Wise Ways

The school's Learning Support System includes academic, physical, social, emotional, and behavioral programming based on school-wide, targeted group and individualized needs. (CL1)

Evidence Review:
The President's New Freedom Commission on Mental Health was charged with identifying the problems and gaps in the mental health system and making recommendations for immediate improvements at the federal, state, and local levels. Their findings confirmed that there are unmet needs and many barriers to obtaining care for people with mental illness, including children. One of their recommendations is to transform the mental health system so that mental health issues are identified early and that both children and adults receive care early after the detection of mental health issues which will help prevent these issues from worsening and potentially prevent the onset of a "co-occurring substance use disorder and breaking a cycle that otherwise can lead to school failure and other problems." In addition, the Commission recommends the promotion of mental health in young children and the improvement and expansion of school mental health programs.

Source: New Freedom Commission on Mental Health. *Achieving the Promise: Transforming Mental Health Care in America.*

Evidence Review:
Although individuals who are already affected by a mental, emotional, and behavioral (MEB) disorder should receive the best evidence-based treatment available, preventing MEB disorders should be a national priority due to the potential lifetime benefits and in order to circumvent the negative impacts of and substantial costs these disorders can have on individuals, families, and society. Many factors that place young people or groups of young people at risk for developing these disorders have been identified as well as other protective factors and a number of evidence-based promotion and prevention programs and practices should be considered for broad implementation. Development takes place within multiple settings and contexts, including schools. Schools can promote developmental competencies through aspects of school context such as teacher behavior, pedagogy, organizational characteristics of the school, and family-school relations (Smith et.al, 2004). In addition, several school-based prevention programs have demonstrated positive outcomes. For example, the *Good Behavior Game,* a first grade classroom management intervention:

- reduced disruptive behavior and increased academic engaged time;
- reduced likelihood that initially aggressive students would receive a diagnosis of conduct disorder by sixth grade; and
- significantly reduced likelihood that persistently highly aggressive males would receive a diagnosis of antisocial personality disorder as a young adult.

Source: National Research Council and Institute of Medicine of the National Academies. *Preventing Mental, Emotional, and Behavioral Disorders Among Young People, Progress and Possibilities.*

Reference and Other Resource:
Smith, E.P., Boutte, G.S., Zigler, E., and Finn-Stevenson, M. (2004). Opportunities for schools to promote resilience in children and youth. In K.I. Maton, C.J. Schellenbach, B.J. Leadbeater, and A.L. Solarz (Eds.), *Investing in Children, Youth, Families, and Communities: Strength-Based Research and Policy* (pp. 213-232). Washington, DC: American Psychological Association.

Evidence Review:
Concern about overburdened health care systems, high costs, and fragmented approaches to children's mental has lead Georgetown University to develop a conceptual framework to address

the mental health of children that draws on the well-established and successful public health approach. Guiding principles of this framework include:

• Taking a population focus, which requires an emphasis on the mental health of *all* children. Data need to be gathered at population levels to drive decisions about interventions and to ensure they are implemented and sustained effectively for entire populations.

• Placing greater emphasis on creating environments that promote and support optimal mental health and on developing skills that enhance resilience.

• Balancing the focus on children's mental health problems with a focus on children's "positive" mental health—increasing our measurement of positive mental health and striving to optimize positive mental health for every child.

• Working collaboratively across a broad range of systems and sectors, from the child mental health care system to the public health system to all the other settings and structures that impact children's well-being.

• Adapting the implementation to local contexts—taking local needs and strengths into consideration when implementing the framework.

Source: Georgetown University, *A Public Health Approach to Children's Mental Health: A Conceptual Framework*

Evidence Review:
Response to Intervention (RtI) "models focusing on academic instruction or support for social behavior share an emphasis on prevention and both types of models have created tiered approaches that have their roots in public health (e.g., Simeonnson, 1994)".

Source: University of South Florida, *Response to Intervention and the Pyramid Model, June 2009*.

Reference and Other Resource:
Simeonnson, R. J. (1994). Promoting children's health education, and well being. In R. J. Simeonsson (Ed.), *Risk, resilience, and prevention: Promoting the well-being of all children* (pp. 3-12). Baltimore: Paul H. Brookes.

Evidence Review:
Response to Intervention (RtI) is "the practice of providing 1) high-quality instruction/ intervention matched to student needs and 2) using learning rate over time and level of performance to 3) make important educational decisions" (*Batsche, et al., 2005)*. This means using differentiated instructional strategies for all learners, providing all learners with scientific, research-based interventions, continuously measuring student performance using scientifically research-based progress monitoring instruments for all learners and making educational decisions based on a student's response to interventions.

RtI has three essential components: 1) using a three tier model of school supports, 2) utilizing a problem-solving method for decision-making, and 3) having an integrated data system that informs instruction.

Source: The Illinois State Response to Intervention (RtI) Plan, January 1, 2008

Evidence Review:

According to Adelman and Taylor (2010), if Response to Intervention (RtI) is treated simply as a matter of providing more and better instruction and student motivation is not taken into account, there is no way to validly assess whether or not a student has a true disability or disorder. If this is the premise, it is also unlikely to be effective for a great many students. However, if the strategies are understood as part of a comprehensive system of classroom and school-wide learning supports, schools will be in a position to not only address problems effectively early after their onset, but will prevent many from occurring.

Adelman and Taylor (2010) recommend that the 3-tiered RtI framework expand to ensure an optimal learning environment that takes student motivation into account and addresses barriers to teaching and learning and re-engages disengaged students. "Implied in all this is that specified staff are working to ensure (1) development of an optimal learning environment in classrooms and schoolwide, (2) classroom teachers are learning how to implement "well-designed early intervention" in the classroom, and (3) support staff are learning how to play a role, often directly in the classroom, to expand intervention strategies as necessary."

Source: Center for Mental Health in Schools at UCLA, *Response to Intervention*

Evidence Review:
A meta-analysis of Three-Tier Models of Reading and Behavior was conducted in which the relative impact of a reading only model, a behavior only model and an integrated model were evaluated. The majority of the studies took place at the elementary level. The reading investigations and the integrated investigations primarily occurred at the Tier II level where as the behavior investigations typically took place at the tier I level. Findings from this meta-analysis showed that reading outcomes were positive for all three models. However, the integrated model resulted in the largest magnitude of the effect size. The magnitude of the effect sizes for the reading and behavior only models on reading outcomes were moderate and small, respectively. The integrated model and the behavior only models also positively impacted behavioral outcomes. A moderate effect size was found for the integrated model on behavioral outcomes…, whereas the magnitude of the behavior-only model on behavior… was slightly lower." Although findings from this meta-analysis did not indicate a positive impact on behavioral outcomes from the reading only models, other researchers have found that improving reading skills through reading interventions also improves social adjustment (Benner, Kinder, Beaudoin, Stein, & Hirschmann, 2005; National Reading Pan, 2000; Simmons & Kameenui, 1998). Based on these findings, Sugai and Horner (1999) suggest that "an integrated systems approach to preventing reading difficulties and behavioral challenges may not only maximize outcomes but also be a resourceful tactic to address both issues simultaneously."

Source: Stewart, Rachel M., et.al. (2007). Three-Tier Models of Reading and Behavior: A Research Review. *Journal of Positive Behavior Interventions.*

References and Other Resources:

Benner, G.J., Kinder, D., Beaudoin, K., Stein, M., & Hirschmann, K. (2005). The effects of the Corrective Reading Decoding program on the basic reading skills and social adjustment of students with high-incidence disabilities. Journal of Direct Instruction, 5, 67-80.

National Reading Panel. (2000). *Teaching children to read: An evidence-based assessment of the scientific research literature on reading and its implications for reading instruction: Reports of the subgroups* (NIH Publication No. 00-4754_. Washington, DC: U.S. Government Printing Office.

Simmons, D.C., & Kameenui, E.J. (1998). *What reading research tells us about children with diverse learning needs: Bases and basics.* Mahwah, NJ: Erlbaum.

Sugai, G., & Horner, R. H. (1999). Discipline and behavioral support: Practices, pitfalls, and promises. *Effective School Practices, 17, 10-22.*

Evidence Review:
There is a growing body of research that demonstrates the positive impact of supportive programs and services that promote conditions for learning and address any barriers to learning. These programs and services, also known as "learning supports", enable students to learn and teachers

to teach and have result in: improved school attendance, fewer behavior problems, improved interpersonal skills, enhanced achievement, and increased bonding at school and at home. The findings also highlight the importance of coalescing activities into a comprehensive multifaceted approach.

Adelman and Taylor have found that in most districts, learning supports "are fragmented, overspecialized, counterproductively competitive, unsustainable, and fundamentally marginalized in policy and practice." They highly recommend schools/districts to have policies that move toward and/or support a three component system (i.e., curriculum and instruction, governance, and a comprehensive coordinated system of learning supports). Operational infrastructure to support a comprehensive system of supports would include system mechanisms that:

1) unify all direct efforts to promote necessary conditions for learning (e.g., SEL and positive school climate) and address factors interfering with learning and teaching at a school (e.g., bullying, disengagement, mental health issues, behavior problems);
2) provide equitable capacity building;
3) connect families of schools with each other and with a wider range of community resources; and
4) weave together school, home, and community resources in ways that enhance effectiveness and achieve economies of scales.

A comprehensive Learning Supports System utilizes the 3-tiered RtI framework to provide a full continuum of interventions (i.e., promotion of physical, social, emotional, behavioral and cognitive development and prevention of problems, targeted interventions that occur early after onset, and intensive interventions) that encompasses:

1. Classroom Enhancement & Youth Development
2. Support for Transitions
3. Crisis Response and Prevention
4. Home Involvement
5. Student and Family Assistance
6. Community Outreach (including Volunteer Participation)

Sources: Center for Mental Health in Schools at UCLA:

- Addressing Barriers to Learning & Promoting Healthy Development: A Usable Research-Base
- Mental Health in Schools: Why Focus on School Policy?

Evidence Review:
In order to transmit innovative programs and practices to various human service fields including the fields of mental health and education, changes at the system, organization, program, and practice levels are necessary. "Only when effective practices and programs are fully implemented should we expect positive outcomes (Bernfeld, 2001; Fixsen & Blase, 1993; Institute of Medicine, 2001; Washington State Institute for Public Policy, 2002)."

Paramount to the successful implementation of an innovative program or practice is having knowledge about the community's strengths and needs prior to the selection of the program or practice. Research findings have also revealed the importance of community buy-in when trying to implement a new program or practice. "Community" could refer to members of a city, neighborhood, or organization (e.g., school staff). Some buy-in strategies include:

- Staff participation in the decision-making and planning processes;
- Communication that clearly articulates the need for change which would encompass the current status of efforts, how the innovation contributes to the larger agenda, and the cost-effectiveness of the strategies;

- Identification and mobilization of key stakeholders;
- Mobilization of a critical mass of support through social marketing strategies;
- Obtaining support of key policy makers;
- Communication that clearly articulates how functions can be institutionalized through existing, modified, or new infrastructures and operational mechanisms; and
- Formulation of a long-range strategic plan.

Following exploration and adoption of evidence based program(s) and/or practice(s), effective implementation sites will progress through these phases of implementation:

- *Program Installation* encompasses the necessary preparation activities prior to actually doing anything different with the consumers. This includes ensuring that structural supports like funding streams, communication mechanisms, and policies and procedures are in place. It may also require obtaining necessary human resources, space, supplies and technology to implement the programs and/or practices with fidelity.

- *Initial Implementation* requires changes in the overall environment and may require changes in skill levels, organizational capacity, and organizational cultures. "During the initial stage of implementation the compelling forces of fear of change, inertia, and investment in the status quo combine with the inherently difficult and complex work of implementing something new."

- *Full Operation* occurs when new learning becomes integrated into practitioner and organizational practices. In this phase, practitioners implement the practice(s) and/or program(s) with proficiency and skills, and administrators support the new practice(s) and/or program(s).

- *Innovation* happens once a program is fully implemented with fidelity and a practitioner takes advantage of an opportunity to "refine and expand both the treatment practices and programs and the implementation practices" while maintaining core components of the evidence-based practices and programs.

- *Sustainability* is necessary for the long-term survival of effective programs/practices and the continuation of positive outcomes in the context of a changing world. Implementation site leaders and practitioners must be aware of the shifting ecology and "adjust without losing the functional components of the evidence-based program or dying due to a lack of essential financial and political support."

Features of many successful implementation programs included a high level of involvement by program developers on a continuing basis and the utilization of a combination of active approaches to implementation (e.g., phone calls, fliers, and face to face invitations as part of outreach efforts). Several core implementation components of successfully implemented practices and programs were found throughout the research literature. "These components are *staff selection, preservice and inservice training*, *ongoing consultation and coaching, staff and program evaluation, facilitative administrative support, and systems interventions.* These interactive processes are integrated to maximize their influence on staff behavior and the organizational culture."

Source: Fixsen, D. et. al (2005), Implementation Research: A Synthesis of the Literature

References and Other Resources:

Bernfeld, G. A. (2001). The struggle for treatment integrity in a "dis-integrated" service delivery system. In G. A. Bernfeld, D. P. Farrington & A. W. Leschied (Eds.), *Offender rehabilitation in practice: Implementing and evaluating effective programs* (pp. 167-188). London: Wiley.

Fixsen, D. L., & Blase, K. A. (1993). Creating new realities: Program development and dissemination. *Journal of Applied Behavior Analysis, 26,* 597-615.

Institute of Medicine - Committee on Quality of Health Care in America. (2001). *Crossing the quality chasm: A*

new health system for the 21st century. Washington, D.C.: National Academy Press.
Washington State Institute for Public Policy. (2002). *Washington State's Implementation of Functional Family Therapy for Juvenile Off enders: Preliminary Findings* (No. 02-08-1201). Olympia, WA: Washington State Institute for Public Policy.