MHSOAC *School-Based Mental Health Services for Children in Early Education* Project
Protocol for Proposed Pilot Study
Draft June 26, 2017

Introduction

The *School-Based Mental Health Services for Children in Early Education* is a research project designed to collect information from stakeholders, the research literature, and innovative school-based models with demonstrated success, with the intent of developing policy recommendations to improve access and the delivery of mental health services for young school-aged children.

The project dates back to September 2014 when the Mental Health Services Oversight and Accountability Commission (MHSOAC) hosted a task force meeting of leaders in the fields of education and mental health, along with representatives from the California Endowment, Sierra Health Foundation, and the Blue Shield Foundation, to discuss the challenges and missed opportunities to effectively identify and help children in need of mental health services. Consensus was reached at this meeting that most current practices do not adequately support children demonstrating emotional and behavioral needs toward reaching their full academic potential and avoiding unnecessary placements in special education. Meeting attendees were supportive of alternative approaches, but indicated that a new model(s) must be based on empirical findings demonstrating promising outcomes from a well-designed pilot study.

In 2016, the MHSOAC began to institute and implement policy projects. The support for and structure of these projects provided the opportunity to prioritize "schools and mental health" as a topic area for the Commission to focus resources and staff efforts to collect information through public engagement activities and other means with the goal of developing an "action agenda" to potentially guide statewide legislative action or prioritize county services to better serve young students in California.

David Gordon, Sacramento County Superintendent of Schools, continued in his leadership role on the Commission in this area and was named as chair of the Schools and Mental Health project Subcommittee, and was joined by fellow Commissioners Richard Van Horn and Gladys Mitchell.

December 6, 2016 Site Visit and Subcommittee Workgroup Meeting

The project formally began in December 2016 with a site visit to Bell Avenue Elementary School in Sacramento, followed by a Subcommittee Workgroup meeting at the Greater Sacramento Urban League that included over 100 attendees from over 50 organizations.[1] In his introductory remarks at the Subcommittee Workgroup meeting, Commissioner and Subcommittee Chair David Gordon outlined four goals for the project:

1. Bring education and mental health partners closer together in the interest of providing higher quality, more timely services.
2. Encourage innovation in services for young children with mental health needs.

[1] Detailed summaries of the public engagement activities completed to date can be found at: http://mhsoac.ca.gov/projects.

3. Break the "fail first" paradigm; promote the earliest possible interventions with young people and families, including pre-school education.
4. Head off early learning problems from becoming life-long problems.

Introductory comments at the meeting were also provided by State Senator and Commissioner Jim Beall and Commission and Subcommittee member Gladys Mitchell who shared her lived experiences and stressed the importance of parents/caregivers as advocates for their children with mental health needs. Presentations were provided by experts in the areas of multi-tiered systems framework with a continuum of support for children and families. In addition, special education and school staff, and consumers shared their experiences with the scope and consequences of unmet mental health needs among young children.

January 26, 2017 Commission Meeting

A January 26, 2017, public hearing before the full Commission began with MHSOAC Commissioner and California State Superintendent of Public Instruction, Tom Torlakson, affirming the importance of the topic area and the ongoing support for the project by the California Department of Education. Next, subject matter experts, consumers, parents of consumers, and school staff testified before the full Commission on unmet mental health needs of children; perceived barriers to early intervention in schools; gaps in care and services; and evidence-based models and solutions.

The following seven components were identified at the public hearing as critical to successfully addressing children's mental health needs:

1. Multi-tiered system of supports
2. Integrated, coordinated services
3. Multi-disciplinary teams and decision making
4. Data-driven practices
5. Parent engagement
6. Cultural sensitivity
7. Trauma-informed staff

April 26, 2017 Site Visit

These components were a part of the models that were observed by Subcommittee members and others affiliated with the project during the December 6, 2016 site visit to Bell Avenue Elementary School, and the April 26, 2017 visit to Grant Elementary School in Richmond. For example, the Unconditional Education model that Seneca Family of Agencies implemented at Grant Elementary integrates a multi-tiered system of academic, behavioral, and social emotional supports into the school environment. All school staff are engaged to provide trauma-informed services to the entire student body and their families. The model relies on data to monitor the student population and identify those students in need of more targeted or intensive services, and ensure that students receive the least restrictive intervention at the earliest possible time. Program activities of the Unconditional Education model are in line with the goals of the MHSOAC project. Accordingly, the number of children eventually needing to be placed into special education due to emotional and behavior challenges should decrease, along with the resulting individual and societal negative consequences that have been documented in the research literature for these students.

The site visit included discussions with Ken Berrick of Seneca who developed the Unconditional Education model in collaboration with Seneca's education leadership team. Mr. Berrick noted that he anticipated that it will take approximately three years for the model implemented at Grant Elementary to reduce downstream costs through early intervention. Seneca presented information that other school districts were able to invest the savings to expand the program to additional schools at no additional cost.

Proposed Pilot Study

The remainder of this document outlines a proposed pilot study, as first conceived at the September 2014 task force meeting, based on information collected from project activities to date, and in partnership with researchers and practitioners from the evidence-based, multi-tiered model called Positive Behavioral Interventions and Supports (PBIS). The proposed study will include a more systematic collection of emotional and behavioral data and team decision-making based on this information. The primary intervention will be the establishment of "Integrated Intervention Teams" of school staff, parents, community partners, and others who will be provided with ongoing, in-person coaching, training, and technical assistance at 15 selected California elementary schools. Incorporating new, innovative project-specific strategies into the PBIS framework provide a number of advantages, including recruiting schools for the pilot that have demonstrated a willingness and support for new school-based approaches and being able to tap into data from existing reporting processes. Finally, the proposed study will be unique to the field in that it will assess facilitators and barriers to children and school outcomes in relation to community level factors, including the relationships between implementing schools/districts, county behavioral health departments, and service providers.

A number of community-level challenges were identified by stakeholders that result in delays or disruptions in children receiving mental health services. For example, no formal mechanisms for referrals and coordinating care with community mental health providers exist for children whose mental health needs require services outside of the school, or suspicion and implicit distrust in the relationship between schools and community mental health providers can impair their ability to effectively work together. Moreover, families and/or school personnel seeking timely services can encounter barriers such as long wait times or waiting lists for appointments.

The findings from the pilot study (as well as other project-related activities) have the promise of providing the Commission with information that could lead to a recommendation that similar services be expanded across California with the goal of better addressing students' mental health needs as early as possible.

Overview of Positive Behavior Interventions and Supports (PBIS)

PBIS was developed in the late 1980's by educational and behavioral experts at the University of Oregon in response to school discipline practices that were reactive, inconsistent, punitive, and ultimately, ineffective. During this time, "zero tolerance" policies were popular in education, with student suspensions and expulsions as common forms of discipline. With a foundation from behavior science, the developers of PBIS focused on shifting the school discipline paradigm from reactive toward proactive, positive approaches: teach and recognize behavior directly, school-wide, and for all students, and focus on changing adult behavior to be more positive, consistent, and predictable.

Across the country and in California, school pushout continues to be a problem. In the 2014-15 school year, approximately 420,000 California students were suspended (Fix School Discipline, 2017). Over 30% of these suspensions were for minor disruptive behavior, in some cases known as "willful defiance," with students of color and those with mental health disabilities disproportionately affected. PBIS can be effective in reducing suspensions. One study found that implementation of PBIS in K-12 grades resulted in a significant reduction in office discipline referrals and suspensions across 28 schools (Fix School Discipline, 2017).

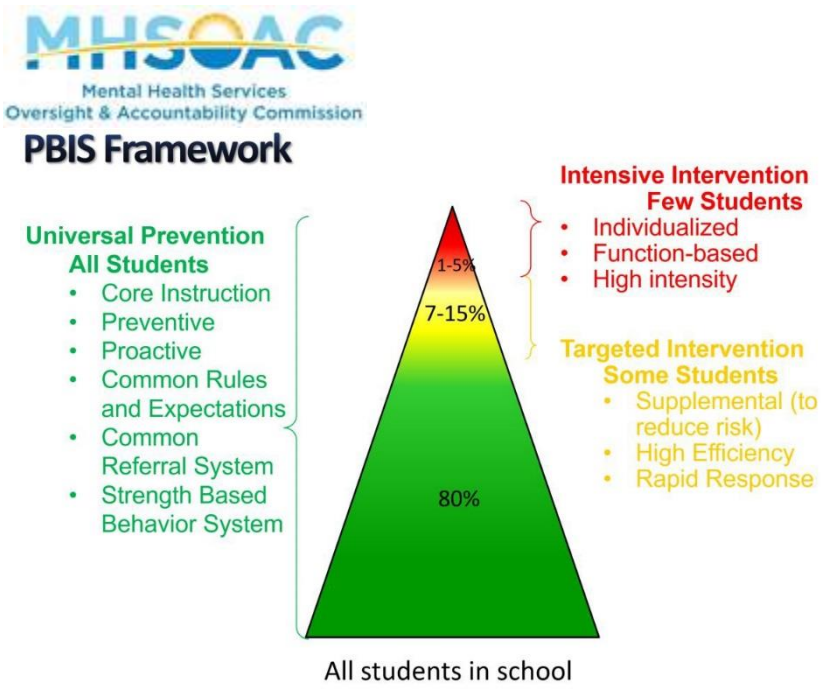
When PBIS is implemented correctly, system-wide changes within an individual school or across all schools within a district occur. A core component of PBIS is building an intervention team which consists of approximately 10 members from the participating school. Team members are often administrators, classified staff, counselors, regular and special education teachers, parents, and students. Multi-day trainings are provided by PBIS instructors to team members.

The primary intervention activity of PBIS is teaching students what are the expected behaviors in the same manner as they are taught any core curriculum subject. Each school selects three to five behavioral expectations that are positively stated and are designed to be easy for students to remember. In other words, rather than telling students what *not to do* (e.g. no talking in class, no cell phone use), PBIS emphasizes teaching students the behaviors or social skills that are expected from them, such as:

- Be Safe, Be Responsible, Be Respectful
- Achievement, Responsibility, Connection, and Safety

After the PBIS intervention team identifies three to five behavioral expectations, they will take their recommendations to the school staff to ensure that at least 80% are supportive of the chosen expectations. Consistency from class to class and adult to adult is very important for successful implementation of PBIS.

The positive, consistent, predictable, equitable, and safe school environment possible with PBIS is achieved through three tiers of implementation. This three-tiered framework is similar to the public health model of prevention, early intervention, and tertiary intervention. At Tier 1, the school implements school-wide practices and policies, such as the three to five behavioral expectations, an acknowledgement system for rewarding positive behavior, and a consistent and fair discipline system. At Tier 2, schools support students at risk with small group or targeted interventions, such as Check In, Check Out, or social emotional groups. At Tier 3, students with intensive needs receive mental health counseling, intensive behavioral support, or in some cases are referred for a special education assessment. Schools implementing PBIS will typically see 80% of students respond to the supports in Tier 1, 7% to 15% needing targeted intervention (Tier 2), and 1% to 5% needing intensive interventions (Tier 3). This tiered system is referred to as the PBIS framework, and is depicted in the figure below.



Implementation of PBIS occurs in phases to ensure that districts/schools have the capacity and infrastructure to support the necessary efforts, and that the later implementation of each tier meets fidelity (the framework was implemented as intended) criteria and provides a strong foundation for subsequent tiers. In other words, Tier 1 needs to be successfully in place before a school is ready to build their Tier 2 and 3 supports. Full implementation of PBIS Tiers 1, 2, and 3 usually takes at minimum three years.

Tier 2 and Tier 3 activities are reimbursable by either Medi-Cal or commercial insurance because they consist of services that can be considered medically necessary for an individual with a mental health diagnosis or the initial evaluation necessary to create such a diagnosis. Proper, full implementation includes a partnership with an insurance-covered private clinician for schools with a low percentage of Medi-Cal students or a partnership with a county-funded community mental health provider offering on campus services. This component is essential to making the program cost-effective and sustainable as well as maximizing the availability and utilization of other funding to minimize school costs. Universal supports (Tier 1) can be funded by utilizing non-Medi-Cal or private insurance revenue streams such as general education funds, Mental Health Services Act funds, Local Control Funding Formula funds, Special Education disproportionality funds, private grants, and more.

The first step prior to implementation activities is to have the districts assess their readiness and commitment to implement PBIS (e.g., buy-in, leadership approval, and action planning). A District Capacity Assessment (DCA) allows the district leadership and teams to reflect on their current processes and practices, and use this information to build an action plan for supporting innovations such as PBIS. In this exploration phase, a number of activities occur such as developing a district leadership team and identifying intervention teams and leads to facilitate PBIS implementation.

The following provides a brief overview of the PBIS implementation phases and some of the specific areas/activities addressed in each year. The California PBIS Network provides four-days of PBIS training each year in addition to ongoing, monthly consultation and coaching.

1. Year One – Tier 1
    - Developing school-wide rules and expectations, classroom expectations, and a consistent consequence system
    - Developing a data monitoring system to use for decision-making
    - Engaging families and communities
    - Establishing a Tier 1 intervention team

2. Year Two – Tiers 1 and 2
    - Enhancing classroom management of behavior
    - Identifying and implementing Tier 2 interventions and universal screening tools
    - Establishing a Tier 2 intervention team

3. Year Three – Tiers 1, 2, and 3
    - Identifying and implementing Tier 3 interventions
    - Establishing a Tier 3 intervention team (usually Tier 2 and Tier 3 are the same)
    - Developing behavioral support plans and person-centered plans (e.g., setting goals, collecting data)

At the end of each year, the district/school planning team completes the PBIS Tiered Fidelity Inventory (TFI) which provides scores on implementing the core features of Tier 1, 2, and 3. For example, at the end of Year II districts/schools would complete the TFI for Tiers 1 and 2 and receive a score for each tier. A score of 70% or above is considered to be an acceptable level of implementation that should theoretically result in improved student outcomes.

Empirical research indicates that implementation of (Tier 1) PBIS system is associated with sustainable changes in disciplinary practices and improved positive behavior among students (Barrett, Bradshaw, & Lewis-Palmer, 2008; Bradshaw, Horner et al., 2009). Quality implementation of school-wide PBIS has been linked with significant reductions in disruptive behaviors and improved social skill knowledge (Barrett et al., 2008; Horner et al., 2009; Metzler, Biglan, Rusby, & Sprague, 2001; Sprague, et al., 2001). Specifically, several studies, including two randomized controlled studies of school-wide PBIS in elementary schools, have shown that high quality implementation of the approach is associated with significant reductions in office discipline referrals and suspensions (Bradshaw, Mitchell, & Leaf, 2010; Horner et al., 2009) and other problem behavior (McIntosh, Bennett, & Price, 2011), such as teacher-ratings of classroom behavior problems, concentration problems, emotion regulation problems, and bullying (Bradshaw, Waasdorp, & Leaf, in press; Waasdorp, Bradshaw, & Leaf, 2012).

Significant improvements also have been observed in student reports of school climate (Horner et al., 2009; McIntosh et al., 2011), staff reports of the school's organizational health (e.g., principal leadership, teacher affiliation, and academic emphasis) (Bradshaw, Koth et al., 2008; Bradshaw, Koth, Thornton, & Leaf, 2009; McIntosh et al., 2011), teacher ratings of self-efficacy (Kelm & McIntosh, 2012; Ross & Horner, 2009), and academic achievement (Bradshaw et al., 2010; Horner et al., 2009; McIntosh et al., 2011).

The growing body of research studies provide evidence that PBIS has a positive impact on the following nine student- and school-level outcomes for students.

1. Increased academic performance
2. Increased attendance
3. Improved perception of safety
4. Reduction in bullying behaviors
5. Improved organizational efficiency
6. Reduction in staff turnover
7. Increased perception of teacher efficacy
8. Improved social emotional competence
9. Reduction in problem behaviors

The proposed pilot study for the *School-Based Mental Health Services for Children in Early Education* project will be able to reduce the need for unnecessary high-cost placements in special education and eventually reduce total placements through improved social emotional competence and reductions in problem behaviors. To date, research of PBIS has not included a focus on how community-level factors, such as the relationship between schools and county behavior health departments, influence student and school outcomes. Before we provide details on the proposed pilot study, including the assessment of baseline and changes in community-level factors, we present below a summary of PBIS within California.

PBIS in California

Over 2,400 California schools are currently actively engaged in implementing PBIS; the majority (n=1,519) are elementary schools and 233 are pre-K schools. Most schools have sought out and adopted PBIS from their own initiative or with the support and assistance from their district. The growth in the adoption of PBIS is associated with the development of the California PBIS Coalition (CPC), change in delivery of special education under AB114, Local Control Funding Formula (LCFF) and the School Climate Transformation Grant (SCTG). An important feature of PBIS is that at least annually schools self-assess the level of fidelity with which they are implementing the core features of Tier 1 (all students, all places, all times), Tier 2 (modest individual or group support), and Tier 3 (individualized, high-intensity support). The TFI is a validated measure for identifying the key features of implementation at each tier of support. The Office of Special Education and Planning, PBIS National Technical Assistance Center has determined that a score of 70% or better indicates successful implementation. During the 2016-17 academic year, of 99% of schools reporting Tier 1 PBIS self-assessments demonstrated fidelity scores at or above the 70% criterion.

Only some of the schools implementing PBIS are actually providing Tier 2 and Tier 3 services, which means identifying at-risk students and ensuring on-site access to necessary mental health services in order to prevent mental health challenges from becoming severe and disabling. Very few of the schools currently have an on campus clinician able to bill Medi-Cal or commercial insurance for the Tier 2 and Tier 3 services which makes them less cost-effective than they would otherwise be.

During the last four years there has been a targeted effort to integrate mental health and behavioral systems in California schools using PBIS. Federal Department of Education, School Climate

Transformation Grant awards were provided to 15 districts in California, the largest award in the nation. Regional PBIS TA Centers in supporting this growth the CPC has developed the capacity to align mental health and school behavior support systems.

Proposed Pilot Study: Introduction

The proposed MHSOAC pilot study will be implemented within 15 elementary and/or pre-K schools that have demonstrated PBIS Tier 1 fidelity. The study will differ from standard PBIS implementation in two important ways. First, the districts/schools will receive intense training, coaching, technical assistance, and evaluation supports to build an "Integrated Intervention Team" with outside county/community mental health agencies and to document implementation of an integrated behavior and mental health support framework. Second, community-level factors that facilitate or impede student and school outcomes will be assessed over the course of the study period. Each of these unique areas of study is explained below.

Proposed Pilot Study: Supports to Integrated Intervention Team

The primary intervention of the is project is to facilitate the development of an integrated intervention team supported by project consultants Michael Lombardo and experts from the Center for Social Behavior Supports (CSBS) who have been instrumental in conceptualizing the Interconnected Systems Framework (ISF). Through the unique lens of ISF, this integrated intervention team will be established as leaders within the education and mental health systems (i.e., key stakeholders), develop a shared mission and set of policies related to role and function of each partner across the district and school level for the proposed pilot study. This shared approach will be documented in memorandums of understanding (MOUs) and integrated action plans that clarify how the two systems will operate as one. Furthermore, these agreements will articulate how district and school teams function. To further facilitate the ISF single system approach, team members will engage in blended (i.e., education and mental health in tandem) professional development (PD) inclusive of training, technical assistance, and coaching; a multi-layered approach to PD found to best support adults in implementing strategies to impact student outcomes (Joyce & Showers, 2002). Professional development will occur in tandem so partners can simultaneously learn about one another's systems; understand the breadth and depth of mental health challenges; learn school and community approaches to identifying need; review expanded data; and select, implement, and evaluate (i.e., fidelity and impact) evidence-based intervention.

Data will inform teams and assist in the select prevention and intervention strategies, across the multi-tiered system of support, to promote mental health wellness for all students within the selected pilot schools. Essential to the ISF are expanded screening data inclusive of typical school data augmented by community data. Within the ISF, screening data will include using typical school measures (e.g., attendance, grades, office referrals, etc.), formal screening tools and procedures (e.g., identify externalizing and internalizing concerns), and community data (e.g., number of families with open child welfare cases, poverty rates, food pantry visits, number of families who access behavioral health for crisis, etc.). The integrated intervention team will use these data to inform the universal social emotional curriculum and selection of interventions matched to group or individual student need. Team members will provide PD (i.e., training, coaching, and supporting fidelity) to those individuals delivering the interventions. The ISF process will go beyond student access by guiding teams to systematically monitor the number of students receiving each available intervention; implementation fidelity of each

intervention; and student progress towards desired outcomes. To date, the ISF has been disseminated via a monograph (www.pbis.org; Barrett et al., 2013); and through a national workgroup targeted to create knowledge development sites; provide structured training and TA via webinar; develop, test, and refine implementation tools; and to produce publications and presentations. This work has led to the development of a preliminary curriculum and implementation tools that will be used and further developed through this project.

For this pilot study, five state-level PBIS Coalition members will be identified and form a Specialized Coaching Unit (SCU). Each member will be assigned to a district/school/community to train, mentor, and coach throughout the project. The Center for Social Behavioral Support, will hold two to four days of planning and readiness development for the SCUs to prepare them for working with the study participants. In implementation Years 1 & 2, the CSBS and SCU will provide four-day school-based training for the school/community Integrated Intervention Teams followed by three to five onsite visits, five webinars, monthly meetings, and technical assistance calls to support the Integrated Intervention Teams.

Proposed Pilot Study: Community-Level Factors

To meet the complex needs of students requires an integrated system where both schools and community mental health can efficiently deploy prevention and interventions efforts. Families must also be able to access appropriate mental health services outside the school -- within the community -- to fully address the mental health needs of young student population. Access may be limited by the unavailability of services within the community, lack of knowledge among school staff that such services are available, or additional factors such as uncooperative relations between the staff at schools and service organizations and funding obstacles that impede referrals and/or linkages for needed services.

The proposed pilot study will assess the potential for the intervention to improve relations between schools and organizations that provide services that could address the mental health needs of the target populations, and how these relations impact students and school outcomes. The services could be provided through the county behavioral health department or their funded provider agencies, or by community-based agencies not receiving county support.

Proposed Pilot Study: Assessing Outcomes

Outcomes from PBIS can be observed at the community, district, school, and student levels. Table 1 displays the district, school, and student outcomes that will be assessed.

Community-Level Outcomes. For the proposed pilot study, these measures will be assessed by administering a brief questionnaire to key staff (e.g., counselors, nurses, school psychologists, school social workers, principals) at the selected schools at the beginning of the pilot study and every six months thereafter to assess changes over time. The items will assess knowledge of all services available within the community, the perceived relationship with each service provider, and the degree to which the schools utilizes the services of each provider for on-site services or referrals.

Table 1. District, School, and Student Outcomes from PBIS

Level	Outcome	Instrument or Data Systems	Source of Data	Frequency of Completion or Submission
District	Capacity to Implement ISF	District Capacity Assessment	External evaluator assessment with District Leadership Team	At least once per year, preferably twice per year
School	Fidelity of implementation	Tiered fidelity inventory	District coach with school leadership team	Three times per year (Full Tiers 1, 2, 3) in fall then target tier in Jan and May
	Student social behavior	School-Wide Information System	School personnel	Continuous
	Student academic behavior	Standardized academic measures (Smarter Balance)	School testing process	Annual (more often if progress monitoring is used
	School climate	California school climate survey	Staff Survey	Annual
Student	Social Emotional Learning	SSRS, or equivalent	Student report	Annual
	Graduation	School records	School data system	Annual
	Risk of Juvenile Justice contact	Juvenile justice records	Juvenile justice records	Annual

Student-Level Outcomes:

- Office discipline referrals
- Suspensions
- Expulsion
- Attendances
- School social climate
- School referral to special education
- School placements in special education for children with emotional and behavior needs

These outcomes will be available for students. The available data will allow for analyses specific and in comparison with those students with disabilities and students of color.

The study will also include detailed information on the cost of each component of the program and a cost-benefit analysis that compares special education costs before and after implementation and also in comparison to other similar schools which have not implemented the proposed intervention activities.

The study will also include a how-to manual that describe the steps for development and implementation.

Proposed Pilot Study: Selection and Recruitment of Schools

As previously discussed, elementary and pre-K schools that have demonstrated successful implementation of Tier 1 activities will be eligible for study participation. An analysis of this data by the California PBIS Coalition in April 2017 revealed that 536 schools had TFI scores of 70% or better. Table 2 shows the distribution of these schools by rural versus urban location and the number of schools with pre-K.

Table 2. California Elementary Schools Achieving PBIS Tier 1 Fidelity by County Superintendent of Schools Regions Overall and by Rural or Urban Area, April 2017

Region*	Number of Schools Overall	Number of Rural Schools	Number of Urban Schools	Number of Schools with Pre-K
1	11	11	0	5
2	13	8	5	2
3	19	5	14	10
4	130	10	120	64
5	31	3	28	14
6	7	2	5	2
7	32	19	13	10
8	43	3	40	18
9	63	0	63	19
10	87	34	53	38
11	100	13	87	51
Total	536	108 (20.1%)	428 (79.9%)	233 (43.5%)

* County Office of Education Superintendent Service Areas

The process of identifying those elementary and pre-K schools to approach for study participation will be based on factors such as urban and rural geographic location across the State. Selection of schools might for example be based on the distribution of schools across the 11 County Office of Education Superintendent Service Areas.

Estimated Project Budget: Year 1

Cost Area	Activities	Projected Cost
Training and Technical Assistance/Coaching to Selected Schools to Support Integrated Intervention Teams	• Assist MHSOAC with project oversight and coordination • Assist in recruitment of districts and schools • Technical Assistance (TA) and coaching support for 15 selected schools, in-person, webinar support, and telephone consultation (estimated 123 days across the schools) • Training and coaching of districts, schools, public agency and community providers • Training and coaching of California ISF trainers for sustainability and replication • Within-State travel and lodging	$345,000
Support to Schools	Support to selected schools for implementing data systems for decision making and for fidelity intervention. These include: • School Wide Information System (SWIS) – assists schools to collect, summarize, and use student behavior data for decision making • District Capacity Assessment (DCA) - action assessment designed to help educational district leaders and staff better align resources with intended outcomes and develop action plans to support the use of effective innovations. • PBIS Assessment (Tier Fidelity Inventory) - improves the efficiency and accuracy with which surveys can be used to complete four purposes: 1. Initial assessment of discipline practices to determine how SWPBIS should be adopted 2. Implementation assessment of the fidelity with which schools use SWPBIS procedures 3. Sustained assessment of SWPBIS implementation at all three tiers to promote ongoing use of core SWPBIS features 4. Assist in designing action plans to improve implementation fidelity	$37,500
Evaluation	Evaluation cost will include the analysis and reporting by the National Technical Assistance Center to the MHSOAC and stakeholders.	$1,000

Proposed Pilot Study: Timeline

Activities	Date
Project Subcommittee Workgroup meeting	June 30, 2017
Summarize feedback from meeting	July 5, 2017
Incorporate feedback into protocol	July 11, 2017
Present study to full Commission	July 27, 2017
Project kickoff and planning meeting	Aug 2017
Finalize budget, subcontracts, staffing model, and personnel	Sept 2017
Develop manual of operations	Sept 2017
Develop Interconnected Systems Framework (ISF) materials	Sept 2017
Select and recruit districts, schools, and county/community mental health providers	Nov-Dec 2017
Provide training to trainers and technical assistance	Nov-Dec 2017
Provide initial training	Jan-Feb 2018
Ongoing in-depth training and team building	Mar-Apr 2018
Planning and coordination in preparation for school year	May-July 2018
Launch PBIS – ISF with on-going technical assistance	Aug-Sept 2018
Monthly technical assistance to schools, districts, and county/community providers	Sept 2018-May 2019
Initial analyses and interpretation of findings	May-July 2019
Final report to Commission	July 2019
Final analyses and interpretation of findings	May-June 2020
Supplemental report to Commission	July 2020


COMPLETION DATE
ACTIVITIES
06/30/17
07/05/17
07/11/17
07/27/17
08/01/17
09/01/17
11/01/17
12/01/17
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05/01/18
07/01/18
Project Subcommittee Workgroup meeting
Summarize feedback from meeting
Incorporate feedback into protocol
Present study to full Commission
Project kickoff and planning meeting
Finalize budget, subcontracts, & staffing
Develop manual of operations
Develop Interconnected Systems Framework (ISF) materials
Select & recruit districts, schools, & community MH providers
Provide training to trainers & TA
Provide initial training
On-going in-depth training and team building
Planning & coordination in preparation for school year
Launch PBIS - ISF with on-going TA
Monthly TA to schools, districts, & county/community providers
Initial analyses & interpretation of findings
Final Report to Commission
Final analyses & interpretation of findings
Supplemental report to Commission

References

Barrett, S.B., Bradshaw, C.P. & Lewis-Palmer, T. (2008). Maryland statewide PBIS initiative: Systems, evaluation, and next steps. Journal of Positive Behavior Interventions, 10, 105-114.

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(2), 100-115.

Bradshaw, C.P., Koth, C.W., Bevans, K.B., Ialongo, N., & Leaf, P.J. (2008). The impact of school-wide Positive Behavioral Interventions and Supports (PBIS) on the organizational health of elementary schools. School Psychology Quarterly, 23(4), 462-473.

Bradshaw, C. P., Mitchell, M. M., & Leaf, P. J. (2010). Examining the effects of School-Wide Positive Behavioral Interventions and Supports on student outcomes: Results from a randomized controlled effectiveness trial in elementary schools. Journal of Positive Behavior Interventions, 12, 133-148.

Bradshaw, C.P., Reinke, W. M., Brown, L. D., Bevans, K.B., & Leaf, P.J. (2008). Implementation of school-wide Positive Behavioral Interventions and Supports (PBIS) in elementary schools: Observations from a randomized trial. Education & Treatment of Children, 31, 1-26.

Bradshaw, C., Waasdorp, T., Leaf. P. (in press). Effects of School-wide positive behavioral interventions and supports on child behavior problems and adjustment. Pediatrics.

Horner, R., Sugai, G., Smolkowski, K., Eber, L., Nakasato, J., Todd, A., & Esperanza, J. (2009). A randomized, wait-list controlled effectiveness trial assessing school-wide positive behavior support in elementary schools. Journal of Positive Behavior Interventions, 11, 133-145.

Kelm J. L., McIntosh K. (2012). Effects of school-wide positive behavior support on teacher self-efficacy. Psychology in the Schools, 49, 137-147.

McIntosh, K., Bennett, J., & Price, K. (2011). Evaluation of social and academic effects of school-wide positive behaviour support in a Canadian school district. Exceptionality Education International, 22(1), 46-60.

Metzler, C. E., Biglan, A., Rusby, J. C., Sprague, J. R. (2001). Evaluation of a comprehensive behavior management program to improve school-wide positive behavior support. Education and Treatment of Children, 24, 448-479.

Ross, S. W., & Horner, R. H. (2009). Bully prevention in positive behavior support. Journal of Applied Behavior Analysis, 42(4), 747-759.

Sprague, J., Walker, H., Golly, A., White, K., Myers, D., & Shannon, T. (2001). Translating research into effective practice: The effects of a universal staff and student intervention on indicators of discipline and school safety. *Education and Treatment of Children,* 24(4), 495-511.

Waasdorp, T., Bradshaw, C., & Leaf, P. (2012). The Impact of Schoolwide Positive Behavioral Interventions and Supports on Bullying and Peer Rejection: A Randomized Controlled Effectiveness Trial. Archive of Pediatric Adolescent Medicine. 2012; 166(2), 149-156.