

# PBIS Forum in Brief: Aligning and Integrating Mental Health and PBIS to Build Priority for Wellness

PBIS Leadership Forum- *Roundtable Dialogue*

December 2017

## Introduction and Purpose

School districts across the country are attempting to implement multiple initiatives to address the academic, social/emotional, and behavioral needs of their students. The interventions and programs they select may be the result of a mandate, a recently awarded grant, or a staff member learning about a new strategy at a conference. In other words, interventions may not always be selected based on actual need, contextual fit, evidence base, or with an eye towards efficiency and sustainability. One of the most notable areas of need for systematic integration of initiatives in schools is mental health and PBIS.

Although mental health and other community-based providers do work within some school systems, they often exist tangentially to behavior support structures initiated by other school-based personnel. Recognizing the need to create more effective behavioral health systems within schools, key leaders and implementers from multiple national centers came together through a series of meetings, focus groups, etc. to develop solutions. This led to the development of a Monograph describing the need and approach for using an Interconnected Systems Framework (ISF) to fully align mental health and PBIS within schools (Barrett, Eber & Weist, 2013). The ISF approach has continued to develop, with tools and examples from sites across the country. More recently, a [\*“Technical Guide for the Alignment of Initiatives, Programs or Practices in School Districts”\*](#) (OSEP Technical Assistance Center on PBIS, 2016) was developed to offer a series of steps for districts and schools to use for integrating various social/emotional initiatives (e.g. bully prevention, trauma informed responses, restorative practices, etc.) with the ultimate goal of efficient implementation at the classroom and student levels.

The 2017 PBIS Leadership Forum in Chicago, Illinois included 10 presentations, including a roundtable dialogue session, addressing the integration of mental health and PBIS as outlined in [\*Advancing Education Effectiveness: Interconnecting School Mental Health and School-wide Positive Behavior Support\*](#) (Barrett, Eber, Weist, 2013). This ISF for integrating mental health and PBIS in schools promotes and follows the steps for alignment as outlined in the aforementioned Technical Guide for aligning related initiatives.

The purpose of this document is to summarize the Mental Health Integration strand, including the roundtable dialogue, from the 2017 PBIS Leadership Forum in Chicago, Illinois. Recognizing that the ISF provides an example of effective alignment of initiatives, programs and practices in schools, this summary will be organized around the steps included in the Technical Guide for Alignment (see Figure 1 below). Illustrations from sites working to implement the ISF are included as examples of the alignment process. Input and discussion from presenters and participants at the 2017 PBIS Leadership Forum Mental Health Integration sessions and roundtable dialogue, including responses to Frequently Asked Questions (FAQs), are included in this Brief.

Figure 1. *Steps of the Alignment Process*

Steps of the Alignment Process
<ol style="list-style-type: none"><li>1. Coordinate the process with an executive level team</li><li>2. Define the valued outcome(s) to be achieved</li><li>3. Develop an inventory of the related initiative that are currently implemented across the district</li><li>4. Identify core system features for initiatives targeted for alignment</li><li>5. Analyze and make decisions for alignment of initiatives</li><li>6. Design the plan for effective alignment including implementation, evaluation, and professional development</li></ol>
<p><a href="#"><i>“Technical Guide for the Alignment of Initiatives, Programs or Practices in School Districts”</i></a> OSEP Technical Assistance Center on PBIS, 2016.</p>

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## Why Align PBIS and School Mental Health?

PBIS is a Multi-tiered System of Supports (MTSS) approach to address social/emotional, and behavioral needs of all students. Within a school building, multi-disciplinary teams of administrators, staff, students, families, etc., review data and select evidence-based interventions that address a need within the school. Those interventions are progress monitored for fidelity and impact. PBIS is currently being implemented in over 25,000 schools across the nation, and has a wide evidence-base demonstrating improved outcomes for students, especially regarding reductions in acting out behavior (Bradshaw, Mitchell, & Leaf, 2010). Many schools struggle to develop a comprehensive continuum of interventions for students who have complex needs at Tiers II and III, especially with regards to students who are experiencing internalizing mental health issues such as anxiety, depression, and those who have experienced trauma.

In an effort to strengthen interventions for students with the most complex needs, schools often reach out to community mental health providers. Likewise, mental health agencies reach out to schools to partner (i.e., opening an outpatient satellite office within a school building) as they attempt to improve access of mental health services to youth and families. Many times, this outreach from either party is ad hoc, based on convenience or a short-term grant award. Unfortunately, when mental health practitioners are providing services in school buildings, it is often done separately from other behavior supports, and there is often minimal coordination between the providers and school staff and administration. It is not surprising that the evidence to suggest these services improve outcomes for students is lacking (Dowdy, et. al., 2010).

The ISF proposes that when mental health and related community supports are truly integrated within the framework of PBIS, a broader continuum of prevention and intervention strategies across tiers can result in improved outcomes for more youth and families (Barrett et al, 2013). The ISF encourages leaders from both the school and the community, together with youth and family members, to review education data as well as community data and decide together which evidence-based interventions to install and how to monitor both fidelity and outcomes. A unique feature of ISF is that this broader stakeholder group collectively works with expanded data, leading to a more robust and sustainable implementation, a truly integrated system, and sustainable outcomes for an increased number of students.

## Key Messages

Following the publication of the ISF Monograph, four (4) key ISF messages were developed to further guide the alignment and integration of PBIS and mental health (Lever et al 2016; Weist, et. al., 2016). These key messages, outlined in Figure 2, are illustrated in the examples and strategies to follow.

Figure 2. *Four ISF Key Messages*

Four ISF Key Messages
<ol style="list-style-type: none"><li>1. Utilize a single system of delivery</li><li>2. Promote mental health for all</li><li>3. Install with multi-tiered system of support</li><li>4. Move beyond access to mental health interventions with specific outcomes</li></ol> <p>(Lever, Weist, Eber &amp; Barrett, 2016; Weist, Lever, Hoover, Barrett, &amp; Eber, L. 2016)</p>

The following sections provide a summary of ISF implementation examples and strategies mapped on to the six steps described in the Technical Guide for Alignment.

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## **Step 1. Coordinate and lead alignment process with an executive level team.**

Alignment of related initiatives needs to begin at the district level as the system features that sustain effective implementation of any/all initiatives are grounded at the district level. For example, staff allocation, professional development, evaluation and related policies need to be aligned across initiatives at the district level to ensure consistent, accurate and sustainable implementation within the schools.

The first of the ISF Key Messages is the need to deliver all behavioral/mental health support through one single system of delivery. At the district/community level, key stakeholders from both the school district and any partnering community agencies need to commit to being active participants on a leadership team that develops a shared mission, consensus on shared outcomes and creates the policies and operational procedures that guide the integration of mental health and PBIS at the school level. This team needs to include those within the organization(s) who have the authority to allocate resources, develop policies and commit to necessary and critical changes in how personnel function at the school and student level. Building on the interagency System of Care values (Stroul, et. al., 2010) this integrated team should include youth/family voice and may include membership from the following areas to ensure local stakeholders are fully represented: School System Student Services and Special Education Directors, Local Mental Health Providers, Juvenile Services Coordinator/Law Enforcement, Coalition of Families Offices, Social Services Representative, etc.

If a school district is just getting started with PBIS, they can apply the PBIS Leadership structure outlined in the *PBIS Blueprint: Part 1 – Foundations and Supporting Information* (OSEP Technical Assistance Center on PBIS, 2015) by establishing a District/Community Leadership Team (DCLT) that includes participation of community stakeholders from the initiation of their PBIS effort. For school districts with an established PBIS Leadership Team, they will need to invite the leaders from their community agencies to join their team as they revise their mission, goals, and action plan to move towards integration of mental health into their PBIS structures. Following the recognized PBIS leadership model (OSEP Technical Assistance Center on PBIS, 2015), this process should take place first at the district level followed by similar integration within leadership teams at the school level.

Resource mapping, sharing and data review are strategies to assist school districts in the development of the team. For example, a school may have an existing partnership with a mental health agency that currently places a therapist in the building to provide services to a caseload of students. The Executive Director of this organization or his/her designee should be invited to participate in the DCLT. The goal would be for increased collaboration between the agency, school and families. For example, the Director may be able to reallocate staff to allow clinicians to participate in building level system teams at each tier, where interventions can be collaboratively developed and monitored

## **Step 2. Define the valued outcome(s) to be achieved.**

Ensuring consensus on the outcome(s) to be achieved is a critical step in aligning related initiatives. Leaders of the various initiatives may need to be assured that the goals of “their” program will be met. Furthermore, engaging the leaders in agreement about common goals will also allow the team to determine if existing initiatives and programs are being adequately assessed to ensure outcomes. Within the ISF, both school and community data should be considered in the determination of a shared mission and valued outcome(s). Figure 3 includes examples of school and community data that can be considered by teams as they reach consensus on valued outcome(s) for the alignment of PBIS and mental health.

The second ISF Key Message is that mental health is for ALL, thus emphasizing the need for a full array of mental health supports including prevention that can be delivered through instruction in classrooms by

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teachers. The alignment of mental health with PBIS is typically focused on the development of a stronger system that can lead to improved outcomes for ALL students. Often a DCLT will target a specific group that has been unrecognized or underserved (i.e. students with internalizing mental health needs) as they come to consensus on a mission statement that defines their valued outcome(s) to be achieved.

For example, a community mental health agency had aggregate data to indicate an increase in hospitalizations for suicidal ideation across their county. Recognizing the lack of systemic suicide prevention and intervention, the DCLT created action steps to address this issue with regard to their shared mission and agreed upon valued outcome around improved health of ALL students, especially those currently underserved in both schools and the community. Addressing this critical data point through a single leadership team allowed for suicide prevention and intervention strategies to be identified and installed in an expedited and efficient manner. Funding was also easily secured from both a school and community agency as key stakeholders were involved in the decision making and data was used for identifying need.

By reviewing both school and community data, the school-based leadership team may be able to determine measurable goals at each tier. Ensuring a broader array of stakeholders on the school-based teams is an important feature of the ISF. For example, a high school Tier I team identified that over half of their office discipline referrals across all grades were from students who were also tardy to school in the morning, representing over half of all students in the school. At this school, students and families were responsible to provide their own transportation and school personnel were concentrating on this issue. Following the ISF/SOC principal of youth/family voice, the Tier I team, included students who helped redirect the focus of the team to how students spent their time prior to the start of the school day. The student input guided the team to develop an action plan focused on what would motivate students to arrive at school on time. Students were surveyed and indicated they most often stopped for coffee or breakfast items before school. The team, with support from administration, started a coffee shop in the cafeteria, where students could purchase healthy food and beverages in the morning. The team was able to significantly decrease the number of students who were tardy to school in a short period of time. In addition, they used the funds from the coffee shop to support other aspects of their ISF implementation.

Figure 3

School Data	Community Data
<ul style="list-style-type: none"> <li>● Attendance</li> <li>● Grades</li> <li>● Office Discipline Referrals (ODRs)</li> <li>● Suspensions</li> <li>● Visits to school nurse</li> <li>● Visits to school clinician</li> <li>● Universal Screening Data</li> </ul>	<ul style="list-style-type: none"> <li>● Number of families who are homeless</li> <li>● Number of families accessing food pantry</li> <li>● Number of calls/visits to mental health crisis center</li> <li>● Number of families receiving support/intervention from Child Protection</li> <li>● Number of youth arrested and/or on probation</li> </ul>

### Step 3. Develop an inventory of the related initiatives currently being implemented across the district.

Assessing what is currently being provided is an important step in the alignment process. Schools and community organizations may come to the integration process with their own unique goals and initiatives, that need to be shared and recognized. When detailing an inventory of existing initiatives, the team should acknowledge the unique as well as shared goals of various programs, including any state and federal standards that may be driving various initiatives. For example, states may mandate that issues such as bully prevention,

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character education and/or suicide prevention be addressed in schools; and community agencies may have existing/separate ‘services’ that are similar. As this newly structured leadership team moves toward a shared strategic plan, they will benefit from identifying commonalities across agency initiatives. For example, action plans can reflect goals for achievement in academics, behavior, social emotional learning, while acknowledging the need to provide preventive mental health strategies that support all students, including those previously ‘referred’ for mental health interventions that can now be integrated into a school-based continuum.

When implementing ISF, a DCLT establishes an inventory of initiatives, and then looks at what practices are already in place to support these initiatives and reviews the documented effectiveness of each. Conducting resource mapping, both for the district and for each school, is a way to assess what is in place. In addition to identifying the practices and evaluation processes/data for each initiative or program, it is also necessary to identify which agencies/personnel are providing the different practices. This resource mapping helps identify if community mental health providers and school-employed clinicians are delivering related interventions separately and if there is a need to develop structures for consistent evaluation of outcomes and linkage back to the classroom. It is not uncommon to discover that the same students are receiving different interventions from various providers without clear linkage.

A unique ISF feature for the systemic integration of mental health into the PBIS framework, is active participation of both community and school employed clinicians on the system teams at all tiers within the schools. They collectively review school and community data including screening for social/emotional and behavioral needs. Their combined expertise guides the team selection of evidence-based interventions that can be progress monitored for both fidelity and impact. For example, a community-clinician who joined a Central Illinois High School Tier II team helped the team to recognize that a group of students targeted for support due to school-based data points had likely experienced trauma that was impacting them at school. The community mental health clinician and a school counselor worked together to select an evidence-based trauma-informed group intervention to add to their Tier II continuum. The community clinician and the school social worker co-facilitated the intervention that focused on teaching social and coping skills as replacements for the ‘fight, flight or freeze’ data points. Data was collected both pre and post participation in the group. After receiving the intervention, students’ academic and behavior data improved and, through use of a specific survey, students reported feeling more connected and able to cope at school.

### **Step 4. Identify the core system features for initiatives targeted for alignment.**

Once the leadership team has identified the initiatives to be aligned, the MTSS core system features can be identified and analyzed. The MTSS core system features include: a **leadership team** implementing and monitoring initiatives, **outcome and fidelity measure(s)** used to monitor implementation, a **process for selection of evidence based practices**, comprehensive **screening measures**, and a professional development plan that includes **coaching and performance feedback**. Each initiative/program/practice targeted for alignment should be assessed per each of these core features.

The third ISF Key Message is the use of a multi-tiered system of support (MTSS). The PBIS framework is a MTSS and implementing an ISF involves building and expanding an integrated system using the MTSS core features. For example, an MTSS is defined by the use of leadership teams to explore/adopt, install and implement practices. As previously mentioned, the ISF calls for including mental health providers as active participants on these teams to review an expanded set of school and community data. Rather than the community providers meeting separately to discuss their work, they become part of the school-based teams that collectively use data to make decisions about intervention selection as well as progress monitoring.

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In one school, prior to aligning mental health and PBIS, a student who experienced anxiety in the classroom met with a clinician 30 minutes per week. The student often spent the time coloring, which was relaxing. The student reported feeling positive about spending time with the clinician, however, she still experienced significant anxiety in class. After the integration process was initiated, a cross-system team moved to select an evidence-based intervention for students with anxiety. The staff and clinicians received training in the intervention, specifically, the skills that would be taught and how to prompt the use of the skills, as well as praise the student for using new skills. The student, family, and teacher were all involved in the intervention. Over time, the student was able to utilize the strategies taught and reported a reduction in anxiety during the school day.

### **Step 5. Analyze and make decisions for alignment of initiatives.**

The district-level leadership team reaches consensus about a common mission/vision and prioritizes collective goals for students. This typically leads to an assessment of how the system can be restructured to ensure efficient focus on the shared goals. To prevent the team from becoming overwhelmed with implementing too many initiatives at the same time, priority should be given to the top two to three agreed upon goals to be addressed ensuring all selected goals are related to the mission and valued outcome(s).

Some of the more challenging alignment decisions involve choosing which programs and initiatives to continue and which may be counter-indicative or inefficient to achieve valued outcomes. Other decisions may focus on roles of staff, including changes in job descriptions and functions. Within the ISF, this assessment of programs and initiatives is a key function of the blended DCLT. This includes assessing what teams, workgroups, committees, and initiatives related to social/emotional behavior already exist, including those organized by community providers as well as those led by school-employed personnel. The DCLT should (a) establish integrated implementation goals, (b) determine an evaluation plan, and (c) outline what data will be used to monitor impact and fidelity of all interventions within the single system of delivery.

A school district, featured in the ISF monograph (*Barrett, Eber, Weist, 2013*), prioritized their goals each year in an integrated action plan. They have more than twenty community partners and about sixty different service agency providers who support students across the district. Each year, they divide their school and community alliance into workgroups around these prioritized goals. Some workgroup priorities have included family engagement, reduction of gang activity, trauma-informed care, and selection and installation of restorative practices. Having an integrated DCLT to prioritize common goals and establish workgroups has aligned the work of all partners supporting both school and community partners to work efficiently towards the shared mission and valued outcome(s).

It has been common practice for interventions provided by community mental health agencies and school-employed personnel to be monitored separately rather than in an integrated system. In order to work collaboratively as a single system, the school district and partnering organization(s) may need to develop a Memorandum of Understanding (MOU) to clarify the roles and responsibilities of each organization and their staff. Consideration should be given for perceived barriers for staff to work together on teams, how staff time is funded, and how information will be shared (confidentiality). The ISF Monograph (*Barrett, Eber, Weist, 2013*) provides guiding questions to facilitate these conversations, which at first may seem uncomfortable, as leaders may not be used to discussing these topics outside their own agencies. Additional topics that will need to come to be addressed are regarding communication, collaboration, and the shared agenda of serving the children, youth, and families in their charge. For example, articulating, “mental health clinicians will sit on the Tier I systems team and review school level data,” would be an item to include.

Essential to an integrated action plan is outlining a blended professional development and implementation

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plan. The comprehensive review of school and community data will assist the team in identifying the top priorities to address. Depending on the size of the district/community, consideration will need to be given to elementary versus secondary demographics and other contextual elements. One data point that often comes up in sites across the country is regarding students who have been impacted by trauma. Traumatic events can impact students physically, socially, emotionally, and behaviorally. In this example, the DCLT will need to determine if the percentage of students impacted by trauma is less than five percent (Tier III); between five and fifteen percent (Tier II); or more than twenty percent (Tier I). This will help the team to determine the extent of the supports to put in place to address this need. Regardless, one goal would be for all staff from the school and mental health provider agency to receive training on trauma, its impact, and how to be trauma-informed in their interactions with youth and families.

## **Step 6. Design the plan for effective alignment including implementation, evaluation, and professional development.**

Now that the DCLT has established common vision and identified initiatives to support these goals, the team needs to define how to accomplish this work. An integrated action plan details how related initiatives will be implemented from the classroom level on up. A blended plan allows for prioritizing resources for professional development, including coaching and performance feedback, as well as consistent evaluation of all programs and practices. For example, providing adequate support to ensure accurate and effective implementation of both academic and behavior MTSS requires a collaborative effort to avoid a ‘competitive’ context within the central administration.

Implementing ISF requires district/school and community leaders to collectively action plan to ensure the social, emotional, behavioral, and mental health of all students, families, and staff. This may be a different approach if the district/school has previously operated by referring or handing off some students to a separate mental health delivery system. Ongoing assessment of need, including the use of a universal screener that captures both externalizing and internalizing concerns, is needed. The use of fidelity tools, and other assessments, can be incorporated in an evaluation plan that monitors both fidelity and impact of interventions and the overall system.

The fourth ISF Key Message is moving beyond access, to ensure explicit measurement of student level outcomes, rather than simply counting the number of students accessing services and treatment plans. At the building and classroom level, the cross-stakeholder system teams will need to develop decision rules regarding how students are placed in interventions, progress monitored, and how they will exit an intervention. These decision-rules need to apply to all interventions provided by both community and school-employed staff. For example, in a school implementing an ISF, a student may be referred to a clinician for an individualized intervention if they are at risk of change of placement; reach a determined threshold on a screener; and/or have not responded to other targeted interventions. The clinician will need to conduct further assessment in order for the Tier III Team to ascertain what type of evidence-base intervention to select. Then, once selected and implemented, the clinician will need to collect and monitor both fidelity and outcome data and report this progress to the Tier III system team.

Both school district and mental health leadership need to ensure implementation fidelity of interventions. Ongoing coaching and technical assistance by trained facilitators at the district and building level are a key feature of successful implementation. These individuals may have other existing roles such as a clinical supervisor from the mental health agency or a district level person with behavioral expertise, such as the supervisor of school employed clinicians (psychologists, social workers, school counselors). District and community administrators can reallocate some of the time of these individuals to ensure dedicated FTE (full time equivalent) is available for coaching and technical assistance.

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For example, a district implementing ISF for several years identified a large percentage of behavior problems occurring in kindergarten across their eleven elementary schools. A decision was made to train kindergarten teachers in Prevent-Teach-Reinforce (PTR) for young children. Although PTR is typically used for individual intervention, teachers were trained to use this function-based strategy for classroom management. In addition, individual students and families at each school were identified to receive Parent Child Interactive Therapy (PCIT) (Bjørseth & Wichstrøm, 2016) from mental health clinicians trained to deliver this evidence-based strategy. When reviewing the data one year later it was unclear if these two interventions produced their desired outcomes. It was determined that additional coaching and technical assistance would be put into place in addition to ongoing fidelity checks and a further review of outcome data.

There are two primary tools that can be considered for use in implementing and evaluating ISF at the school-level. The first is the [ISF Implementation Inventory](#) (Splett, et. al., 2016), which assesses the domains of implementation at the building level across tiers. This tool has scoring criteria to both develop an action plan and to assess fidelity of implementation of ISF. The second is the [Action Planning Companion Guide to the Tiered Fidelity Inventory](#) (TFI), which includes ISF enhancements to each item on the TFI. This tool is not used for scoring, however, teams can develop action plans based on the identified ISF enhancements. It is imperative that decisions are made regarding evaluation for fidelity, impact, and sustainability. Continuous quality improvement at both the building and district level are goals that should be incorporated into the action plans.

## Conclusion

Schools are faced with an ever-growing need to meet the academic, social, emotional, and behavioral needs of their students. Community mental health providers often seek ways to help children, youth, and families both access and benefit from high quality interventions with demonstrated outcomes. School districts and mental health providers can coalesce around the need for a continuum of evidence-based interventions for students that address social/emotional and behavioral needs. Utilizing the six steps outlined above, these two systems can develop an ISF to align their data, practices, and policies, and achieve their common goals. Monitoring interventions for fidelity and impact will ensure improved outcomes for students across home, school, and community. This Brief can serve as a resource for leaders who are invested in being more effective and efficient with their resources. Additional tools are available that sites may find helpful as they navigate through the process of alignment.

## Frequently asked questions

*Questions generated by participants and discussed across presenters and participants*

### **Q. Can you talk about strategies for aligning ISF and trauma informed schools?**

**A:** Implementing Tier I PBIS with fidelity *creates a safe, predictable, and consistent environment* for all students, and especially students who have experienced trauma. A recent technical assistance brief, [Getting Back to School after Disruptions: Resources for Making Your School Year Safe, More Predictable, and More Positive](#), reinforces how Tier I PBIS practices support students who have recently experienced a traumatic event. A multi-tiered framework is key to integrating trauma-informed practices. Analyzing school outcome data (i.e.: attendance, ODRs, visits to school nurse/counselor, crisis calls) with community partner voice determines which tier needs to be enhanced by adding trauma informed practices. For example, a school with 20% of students with 1 or more ODR, 10% of students requesting to see the school based clinician, and referring 5% of students for crisis support would integrate trauma-informed practices at Tier I to support all students, such as enhancing social emotional skills taught at Tier I to include replacement skills for fight, flight, and freeze or

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classroom-wide routines for self-regulation. While another school with 8% of students receiving 1 or more ODR, 5% of students requesting to see the school based clinician, and referring 2% of students for crisis support would most likely consider adding trauma-informed interventions within their Tier II continuum to support some students. Providing professional development for all staff to understand what trauma is, how trauma impacts student learning, and how current practices support all students, especially students impacted by trauma, is recommended for all schools. To hear more, listen to ISF Targeted Workgroup: [Installing Trauma-Informed Care Through Mental Health Integration in MTSS](#) recorded webinar.

**Q: Does anyone have helpful hints on how to bring community partnerships into schools?**

**A:** Start by either establishing a District Community Leadership Team (DCLT) or inviting key community stakeholders (e.g.: Director of community mental health agency) to your standing District Leadership Team. Once key stakeholders are at the table, utilize school and community data to develop a shared vision based upon needs. Outline what resources are available within the community and school through a resource mapping process. Then define what additional resources may be needed and how to fill in gaps. Additionally, ensure cross training is provided to develop capacity of both school and community systems to understand the other system, for example, including community partners in a training on PBIS. Funding for community partnerships is, of course, an obstacle that must be addressed, but when the key stakeholders are involved from the start and are committed to the same shared vision, overcoming the obstacle is easier.

**Q. How do you build capacity with staff to support extreme mental health needs of students, especially in day programs?**

**A:** First, providing continued professional development to ensure that staff are able to articulate and believe that the tiered system of supports breaks down in all settings, even alternate programming settings (e.g., mental health treatment centers, juvenile justice). Then including staff in data based decision making by having representative staff on Tier I and Tier II/III systems teams to identify student need and match interventions to the student need. Continuing to have representative teams monitor fidelity of implementation and student outcomes from interventions and sharing data with all staff to demonstrate student response to interventions in place at each tier will reinforce the message that tiered supports are established by the needs of population.

**Q: What are schools doing to inform their staff on using language that identifies student needs without disempowering the student?**

**A:** Disempowering language tends to occur more often with students with behavioral or mental health needs. For example, some common examples are: “Tier III kid”, “he’s ADHD”, or “red kid.” When it comes to physical health we tend to not generalize the student’s physical health need to their identify, such as “peanut allergy kid”, and instead use person first language. This demonstrates that using empowering language to describe students with behavioral needs can be a philosophy shift for many. Start with professional development to define what disempowering language is, why it is disempowering, and how to use empowering language. Effective professional development needs to extend beyond teaching to include modeling and opportunities for practice. Ensure your professional development includes teaching, modeling, and opportunities for staff to receive corrective feedback in safe environments.

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