more effectively managed. The goal is for one set of multi-tiered teams to design and monitor all interventions provided to students, resulting in an expanded continuum of supports through a unified system that is more efficiently able to meet and monitor the behavioral/mental health concerns of all students.

Step 1a: Identify needs for merging teams with similar goals.

As described above, established teaming structures for blending PBIS and other mental health efforts creates a foundation for a comprehensive system where all social-emotional-behavioral efforts are combined into a single system within the school. If schools have multiple teams that address social-emotional-behavioral needs, staff can feel overloaded with meetings and unaware of potential overlap of efforts. Additionally, families, students, and teachers can be confused about where and how to seek assistance. Consolidating teams into one set of multi-tier teams can improve efficiency and reduce confusion and stress.

Coaches and school leaders are encouraged to use the *Aligning Teaming Structures: Working Smarter, Not Harder*[33] worksheet to review all existing teams for consideration of streamlining. This task involves identifying all related teams, purpose/goals for each team, use of data and measurable outcomes used by teams, staff involved, and student groups targeted. This task will set up the discussion to identify potential overlap and the need for reorganizing for maximum efficiency. For example, the importance of a single set of teams is recognized as coaches, and leaders discover multiple teams with similar goals that often operate using a different set of rules and processes (e.g., agenda, request for assistance process, data-based decision making). The example of a school's completed teaming worksheet in Table 5.1 illustrates an overlap in three different school-wide teams, justifying the school's decisions to streamline into one universal Climate & Culture Team that uses an expanded data set and includes relevant leaders and coaches.

Table 5.1: Aligning Teaming Structures: Working Smarter, Not Harder

Initiative/ Committee/ Team	Purpose and Strategic Goal Supported	Data Based / Measurable Outcome(s)	Target Group	Staff Involved	Overlap? Modify? Eliminate?
PBIS	Ensure positive, safe, predictable and consistent environment	ODRs, suspensions, attendance, universal screening data, school climate surveys	All students, staff, and families	• Principal • Social Worker • 3 General Education Teachers • 1 Special Education Teacher	• Overlapping purpose of PBIS/Safety/Trauma-informed Teams • Combine teams and name Climate & Culture Leadership Team • Ensure Trauma-informed leads are part of team • Additional meeting time in May for updating safety protocols
Safety/Crisis team	Update protocols to ensure safe environment and plan for crisis	None	All students, staff, and families	• Principal • Social Worker • 2 General Education Teachers	Expand use of data to monitor police contacts from school and safety assessments conducted
Trauma Informed Team	Ensure students feel safe, supported and ready to learn	ODRs, suspensions, attendance, universal screening data, school climate surveys	All students, staff, and families	• Principal • Social Worker • 2 General Education Teachers • 1 Special Education Teacher	• Overlap with PBIS team • Combine team ensuring Mr. Smith and Mrs. Morris are on theteam as PBIS Coaches

Step 1b: Expand team membership.

Once the teams with similar goals have been merged, teams can consider adding other partners who can provide an expanded view of data to inform strategies across school, home, and community. District coaches can guide schools as they make decisions about adding clinical expertise as well as family and student representatives to multi-tiered teams. For example, the community employed clinicians participating on Tier 1 teams can bring additional data for team consideration. The experiences of community partners, families, and students will provide different perspectives as teams review data, select instructional strategies, and design professional development for teaching social-emo-

tional-behavioral competencies. In some schools, community clinicians are team members, but due to funding restraints or conflicts in schedules, are not able to regularly participate in team meetings. The district community leadership team will need to continuously discuss and make decisions about how to remove these types of barriers and assist with overcoming new challenges that may arise during the school installation phase. The *Team Membership Inventory*[34] provides coaches with a process to guide leaders to identify essential members missing from teams.

Step 1c: Establish roles and functions of teams across tiers of support.

After members are added to the multi-tiered teams, the next step will be defining the role and function of teams, with the primary purpose of building and supporting systems to ensure effectiveness across tiers. Coaches and leaders can use the *Systems Conversations for School-based Teams*[35] as they review and clarify the purpose of these teams and identify areas where they may need coaching and technical assistance with the focus around team-based selection and monitoring of evidence-based practices. Table 5.2 below provides descriptions of the essential functions of the teams, illustrating the shift away from discussing individual students to monitoring and supporting the effectiveness of the multi-tiered systems.

Table 5.2: Systems Conversations for School-Based Teams

Multidisciplinary Tier 1 Team	Multidisciplinary Tier 2 Systems Team	Multidisciplinary Tier 3 Systems Team
• Coordinates and monitors support for all students, all staff, and all settings • Focuses on prevention and early identification of student needs across the school/community • Monitors data to identify when and how to adjust the system to meet the needs of the whole school/community • Develops decision rules for when a student receives additional interventions • Reviews aggregate data from both school and community	• Coordinates and monitors interventions for groups of students needing support beyond Tier 1 • Ensures data-based selection of evidence-based practices for small groups of students • Monitors and ensures timely access for students identified through data and/or request for assistance from student, family, or staff • Reviews how many interventions are in place, how many students are supported through each intervention, and how many of those students are responding	• Coordinates and monitors interventions for all students receiving individual interventions • Ensures data-based selection of evidence-based practices for individual students • Monitors the number of students receiving individual interventions • Evaluates the number of students are responding to individual intervention • Considers needs for additional staff PD and coaching as needed per aggregate data review of the effectiveness

Step 1d: Consider role changes for staff.

Previous chapters have discussed probable role shifts for clinicians and other school-based personnel with the merge to a single system of behavior/mental health support. As discussed in Chapter 4, the district/community leaders will need to address any changes needed in job descriptions, staff allocations, and contractual agreements to ensure adequate representation on teams. As schools begin to establish one set of teams for social-emotional-behavioral support, it will be necessary for coaches and school leaders to examine current roles of staff and develop an understanding of how roles may need to change as the school moves to an interconnected approach. It is recommended that coaches guide this discussion with attention to the roles of administrators and instructional staff, as well as, school and community-based clinicians. Additional professional development may need to be directed to support specific job modifications.

The following section discusses potential changes in clinical, instructional, and administrative roles within an integrated system. Coaches and leaders are encouraged to become familiar with and use this information to identify strategies and action items to support needed modifications at the school level. The Changing Role of Staff: Building Level Discussion Guide[36] was developed to facilitate discussions with the various staff groups and includes items specific to the role of administrators/instructional staff, as well as, school and community employed clinicians. The district professional development plan should include opportunities for school-level personnel to learn about and discuss potential role changes, including dialogue about their perceptions of modified roles. Ongoing coaching should be directed towards clarifying roles and increasing competency and confidence with changes.

Role shifts for administrative and instructional staff.

In recent years, mental health and wellness, including trauma-informed care and school climate, have emerged as a priority in educational policy; yet many staff has not received adequate training and support to implement prevention-based mental health support with confidence and fidelity. The move to an integrated system requires attention to the shifting roles for school administrators and instructional staff who have historically focused primarily on the academic needs of their students. With appropriate funding and support from the district, school leaders will be able to dedicate professional development days to prepare all instructional staff to promote positive, predictable school environments and embed social-emotional-behavioral competencies across academic content areas. New areas of professional development should address the importance of developing relationships with students and how connections with students will be addressed systemically in the school. Other skill sets needed for instructional staff include how to complete universal screeners to identify students who are at risk and how to use the multi-tiered request for assistance process.

It is important to recognize the essential role school based leaders have in supporting

their staff as mental health is positioned within their MTSS system. As the mental health needs of all students become a focus in schools, self-care strategies for staff should also be considered. Leaders will develop plans for additional support to staff by establishing priority areas and pacing for professional development days based on input from staff and district leaders. As leaders engage in this integrated effort, they will need to validate mental health as a priority for staff and students by not only including the topic in professional development time but also addressing it in staff meetings and identifying time in master schedules to provide supports.

The changing role of school clinicians.

Traditionally within schools, social workers, psychologists, and counselors have narrowly defined roles that include responsibility for selecting and implementing social-emotional-behavioral social interventions for a specific caseload of students and, in some case, teaching social-emotional-behavioral lessons in the classroom. In an integrated system, school staff with behavioral/mental health expertise engage in team-based system activities, including data review, intervention design, progress monitoring, and design of professional development. As the multi-tiered system of social-emotional-behavioral support expands across tiers, school psychologists, counselors and social workers begin to function as social/emotional leaders, guiding team selection of evidence-based social emotional curriculum, and providing professional development to teachers on how to integrate social-emotional-behavioral instruction within their academic content. Another role modification involves clinicians moving from an approach of independently providing interventions to an identified caseload of students to a system where all interventions are selected, and monitored through the single set of teams, regardless of who is delivering the intervention.

The changing role of community clinicians based in schools.

As discussed in previous chapters, community employed clinicians in schools have traditionally worked in a co-located model, where they independently determine the interventions or strategies to use when working with groups or individual students. Although communication and collaboration with school staff may happen, it is typically limited to sharing information about how to support specific students. In a single system of delivery, community clinicians based in schools will now actively participate in the multi-tiered teams, sharing decision-making about intervention selection, problem-solving, and progress monitoring. This team-based dialogue will address all students regardless of who facilitates the actual intervention. Clinicians, with the support of their agency supervisors, will collaborate with school leadership to clarify their new role and identify their comfort level with specific changes. As such, training and coaching activities will need to be customized to address their specific needs.

Professional development activities that include both community and school employed staff should be designed to fit the needs within each school, including training and ongoing dialogue sessions outside of team meetings. For example, a community clinician may

have limited experiences working alongside staff in schools and, despite of having offices in the school, may have limited knowledge of school teaming structures, school operations, or how school personnel provide interventions. In these circumstances, a school employee may be assigned as a partner to the community clinician to help orient them to the overall school operations and culture.

Step 1e: Establish team operating procedures and problem-solving approaches.

Consistent operating procedures and routines improve implementation and sustainability of best practices, leading to improved student and school outcomes (McIntosh, 2016). A critical step for the emerging single set of teams is to establish team operating procedures that support efficient problem-solving within the MTSS system that now includes community partners and family/youth members. These operating procedures include agreement about team norms, roles of team members, regularly scheduled meeting times, and a procedural agenda for team meetings. As school-based teams expand beyond teachers and school-employed personnel, it is vital to ensure all members have a voice in and an understanding of how the team will function. Communication and confidentiality are examples of team operating procedures that need to be clearly defined as systems work together with a primary focus on improved student outcomes.

Team norms.

Team norms are established through agreements that define how teams will operate. These norms guide the behavior of team members to ensure efficiency, effectiveness and a sense of cohesion. Common norms typically include expectations about starting and ending on time, listening for understanding, and being an active participant. Establishing an orientation process in the initial stages of new teams or when team membership has expanded, can ensure all members have a shared understanding of how the team will conduct its activities within a structure that includes both the education and the community mental health systems. All members, including families, can benefit from an introduction to each system including a discussion of professional jargon (e.g., acronyms), organizational structures (e.g., hierarchy in reporting), and data systems (e.g., comprehensive data dashboard). Investing in a shared understanding upfront between systems can improve the team's efficiency and effectiveness.

Creating an environment to ensure equitable voice and participation is essential with expanded team membership. Teams may want to consider an agreement to ensure the team members feel comfortable to inquire or ask when something is unclear about a system. For example, a norm may be to seek clarity as needed. Adding a team norms such as, value all levels of expertise and seek input from all voices, may support teams in hearing the voices of all stakeholders equally. Providing suggestions on how to contribute and a detailed review of relevant policies and agreements such as confidentiality (discussed below) could strengthen participation.

Confidentiality and communication.

Protecting student records, private information, and sensitive personal data are substantial legal and ethical considerations. In traditional co-located models of SMH, efforts to protect mental health information can also become a perceived barrier to supporting the needs of students. Clinicians and other team members are sometimes reluctant to share information because of how laws and policies are interpreted. This absence of information can lead to a lack of communication about interventions or discussion of student concerns altogether. Having clear expectations about how to address confidentiality will protect the privacy and eliminate potential barriers to effectively supporting interventions across settings.

As described in Chapter 4, it is the role of the district to define policies and agreements about confidentiality with partnering agencies and document the decisions in contractual agreements or memorandums of understanding (MOUs). These expectations about how information is shared will need to be communicated across school teams. Coaches may support teams to ensure all staff understand and adhere to confidentiality agreements. The agreements should include how information is to be documented, with whom certain information and data can be shared, and under which circumstances sensitive information will be disclosed. For example, there will need to be a protocol about how progress monitoring of interventions will be documented, stored, and who will have access to this information.

The various meetings that occur across a multi-tiered system involve a range of school staff (teachers, administrators, coaches, family representatives, etc.) and the confidentiality agreements at the higher tiers will need to address aggregate data about groups of students, as well as, how student-specific information will be shared. If a school is already implementing PBIS and has a co-located mental health model, they may have had different 'rules' about information sharing in the separate systems/teams. When moving to an interconnected system, the teams may need direct coaching and technical assistance around confidentiality as they move from separate teams to a single set of teams at these more intensive tiers. The following sections discuss confidentiality across the tiers with respect to what types of data and discussions should and should not occur within the meetings at the various tiers.

Confidentiality at Tier 1.

At Tier 1, teams discuss data pertinent to all students, staff, and settings in aggregate. Because school and community data are reviewed broadly at Tier 1, teams do not discuss individual students. Confidentiality at this tier will include decisions on what information the team will and will not share with other stakeholders. For example, the team may have access to data on staff who need additional support with classroom management practices. This sharing of information is an administrative and coaching issue and is not information that team members would share outside of the team meeting.

Confidentiality at Tier 2.

Within the PBIS Framework, there are typically two types of meetings that occur at Tier 2: a systems meeting and a problem-solving meeting. At the systems level, teams do not discuss individual students, but instead, review the effectiveness of the overall system by discussing the number of students supported through each intervention and the number of students responding to each intervention. For example, a clinician facilitating a small group intervention for students with depression would share skills being taught and data indicating how many students were making progress. The clinician would not share details of what students were sharing during the group intervention. Fidelity data is also reviewed to allow the team to determine if the lack of effectiveness is related to the accuracy of the delivery of the intervention or a mismatch between the intervention and the needs of the students. Confidentiality decisions address how fidelity and progress monitoring data are described and who has access to the data outside of the team meeting.

The second type of Tier 2 meeting follows a problem-solving method, designed to create a support plan for students who have not responded adequately to lower-level Tier 2 interventions, but who do not require a highly individualized Tier 3 process and plan. These meetings typically follow a brief, structured problem-solving format (approximately 20 minutes per student) for developing a quick/simple behavior support plan for one student at a time. This team is a standing team trained to conduct this brief behavior intervention planning and may include students and their teachers and family. For example, there may be a student participating in a small group intervention for coping skills who has begun experiencing active fight, flight, or freeze because of a recent trauma in the community. In developing a support plan, the team may discuss the traumatic event and how it is manifesting in the student's presenting problems at school. Confidentiality routines might include sharing the designated release form with the family and team members, with the acknowledgment that families always have the option to decide what information can and cannot be shared outside of the meeting.

Confidentiality at Tier 3.

Like Tier 2, the Tier 3 Systems team meetings focus on access, fidelity, and overall effectiveness of all Tier 3 interventions. This systematic review of interventions is organized by categories (e.g., complex function-based behavior support plans, person-centered plans, cognitive behavioral therapy plans), with a discussion about the number of students supported with each type of intervention, the number of students experiencing success, and the levels of fidelity of the different interventions. Tertiary Systems meetings do not include the development of interventions for individual students, as each student needing Tier 3 support has *their individual team* that meets regularly to build networks of support, design and refine specific strategies, and review data. The Tertiary Systems Team is instead charged with monitoring the student identification process, selecting interventions, assessing supports needed for Tier 3 facilitators, ensuring quick access for students, and examining aggre-

gate Tier 3 fidelity and outcome data in the same way the Secondary Systems team does for Tier 2 interventions.

Like the Tier 2 problem-solving intervention process, confidentiality policies and agreements relative to individual student intervention teams also involve release of information forms with families/youth always having the option to decide what is shared with whom. Tier 3 interventions effectively engage families who need to be active participants in decision-making, thus consenting to sharing information about their child across systems. However, it is still esssential to routinely address confidentiality, reminding team members about not to share information outside of the intervention team. Typically, organizations have formal release of information forms that are used, and as partnering agencies merge into one system, the executive level district/community team will make decisions about which release forms will be needed. These decisions provide documentation of the agreements between entities for sharing protected information. It is recommended that coaches and leaders ensure that all participants of individual Tier 3 intervention teams continuously review the confidentiality agreements with all team members and ensure families and students are comfortable with decisions about sharing information.

Meeting routines and procedures.

Once there is shared understanding of how the team will operate, teams assign individual team member roles. The team will designate a facilitator, minute taker/recorder, and data analyst and identify back-ups for each role. Team agreement on activities for each role before, during, and after the meeting needs to be established. It may be useful to identify two team members, a school-based and community-based team member, for the data analyst role within an integrated model. Having a data analyst role from both systems could ensure data and perceptions from both systems are incorporated within the problem-solving process. Establishing the role of a gatekeeper may also support teams in adhering to established norms around equity of voice and expertise of all team members. The role of a gatekeeper could be an additional team member role or a role for the meeting facilitator. Coaches can regularly guide teams through the process of identifying expectations for each role, assigning team members to each role, and determining scheduled meeting dates and times.

The Team Initiated Problem Solving (TIPS) process (Todd et al., 2011), designed for use by both behavior and academic teams in schools, provides a model to guide efficient team meetings where data is used throughout the problem-solving process. Using the TIPS process to support teams with problem-solving has been shown to have a positive impact on student outcomes (Preston et al., 2015) as it guides the team to the common focus on student/school outcomes. The Sample - TIPS meeting agenda[37] provides a structured and consistent format for agenda, notes, and action planning and can be used to guide the systems work within teams at each tier; it can also be used within individualized (Tier 3) student intervention teams. Specific training and coaching are essential to building fluency with TIPS (Newton et al., 2011; for more information, visit www.pbis.org).

It is standard practice within the TIPS process to display the agenda during the meeting, documenting the data-based decision-making process for all to see as the meeting progresses. For each problem that requires a solution, the team proceeds through the following steps: (a) identifies the who, what, when, where, and why; (b) sets a goal that defines the level at which the problem is no longer a problem, (c) brainstorms solutions and decides what will be done to bring about the desired change, (d) uses data to determine if the action steps were done with fidelity, (e) uses data to determine if the solution is having the desired impact on the outcome, and (f) makes decisions to continue, modify, or stop the plan (Preston et al., 2015). The expanded team membership within an integrated model will ensure both school and community data are utilized within the problem-solving process. Table 5.3 provides a Tier 2 team example to illustrate the TIPs process.

Table 5.3 TIPS Example for a Check-in Check-out (CICO) Intervention

Precise Problem Statement *What? When? Where? Who? Why? How Often***?**	**Goal and Timeline** *What? By When?*	**Solution Actions** *By Who? By When?*	**Identify Fidelity and Outcome Data** *What? When? Who?*
Seven students who participated in a CICO intervention have not made progress per 4 weeks of Daily progress Report (DPR) scores. These students have elevated risk levels for internalizing concerns on the universal screener and have, on average, missed classes 10% more than peers due to visits to the nurse or absences. Current levels, See data spreadsheet for student data on: • CICO scores • screening results • attendance • Time out of class	These seven students will participate in a small group intervention taught weekly for eight weeks. Skills include how to identify feelings, how to use a cognitive STOP strategy, and how to ask for help. Students will report the use of skills in the self-report survey. The goals include increasing: • attendance to 90% • time in-class to 90%; • DPR scores to 80%; • use of skills taught by 80%	The school social worker and clinician from Sunny Mental Health co-facilitate this intervention. It meets on Tuesdays during the flex period.	Fidelity data to collect: Intervention facilitators to share group agenda and attendance with intervention coordinator. Outcome data to collect: Attendance, DPR scores, and student self-report survey collected weekly by intervention facilitators.

Step 2: Assess the Current Systems, Data, and Practices

As schools begin to establish a single structure for merging the efforts of educational, mental health, and other community partners, they will identify current systems, data and practices for areas of strength and features that need improvement. All districts and schools, even schools within the same district, will be at different places in implementation of PBIS and school mental health. Some districts and schools will have contracts with mental health partners and some will not. Assessing the status of existing PBIS and school mental health systems, data being used to inform decisions, and interventions currently in place will be critical to developing an action plan for integration into a single system. The following section describes several activities and tools that can be used by coaches and teams to assess the current status of PBIS and mental health structures, and student need based on their school and community data. In schools with established PBIS structures, these discussions will typically occur within Tier 1 and Tier 2 teams. However, schools may choose to have a merged leadership team examine how teams across the tiers engage in the assessment activities needed to move to an interconnected system.

Step 2a: Assess current status of PBIS and mental health in the school(s).

The ISF uses the PBIS framework to integrate and expand the availability and effectiveness of evidence-based interventions for all students. As part of assessing the status of or readiness for PBIS, coaches support school teams to determine the extent to which the core features of PBIS are in place. The Tiered Fidelity Inventory (TFI)[38] (Algozzine et al., 2014) can be used as (a) an initial assessment to determine the extent to which features of PBIS are in place, (b) a guide for implementing core features across all 3 Tiers, and (c) an ongoing analysis of fidelity. If the SWPBIS TFI is already being used in the school, the coach can review the latest assessment with the team(s), assisting them in determining which features they should focus on for improvement. If the school is new to PBIS, or needs an updated fidelity check, an experienced PBIS coach should walk team(s) through the SWPBIS TFI to establish a baseline measure of features and set the stage for planning the installation or improvement of the PBIS/ISF components. The school walk through component of the SWPBIS TFI should also be used. This process includes administrative, staff, and student interviews and a review of data sources, handbooks, procedure manuals, and the code of conduct to secure an accurate baseline assessment.

The school may also have data about the current status of a mental health system that can help to determine overall areas of strength as well as areas for improvement. For example, if the school has used the previously mentioned School Mental Health Quality Assessment School Version (Connors et al., 2016) they may have an assessment of screening efforts, funding, resource allocation and documentation of interventions. Rather than these results being reviewed by a separate co-located team, this data is now being combined with the results of the

SWPBIS TFI so the newly integrated team can assess all aspects of mental health/behavioral systems, data and practices.

Coaches, to support specific and deliberate integration of mental health components into the PBIS framework, are encouraged to use the ISF Action Planning Companion Guide to the SWPBIS Tiered Fidelity Inventory[39] with the merged leadership team(s). The ISF Action Planning Companion Guide builds on the SWPBIS TFI by providing mental health features aligned with each item of the inventory and can be used by the coach to help the team assess and plan specific mental health enhancements for the developing integrated system. For example, enhancements to the teaming items on the TFI address the addition of community partners and families on teams; and enhancements to data items encourage broader social/emotional indicators, including community data, to inform Tier 1 instruction. It should be noted that the ISF action planning items do not impact scores on the SWPBIS TFI, but are used to guide the development of a single system of delivery.

Step 2b: Assess structures for identifying students who need access to supports.

Traditionally schools have used a referral process that transfers the responsibility and ownership for student's mental health interventions to a separate person or system, even when located and provided within the school. Integrated teams use an internal request for assistance process that places decisions about all interventions (e.g., who will deliver what interventions and how impact will be monitored) within the single set of blended teams. The use of a referral is reserved for circumstances outside the current scope of the integrated service teams such as students with specific medical or family support needs. Since this may be a substantial change for schools and partnering agencies, leaders will need time to assess the current process for requesting assistance and discuss strategies for modifying current procedures to reflect an integrated approach. The guiding questions in Figure 5.1 are designed to assist teams in assessing the current status of their process for identifying students who need additional supports so they can develop strategies for moving to a single request for assistance process to be used within the integrated system.

Figure 5.1 Guiding Questions to Assess Process for Identifying Students

Guiding Questions to Assess Process for Identifying Students for Intervention

1. Is there one or multiple systems in the school for managing requests for assistance across tiers?
2. Is there one or multiple requests for assistance form(s)?
3. What are the data thresholds currently in place for accessing supports? (e.g., three minor infractions to access a check-in check-out intervention)
4. Is the process for making/managing/responding to requests for assistance clearly defined and documented?

Step 2c: Conduct an intervention inventory.

Per Step 2a above, the team examines their PBIS and school mental health status to understand better how an integrated system builds on the foundation of PBIS. In Step 2b, the team examined how students currently access supports, noting what will be different in an integrated system. Now the team(s) will conduct an in-depth analysis of existing social-emotional-behavioral interventions that are in place within their school. The *School Level Intervention Mapping Tool*[40] can be used to guide the team through this process by first listing all of the existing social-emotional-behavioral interventions/programs currently being implemented across the tiers. Next, the team(s) will review each type of support to ensure it adheres to the MTSS core features by examining the extent to which each intervention meets evidence-based criteria, is being implemented with fidelity, and is achieving the intended outcome. The school-level intervention mapping tool will also focus team discussion on the number of students referred for additional supports, supported with each intervention, and making progress per the evaluation criteria for the specific intervention.

The School Level Intervention Mapping Tool in the Installation Guide includes an example of a completed school inventory with items that have been flagged indicating a need for action. In this example, the team determined identified a divorce group that was not linked to a specific evidenced-based curriculum and did not employ a progress monitoring system. Furthermore, the divorce group did not consider the specific needs of the students but rather assumed that all students experiencing a common situation needed the same type of support. Ultimately the team dissolved the group as they established a formal routine for selecting evidence-based practices matched to specific student need instead of selecting students to participate in a group who shared a common circumstance.

As the team(s) complete the inventory, coaches will guide team members also to consider the results of the Initiative Inventory completed by the district community leadership team (see Chapter 4) and the impact on their school system. For example, the district/community leaders may have already decided to integrate initiatives with similar outcomes or eliminate a specific initiative that is not having a positive student impact. Similarly, if gaps in their continuum of supports are identified, the school team will use the process and protocol for selecting evidence-based interventions that were developed by the district team (e.g., Hexagon Tool). Coaches and leaders who participated in establishing the district protocol should assist setting up similar protocol at the school level.

Step 2d: Assess data being used to identify social-emotional-behavioral needs.

During this step, team(s) will consider the types of data they are currently using to detect the needs of their students and potential gaps in the continuum of supports. Schools that are implementing PBIS may already have systems in place to routinely review discipline, attendance, and academic data. Some schools may be examining school climate and student survey data. The district coaches may also be prompting discussion about available community data

that could be useful as teams begin planning to expand their multi-tiered system. By first taking inventory of available school and community data, the team will be ready to consider how to use a broader set of data to inform their systems so that the full range of social-emotional-behavioral needs can be addressed beginning at the Tier 1 level. Table 5.4 provides examples of data sources organized into three categories: basic school data traditionally used by school teams; expanded social-emotional-behavioral data to address broader mental health needs; and community data that can inform prevention and interventions in an expanded continuum. After reviewing their current data, the team can begin discussing strategies for improving their use of data for decision making by considering additional data sources that could widen the impact on student social-emotional-behavioral functioning of students.

Table 5.4: Data Sources to Consider for an Integrated PBIS/Mental Health System

Traditional School Data	Expanded School Data	Community Data
• Office Referral Rates (by location, time, grade, problem behavior, race/ethnicity, students with IEP) • Attendance rates for students and staff • Academic data • Graduation rates • Minor incident reports and instructional time	• Nursing/School Counselor logs • Teacher ratings of student social emotional behavior/effort (Universal screening data) • Student, staff, and family focus groups • Family screener • Climate data	• Demographic data for the school/ neighborhood, community and/ or district • Socio-economic status, free and reduced lunch rates • Homelessness rates • Incarceration rates • Issues related to environmental changes and weather events • Drug use/rate of drug overdoses • Crisis center calls, suicide attempts • Issues related to families' immigration status • School and workplace violent incidents • Military deployment schedules

In summary, the school team(s) has examined the status of PBIS and mental health, assessed current structures for identifying students needing additional supports, and considered additional data sources to address more significant issues that contribute to the wellbeing of students. This analysis allows the team to identify areas of strength and areas of focus for expanding and aligning their systems. In Step 3, the team will begin to make decisions for strengthening their implementation efforts using the core features of MTSS.

Step 3: Establish School Level Procedures and Routines of a MTSS

A critical part of strengthening implementation efforts is to establish routines and procedures of a MTSS at both the district and school level. As the district establishes a standard set of routines and procedures for the integrated system, district coaches will guide the school level teams in the selected pilot schools to develop a similar set of protocols to support the integrated MTSS framework. Specifically, schools will need to establish routines and procedures for (a) implementing universal screening, (b) identifying a request for assistance process, (c) engaging in data-based decision making, (d) selecting evidenced-based interventions, (d) monitoring fidelity, and e) monitoring outcomes.

Step 3a: Develop a process for implementing universal screening.

As previously discussed, it is important that decisions for installing universal screening must be established by the district community leadership team rather than by individual schools. These district-level decisions include a selection of screening instruments and how the information will be shared with families/students including clarification of how to opt out of the screening. Additional district level determinations include how frequently the screener will be completed and which teachers will rate each student at various grade levels (e.g., classroom teacher, first-period teacher, social studies teacher).

District leaders and coaches will assist school leaders to develop and implement a schedule and plan to ensure screening is conducted at the intervals indicated within the district protocol and data are available for teams to use promptly. The schedule should include dates for training facilitators at the school, orienting faculty, communicating with families, conducting and scoring the screening, reviewing results by teams, and sharing results with staff and families. The *Universal Screener Timeline*[41] provides a sample schedule for school-level installation of Universal Screening.

As discussed in Chapter 4, the availability of screening data that identifies internalizing, as well as, externalizing social-emotional-behavioral needs is essential. Additionally, screening data should be used in combination with other data sources available to teams. For example, school teams should consider combining the screening data with any early detection data the district is using for academics and behavior as the combined data may better inform the identification and intervention process. An expansion of screening data, including supplementary

screening or assessment measures for targeted groups of students, may be needed for students identified as having higher-level needs. For example, the district may have identified instruments and procedures for schools wanting to do more in-depth screening for depression, anxiety, or trauma to guide decisions about Tier 2/3 supports. Also, some students who have intensive needs may need a more comprehensive assessment conducted by a trained clinician.

Some Tier 2/3 responses must be available before screening occurs (e.g., a simple check-in check-out procedure and a system for Tier 2 groups are already established) and that the teams are poised to assign interventions as needed. Additionally, coaches should ensure that teams have clear decision rules to determine when students need additional supports through each tier. As a general guide, consider the percentages reflected in the three-tiered framework where schools should meet the needs of approximately 80% of student needs with Tier 1, 10% of student needs with Tier 2, and 5% of student needs with Tier 3. If large numbers of students are struggling with a particular skill or issue, then it may be more efficient to develop a solution that is implemented at Tier 1. For example, if 40% of students identify as 'at risk' for anxiety, the team may want to consider having teachers provide direct instruction on specific coping skills to all students by adding these skills into the Tier 1 teaching matrix. If only 10% of students are found to be at risk in this area, instruction of coping skills may be added to the continuum at Tier 2. Schools already implementing PBIS Tier 1 and Tier 2 will be familiar with these types of decision rules but may need to adjust or expand them to support the use of the screening data. Schools not experienced with PBIS may need more training and support on how to establish decision-rules before initiating universal screening.

Coaches will need to ensure that school leaders develop fluency by explaining the need, value, and logistics of universal screening with teachers and families. A suggested strategy is to analogize screening for social-emotional-behavioral needs with established protocols for vision and hearing screening. This type of comparison can help reduce the stigma around mental health and clarify the importance of early detection. Additional professional development for school teams will be needed on how to use the screening data promptly to ensure interventions are matched to presenting problems and are available across tiers. The *Best Practices in Universal Screening for Social, Emotional, and Behavioral Outcomes: An Implementation Guide*[42] provides guidance to school teams for utilizing universal screening data for interventions and engaging stakeholders.

Step 3b: Develop a request for assistance process for identifying students who need additional supports.

As discussed in Step 2c, the newly integrated teams have the task to install a single request for assistance process to identify and quickly connect students to the full array of social-emotional-behavioral interventions available through both school and community employed personnel. The first use of universal screening may lead to more students iden-

tified as needing additional supports and teams will need to be ready to respond quickly, following a protocol that is streamlined through a single point of access. This use of a single point of access for all interventions could be a significant change if schools previously had separate forms and procedures for different systems.

Experienced PBIS teams with established Tier 2/3 processes, will likely be modifying or extending their current system to now include all requests within the newly integrated structure regardless of who (school or community employed) will be providing the intervention(s). Schools who have not reached PBIS Tier 2 and 3 fidelity, may need more training and support to develop their process for managing requests for assistance through a single set of teams. The district community leadership team will have set the stage for this transition by investing in a district-wide approach for the identification process and ensuring that school-level teams have access to the professional development and coaching needed. After careful examination of the current system, the school team will work with district coaches to modify the current system by designing a request for assistance process that includes designating a Tier 2 Coordinator, often a school counselor or other clinician, who can quickly sort students by level of need.

The request for assistance form should include the student's name, grade, date, type of concern, and name of the person completing the form. As noted in the *Sample Request for Assistance Form*,[43] the form should be easy to complete and submitted to the Tier 2 Coordinator who will manage the request for assistance system and make decisions between scheduled meetings. Most students should start receiving a Tier 2 support (e.g. accessing a simple check-in/check-out procedure) within a 72-hour period as basic Tier 2 supports should be continuously available for the 7-10% of the population who may need them (Newcomer, Freeman & Barrett, 2013; Yu). For students who need immediate support to ensure safety, specialized staff will follow emergency procedures to ensure the student is safe. Once students begin receiving supports, information is collected and teams can make decisions that more specifically match skill-building interventions.

Step 3c: Develop routines for data-based decision making.

During this step, the team will develop data-based routines for examining school level data as well as information about the broader community context including strengths and protective factors. Additionally, the team will develop decision rules to ensure students receive supports at the first sign of need. These decision rules include identifying data sources at the community and school-level, defining entrance criteria for students who need additional supports, and establishing thresholds or potential red flags that alert the team to increase supports at the system level. School based teams who are experienced with organizing structures around the academic and/or behavior needs of their students will likely be familiar with team-based data-informed problem-solving. Their task will be to engage community clinicians and other new team members with their data-based procedures to ensure all interventions are supported

with data and progress monitoring structures. For teams who have not established Tier 2 systems, more training and district level supports will be required to establish these data routines.

Identify and review expanded data sources.

In Step 2, the team reviewed current data sources and began discussing data that could be used to ensure all students requiring supports are identified at the first sign of need. Now the team will define and adopt a range of relevant data sources to guide their efforts. As previously discussed, teams will want to expand beyond the typical school-level data that focus primarily on students with externalizing behaviors (e.g. absences, tardies, office referrals, suspension data to ensure they are identifying students with internalizing, as well as, externalizing needs. Examples include loss of instructional time as documented in nurse and counseling logs and systematic screening data. Additionally, teams will identify community data (e.g. demographic information, student and family surveys, opioid misuse, unemployment rates, natural disaster impacts) thus establishing a data-based routine allowing members to analyze trends and quickly make informed instructional decisions regularly. There should be multiple ways of uncovering student needs and the process should be highly visible so families and students can also participate in the nomination process.

By examining school data in the context of the more extensive community data, teams should have more informed discussions about student need as they strengthen their Tier 1 efforts and design strategies at Tiers 2/3. Table 5.5 provides an example of how a merged mental health/behavior team organized their key findings as they examined multiple data sources at the population level. Upon review, the team noticed an increase in numbers of students with anxiety concerns in both the screener and student surveys. After seeing the trend, a team member suggested reviewing drug addiction rates specific to their neighborhood and found that more than 20% of their families had been impacted by opioid misuse as compared to 5% district-wide. Teachers also confirmed reports that many students were feeling worried about their parents during the school day. Since the numbers exceeded 20% of the students, the team decided to adjust Tier 1 supports by adding a series of coping skills into their teaching matrix and to teach these skills during previously established classroom meetings. School leaders dedicated additional time in their professional learning community and assigned coaching supports to help prepare teachers to deliver the coping skills sessions as a logical enhancement to their social-emotional-behavior curriculum. Once the adjustments were in place, staff and student survey information was collected. These data, combined with attendance and screening information, was used to ensure the changes were adequate for most of the students. Additionally, they quickly developed a plan to increase supports for students who required more support with these skills.

Table 5.5: School Examples of Analyzing Multiple Data Sources

Data Type	Data Sources	General Trends and Key Findings
School Data	Climate Survey	• 60% of students feel like they belong to the school community • 80% of our staff feel like they belong to the school community • 60% of students feel safe at school.
	Youth Risk Assessment Survey	• 23% of students reported being in a fight one or more times during the last 12 months. • 6% of students reported they had been threatened with a weapon on school property.
	Academic Health	• 80% of students are on track to graduate on time • 70% of students are reading at proficiency
	Social Behavior Health	• 70% of students have engaged in behavior resulting in 0-1 office referrals during the last 12 months • 30% of students screened positive for anxiety
	Attendance Data	• 94% attendance rate with variability across sub-groups.
Community Data	Census Data	• 11% of families living in poverty • 5% unemployment rate
	Community Assets and Wellness	• 50% of students live within a mile of a park or faith-based building.
	Community Health Indicator	• 5% of homes in our community have elevated lead levels.
	Behavior Risk Factor Surveillance Data: Health Risk Behaviors	• 15% of families are without health insurance (as compared to 6% district-wide) • 20% of families impacted by opioid misuse (as compared to 5% district-wide)

Entrance criteria and data thresholds.

Once the team determines what data sources will be used at the population level, the team will also need to develop decision rules for how students access supports. These data sources will allow teams to recognize when to strengthen Tier 1 implementation to better support all students and when to increase supports for selected groups or individual students. As described above, team(s) will continuously

monitor trends looking for patterns at the population level to detect when large numbers of students are demonstrating similar behaviors (e.g., chronic absences, tardies in specific classrooms, self-report of anxiety) which would indicate the need to problem solve at Tier 1. Similarly, problems experienced by a smaller number of students would indicate a need for more targeted interventions.

The team will need to establish system-level thresholds or potential red flags that alert the team to invest at the school-wide level before addressing individual student need. In the previously described example, if more than 30-40% of students screen positively for anxiety, the team will look for ways to strengthen the Tier 1 system to address the large percentage of students with similar needs. This may be a shift in thinking and practice as schools have traditionally steered problems they considered as mental health in nature (e.g., anxiety, depression) to clinicians for individual support without consideration of system-level supports (e.g., allowing quiet spaces for lunch) that can prevent escalation of problems in more significant numbers of students.

Establishing thresholds for action (e.g. percent of students expected to be experiencing success) and use of data for ongoing progress monitoring should be established across all tiers of support as well as, at the individual student intervention team (e.g. how many absences signal a need for the team to revise a student-specific strategy). As team-based problem-solving at both student and system levels may be new for school and community clinicians, ongoing coaching will be needed to support the transition to team-based data use.

Step 3d. Develop a process for selecting evidence-based interventions.

Team-based selection of evidence-based practices is a critical component of MTSS and perhaps a significant change for clinicians who previously operated in a co-located system. Rather than deciding individually about interventions for students, they will now participate in the selection process as part of a Tier 2 or Tier 3 team. It is essential for school teams to establish a routine for how they will decide if interventions currently available are enough to meet identified needs or if they need to design or adopt a new intervention. Based on the intervention mapping process described in Step 2c, the Tier 2/3 teams should understand interventions currently available and which of the interventions have the necessary features (e.g., established fidelity and outcome measures). Their task is to match interventions to presenting problems to ensure the highest likelihood of impact. If the team determines that a new, evidence-based intervention is required, the team will need to follow an established procedure for how selection will occur. The selection process should include (a) documenting the evidence base for the proposed intervention, (b) ensuring the intervention is matched specifically to the data that indicates unmet student need, (c) documentation of entrance-exit rules for the intervention, and (d) defined fidelity and evaluation procedures and tools for the proposed intervention.

If the district team has adopted the *Hexagon Tool*[44] (Metz & Louison, 2019) as part of the protocol for selecting evidence-based interventions (see Chapter 4), school teams can use a similar protocol to guide their decision-making for the adoption of new practices. The Consumer Guide for Selecting Evidence-based Mental Health Services[45] (Putnam et al., 2013) is also recommended to help teams establish a procedure for team-based selection. Additionally, the previously described Team Initiated Problem-Solving process will be helpful to keep the team focused on data-based selection of interventions. Training and coaching will be needed to support schools as they begin to operate in this team-based selection process, especially at Tiers 2/3. Additionally, professional development for clinicians and teachers supporting the use of selected interventions will need to be a part of the team discussion and plan.

Step 3e: Establish a process for tracking fidelity of all interventions.

As teams decide which interventions will be available at their school, they will need to establish a process for monitoring fidelity of interventions. The evaluation plan and data collection schedule developed by the district community leadership team should provide guidance on how this will be accomplished. Measuring fidelity will assist the team in establishing routines for regularly reviewing the quality of effort, the effectiveness of the intervention, and adjustments to training and coaching necessary to meet staff needs and implementation efforts. With support from district leadership and coaches, the teams will need to determine how fidelity will be measured for each intervention; this needs to be decided before prior to implementing and assessing effectiveness.

Schools already implementing PBIS will have experience with monitoring fidelity for their PBIS structures and some of the interventions. (e.g. SWPBIS Tiered Fidelity Inventory (TFI), fidelity checklist for a check-in check-out intervention). When a team chooses to install an intervention that does not have fidelity measures established, the team will need to develop such a measure. Teams can select or build fidelity measures by identifying the (a) area of focus, (b) type of measure, (c) method by which the team will collect fidelity information, and (d) schedule or frequency of data collection (Conley, 2019). Table 5.6 provides factors for the team to consider in choosing or designing fidelity tools.

Table 5.6: Factors to Guide Choice of Fidelity Measures (adapted from Conley, 2019)

Category	Factor
Focus	**Practices.** The accuracy, consistency, and quality of the plan activities that are directly delivered to the student (e.g., prompting, instruction, reinforcement).
	System. The accuracy, consistency, and quality of the coordination and indirect tasks that support implementer practices and timely, data-based decision making.
Type	**Summary rating.** A written or verbal indication of overall implementation fidelity to all the behavior plan components on a small Likert-type scale (e.g., 0-4).
	Quick checklist. A written list of three-to-five high-priority plan components completed by one or more implementers of the plan as a yes/no or Likert-type scale (e.g., 0-3).
	Comprehensive checklist. A written list of all plan components completed by one or more implementers of the plan, usually as a yes/no to list of components (e.g., 1-10) or Likert-type scale (e.g., 0-3).
	Anecdotal. A free-form written or verbal description of implementation fidelity. *This is often a supplement to the above fidelity measure types.*
Method	**Anonymous self-rating.** One or more implementers of the plan complete an anonymous written (or electronic) measure of implementation fidelity.
	Open self-rating. One or more implementers of the plan complete a verbal or written measure of implementation fidelity.
	Interview. A coach or peer meets with one or more implementers to discuss implementation and collaboratively complete a measure of implementation fidelity.
	Observation. A coach or peer observes one or more implementers and completes a measure of implementation. Feedback is provided to implementer(s) after the observation.
Schedule	**Monthly.** One or two times per month
	Weekly. One or more times per week
	Daily. One or more times per day
	Contingent. When specific setting events or antecedents occur (less common)

Step 3f: Establish a process for monitoring the outcomes of all interventions.

Monitoring student progress is an essential data-based routine for evaluating the effectiveness of the intervention. Using data to progress monitor informs the response to student needs and decisions to adjust, continue, or fade the intervention(s). During this step, the team will establish a process to monitor the data that was used to identify the students for the intervention (e.g., office referrals, nurse visits, universal screenings) as well as collecting information to determine if students are using new skills across settings. For example, if students are being taught coping skills and have the option to seek alternative quiet spaces during lunch, the team would conduct direct observations to monitor student use of this new skill across settings (e.g., classrooms, lunchroom). Additionally, the team can review screening data and student survey information to confirm the effectiveness of the intervention.

Students receiving supports beyond Tier 1 will require more frequent assessment and specified increase in adult support as interventions increase in complexity. For example, when a daily progress report is used with a check-in-check-out process, a routine that reminds staff to prompt and reinforce school-wide expectations for participating students is established. For students receiving additional supports through a coping skills group, the daily progress report can be modified to include a skill taught within the group, prompting the teacher to reinforce the behavior of focus for the Tier 2 group. Figure 5.2 provides a sample of a *Layered Daily Progress Report*,[46] illustrating how specific skills taught in groups (e.g., use calming strategy) can be added to the daily progress report. This layered use of the daily progress report structures a regular communication loop between staff facilitating the group and teachers supporting the use of the skill across settings. In addition to ensuring teachers are aware of what skills to look for in the classroom and other settings, the layered daily progress report also provides a prompt for teachers to pre-correct, re-teach and provide feedback to students throughout the day, increasing the likelihood for transference and generalization of new skills into natural settings. A note of caution is needed to ensure teachers

Figure 5.2 – Layered Daily Progress Report Example

Layered Daily Progress Report				
SW-EXPECTATIONS	**1st block**	**2nd block**	**3rd block**	**4th block**
Be Safe Use calming strategy	2 1 0	2 1 0	2 1 0	2 1 0
Be Respectful Use safe hands	2 1 0	2 1 0	2 1 0	2 1 0
Be Responsible Connect with safe person	2 1 0	2 1 0	2 1 0	2 1 0
Total Points				
Teacher Initials				

continue to give points for the basic expectation on the report (e.g., be safe, be respectful), thus not requiring the student to demonstrate the new skill in order to receive their points as that could place an additional burden on the student who is accessing the higher level of instruction through the group.

In addition to reviewing individual student progress, the team also needs to monitor the overall impact of interventions by category closely. The *PBIS Tier 2/3 Tracking Tool*[47] can be used to monitor and problem solve aggregate student outcome data by reviewing the percentage of students receiving each support compared to the percentage of students experiencing success through the intervention. For example, if 45 students are accessing a check-in check-out intervention, and 43 of them are experiencing success (per points on the daily progress report), the team would likely determine the intervention to be effective. However, if ten students are participating in a coping skills group but only three students are experiencing success (e.g., reduction in presenting problem, or evidence that student is using skills), the team should consider reviewing fidelity data prior to adding supports for the students as there may be need to ensure staff are adequately supporting students to use new skills across settings. By examining the relationship between the proportion of students demonstrating success and fidelity, the team will determine if the adults need additional guidance (e.g. additional training and coaching) or if the support for the student needs to be modified. Using the Tier 2/3 tracking tool during each meeting shapes the behavior of the team to establish this new data-based routine (e.g., monitoring both the individual student progress and intervention fidelity) and prevents the team from moving to individualizing interventions too soon.

Step 4: Develop an Integrated Action Plan

As described in the preceding sections, the activities and tools in the *ISF School Level Installation Guide*[48] supports teams to examine their current system and generate specific actions for moving into an integrated service delivery model. As schools begin implementing a single structure for providing mental health/behavior supports, the merged team(s) will need to continuously assess areas of strength and features that need improvement, refining their strategies as they progress. In addition to identifying the strengths and addressing areas of improvement, the team will need to modify their evaluation process by monitoring the effectiveness of the overall system, monitoring student impact and continuously adapt the training and coaching plan to support the specific needs of staff within the school community.

Step 4a: Monitoring the effectiveness of the system.

As part of the evaluation plan developed at the district level, school teams are encouraged to monitor the overall effectiveness of an interconnected approach by using the ISF Implementation Inventory Version 3[49] (ISF-II; Splett, Perales & Weist, 2019). This school level fidelity instrument, introduced in Chapter 4, assesses the features of an integrated model

across the tiers of support, as well as, the overall effectiveness of the integrated system. Recent research as part of a national validation study found this tool to be a reliable and psychometrically valid measure of ISF implementation at all three tiers, with high usability ratings from stakeholders across 9 states, 16 school districts, and nearly 100 schools (Splett et al., under review). It provides an implementation score at each tier like the TFI and also requires completion of a SWPBIS fidelity measure such as the TFI contemporaneously in order to ensure the behavioral intervention strategies of SWPBIS are implemented at all levels of the interconnection. Supported by a coach or experienced facilitator, teams can establish a baseline during installation and repeat the assessment in the spring of each school year. The tool includes an electronic report that highlights areas of strength and improvement that can inform teams as they develop and refine their action plan. Continuous use of this fidelity tool allows teams to assess growth and prioritize activities within their annual action plan.

While the ISF-II can provide school teams with data to measure progress and fidelity over time, coaches can facilitate ongoing technical assistance using other data tools as well. As described in Step 2, schools who have invested in the Tiered Fidelity Inventory can use the *ISF Action Planning Companion Guide to the School-wide Tiered Fidelity Inventory*[50] to expanding their PBIS effort and developing specific action steps for building an integrated approach.

Step 4b: Monitoring student impact.

District-level teams will work side by side with school-level staff to ensure that practices are delivered with fidelity and producing meaningful social-emotional-behavioral outcomes for students. To guide an outcome-driven approach, coaches will support teams to use the problem-solving approach described in Step 1e so that the routine for monitoring student outcomes occurs at least monthly. Teams will determine which data sources (e.g., attendance, nursing logs, office discipline referrals (ODRs), instructional time, suspensions, expulsions, levels of behavior risk gathered from screeners, surveys, and other academic achievement assessments) will be used as markers for social-emotional-behavior change resulting from high fidelity implementation of the ISF. District leaders will provide school teams with a schedule of data collection like the one depicted in Table 5.7 below.

Table 5.7: School Sample Schedule and Tools

Focus	Tool	Schedule			
		Aug–Sept	Oct–Jan	Feb–Mar	April–June
Context/ Input	School Profile for schools entering ISF training	•			
	Training schedule for teams, coaches and trainers, and District Leadership Team	•			
	List of team members	•			
	Participant evaluation of training events	•	•	•	
Fidelity	Tiered Fidelity Inventory		•	•	•
	ISF Implementation Inventory (ISF-II)	•			•
Impact	SWIS Office Discipline Referrals (minor and major)	•	•	•	•
	Standardized Test Scores				•
	Universal Screener (overall decreases of students and staff reporting students in elevated risk categories)		•		•

Monitoring the effectiveness of the system alongside the impact on students is an iterative process of continuous quality improvement. As areas for improvement are identified through the evaluation process, additional training, technical assistance, and coaching may need to be supported by the district. Annual data reports should be shared with the district community leadership team to help inform district-level adjustments to training and coaching.

Step 4c: Conduct professional development.

As described in Chapter 4, the district community leadership team is tasked with establishing a professional development plan and coaching system to support school and community personnel through the installation and implementation of an integrated system. School leaders are responsible for ensuring that merged teams can participate in district-level professional development sessions with additional time scheduled for follow-up training and coaching support. Additionally, specialized staff delivering interventions will require more intensive training and coaching supports. Professional development should also ensure that staff, families, and youth have enough knowledge about all available interventions and how to access them (e.g., request for assistance process).

Leadership teams and designated district coaches (from both the school and community) will need to participate in a series of trainings designed to build fluency with the integrated approach, develop systems to support the expanded set of interventions including the use of data to monitor fidelity and impact. Effective professional development includes training for teams and coaches on how to use the fidelity tools to improve outcomes continuously. Teams will use multiple data sources to determine the effectiveness and work with district leaders to continuously adjust their approach. Designated personnel functioning as coaches will play a significant role in supporting staff to use a new set of routines and procedures. District leadership will need to ensure adequate professional development is provided for coaching personnel so they have the skills to be effective communicators, use multiple data sources to facilitate the problem-solving process with teams, and develop school-based training plan to increase the number of staff with social-emotional–behavioral expertise.

Conclusion

As schools get started with the installation and initial implementation of an integrated system, they will bring together school and community organization and/or agency staff to work together on a single set of multi-disciplinary teams. Decisions about interventions will be made based on an expanded review of data from the school community. The school leadership team will utilize the district community leadership team professional development plan to align with and develop an integrated action plan that includes professional development, communication strategies, and assessment and evaluation. Leaders may recognize that systems change can take time and is an iterative process. That said, careful consideration should be taken before installation to ensure staff are aware of the specific types of student and staff needs within their community and are clear about their role and function in providing supports to students with mental health needs. Furthermore, timeframes should be established in the action plan in order to ensure that the initial installation phase does not last longer than a school year.

CHAPTER SIX

Full Implementation, Sustainability, and Continuous Improvement

Introduction

In September 2016, National Public Radio (NPR) published a special on-line series on The Mental Health Crisis in Our Schools (Anderson & Cardoza, 2016). One of the big messages focused on the notion that mental health in schools needs to be everyone's job. The Interconnected Systems Framework (ISF) holds great promise in improving the mental health of our youth by creating an environment where teachers and all school staff have increased confidence and competence in their role within a prevention-based comprehensive system of behavioral/mental health support. Implementing a truly integrated way of working together involves organizational change, requiring active leadership from those in authority to blend or braid funding streams, reposition personnel, and update policy and procedures to support the interconnected framework. In this chapter, we will examine the full implementation of an ISF, how to sustain its implementation, and engage in continuous improvement to maximize its effectiveness and efficiency. The four key messages of ISF described in Chapter 2 represent the ultimate goals of ISF at full implementation. Those messages -- (a) to utilize a single delivery system of delivery, (b) to promote mental health for all, (c) to move beyond "access to services" to focusing on outcomes, and (d) to install with a multi-tiered system of support, are intertwined with the description of movement to full implementation and sustainability in this chapter. A discussion of future directions is also included.

> "From parents to principals to teachers to the lunch staff: Everyone helps create a safe, caring environment. A place where mental health problems aren't stigmatized. Everyone watches for warning signs in a child-such as changes in mood, headaches, slipping grades and missing class." (National Public Radio, 2016).

Stages of Implementation

The application of the ISF follows the logic of stages of implementation. These stages of implementation are summarized in Figure 6.1 and include exploration (Chapter 3), where states and districts investigate the changes needed and the potential impact of moving towards an integrated system. Chapters 4 and 5 describe the steps for installation, where districts and schools initially begin to implement an ISF, which, over time, leads to full implementation. During this

period, the district has begun to build capacity with district-level leaders, coaches, and trainers, typically relying on external technical assistance (TA) to train and support district and school-level teams. Sustainability involves the gradual shift to local personnel taking over the training and TA as more schools are brought onboard, per the multi-year year district action plan that is continuously updated to ensure support structures adapt to meet the changing needs of schools.

Figure 6.1 Stages of Implementation

Stages of Implementation	
Sustainability *Gradual shift of capacity over time*	**Exploration / Adoption** *Assess need, explore and select evidence based practices*
	Installation *Allocate resources to support implementation*
	Implementation *Beginning implementation stages*
	Full Implementation *Practices are norm and integrated into policy and procedure*

An example of this process is the Scranton (PA) School District, which was highlighted in Chapter 3 to illustrate the early stages of the implementation process in two demonstration schools. Because the leadership and stakeholders saw a positive impact, they made commitments to capacity building and sustainability as they added new schools each year, including middle and high schools. During the demonstration process with two schools, only one mental health provider agency was involved. As they expanded their approach to other schools, additional providers became involved. These provider agencies had key leaders join the district/community leadership team, while their clinicians joined the school teaming structures. During installation and initial implementation, the district and school teams were supported directly by outside trainers and facilitators. Coaches, identified from both the district and mental health provider agencies observed and partnered with the external trainers, thus building fluency with the ISF components. As new schools began installing the ISF, the local coaches used their newly acquired skills and were able to initiate more of the technical assistance to schools, and the external coaches shifted to emphasize supporting the local coaches (Perales & Leitzel, 2014).

The essential task of leadership is to ensure the sustainability of the newly integrated and strengthened system. McIntosh et al. (2013) suggest four factors to increase sustainability. They are (a) promoting and prioritizing the initiative, (b) ensuring effectiveness, (c) increasing efficiency in its implementation, and (d) using data for continuous regeneration (also see McIntosh, Horner, & Sugai, 2009). Throughout this chapter, we will provide examples of steps undertaken to promote these sustainability factors, with initial discussion on the critical role of the executive leadership team at the district/community level. Those operating at the state level are encouraged to apply these same factors to their ISF efforts.

Full Implementation at the District Level

A fully functioning district/community leadership team is the focal point in the development of a single system of delivery. Diverse stakeholders representing executive leadership of the school districts, critical decision-makers from multi-disciplinary partners in the community, and family/youth representation are essential. This team, at full implementation, has formal structures in place, which include (a) ongoing regular meetings of the stakeholders, (b) operating procedures and routines that improve efficiency and effectiveness, and (c) flexible resource allocation that match community specific needs and achieve maximum student benefit. These structures assist in sustainability by prioritizing the initiative with a focus on continuous improvement. As described in Chapter 4, the leadership team is guided by the mission statement they developed together, which is congruent with the goals of an ISF. The team continues to conduct data reviews and adjust policies as needed to ensure that personnel can work through similar team structures at the school-level.

As implementation improves across the district, the leadership continues to build this team, continuing to recruit additional partners. In this process, contractual agreements or memorandums of understanding (MOUs) are revisited annually among the school district and community partners to ensure they reflect any changes in critical areas such as funding, confidentiality, or how personnel are allocated. From the MOU and an annual review of fidelity and outcome data, the team uses an action plan to improve the application of an ISF, maximizing efficiency and effectiveness at the school level through a single set of teams. The development of this action plan should improve organizational structures that influence the way the mental health agencies, the school district, and other vital stakeholders support the ISF. Policies that reflect a priority for social-emotional-behavioral health and clear implementation guidelines need to be revisited and updated to ensure support for an integrated approach at the school-level. For example, if coaches report clinicians are struggling to manage their roles on systems teams due to competing priorities for their time, executive leadership may need to consider a time study of their activities (see Chapter 4) to make decisions about adjustments in job descriptions or staff allocations.

A key message is installing an ISF within the school's multi-tiered system of support (MTSS). As described in Chapter 4, the executive level leadership is encouraged to commit to the ongoing measurement of the integrity of multi-tiered implementation by a tool such as the National Technical Assistance Center's PBIS District Systems Fidelity Inventory (DSFI). This district/community level assessment provides the leadership with knowledge and consensus about the implementation status of the core features of PBIS by having the team discuss and rate the current implementation across the schools. Additionally, use of the DSFI will guide integration and alignment efforts, and help

leadership prioritize enhancement activities as the district/community action plan is updated at least annually. At full implementation, the leadership team expands executive functions to enhance stakeholder engagement, funding, policy, systems alignment, and workforce capacity while supporting the necessary implementation functions (e.g., training, coaching, and evaluation). For example, the expectation that all organizations bring new funding opportunities to this multi-disciplinary leadership team for discussion and planning ensures the single integrated system is strengthened.

The following sections further describe the functions of executive leadership that reflect a vision of sustainability for the ISF: stakeholder engagement, workforce capacity, funding/alignment, and marketing. The role of the district/community leadership team in applying the MTSS features to all social-emotional-behavioral systems is also included. Examples from knowledge development and demonstration sites across the country are provided to illustrate how the ISF approach is used across different communities.

Stakeholder Engagement

As teams and pilot schools become more confident with integration, and as knowledge of the enhanced behavioral/mental health system spreads through the community, district/community leadership teams expand, inviting new members to participate. This includes additional agency partners as well as family/youth representatives. Families/youth actively participating in leadership teams help change the conversation that guides needed shifts in funding and policy (see Weist, Garbacz, Lane, & Kincaid, 2017, and the Family-School-Community Alliance[51] for a range of relevant resources). Leaders from other systems such as juvenile justice, child welfare, or other community organizations should also be engaged to connect systems further. As the district gets closer to full implementation, a greater number of school-based leaders join the effort as an increased number of schools are added across the continuum of preschools, elementary, middle, and high schools as well as alternative schools and before and after school programs. Attending to feeder patterns and connections that already exist among schools will be helpful in purposeful mutual support and sharing of lessons learned.

Districts typically begin implementation of the ISF with a small number of community mental health providers, often those with whom they have current contracts. At initial installation, these personnel are typically not well integrated into schools, with their work instead reflecting a co-located arrangement. Thus, a key challenge is to create a plan for moving staff to an integrated status. As the district moves to sustainability of the ISF, additional stakeholders are often brought into the blended system to expand and improve the impact of supports provided to students. As new agencies join into the ISF, the change from co-located clinicians to a single system of delivery will need a similar level of effort although the pilot experiences should inform and improve the installation with additional partners.

Chippewa Falls, Wisconsin (WI), provides an example of this expansion of partners over time. They began implementation of the ISF with one of their local mental health agencies working in two elementary schools. As the executive team added new agency leadership, they were able to initiate the ISF in additional schools as they simultaneously expanded PBIS structures into Tiers 2/3. Clinicians from the new agencies became part of the teaming structure from the onset and were more efficiently able to participate in team-based problem solving with support from the established coaching structures. The district/community leadership team continued to expand with more agencies requesting to participate. A survey to families about the new partnerships resulted in an increase of family representatives on the district/community team, further strengthening the structures needed to sustain the ISF (Eber & Ganske, 2019).

District/community leadership team development is iterative and continues over time as needs arise. An illustration of full implementation is the Milton, Pennsylvania (PA) Area School District who began to expand the data they reviewed to uncover additional students who may need support. One source of data they used was the Pennsylvania Youth Survey (PAYS; 2018). The PAYS survey is a validated youth survey that can be administered to students in grades 6, 8, 10, and 12 annually. It asks a variety of questions about risk and protective factors. The Milton High School data documented an increase in reports of students feeling depressed or having thoughts of suicide. There was also an increase reported in substance use, physical aggression, and bullying. The school recognized that they needed to expand their teams and continuum of interventions to address these needs. They first reached out to community partners to identify additional mental health partners to assist them. Next, they provided professional development to expand teacher awareness and knowledge about mental health and suicide prevention. Once this was completed, they installed a universal screener for both internalizing and externalizing social-emotional concerns. Finally, they engaged youth leaders within the school to assist with the problem-solving process (Eber, Knoster, & Empson, 2018).

One of the challenges in any systems change initiative is keeping stakeholders at the table and engaged. For example, if many stakeholders are invited from various organizations, such as juvenile justice, child welfare, mental health, family/youth advocacy, and early childhood, it can be challenging to make the agenda a meaningful use of everyone's time. This challenge can be addressed by ensuring that meetings are efficient and involve the use of data that are relevant across stakeholder groups. Celebrations of successful outcomes, including family and student stories, should be shared regularly. Because the district/community leadership team is often a broad group, some decide to operate in smaller workgroups, thus maximizing everyone's participation. For example, a large urban district in Illinois developed workgroups that meet separately to review specific tasks (e.g., job description alignment, youth survey development, authentic family engagement) and report back to and lead discussions with the larger executive-level team.

Workforce Capacity

A vital leadership task is building workforce capacity to implement an ISF including the application of an expanded continuum of evidenced-based practices. Attention to workforce capacity is necessary to ensure that social-emotional-behavior support reaches all students and that the focus is on producing outcomes rather than just providing access. To reach full implementation and ensure sustainability, professional development, including ongoing training and coaching around the implementation of the ISF and the changing role of the clinician, is critical. For example, the clinician may have previously provided individualized interventions separately from school teams and processes and their role has shifted as they become fully integrated into the multi-tiered teams, and actively involved in utilizing data and installing evidence-based practices, across all tiers.

Further elaborating, and as discussed in earlier chapters, roles for both community-employed and school-employed clinician are changing from, in some cases, crisis interventionists to becoming (a) a coach and a consultant with school-wide systems at Tier 1, (b) a coach and a coordinator of systems, teams, and facilitation of interventions at Tier 2, and (c) a coach and facilitator of individualized teams, as well as facilitating interventions with individuals at Tier 3. This evolution in roles allows quicker adaptation to the changing needs of the student population, including training and coaching to teachers to deliver a broader range of mental health supports at Tier 1. As new staff is hired within the district or partnering agencies, revised job descriptions emphasize this change of roles, and hiring practices now focus on selecting applicants with these competencies.

District/community leadership teams, in full implementation, address clinician qualifications and skills, allocation of their time, and identified job activities. The leadership explicates how both education and agency personnel are supervised and evaluated. For example, job descriptions of school-based and community-based clinicians are aligned with the ISF principles, clarifying their active participation on specific teams, expectations for data-based decision making, and team-based selection of interventions they facilitate. In full implementation, the changes to roles are solidified in job descriptions and contractual agreements and ensure clinicians can will implement and refine evidence-based practices across tiers associated with effective data-based decision making. These changes also help to ensure clinicians are engaged in proactive versus reactive (e.g., excessive responding to crises) responding. An example is the previously mentioned Chippewa Falls, WI Unified School District that began the ISF implementation with a group of community 'therapists' co-located in their schools. As they moved to full implementation, they changed the title of this personnel to 'clinicians' to better represent the role within an interconnected system.

Data-Based Decision Making

As the ISF initiative moves toward full implementation, there is increasing documentation of intervention fidelity and student outcomes at the school level, and these data are shared with the district/community leadership team, assisting them with decisions that affect all schools. Using an efficient and accessible data system such as the School-wide Information System (SWIS) Educational and Community Supports (2019) or similar data systems, the district/community leaders can access school-level data in aggregate for regular review of changes in social-emotional-behavioral as well as academic outcomes. This expanded review of data represents the move from monitoring just access (e.g., counting how many students were 'referred' for mental health services) to a focus on outcomes (e.g., how many students have documented evidence of functional improvement following participation in a specific intervention). This school-level student outcome data, including academic outcomes, combined with community data (e.g., emergency room visits, overdoses, child welfare referrals), further inform district/community planning on how to allocate and or reposition resources to prevent school failure and better support readiness for learning for all students.

An example of district/community use of data involves a Pennsylvania district that had adopted a social skills curriculum as an intervention for small groups of students (Tier 2). In reviewing district-wide youth survey data, the district/community leadership team recognized an increase in vaping was prevalent across all student groups at all schools. The curriculum they were using for Tier 2 groups had evidence for substance abuse prevention and explicitly teaching students to respond to peer pressure. They decided to integrate this curriculum at Tier 1 across the district, adjusting both their health curriculum and their behavioral teaching matrix to incorporate lessons for teaching prevention strategies to all students. The leadership team also developed a process to continuously monitor youth survey responses and discipline data related to incidences of substance use or possession of paraphernalia as indicators of progress (Barrett & Perales, 2019).

An additional example involves a newly hired clinician from a mental health agency who joined the Tier 2 team. The expanded team identified a group of students who were acting out with physical aggression in response to a traumatic event that happened within the community. The team selected a coping skills evidenced-based intervention to address both the behavior and the trauma and developed an implementation plan. The clinicians taught coping strategies and other skills in Tier 2 groups while also assisting the team to teach and support teachers, family members, and others on how to use instructional strategies to reinforce coping skills across locations in the school. Both fidelity and impact data were monitored to guide refinements and improvements over time.

Use of universal screening data at the district/community level.

In the promotion of mental health for all, universal screening is routinely conducted to

identify students at the first sign of social-emotional-behavioral risk in fully implementing districts. As discussed in earlier chapters, this approach to early detection is driven by district-level decisions (e.g., which screener to use, timeframes, communication with families) and addresses both internalizing and externalizing concerns. In full implementation, these screening data are not only used continuously at the school level to connect students with interventions but are reviewed in aggregate by the district/community team to assess whole population needs. For example, if schools in specific neighborhoods see an increase in indicators for anxiety and depression, the district/community leadership team may adopt and support the installation of an evidence-based early intervention curriculum to be installed as part of Tier 1 social-emotional-behavioral systems in those schools.

The Scranton, PA district/community team who reviewed annual behavior data from all their elementary schools observed that kindergarten teachers were struggling with student behavior. Increased suspensions and elevated risk scores in acting-out behavior were noticeable across all elementary schools. The leadership team decided to adapt and apply a behavior intervention typically used at Tier 3 as a classroom practice. This intervention involved teaching Kindergarten teachers a process for changing their approach to incorporate a 'prevent, teach, reinforce' process (Dunlap, et al, 2013) for application in the classroom. The teachers were provided with specific professional development, and coaches supported the installation of the intervention within the classrooms across the district. Concurrently, extra support for families was organized, with information and guidance about positive behavior support strategies provided to all families of kindergarten students. A process to engage selected families and students in an individualized intervention provided by a community mental health agency was also initiated (Perales & Leitzel, 2014).

Resource Alignment

Districts moving towards full implementation often acquire additional funding or resources through a grant and/or through flexible funding to initiate or strengthen the ISF effort. These additional resources are helpful, but the leadership team should pay careful attention to how they are used to not only support operational costs but to build the capacity of the system. During ongoing reviews, it is often useful to examine how higher-level structures such as county, state or federal resources are used to support the initiative. For example, if resources are going to be used to build and develop district/community data systems, the district leaders need to ensure the data system is useful to the schools on a daily basis for decision-making. If the district team is actively involved with school level team efforts (e.g. school learning walks, school-based trainings) they will be aware that schools need data disaggregated by subgroups to help them focus on vulnerable populations. They may also discover the need for the data system to sort multiple data sets (e.g. surveys, screeners, attendance, academic) that provide an accurate picture of how their students

are performing within the school environment. By installing feedback loops and spending more time in schools, district/community leadership team members can more easily make data-based, consumer informed decisions. Another purpose of an ongoing review process might be to build the capacity of staff to implement additional evidence-based practices, with attention to sufficient coaching support to ensure fidelity and impact. The Hexagon activity described in Chapter 4 could be used to assess the need for a new potential intervention, and the resources (e.g. training and coaching) needed for it to be successfully implemented.

Although grants can be helpful for startup and early learning, the goal is to build an action plan that builds and sustains capacity across the system. District and community leaders may need to collaborate with decision-makers at the state level, such as state departments of education, mental health, and human services, or managed care organizations in order to expand funding options. When state-level leaders see the value in a single system of delivery or the potential return on investment, they are more likely to change the funding structures to allow for community partners to be more flexible in their service delivery. For example, in New Hampshire, the RENEW (Rehabilitation, Empowerment, Natural Supports, Education, and Work) model of person-centered planning for adolescents (Malloy, 2010) became a Medicaid eligible intervention after it was demonstrated to improve outcomes for young people. The state of Pennsylvania is another example of state partners and managed care organizations changing policies to allow for more flexible service delivery and for clinicians from mental health agencies to be on school leadership teams.

A potential funding approach for an interconnected system is blended or braided funding across agencies. For example, in Charleston, South Carolina (SC), the school district pays the Department of Mental Health for school-based clinicians, and most of the clinicians work in the schools versus less accessible clinics. In SC, there is a priority for mental health system partnerships in all schools by 2022, and a key component is some funding from districts to support clinician involvement in the MTSS. For example, 20% of funding for the clinician for full-time services for the school is a win for the district (in obtaining full-time staff for part-time funding) and for the mental health center (in enabling more productive services in a more accessible setting). This funding also helps move the clinician from a co-located model where there is pressure to completely fund services through fees for services, to the integrated model as in the ISF, with 20% funding supporting the clinician's work on the school PBIS or MTSS team and involved in tier 1 and tier 2 programming.

Marketing

As this integrated behavior/mental health framework becomes the natural order of doing business, teams often adopt a marketing plan shared on the district's website that describes how the district is working with various partners to improve their student's wellness. Outreach, using various platforms, would inform stakeholders of the status and benefits of the ISF ini-

tiative. These would include board members of the district as well as the board members of the organizations themselves and local, regional, and state government agencies of mental health and developmental disabilities. For example, the Keystone Central school district in Pennsylvania, worked with several community organizations to improve family-school-community partnerships. Each month, they held an event with a theme that supported improved relationships with families. They had a marketing campaign using websites, social media, and other platforms to encourage families to attend and to foster collaborative partnerships. One month focused on reading, and each family was given a book. One month focused on substance abuse prevention, where healthy family activities were shared, including families entered drawings for board games and movie theater tickets (Moss, et al., 2017). Through these processes, families are likely to have improved perceptions of their interactions with the district, and mental health stigma can be reduced (Weist et al., 2017).

Full Implementation at the School Level

As discussed in previous chapters, the hallmark of an ISF at the school level is the shift from a co-located mental health system to a single system of mental health that is embedded in previously or newly established PBIS structures. In full implementation, multi-tiered teams align and integrate personnel and stakeholders that address all social-emotional-behavioral efforts through a unified system. These teams now have a full range of members that includes students and families as well as expanded clinical expertise. Both school and community employed clinicians have moved from their traditional roles of sole responsibility for selecting and implementing interventions for a specific caseload of students to shared decision-making through teams. Job descriptions and contractual agreements now include collective data review, intervention design, progress monitoring, and design of professional development.

A fully interconnected system at the school level is typified by an expanded continuum of supports for students, families, and staff that address internalizing issues as rigorously as externalizing problem behavior (Weist et al., 2018). Ongoing coaching is needed for teams of school staff, working together with families and community partners to uncover and quickly address the social-emotional-behavior needs of their students. Although they may have been familiar with assessing school-wide behavioral structures, school personnel come to appreciate how interventions for anxiety and depression can also be supported in the classroom and assessed for progress. As previously mentioned, sustainability is linked to efficiency and use of data (McIntosh et al., 2013), so as schools align and integrate personnel and stakeholders to address all social-emotional-behavioral efforts through a unified system, they increase the likelihood of effective interventions being applied for a more comprehensive array of student needs.

Initially, school staff may have questions, possibly concerns, about the expectation that supporting student mental health involves all school staff. Clinicians sometimes also express

hesitation about the blended system as doing their work within a school-based teaming structure may also bring different expectations about, for example, progress monitoring and other MTSS features. Over time, roles become established, and the features of an MTSS are eventually applied to all interventions as team members establish clarity and increasing confidence in roles and functions across the tiers of support. Ongoing coaching from both community mental health and school personnel augments the professional development activities designed to support both community and school employed staff to build competencies to support the needs within each school.

In this integrated system, there are role shifts in administrative and instructional staff. For example, school leaders dedicate professional development days to teach and support all instructional staff to promote positive, predictable school environments by embedding social, emotional competencies across academic content areas. The instructional staff is focused on developing relationships with students as well as how to administer social-emotional-behavioral screening tools to identify students who are at risk. Teachers and families become familiar with the multi-tiered request for assistance process. Confidentially and communication agreements allow efficient dialogue across all stakeholders, respecting confidential information, and the laws and regulations governing the school and mental health records.

An additional aspect of sustainable change involves modification in the language used to describe behavioral/mental health prevention and supports and how they are provided to students. These changes include more precise dialogue about what can be expected by those who interact with the students in their natural environments, such as the classroom. For example, renaming 'therapists' as 'clinicians' confirms role changes and represents a shift in interactions between how teachers and clinicians work together on teams to decide what practices would be most likely to produce a desired change for the students. Rather than saying a student is being 'seen' by a counselor or is 'in counseling,' teachers, students and families can name a specific intervention, it's needed dosage and frequency, and when they should see what level of change. These language adjustments signify a shift towards transparency of what mental health support is and establishes a context for the message that mental health is everyone's job in schools. The following section provides further discussion and examples of the move from co-located to a single system of behavioral health, with illustrations of the impact of MTSS features on school-level systems, practices, and data.

MTSS Features Applied across the Interconnected System at the School Level

Integrating all social-emotional-behavioral efforts through one system results in improved consistency in how interventions are provided, with the notable application of MTSS features. As school teams become comfortable with established MTSS routines and procedures, more precise use of data guides teams to refine practices,

contributing to greater effectiveness. Below is further discussion and examples illustrating the impact of an ISF with regards to continuous regeneration, system responses at first sign of need, linking interventions across tiers, and staff wellness.

Continuous regeneration.

At full implementation, each school is more aware of its strengths and areas for improvement in the single system of behavioral/mental health support. An action plan addresses areas of needed improvement. Using the SWPBIS Tiered Fidelity Inventory on an annual basis helps teams to determine the extent to which the features of PBIS are in place and provide guidance for implementing the core features at all three tiers. As described in Chapter 4, using the *ISF Action Planning Companion Guide to the SWPBIS Tiered Fidelity Inventory*[52] determines the extent that the integration of mental health components is included in the PBIS framework and provides direction for the integration of mental health components for action planning. For example, the teams are now multi-disciplinary and use community data along with school data to determine the specific expansion of social-emotional-behavioral skills routinely taught to all students.

Core Features of MTSS

1. **Effective teams**
2. **Data**-based decision making
3. Formal processes for the selection and implementation of **evidence-based practices** (EBP)
4. **Early access** through the use of comprehensive screening
5. Rigorous **progress-monitoring** for fidelity and effectiveness
6. Professional Development and ongoing **coaching**

Schools implementing an integrated approach are encouraged to improve the fidelity of core features of the PBIS framework through an enhanced lens to ensure that both internalizing and externalizing needs of all students are being met. As a result, the teams incorporate a broader range of social/emotional skills into their school-wide expectations through weekly lesson plans that increase staff use of the expanded language of school-wide expectations to prompt, acknowledge, and pre-correct skills needed for emotional regulation and problem-solving new ways to respond to stress and anxiety. Table 6.1 provides an example of such an expanded school-wide teaching matrix.

Table 6.1: Teaching Matrix of Social-Emotional-Behavioral Skills

School-wide Expectations	Incorporate Social-emotional Competencies				
	All Settings	**Hallways**	**Lunch**	**Bus**	**Online**
Respect	• Be on time. • Assume positive intent.	• Walk to the right. • Use level 2 voice volume.	• Invite those sitting alone to join.	• Stay in my seat.	• Consider the feelings of others before I post. • Be an upstander – speak up when I see unsafe behavior.
Achieving and Organized	• Hands and feet to self. • • Help/share with others.	• Walk directly to my designated area.	• Have a lunch plan. • Choose a quiet or social lunch area. • Invite friends to join.	• Have a plan. • Use headphones to listen to music.	• Check my feelings before I post. • Re-read the message before I post.
Responsible	• Recycle. • Be prepared.	• Pick up litter. • Maintain physical space.	• Use my breathing technique. • Listen to my signals.	• Watch for my stop. • Use level 1 voice.	• Double-check sources before I post. • Think before I forward.

Action at first sign of need. At full implementation, schools have established structures to identify students who are at risk of internalizing as well as externalizing conditions. This full implementation includes an expanded use of both school-based data, (e.g., discipline referrals, attendance, minor incident reports, social-emotional-behavioral screening) as well as community data (e.g., homelessness, incarceration rates). Based on a review and assessment of existing interventions, the school has expanded the range of evidence-based interventions that would meet the needs of the student population.

As described in Chapter 5, a request for assistance process is an essential component of a system that routinely provides an expanded range of supports at first sign of need. Schools that build fluency with early responses can prevent problems from escalating and requiring more intensive supports. For example, a school in

Iowa developed a request for assistance form that parents, teachers, and others could use to seek help for a student. The team reviewed requests in addition to routinely monitoring data, such as attendance, grades, nurse visits, and screening results. A parent filled out the request for assistance for her daughter because she was concerned that there was a change in her mood and behavior. The team reviewed data for this student, and the only data point that was of concern was an increase in visits to the nurse. The team selected a daily check-in check-out intervention for this student to receive. After several weeks of this intervention, nurse visits decreased, and the parent perception of her child's progress was that she had shown improvement in her functioning following this increased dosage and frequency of positive teacher attention throughout her day.

Expanded types and use of data.

School teams re-configured to be multi-disciplinary have the advantage of a broader viewpoint that also includes a focus on different or new data sources. As these school teams become more proficient with different data, they can expand the reach of their problem-solving. For example, an elementary school team in Marion County Florida was reviewing school and community data to determine needs. They recognized that multiple child welfare workers were coming into school to investigate reports of abuse and neglect that had been made to their hotline. The team made outreach to the local Department of Child and Family Services and invited a representative to join their team. The team began to monitor these data and developed an action plan to not only support these students but to offer support to impacted families (Splett, Perales, & Weist, 2018). This is a potentially powerful mental health prevention strategy due to the understandably high incidence of school failure and mental health problems within this vulnerable population.

The schools continuously share data to ensure staff buy-in and support as well as aim for sustainability. These data may include examples of improved fidelity, increased instructional time, improved student impact, as shown by reductions in office discipline referrals, and improvement in student wellness. Improvements in economic impact could be measured by reductions in the time allocated to discipline as well as less use of expensive out-of-district placements (Putnam, Luiselli, Sennett, & Malonson, 2002). Dissemination strategies might include the use of the district's and school's website, newsletters, social media, robocalls to families, board meetings, and various trainings. For example, an elementary school in Florida began to install the universal screening protocol designed for use across the district. Screening occurred once in the fall and once in the spring. Using a spreadsheet developed through the district/community leadership team, the coach guided the school teams to organize their screening with their district's early warning system data that included academic risk factors such as grades, absences. The spreadsheet combined the social-emotional data with academic risk indicators and calculated overall risk levels for students, allowing the team to identify students who needed targeted or individual interventions quickly. The teams

were able to use this combined data set to link these students to appropriate interventions. The school team saw a reduction of students being indicated as at risk in the screening data over time. This information was shared through multiple district/community modalities and helped increase the promotion of the integration efforts, a critical factor in sustainability (Splett, Eber, & Abshier, 2018).

Linking interventions across tiers and into the classroom.

As schools fully implement an ISF, Tier 1 is strengthened with the addition of social/emotional skills brought into the teaching matrix, thus expanding the prevention focus. The robust Tier 2 practices designed for those students identified as at-risk for internalizing and externalizing problems are deliberately linked to the skills taught at Tier 1. The continuum of Tier 2 targeted group instruction includes options for students in need of developing coping skills and other strategies to replace the flight, fright, or freeze behaviors typical for students reacting to trauma.

Schools develop routines for selecting and implementing evidenced-based interventions to address the needs of their students as well as a process for adding interventions as the need arises. Students needing Tier 3 supports have well-coordinated intervention plans that integrate both school and community services using relevant data-based decision making. This use of data supports the sustainability of implementation by improving efficiency and using this data to ensure continuous regeneration. In the case of a traumatic event such as a natural disaster, both school and community resources can be deployed in a coordinated way.

Clinicians who are facilitating Tier 2/3 interventions, delineate the skills they are teaching students (e.g., social, coping, emotional regulation, problem-solving) so teams can ensure systemic linking and layering onto what students are taught at Tier 1. This consistency across tiers promotes teacher-directed practice for Tier 2/3 interventions in the classroom, strengthening the interventions as emerging skills are practiced and reinforced in the natural setting of the classroom. Clinicians, teachers, and other school-based staff become fluent with reinforcing skills being taught in small group and individual interventions by linking these more specialized interventions directly to the Tier 1 and Tier 2 activities in the classroom. For example, teachers can use the daily check-in check-out process in the classroom to provide structured feedback of skills taught in higher-level interventions by linking these skills through the layered progress report (see Chapter 5).

School climate and staff wellness.

A positive school climate impacts students' academic and social success but also impacts organizational health and staff efficacy. (Bradshaw, Koth, Thornton, & Leaf, 2009). Staff wellness is a critical component of a healthy school. Districts that invest in staff wellness programs see reductions in sick days, staff turnover, workplace injuries, and worker compensation claims, substantially reducing overall organizational costs (Bradshaw et al., 2009). Developing and supporting a healthy workforce includes employee assistance programs that offer

comprehensive health care and other workplace wellness plans that increase healthy behaviors. These strategies, combined with information to improve mental health literacy, can also contribute to reducing stigma about mental health. Professional learning communities that promote continuous growth and social networks for employees are also suggested. Critical aspects of professional learning should include coaching supports with performance feedback, time for developing examples for embedding social, emotional, behavioral competencies alongside academic content.

The stigma around mental health can be reduced as teachers become more knowledgeable about and comfortable with prevention and early intervention strategies in the classroom with regards to more internalizing issues (e.g., anxiety and depression). The increase in direct instruction around emotional regulation and coping skills for anxiety and depression at the lower tiers of the continuum are indicators of an expanded system of behavioral/mental health support, with emphasis on prevention and early intervention. Other notable targets in an improved system for supporting all students include increasing inclusive opportunities for vulnerable populations such as students with disabilities and reductions in the number of students placed in more restrictive settings including out of district placements (Putnam, Luiselli, Sennett, & Malonson, 2002). These improvements can result in cost savings for districts that can be invested in building capacity for strengthening both academic and behavior/mental health services. For example, these additional funds could be directed toward an increase in evidenced-based trauma-informed interventions integrated across all tiers to address those students who are at risk of further mental or physical health problems that often comes from exposure to adverse childhood events.

Conclusions and Future Directions

Prevention of social-emotional-behavioral problems is now recognized as a critical part of education, but schools continue to struggle with how to establish a comprehensive system of mental health support. The ISF is an emerging approach for building a comprehensive system to address and respond to the mental health and social-emotional needs of all children and youth with greater efficiency and effectiveness, allowing new knowledge and resources to be aligned and integrated through one system that can produce maximum impact. For example, with an increased awareness of how environmental risk factors (e.g., exposure to toxins like lead, substance abuse, poor nutrition, chronic stress) impact brain development, early detection and quick system wide proactive responses (e.g. public health approach) play a more critical role. Ensuring that all students have a safe, predictable and consistent learning environment can counteract risk factors. The ISF integrates protective factors into the same school-wide systems that provides interventions for the full spectrum of social-emotional-behavioral issues.

Advancing Educational Effectiveness, Volume 2 (see Barrett et al., 2013 for Volume 1[53]) is an implementation guide that provides leaders, practitioners, families and students with specific steps to integrate mental health and PBIS through a single system of support, increasing the likelihood for every child to have a positive school experience. This transformation will require leaders across stakeholder groups to apply the same rigorous approach as they have academic reform efforts. Prevention and wellness promotion efforts need to be embedded in every facet of school life, permeate every interaction and delivered across every setting within the school. A comprehensive system also means that everyone shares the responsibility for mental health promotion- it simply cannot continue to come from one stakeholder group (e.g., education alone) or from one division within the school system (e.g., student services). As all community leaders begin to share responsibility for children's mental health and the ISF continues to be increasingly adopted, implemented, and sustained, several areas remain for community leaders, researchers, families, and students to address, including equitable outcomes for all, and bridging the science-to-service gap.

Equitable Outcomes for All

here are known and longstanding gaps between student groups in educational and mental health systems. For example, students of color often experience lower academic achievement than their ethnic majority peers (Fryer and Levitt, 2004). Students of color are overrepresented in disciplinary actions and in special education (Harry & Klingner, 2014), but underutilize mental health services (Bradshaw, Buckley, & Ialongo, 2008). Students with disabilities are also disproportionately represented in disciplinary actions (Losen & Martinez, 2013) and more likely to be bullied in the school setting than their non-disabled peers (Rose & Gage, 2017). LGBTQ youth are also more likely to be the victims of bullying and peer harassment, and have thoughts of suicide more than their hetero-

sexual peers (Kosciw, Greytak, Zongrone, Clark, & Truong, 2018; Saewyc et al., 2007). A critically important feature of an ISF is that mental health and well-being is for ALL. All means all and there is a need for education and mental health leaders to take up these very pressing and serious issues of equity. The ISF provides a model from which such issues could be addressed.

Inequitable outcomes such as those just mentioned often evolve from both systemic issues (e.g., inequitable insurance access and location of mental health services), as well as culturally responsive services. Given their multi-faceted nature, a student- and family-centered, systemic changing approach to resolving them is necessary. Leaders willing to change systems in order to interconnect education and mental health for improved student outcomes are also well-positioned to change systems in ways that reduce systemic inequities and address implicit biases in these students' environments.

In forthcoming iterations of the ISF, school and community leaders, family and student leaders, researchers, policy makers, and other key stakeholders should consider how the essential features of the ISF can be leveraged to address the implicit biases and systemic inequities that drive inequitable student outcomes. For example, in a newly-launched randomized controlled trial (Enhancing School-Based Violence Prevention through Multilevel Racial/Ethnic Discrimination Intervention, Principal Investigator [PI], C. Halliday-Boykins, National Institute of Minority Health and Disparities, #1R01MD013812; 2019-2024), ISF researchers are leveraging data-driven practices of the ISF to implement a range of bias reduction strategies with school staff and community collaborators (also see Smolkowski, Girvan, McIntosh, Nese, & Horner, 2016).

The study is also leveraging the ISF's features of teaming and universal prevention practices to (1) ensure members of the school and district-community leadership teams include representatives from diverse school communities (e.g., faith-based and community organizations connected to diverse communities) and (2) provide evidence-based implicit bias training to all students and staff in the school environment (Forscher, Mitamura, Dix, Cox, & Devine, 2017). The study expects integrating strategies known to reduce systemic inequities and implicit biases in the school and mental health systems into essential features of the ISF will reduce disproportionate gaps in these students and further improve student outcomes for all.

Bridging the Science-to-Service Gap

Since the last monograph, there has been substantial adoption of the ISF in practice and service settings with many moving towards implementation and sustainability. Examples from real-life communities provided throughout this edition illustrate this movement. Simultaneously, there has been an uptick in research in the area with several large-scale research studies examining student outcomes in the ISF (see Interconnecting PBIS and school mental health to improve school safety: A randomized trial, PI, M.Weist, National Institute of Justice, #2015-CK-BX-0018, 2016-2020) as well as specific components of the model (e.g.,

universal screening in Splett et al., 2018), implementation process (e.g., teaming in Splett et al., 2017), and focus areas (e.g., internalizing problem type Weist et al., 2018). However, research on the ISF is still in its infancy, with only two federally funded studies up to this point, underscoring a critical need area for the field.

Although evidence-based practices from research settings are needed, evaluation of ongoing implementation in service settings could also be leveraged such that practice-based evidence is also established (Splett & Maras, 2011). Partnerships between researchers and ISF implementers are required to meet this need. That is, in addition to the emphasis on evidence-based practices primarily developed in the research setting and disseminated to the practice setting, work is needed to develop practice-based evidence where real-world implementation strategies are evaluated and those found to be promising inform further investigation in more resource-intensive efficacy studies (Cook & Cook, 2016). In this way, the ISF research agenda is driven by the practice setting and strategies tested in randomized controlled trials are already proven feasible and acceptable in the practice setting. Evaluating real world strategies in addition to outcomes in grant-funded randomized controlled trials also exponentially expands the volume of research on the ISF thereby improving our understanding of how to implement the model most effectively. This may be particularly true in the current context where the rapid dissemination and implementation of the ISF provides abounding opportunities to examine potentially promising practices.

However, in order to leverage such opportunities and sustain the momentum, partnerships between all key stakeholders, including school and community leaders, families, trainers, and researchers, are critically needed (Kovacs et a., 2015). In the same way that an ISF builds upon collaborations that interconnect education and mental health systems, partnerships between practice and research settings will also be needed. Researchers and practice leaders should prioritize such partnerships in order to continue building the ISF's evidence base and inform best practices. They may also need to pursue funding mechanisms to support such work and establish communities of practice that involve members from different stakeholder groups with practice and research expertise to learn from one another. Communities of practice involve groups of people who share a concern or passion for something, working together collaboratively and regularly to learn how to do the work better (Wenger-Trayner & Wenger-Trayner, 2015). In order to both build the evidence-base and close the gap between research and practices for the ISF, partnering across research and practice systems in models akin to communities of practice could be particularly impactful in building the ISF evidence-base and narrowing the gap between research and practice.

Conclusion

The Interconnected Systems Framework (ISF) for school mental health and PBIS holds great potential to improve outcomes at the societal level and, as evidenced in this second iteration of the ISF monograph, sites across the country are investing in the ISF, sharing lessons and showcasing their successes. Since the first ISF monograph was published, there has been increased national emphasis on mental health in schools. But popularity can breed fragmentation and as more people join this movement, it will be critically important for researchers, practitioners, families and students to continue to coalesce around the core features of MTSS, continuously adapting to fit local context and culture, keeping student outcomes the top priority. The potential exists for the ISF to radically change student outcomes for large communities of children and youth. The ideas, tools, and strategies for doing so are described in this monograph and being widely adopted, but they need to become the new way of doing business in order to improve the lives of the children and families we serve. The question remains of whether youth-serving systems can effectively integrate as in the ISF, or will they retreat to the status quo of single system service delivery characterized by parallel play? We hope this second monograph is a useful resource for the field in building momentum for true systems integration driven by diverse stakeholders toward broadly improved social, emotional, behavioral, and academic outcomes for students in the U.S. and beyond.

COMMENTARY

Beyond the Tipping Point: Addressing Barriers to Comprehensive School Mental Health

Mental health luminary Dr. Atkins described the first edition (2013) of the **Interconnected Systems Framework (ISF)** monograph as "one large step for PBIS, one giant leap for children's mental health." He recognized that leveraging the foundational principles and practices of Positive Behavioral Interventions and Supports (PBIS) and embedding mental health into the natural infrastructure and staffing of the education sector would drive children's mental health beyond traditionally siloed systems and prevention-intervention paradigms to reflect a more integrated and continuous delivery system.

In the years since, academic and popular literature have increasingly aligned about school mental health reaching a "tipping point" to favor including mental health services within all schools (Hoover, Bostic & Nealis, 2020; Martinez, 2017). The link between mental health and academic success, and the role of schools in promoting student well-being and delivering effective mental health interventions has encouraged ever more schools to integrate a continuum of mental health supports and services (Fazel, Hoagwood, Stephan, & Ford, 2014). For many schools, ISF offers a framework to actualize the goal of national scaling up of school mental health. In this second edition of the ISF monograph, the authors describe national and local successes of ISF, offering more concrete steps to create an integrated system of education and mental health supports, emphasizing the "how to" of ISF by offering "real world" examples and specific strategies. District and school building leaders will appreciate this guidance on selecting, delivering, and evaluating evidence-based mental health practices across multiple tiers of intervention, from promoting universal mental health to addressing the most complex mental health challenges that interfere with learning.

Using the analogy offered by Atkins (2013), child mental health is now poised to take an even larger step. Our current predicament is that amidst a growing evidence base supporting integrated school mental health, school districts still vary widely in what they now provide as *comprehensive school mental health* (Hoover et al., 2019). So, our efforts to embrace the offerings in this ISF guidance must be coupled with a recognition and earnest tackling of the primary obstacles still impeding widescale integration of mental health in schools.

First, stigma continues to hinder mental health integration in education. District and community leadership will require support to address and penetrate the stigma persisting around mental illness. Many educators

and families believe that schools are in the business of academics and consider mental health a private matter apart from our school systems. Mental health remains a taboo topic in several communities, with families encouraged to avoid school services and to only seek care in private, community-based clinics. The lack of cultural responsiveness in our mental health systems only worsens this stigma, particularly for youth and families of color whose behavioral manifestations of emotional challenges have historically resulted in a punitive response rather than a response that promotes student well-being. This monograph offers suggestions for decreasing stigma, including improving mental health literacy for educators, families and students, and conducting marketing that normalizes mental health care in schools. To further decrease mental illness stigma and advance our efforts to improve student mental health, we must also embrace a conceptualization of *"complete mental health,"* with a focus on student well-being, resilience, and strengths. Drs. Furlong, Dowdy and colleagues have demonstrated that our current narrow focus on "externalizing and internalizing" problems, and identifying the 15-20% of students with most impairment, have left us without information about the assets and strengths of students that buffer against mental illness and promote positive mental health and academic success (Dowdy et al., 2015; Furlong, Dowdy, Carnazzo, Bovery, & Kim, 2014). They demonstrate that a broader conceptualization of mental health that moves beyond a deficit-based psychopathology model to one that considers and measures factors like *engaged living, belief in self and others, and emotional competence* resonates better with students, families and school staff and is also more predictive of current and future success. The ISF monograph offers tremendous guidance on how schools can use data to make informed decisions about students' mental health needs and progress. As districts and schools embark on improved student information systems for identifying and triaging students into mental health supports, an enhanced understanding of mental health in our assessments and our interventions may diminish stigma. Concretely, districts may wish to consider mental health screening and monitoring that reflects a co-vitality framework of student functioning, coupling assessment of emotional and behavioral problems with subjective well-being and psychological/coping strengths (Moore, Dowdy, Nylund-Gibson, & Furlong, 2019). Such interventions would move beyond focusing on the negative (reductions in problematic emotions and behaviors), to focus also on positive outcomes that promote flourishing.

Second, as discussed above, *mental health* is a unique, evolving construct that also stretches PBIS into new territory and applications. It is imperative that as we align mental health with existing PBIS structures that we simultaneously recognize the distinctions of mental health from other behaviors traditionally addressed within the PBIS framework. For example, the authors advocate demystification of mental health by establishing open dialogue by school staff about the goals of mental health interventions. Interdisciplinary training of mental health and education staff is a valuable goal to ensure com-

mon language and coverage of a full continuum of emotional and behavioral supports. This will indeed be useful for investing all school staff in a coordinated, familiar mental health language. However, professionals within school systems have unique training, roles, and responsibilities. While some professional development overlaps, it is also important to maintain some boundaries and clarity about who does what, when and for whom so that we do not end up with a diluted set of professional skills in an effort for everyone to know everything about student mental health. To reach the tipping point for integrated school mental health, consideration of the balance of essential knowledge and practices for all school staff with mindful distinctions of more personal student/family information will enhance adoption of integrated school mental health. Similarly, the ISF 2nd Edition appropriately calls for increased implementation *accountability*, including the use of fidelity checklists, to track intervention component delivery. Current empirical studies suggest that over half of what predicts mental health treatment success are the "common" or "non-specific" factors of therapy, including empathy, positive regard, and genuineness of the therapist and characteristics of the therapist-client relationship (Mulder, Murray, & Rucklidge, 2017). While these may be measured, they are not simply a checklist or recipe that an interventionist can follow, yet they greatly influence outcomes. In the same way, not all mental health outcomes are directly measurable by classroom teachers. For example, students experiencing depression, anxiety or post-traumatic stress may be meeting classroom demands sufficiently yet may be struggling internally. Therefore, we must reliably monitor observable behaviors such as classroom disruptions, withdrawn behavior, and school work completion, and also afford room for less observable measures of mental health intervention impact, such as self-reported improvement in mood, functioning, and perceived quality of life. PBIS offers an impressive foundation for integrating mental health into schools, and we will be most successful if we carefully consider the ways in which school mental health will require inclusion of important components of effective interventions and how the PBIS approach can be adapted to address needs in diverse school systems.

Third, a significant obstacle to comprehensive, integrated school mental health remains stable funding support. Ultimately, this challenge reiterates who harbors the responsibility for student mental health– mental health, education, or both? Wide-scale implementation of effective mental health integration in schools is most effective when sufficient resources are allocated by *all* child-serving systems to support a sustainable, comprehensive, accountable school mental health delivery system. The authors astutely recognize that reliance on a fee-for-service model of school mental health places unrealistic financial burden on our current healthcare system, just as "walled" models of school mental health, where schools bear the burden for all student mental health supports/services, reflect an unfair over-reliance on the education sector. Braided and blended funding models, such as examples cited in Pennsylvania and South Carolina, best invest multiple child systems in comprehensive mental

health. To advance comprehensive school mental health expansion, particularly to less well-resourced schools/communities, these creative approaches to linking funding streams need to become familiar to state and local school and mental health leaders, as well as our advocacy partners.

Enthusiasm for this ISF guidance package will remain high, and the authors are to be commended for constructing a roadmap for school districts to realize the potential of school mental health. The diligence and detail these authors have demonstrated in compiling this resource will further propel our school mental health field forward. Paired with vigilant discussion and attention to the other factors discussed in this commentary – the unique nature of mental health in the context of PBIS/MTSS, reducing mental health stigma by promoting complete mental health, and advocating for shared funding –we have cause to be optimistic that we will witness comprehensive school mental health move "beyond the tipping point" to a standard of practice for all schools nationwide. Another big step for PBIS, and a giant stride for comprehensive school mental health.

Sharon Hoover, PhD
Professor, University of Maryland School of Medicine
Co-Director, National Center for School Mental Health

Commentary References

Dowdy, E., Furlong, M., Raines, T. C., Bovery, B., Kauffman, B., Kamphaus, R. W., ... & Murdock, J. (2015). Enhancing school-based mental health services with a preventive and promotive approach to universal screening for complete mental health. *Journal of Educational and Psychological Consultation, 25*(2-3), 178-197.

Fazel, M., Hoagwood, K., Stephan, S., & Ford, T. (2014). Mental health interventions in schools in high-income countries. *The Lancet Psychiatry, 1*(5), 377-387. doi:10.1016/S2215-0366(14)70312-8

Furlong, M., Dowdy, E., Carnazzo, K., Bovery, B. L., & Kim, E. (2014). Covitality: Fostering the Building Blocks of Complete Mental Health. *Communique, 42*(8), 1-28.

Hoover, S. A., Bostic, J. Q., & Nealis, L. K. (2020). What Is the Role of Schools in the Treatment of Children's Mental Illness?. In *The Palgrave Handbook of American Mental Health Policy* (pp. 409-447). Palgrave Macmillan, Cham.

Hoover, S., Lever, N., Sachdev, N., Bravo, N., Schlitt, J., Acosta Price, O., Sheriff, L. & Cashman, J. (2019). Advancing Comprehensive School Mental Health: Guidance From the Field. Baltimore, MD: National Center for School Mental Health. University of Maryland School of Medicine.

Martinez, O. N. (2017). Mental health in schools is at a tipping point. Here is what needs to happen. Huffpost. Retrieved January 4, 2020 from https://www.huffpost.com/entry/mental-health-in-schools-is-at-a-tipping-point-here_b_5936e2c0e4b033940169ce57

Moore, S. A., Dowdy, E., Nylund-Gibson, K., & Furlong, M. J. (2019). An Empirical Approach to Complete Mental Health Classification in Adolescents. *School Mental Health*, 1-16.

Mulder, R., Murray, G., and Rucklidge, J. (2017). Common versus specific factors in psychotherapy: opening the black box. *The Lancet Psychiatry 4*, 953–962.

REFERENCES

Alang, S. M. (2019). *Mental health care among blacks in America: Confronting racism and constructing solutions.* Health Services Research, 54(2), 346–355. DOI: 10.1111/1475-6773.13115

Algozzine, B., Barrett, S., Eber, L., George, H., Horner, R., Lewis, T., Putnam, B., Swain-Bradway, J., McIntosh, K., & Sugai, G (2014). *School-wide PBIS Tiered Fidelity Inventory.* OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports. Retrieved from www.pbis.org.

Anderson, M. & Cardoza, A. (2016, August). *Mental Health In Schools: A Hidden Crisis Affecting Millions of Students.* National Public Radio. Retrieved from https://www.npr.org/sections/ed/2016/08/31/464727159/mental-health-in-schools-a-hidden-crisis-affecting-millions-of-students

Anderson C.M, & Kincaid D. (2005). Applying behavior analysis to school violence and discipline problems: Schoolwide positive behavior support. *The Behavior Analyst. 28*, 49–64.

Bains, R.M. (2014). African American adolescents and mental health care: A meta-synthesis. *Journal of Child and Adolescent Psychiatric Nursing, 27*, 83-92.

Barrett, S., Eber, L., Perales, K., Pohlman, K., & VanEcker, E. (2016). *Interconnected Systems Framework Action Planning Companion Guide.* Unpublished manual. www.midwestpbis.org

Barrett, S., Eber, L., Weist, M.D. (2009). Development of an Interconnected Systems Framework for School Mental Health pg. 1 chpt 1

Barrett, S., Eber, L. & Weist, M. (2013). *Advancing Education Effectiveness: Interconnecting School Mental Health and School-wide Positive Behavior Support.* Center for Positive Behavioral Interventions and Supports (funded by the Office of Special Education Programs, U.S. Department of Education). Eugene, Oregon: University of Oregon Press. Retrieved from: https://www.pbis.org/common/cms/files/Current%20Topics/Final-Monograph.pdf

Barrett, S., Perales, K., & Eber, L. (2017). *Interconnected Systems Framework District Community Implementation Guide.* Unpublished manual. www.midwestpbis.org

Barrett, S., & Perales, K. (2019, October). *Integrating Social Emotional Instruction into the PBIS Framework*, presented at the National PBIS Leadership Forum, Chicago, IL, October, 2019.

REFERENCES

Biglan, A. (2015). *The nurture effect: How the science of human behavior can improve our lives and our world.* Oakland, CA: New Harbinger.

Boles, S., Biglan, A., & Smolkowski, K. (2006). Relationships among negative andpositive behaviors in adolescence. *Journal of Adolescence, 29*,33-52.

Bradshaw, C. P., Buckley, J. A., & Ialongo, N. S. (2008). School-based service uilization among urban children with early onset educational and mental health problems: The squeaky wheel phenomenon. *School Psychology Quarterly, 23*(2), 169.

Bradshaw, C.P., Koth, C. W., Thornton, L. A., & Leaf, P. J. (2009). Altering school climate through school-wide positive behavioral interventions and supports: Findings from a group randomized effectiveness trial. *Prevention Science, 10*, 100-115.

Brown-Chidsey, Steege, & Steege, Mark W. (2010). *Response to Intervention Principles and Strategies for Effective Practice* (2nd ed., Guilford practical intervention in the schools series). New York: Guilford Press.

Cashman, J., Linehan, P., & Rosser, M. (2007). *Communities of Practice: A New Approach to Solving Complex Educational Problems*. Alexandria, VA: National Association of State Directors of Special Education.

Catron, T, Harris, V. S., & Weiss, B. (1998). *Posttreatment Results After 2 Years of Services in the Vanderbilt School-Based Counseling Project.* In M. H. Epstein, K. Kutash & A. Duchnowski (Eds.), Outcomes for children and youth with emotional and behavioral disorders and their families: Programs and evaluation best practices (pp. 653-656). Austin, TX: PRO-ED, Inc.

Centers for Disease Control and Prevention. *2018 Annual Surveillance Report of Drug Related Risks and Outcomes* — United States. Surveillance Special Report.

Centers for Disease Control and Prevention (2013). *Mental Health Surveillance Among Children-United States, 2005-2011*. MMWR 2013: 62, 1-35.

Center on Positive Behavioral Interventions and Supports (2019). *Positive Behavioral Interventions and Supports District Systems Fidelity Inventory (DSFI) – Pilot version 0.1*. Eugene, OR: University of Oregon. Retrieved from www.pbis.org.

Center on Positive Behavioral Interventions and Supports. (2015). *Positive Behavioral Interventions and Supports (PBIS) Implementation Blueprint.* Eugene, OR: University of Oregon. Retrieved from www.pbis.org.

Center on Positive Behavioral Interventions and Supports (2019). *Positive Behavioral Interventions and Supports State Systems Fidelity Inventory (SSFI) – Pilot version 0.1*. Eugene, OR: University of Oregon. Retrieved from www.pbis.org.

Child and Adolescent Health Measurement Initiative (2017). National Survey of Children's Health (NSCH) Data Query. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved [09/01/19] from www.child-healthdata.org. CAHMI: www.cahmi.org.

Coffey, J. H., & Horner, R. H. (2012). The sustainability of schoolwide positive behavior interventions and supports. *Exceptional Children, 78*(4), 407 422. https://doi.org/10.1177/001440291207800402

Conley, K. M. (2019). *Choosing the right implementation fidelity measure for your behavior plan.* Training handout. PBISApps. Eugene, OR

Connors, E., Stephan, S., Lever, N., Ereshefsky, S., Mosby, A., & Bohnenkamp, J. (2016). A national initiative to advance school mental health performance measurement in the United States. *Advances in School Mental Health Promotion, 9*(1), 50-69. Doi: 10.1080/1754730X.2015.1123639

Cook, B. G., & Cook, L. (2016). Leveraging evidence-based practice through partnerships based on practice-based evidence. Learning Disabilities: *A Contemporary Journal, 14*(2), 143-157.

David-Ferdon C., Hertz M.F. (2009) *Electronic Media and Youth Violence: A CDC Issue Brief for Researchers.* Atlanta (GA): Centers for Disease Control; 2009.

Derefinko, K. J., Salgado Garcia, F.I., Talley, K.M., Bursac, Z Johnson, K.C., Murphy, J.G., ... Sumrok, D.D. (2019). Adverse childhood experiences predict opioid relapse during treatment among rural adults. *Addictive Behaviors, 96*, 171-174

Drapeau, C. W., & McIntosh, J. L. (for the American Association of Suicidology). (2018). U.S.A. suicide 2017: Official Final Data. Washington, DC: American Association of Suicidology, dated December 10, 2018, retrieved from http://www.suicidology.org.

Dryfoos, J. G. (1994). *Full-Service Schools: A Revolution in Health and Social Services for Children, Youth, and Families*. San Francisco, CA: Jossey-Bass.

Dunlap, G., Wilson, K., Strain, P., & Lee, J. (2013). *Prevent-Teach-Reinforce for Young Children.* Baltimore, Maryland: Brookes Publishing.

Eber, L. & Ganske, J. (2019, October). *Integrating Mental Health at the District & School Level: Steps for Installation*, presented at the National PBIS Leadership Forum, Chicago, IL, October, 2019.

Eber, L., Knoster, T., & Empson, D. (2018, October). *Integrating Suicide Prevention within PBIS*, presented at the National PBIS Leadership Forum, Chicago, IL, October, 2018.

Eber, L., Weist, M.D., & Barrett, S. (2013). *An introduction to the Interconnected Systems Framework.* In S. Barrett, L. Eber, & M. Weist (Eds.), Advancing education effectiveness: An interconnected systems framework for Positive Behavioral Interventions and Supports (PBIS) and school mental health (pp. 317). Center for Positive Behavioral Interventions and Supports (funded by the Office of Special Education Programs, U.S. Department of Education). Eugene, Oregon, University of Oregon Press.

Educational and Community Supports. (2019). School-wide Information System. Retrieved from https://www.pbisapps.org/Applications/Pages/SWIS-Suite.aspx.

Enhancing School-Based Violence Prevention through Multilevel Racial/Ethnic Discrimination Intervention, Principal Investigator [PI], C. Halliday-Boykins, National Institute of Minority Health and Disparities, #1R01MD013812; 2019-2024)

Elias, M. J., Gager, P., & Leon, S. (1997). Spreading a warm blanket of prevention over all children: Guidelines for selecting substance abuse and related prevention curricula for use in the schools. *The Journal of Primary Prevention, 18*(1), 41-69.

Evans, S. W., & Weist, M. D. (2004). Commentary: Implementing empirically supported treatments in the schools: What are we asking? *Clinical Child and Family Psychology Review, 7*, 263-267.

Every Student Succeeds Act of 2017, S. 1177, 114th Cong. (2017). Family Educational Rights and Privacy Act of 1974, 20 U.S.C. § 1232g (1974).

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M. Edwards, V.E.,. . Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), 245-258.

Fixsen, D. L., Blase, K. A., Horner, R., & Sugai, G. (2009, February). *Scaling-up Evidence Based Practices in Education.* Scaling-up Brief #1. Chapel Hill: The University of North Carolina, FPG, SISEP.

Fixsen, D.L., Naoom, S.F., Blase, K.A., Friedman, R.M. & Wallace, F. (2005). *Implementation Research: A synthesis of the Literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

Forscher PS, Mitamura C, Dix EL, Cox WTL, Devine PG. Breaking the prejudice habit: Mechanisms, timecourse, and longevity. *Journal of Experimental Social Psychology. 2017;72*(Supplement C):133-146.

Fryer Jr, R. G., & Levitt, S. D. (2004). Understanding the black-white test score gap in the first two years of school. *Review of Economics and Statistics, 86*(2), 447-464.

George, H.P., Cox, K.E., Minch, D., & Sandomierski, T. (2018). District practices associated with successful SWPBIS implementation. *Behavioral Disorders, 43*(3), 393-406. doi: 10.1177/0198742917753612.

Gunderson, L.M., Willging, C.E., Trott-Jaramillo, E.M., Green, A.E., Danielle L. Fettes, D.L, Hecht, D.B., & Aarons, G.A. (2018) The good coach: Implementation and sustainment factors that affect coaching as evidence-based intervention fidelity support. *Journal of Children's Services, 13*(1), 1–17. https://doi.org/10.1108/JCS-09-2017-0043.

Harry, B., Klingner, J. K. (2014). Why are so many minority students in special education? *Understanding race & disability in schools* (2nd ed.). New York, NY: Teachers College Press.

Health Insurance Portability and Accountability Act (2004). Washington, D.C.: U.S. Department of Labor, Employee Benefits Security Administration.

Hellebuyck, M., Halpern, M., Nguyen, T., & Fritze, D. (2018). The state of mental health in America. Mental Health America, Inc. Accessed April, 13, 2019.

Heron M. (2019). Deaths: Leading causes for 2017. National Vital Statistics Reports; (68) 6. Hyattsville, MD: National Center for Health Statistics.

Holbrook, J. R., Bitsko, R. H., Danielson, M. L., & Visser, S. N. (2017). Interpreting the prevalence of mental disorders in children: Tribulation and triangulation. *Health Promotion Practice, 18*(1), 5–7. doi:10.1177/1524839916677730

Horner, R. H., Newton, J. S., Todd, A. W., Algozzine, B, Algozzine, K., Cusumano, D., & Preston, A. (2018) A randomized wait-list controlled analysis of Team-Initiated Problem-Solving professional development and use. *Behavioral Disorders, 43*(4), 444-456.

Horner, R.F. & Sugai, G. (2015). School-wide PBIS: an example of applied behavior analysis. Implemented at a scale of social importance. *Behavior Analysis in Practice, 24* February 2015.

Horner, R., Sugai, H., & Fixsen, G. (2017). Implementing effective educational practices at scales of social importance. Clinical Child and Family Psychology Review, 20(1),25-35.

Individuals with Disabilities Education Act, 20 U.S.C. § 614 (1997).

Individuals with Disabilities Education Act, 20 U.S.C. § 1400 (2004).

Interconnecting PBIS and school mental health to improve school safety: A randomized trial, PI, M.Weist, National Institute of Justice, #2015-CK-BX-0018, 2016-2020

Jacob, S. & Coustasse, A. (2008). School-based mental health: A de facto mental health system for children. *Journal of Hospital Marketing & Public Relations, 18*, 197–211. doi:10.1080/15390940802232499

Kamasak, R., Yavuz, M. & Altuntas, G. (2016). Is the relationship between innovation performance and knowledge management contingent on environmental dynamism and learning capability? Evidence from a turbulent market. *Business Research, 9*(2), 229-253.

Kazak, A. E., Hoagwood, K., Weisz, J. R., Hood, K., Kratochwill, T. R., Vargas, L. A., & Banez, G. A. (2010). A meta-systems approach to evidence-based practice for children and adolescents. *American Psychologist, 65*(2), 85-97.

Kelly, M.S. & Whitmore, S. (2017). It's about time: Results from a two-year time study project of school mental health professionals, Paper presented at Center for School Mental Health Annual Conference, Washington, D.C.

Kosciw, J. G., Greytak, E. A., Zongrone, A. D., Clark, C. M., & Truong, N. L. (2018). *The 2017 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual, Transgender, and Queer Youth in Our Nation's Schools.* Gay, Lesbian and Straight Education Network (GLSEN). 121 West 27th Street Suite 804, New York, NY 10001.

Kovacs, R. J. (2015). Using practice-based evidence to reduce disparities in care: A virtuous cycle turns. *Journal of the American College of Cardiology, 66*(11), 1234-1235.

Kutash, K., Duchnowski, A. J., & Green, A. L. (2011). School-based mental health programs for students who have emotional disturbances: Academic and social-emotional outcomes. *School Mental Health, 3*(4), 191-208.

Kutash, K., Duchnowski, A. J. & Lynn, N, (2006). *School-based Mental Health: An Empirical Guide for Decision-makers.* Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies., Research and Training Center for Children's Mental Health.

Lave, J., & Wenger, E. (1991). *Situated Learning: Legitimate Peripheral Participation.* Cambridge, UK: Cambridge University Press. doi: http://dx.doi.org/10.1017/CBO9780511815355

Lester, L., & Cross, D. (2015). The relationship between school climate and mental and emotional wellbeing over the transition from primary to secondary school. *Psychology of Well-Being, 5*(1), 1-15.

Lever, N.A., Adelsheim, S., Prodente, C., Christodulu, K.V., Ambrose, M.G., Schlitt, J., & Weist, M.D. (2003). *System, Agency and Stakeholder Collaboration to Advance Mental Health Programs in Schools.* In M.D. Weist, S.W. Evans, & N.A. Lever (Eds.), Handbook of School Mental Health: Advancing Practice and Research (pp. 149-162). New York, NY: Springer.

Losen, D. J., & Martinez, T. E. (2013). Out of School and Off Track: *The Overuse of Suspensions in American Middle and High Schools.* The UCLA Center for Civil Rights Remedies at The Civil Rights Project.

Mack, K.A., Jones, C.M., Ballesteros, M.F., (2017). Illicit Drug Use, Illict Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas. United States. *MMWR Surveillance Summary 2017; 66* (no. SS-19);1-12 Retrieved from: https://www.cdc.gov/mmwr/volumes/66/ss/ss6619a1.htm

Malloy, J.M, Sundar, V., Hagner, D., Pierias, L. & Viet, T. (2010). The efficacy of the RENEW Model: Individualized school-to-career services for youth at risk of school dropout. *Journal of At-Risk Issues, 15*(2), 17-25.

Martini, R., Hilt, R., Marx, L., Chenven, M., Naylor, M., Sarvet, B., Ptakowski, K. K. (2012). *Best Principles for Integration of Child Psychiatry into the Pediatric Health Home.* Washington, DC: American Academy of Child & Adolescent Psychiatry.

McIntosh, K., Chard, D. J., Boland, J. B., & Horner, R. H. (2006). Demonstration of combined efforts in school-wide academic and behavioral systems and incidence of reading and behavior challenges in early elementary grades. *Journal of Positive Behavioral Interventions, 8*, 146-154.

McIntosh, K., Horner, R. H., & Sugai, G. (2009). *Sustainability of Systems-level Evidence-based Practices in Schools: Current Knowledge and Future Directions.* In W. Sailor, G. Sugai, R. H. Horner, G. Dunlap (Eds), Handbook of Positive Behavior Support (pp. 327-352). New York: Springer

McIntosh, K., Mercer, S., Hume, A., Frank, J. L., Turri, M., & Mathews, S. (2013). Factors related to sustained implementation of schoolwide positive behavior support. *Exceptional Children, 79*(3), 293-311.

Mellin, E. A., Bronstein, L., Anderson-Butcher, D., Amorose, A. G., Ball, A. & Green, J. (2010). Measuring interprofessional team collaboration in expanded school mental health: Model Refinement and Scale Development. *Journal of Interprofessional Care, 24*, 514-523.

Merikangas, K.R., He, J., Brody, D.B., Fisher, P.W., Bourdon, K., & Koretz, D.S. (2010). Prevalence and treatment of mental disorders among US children in the 2001-2004 NHANES. *Pediatrics, 125*(1), 75-81.

Metz, A. & Louison, L. (2019). *The Hexagon Tool: Exploring Context. Chapel Hill, NC: National Implementation Research Network,* Frank Porter Graham Child Development Institute, University of North Carolina at Chapel Hill. Based on Kiser, Zabel, Zachik, & Smith (2007) and Blase, Kiser & Van Dyke (2013).

Moss, D., Peters, D., Baughman, M., & Michaels, B. (2017, May). *The Long and Winding Road to Interconnected Systems Framework,* presented at the PA PBS Implementers Forum, Hershey, PA, May, 2017.

Mulcahy, C., Krezmien, M., & Travers, J. (2016). Improving mathematics performance among secondary students with EBD: A methodological review. *Remedial and Special Education, 37*, 113-128.

Musu, L., Zhang, A., Wang, K., Zhang, J., and Oudekerk, B.A. (2019). *Indicators of School Crime and Safety: 2018* (NCES 2019-047/NCJ 252571). National Center for Education Statistics, U.S. Department of Education, and Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice. Washington, DC.

Nabors, L. A., & Reynolds, M. W. (2000). Program evaluation activities: Outcomes related to treatment for adolescents receiving school-based mental health services. children's services: Social policy, *Research, and Practice, 3*, 175–189.

National Academies of Sciences, Engineering, and Medicine. (2017). *Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use.* Washington, DC: The National Academies Press. doi: https://doi.org/10.17226/24781.

National Alliance on Mental Illness (2017) Retrieved from https://www.nami.org/NAMI/media/NAMI-Media/Infographics/Children-MH-Facts-NAMI.pdf

National Institute on Drug Abuse (2017). *America's Addiction to Opioids: Heroin and Prescription Drug Abuse.* 2014. https://www.drugabuse.gov/about-nida/legislativeactivities/testimony-to-congress/2016/americas-addiction-to-opioids-heroin-prescription-drug-abuse.

National Institute of Mental Health (Feb 2019). *Prevalence of Any Mental Disorder Among Adolescents.* Retrieved from: https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#part_155771

National Public Radio. (Sept 7, 2016). *A silent epidemic: Our public schools are struggling to handle millions of students with mental health problems. Here's why.* Retrieved from: https://apps.npr.org/mental-health/

National Research Council and Institute of Medicine. (2009). *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities.* Washington, DC: National Academies Press. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK32775/

National Technical Assistance Center on Positive Behavior Interventions and Support. (2017). *Technical Guide for Alignment of Initiatives, Programs, Practices in School Districts.* Eugene, OR: Retrieved from http://www.pbis.org

Nellis, L. M. (2012). Maximizing the effectiveness of building teams in response to intervention implementation. *Psychology in the Schools, 49*(3), 245-256.

Newcomer, L., Freeman, R. & Barrett, S. (2013): Essential systems for sustainable implementation of Tier 2 supports, *Journal of Applied School Psychology, 29*:2,126-147.

Newton, J.S., Algozzine, B., Algozzine, K., Horner, R.H., & Todd, A.W. (2011). Building local capacity for training and coaching data-based problem solving with Positive Behavior Intervention and Support teams. *Journal of Applied School Psychology, 27*, 228-245.

Obama, B. (2013). *Remarks on Gun Violence.* Pub Papers 34 (January 16, 2013). Retrieved from: https://obamawhitehouse.archives.gov/sites/default/files/docs/wh_now_is_the_time_full.pdf

O'Connors, E., Stephan, S., Lever, N., Ereshefsky, S., Mosby, A., & Bohnenkamp, J.(2016). A national initiative to advance school mental health performance: Measurement in the United States. *Advanced in School Mental Health Promotion, 9*(1), 50-69. Doi: 10.1080/1754730X.2015.1123639

Pennsylvania Youth Survey. (2018). *Pennsylvania Commission on Crime and Delinquency*. Retrieved from https://www.pccd.pa.gov/Juvenile-Justice/Pages/Pennsylvania-Youth-Survey-(PAYS).aspx

Perales, K. & Leitzel, J. (2014, October). *Integrating Mental Health into Kindergarten/Early Childhood Education*, presented at the National PBIS Leadership Forum, Chicago, IL, October, 2014).

Perales, K., Pohlman, K., Eber, L. & Barrett, S. (2017). *PBIS Forum in Brief: Aligning and Integrating Mental Health and PBIS to Build Priority for Wellness.* 2017 PBIS Leadership Forum. Chicago, IL. Retrieved from: https://www.pbis.org/Common/Cms/files/Forum17_Presentations/RDQ%202%2Brief%20-%20Mental%20Health.pdf

Preston, A., Cusumano, D., & Todd, A. (2015). *PBIS Forum in Brief: Team-Initiated Problem Solving.* U. S. Department of Education, Office of Special Education Programs: National Technical Assistance Center on Positive Behavioral Interventions and Supports. Retrieved from www.pbis.org

Putnam, R., Barrett, S., Eber, L., Lewis, T. & Sugai. G. (2013). *Selecting Mental Health Interventions within a PBIS Approach.* In S. Barrett, L. Eber, & M. Weist (Eds.), Advancing Education Effectiveness: Interconnecting School Mental Health and School-wide Positive Behavior Support. Retrieved from: https://www.pbis.org/common/cms/files/Current%20Topics/Final-Monograph.pdf

Putnam, R.F., Luiselli, J.K., Sennett, K. & Malonson, J. (2002). Cost-efficacy analysis of out-of-district special education placements: An evaluative measure of behavior support intervention in public schools. *Journal of Special Education Leadership, 15*, 17-24.

Romer, N., von der Embse, N., Eklund, K., Kilgus, S., Perales, K., Splett, J.W., Suldo, S., & Wheeler, D. (2019). *Best Practices in Universal Screening for Social, Emotional, and Behavioral Outcomes: An Implementation Guide* Draft Version 1.0.

Rose, C. A., & Gage, N. A. (2017). Exploring the involvement of bullying among students with disabilities over time. *Exceptional Children, 83*(3), 298-314.

Runge, T.J., Knoster, T.P., Moerer, D., Breinich, T., & Palmiero, J. (2017). A practical protocol for situating evidence-based mental health programs and practices within school-wide Positive Behavioral Interventions and Supports. *Advances in school mental health promotion, 10*, 101-112.

Sacks, V., Murphey, D., & Moore, K. (2014). *Adverse Childhood Experiences: National and State-level Prevalence* (Report No. 2014-28). Retrieved from www.childtrends.org/publications/adverse-childhood-experiences-national and state-level-prevalence/.

Saewyc, E. M., Skay, C. L., Pettingell, S., Bearinger, L. H., Resnick, M. D., & Reis, E. (2007). Suicidal ideation and attempts in North American school-based surveys: Are bisexual youth at increasing risk? *Journal of LGBT Health Research, 3*(1), 25–36.

Santiago, C. D., Raviv, T., & Jaycox, L. H. (2018). *Creating healing school communities: School-based interventions for students exposed to trauma.* Concise Guides on Trauma Care Series. APA Books. Available from: American Psychological Association. 750 First Street NE, Washington, DC 20002.

Solis, J. M., Shadur, J. M., Burns, A. R., & Hussong, A. M. (2012). Understanding the diverse needs of children whose parents abuse substances. *Current Drug Abuse Reviews, 5*(2), 135–147.

Smolkowski, K., Girvan, E. J., McIntosh, K., Nese, R. N., & Horner, R. H. (2016). Vulnerable decision points for disproportionate office discipline referrals: Comparisons of discipline for African American and White elementary school students. *Behavioral Disorders, 41*(4), 178-195.

Splett, J. W., Eber, L., & Abshier, D. (2018, October). *Incorporating Universal Screening to Enhance Data-based Decisions for Students with Internalizing Needs*, presented at the National PBIS Leadership Forum, Chicago, IL, October 2018.

Splett, J.W., Fowler, J., Weist, M.D., Dvorsky, M., & McDaniel, H. (2013). The critical role of school psychology in the school mental health movement. *Psychology in the Schools, 50* (3), 245-258.

Splett, J. W., & Maras, M. A. (2011). Closing the gap in school mental health: A community centered model for school psychology. *Psychology in the Schools, 48*(4), 385-399.

Splett, J., Michael, K.D., Minard, C., Stevens, R., Johnson, L., Reynolds, H., …Weist, M.D. (2014). State of the Carolinas: Implementing school mental health and Positive Behavioral Interventions and Supports. *Report on Emotional & Behavioral Disorders in Youth, 14*(4), 87-95.

Splett, J.W., Perales, K., Al-Khatib, A., Raborn, A. & Weist, M.D. (under review) Preliminary development and validation of Interconnected Systems Framework Implementation Inventory (ISF-II). *School Psychology*.

Splett, J.W., Perales, K., Halliday-Boykins, C.A., Gilchrest, C.E., Gibson, N & Weist, M.D. (2017). Best practices for teaming and collaboration in the Interconnected Systems Framework. Journal of Applied *School Psychology, 33*(4), 347-368.

Splett, J.W., Perales, K., & Weist, M.D. (2018). *ISF Implementation Inventory: A Fidelity Tool to Promote PBIS and Mental Health Integration*, presented at the Annual Center for School Mental Health Conference, Las Vegas, NV, October 2018.

Splett, J.W., Perales, K. & Weist, M.D. (2019). *Interconnected Systems Framework. Implementation Inventory (ISF II).* Unpublished Instrument. University of Florida

Splett, J. W., Quell, A., Perales, K., & Weist, M. D. (2016). *Interconnected Systems Framework – Implementation Inventory (ISF-II).* Unpublished instrument. University of Florida, University of South Carolina.

Splett, J. W., Trainor, K., Raborn, A., Halliday-Boykins, C., Dongo, M., Garzona, M., & Weist, M. D. (2018). Comparison of universal mental health screening to students already receiving intervention in a multitiered system of support. *Behavioral Disorders (special issue), 43*(8), 344-356. https://doi.org/10.1177/0198742918761339

Stroul, B., Blau, G., & Friedman, R. (2010). *Updating the System of Care Concept and Philosophy.* Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

Substance Abuse and Mental Health Services Administration. (2018). *Key Substance Use and Mental Health Indicators in the United States: Results from the 2017 National Survey on Drug Use and Health* (HHS Publication No. SMA 18-5068, NSDUH Series H-53). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

Sugai, G., Horner, R. H, Dunlap, G., Hieneman, M., Lewis, T.J, Nelson, C.M . . .Ruef, M. (2000). Applying positive behavior support and functional behavioral assessment in schools. *Journal of Positive Behavior Interventions, 2*(3), 131-143.

Sugai, G., & Horner, R. H. (2009). Responsiveness-to-intervention and school-wide positive behavior supports: Integration of multi-tiered system approaches. *Exceptio nality, 17*(4), 223-237.

Suldo, S. M., Gormley, M. J., DuPaul, G. J., & Anderson-Butcher, D. (2014). The impact of school mental health on student and school-level academic outcomes: Current status of research and future directions. *School Mental Health, 6*(2), 84-98.

Therriault, J.B. (2009). *Developing Early Warning Systems to Identify Potential High School Dropouts.* Washington D.C.: American Institutes for Research. U.S. Department of Education Office of Planning, E. a. (2016). Issue Brief: Early Warning Systems. Washington D.C.: U.S. Department of Education

Todd, A.W., Horner, R.H., Newton, J.S., Algozzine, R.F., Algozzine, K.M., & Frank J.L. (2011). Effects of Team-initiated Problem Solving on decision making by schoolwide behavior support teams. *Journal of Applied School Psychology, 27*, 42-59.

Torio, C.M., Encinosa, W., Berdahl, T., McCormick, C., & Simpson, L.A. (2015). Annual report on health care for children and youth in the United States: National estimates of cost, utilization and expenditures for children and youth with mental health conditions. *Academic Pediatrics, 15*(1), 19-35. https://doi.org/10.1016/j.acap.2014.07.007

Twenge, J.M., Gentile, B., Dewall, C.N., Ma, D., Lacefield, K., & Schurtz, D.R. (2010). Birth cohort increases in psychopathology among young Americans, 1938-2007: A cross-temporal meta-analysis of the MMPI. Clinical *Psychology Review, 30*(2), 145-154.

U.S. Department of Education (2014): *Guiding Principles: A Resource Guide for Improving School Climate and Discipline*, Washington, D.C. Author.

U.S. Department of Education Office of Planning, E. a. (2016). *Issue Brief: Early Warning Systems.* Washington D.C.: U.S. Department of Education

U.S. Department of Health and Human Services, 2016 National Survey of Children's Health, https://www.childhealthdata.org/learn-about-the-nsch/NSCH/data

U.S. Public Health Service. (2000). *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda.* Washington, DC: Department of Health and Human Services. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK44233

Warmbold-Brann, K., Burns, M., Preast, J., Taylor, C., & Aguilar, L. (2017). Meta-analysis of the effect of academic interventions and modifications on student behavior outcomes. *School Psychology Quarterly, 32,* 291-305.

Wenger-Trayner, E., & Wenger-Trayner, B. (2015). *Communities of Practice: A Brief Introduction.* Retrieved from https://wenger-trayner.com/introduction-to-communities-of-practice/

Weist, M. D., Garbacz, S. A., Lane, K. L., & Kincaid, D. (2017). *Aligning and Integrating Family Engagement in Positive Behavioral Interventions and Supports (PBIS): Concepts and Strategies for Families and Schools in Key Contexts.* Center for Positive Behavioral Interventions and Supports (funded by the Office of Special Education Programs, US Department of Education). Eugene, OR: University of Oregon.

Weist, M.D., Lever, N., Stephen, S., Splett, J.W. Barrett, S., & Eber, L. (2016, September 29). *Improving PBIS and School Mental Health Integration within Effective Multi-Tiered Systems of Support: National Resource Center Perspectives*, presented at Center for School Mental Health Conference.

Weist, M.D., Eber, L., Horner, R., Splett, J., Putnam, R., Barrett, S…, Hoover, S. (2018). Improving multitiered systems of support for students with "internalizing" emotional/behavioral problems. *Journal of Positive Behavior Interventions, 20*(3), 172-184.

Weist, M. D., Paternite, C.E., Wheatley-Rowe, D., & Gall, G. (2009). From thought to action in school mental health promotion. *International Journal of Mental Health Promotion, 11*(3), 32–41. doi:10.1080/14623730.2009.9721790

Weist, M.D., Sander, M.A., Lever, N.A., Rosner, L.E., Pruitt, D.B., Lowie, J.A., … Christodulu, K.V. (2002). School mental health's response to terrorism and disaster. *Journal of School Violence, 1* (4), 5-31.

Weisz, J. R., Jensen-Doss, A., & Hawley, K. M. (2006). Evidence-based youth psychotherapies versus usual clinical care: A meta-analysis of direct comparisons. *American Psychologist, 61*, 671.

Ybarra, M.L., Diener-West, M. & Leaf, P. J. (2007). Examining the overlap in internet harassment and school bullying: Implications for school intervention. Journal of *Adolescent Health*, (41)6. 542-550.

Yu, J., Wagner, M., & Shaver, D. (October 2012). *Tertiary Behavior Intervention Models in Elementary and Middle Schools.* http://mdcc.sri.com/documents/MDCC_C2_Followup_OCT2012.pdf. Accessed 23 Feb. 2018.

Zuckerbrot, R, Cheung, A., Jensen, P., Stein, R., Laraque, D. (2018) Guidelines for adolescent depression in primary care (GLAD-PC): Part I. practice preparation, identification, assessment, and initial management. *Pediatrics, 141*(3), 1-21.

EMBEDDED HYPERLINKS

1 www.schoolmentalhealth.org
2 https://obamawhitehouse.archives.gov/issues/preventing-gun-violence
3 https://www.pbis.org
4 http://www.theshapesystem.com
5 https://www.pbis.org/resource/technical-guide-for-alignment-of-initiatives-programs-and-practices-in-school-districts
6 https://www.pbis.org/resource/technical-guide-for-alignment-of-initiatives-programs-and-practices-in-school-districts
7 https://www.pbis.org/resource/pbis-district-systems-fidelity-inventory-dsfi-pilot-version-v0-1
8 https://www.pbis.org/resource/pbis-state-systems-fidelity-inventory-ssfi-pilot-version-v0-1
9 https://www.pbis.org/topics/mental-healthsocial-emotional-well-being
10 https://www.pbis.org/resource/aligning-and-integrating-mental-health-and-pbis-to-build-priority-for-wellness
11 https://www.pbis.org/video-examples/video#mental-healthsocial-emotional-well-being
12 https://drive.google.com/open?id=1HFllCcb3uuP1ExD0gsxBM8PrmwIu8o-4
13 https://drive.google.com/open?id=11bnIZ_lvj5NuviGAJmrQWdo66QgJ5Ryx
14 https://www.pbis.org/resource/pbis-implementation-blueprint-part-1
15 https://www.pbis.org/resource/pbis-district-systems-fidelity-inventory-dsfi-pilot-version-v0-1
16 https://www.pbis.org/resource/pbis-state-systems-fidelity-inventory-ssfi-pilot-version-v0-1
17 https://drive.google.com/open?id=11QrI6SJ45CGYJjnEZWYX70Qa5rgKQxM-
18 https://drive.google.com/open?id=10QWAtkJ8vd2xDsOwmesFwKw5zlsK00NZ
19 https://drive.google.com/open?id=11rh1mNJac8i1PKdwrzuCl_2rnzeIRSki
20 https://www.pbis.org/resource/systematic-screening-tools-universal-behavior-screeners
21 https://www.pbis.org/resource/screening-resources
22 https://drive.google.com/open?id=11yapqSS0VCRbs6ye57n8VUCFwqdCaQqh
23 https://drive.google.com/open?id=1NHXLAc7-C9DJ0qrmxsuKz8tiVW0x6Mqv
24 https://nirn.fpg.unc.edu/resources/hexagon-exploration-tool
25 https://drive.google.com/open?id=1-tyAEISkxWpu3r0AujBhRaJeilwJLNUL
26 https://drive.google.com/open?id=120wxulO0T8r4eSwauDcM4c0SlGtfOxGT
27 https://drive.google.com/open?id=1-tyAEISkxWpu3r0AujBhRaJeilwJLNUL
28 https://drive.google.com/open?id=1-i0Wmd2iL_hhS8oZLhMRGCi1bnQD2mI1
29 http://bit.ly/ISF-II-v3-Manual-and-Tool

30 https://drive.google.com/open?id=12_btzD6Z-Wx9ilIbLOEg-Bd5rHixlbdU
31 https://drive.google.com/open?id=12aUsSOd37G0UgNmPEdb6kA9LFkdXPM_b
32 https://drive.google.com/open?id=12neA1en5rwyq_kQgdjCIYiBUHFB1sQKd
33 https://drive.google.com/open?id=12pGbgCCmpmvkeB8Q4scR5PtAYBUvXWdA
34 https://drive.google.com/open?id=12wzoILNKVgyGrx13RyqkBh9q8Nyrl4tm
35 https://drive.google.com/open?id=10Js-hvE36tBN9CO8LOFx_datUv9NutOM
36 https://drive.google.com/open?id=10T5F0cuRJr2r_WCavz31J9-pTH2YnvHQ
37 https://drive.google.com/open?id=1-0WP_5P82M6YNcRA39Mnu4KbgotE-xRG
38 https://www.pbis.org/resource/tfi
39 https://www.pbis.org/resource/isf-action-planning-companion-guide-to-swpbis-tfi
40 https://drive.google.com/open?id=1-B1PiqYbu7b5QEndfV0xezpZ695-vSyb
41 https://drive.google.com/open?id=11yapqSS0VCRbs6ye57n8VUCFwqdCaQqh
42 https://drive.google.com/open?id=1NHXLAc7-C9DJ0qrmxsuKz8tiVW0x6Mqv
43 https://drive.google.com/open?id=1-FSsYfzGonuSYjqiHIzCf6wzezyRCC_-
44 https://nirn.fpg.unc.edu/resources/hexagon-exploration-tool
45 https://drive.google.com/open?id=1-tyAEISkxWpu3r0AujBhRaJeilwJLNUL
46 https://drive.google.com/open?id=10UBpVoRYxoNyR8HiWd6jlMdafx2EWgh8
47 https://drive.google.com/open?id=1-BImAJgtvIjYPWmOhTDxBTIjuvYVTz6-
48 https://drive.google.com/open?id=12neA1en5rwyq_kQgdjCIYiBUHFB1sQKd
49 http://bit.ly/ISF-II-v3-Manual-and-Tool
50 https://www.pbis.org/resource/isf-action-planning-companion-guide-to-swpbis-tfi
51 https://fscalliance.org/
52 https://www.pbis.org/resource/isf-action-planning-companion-guide-to-swpbis-tfi
53 https://www.pbis.org/resource/advancing-education-effectiveness-interconnecting-school-mental-health-and-school-wide-positive-behavior-support