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## Editors' Corner

### The Importance of School Behavioral Health in 2017

Advancing any program or initiative in the United States will interface with federalism, or the fact that states and local entities share power with the federal government (Weist & Paternite, 2006). In many circumstances, this can result in a patchwork of initiatives with strength in some communities, no progress in others, and a variety of other scenarios in between. This has certainly been the case for school behavioral health (SBH) programs and initiatives. As presented throughout this series of four special issues of the *Report on Emotional & Behavioral Disorders in Youth (EBDY)*, we use the term SBH to reflect more comprehensive school mental health (SMH) efforts working closely with Positive Behavioral Interventions and Supports (PBIS) toward greater depth, quality, and impact in promotion/prevention (Tier 1), early intervention (Tier 2), and intervention within multitiered systems of support (MTSS; Barrett, Eber & Weist, 2013; Weist & Stevens, 2017). Related to federalism, there is significant variability in SMH and PBIS among the U.S. states, and for the most part, these initiatives are not working together as effectively as with well-done SBH (Barrett et al., 2013; Splett et al., 2014).

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Progress in SBH, as in any other movement, is also affected by changes in government, such as have recently occurred in the United States. The lead article of this special issue, by George Sugai and colleagues from the University of Connecticut and the University of North Carolina, discusses how recent changes in government and the political climate are influencing school environments. The generally divisive nature of the political climate in the United States is concerning for many people. However, Sugai and colleagues argue that this climate should in no way represent a barrier to the advancement of our work in schools to improve students' social, emotional, behavioral, and academic (SEBA) functioning, but should, instead, be an impetus for amplified efforts to assure the quality of multitiered promotion/prevention, early intervention, and intervention.

Indeed, this agenda should be viewed as *nonpartisan* because it is about children and youth, optimizing their functioning in SEBA domains and increasing the likelihood that they will graduate from high school, go on to college and/or specialized training, and become productive and contributing members in society, with many benefits to this trajectory, including significant economic benefits for the nation (Aos et al., 2004; Kuklinski et al., 2012; Slade et al., 2009). It should also be noted that there has been very significant federal, state, and local investment in all of the interrelated frameworks of SBH, SMH, PBIS, and MTSS, with leadership from both Republican and Democratic

administrations—e.g., President Bush's Achieving the Promise: Transforming Mental Health Care in America initiative (New Freedom Commission, 2003) and President Obama's Now Is the Time initiative (U.S. Whitehouse, 2013).

### National Climate Change: Doubling Down on Our Precision and Emphasis on Prevention and Behavioral Sciences

This special issue of *EBDY* underscores the critical importance of SBH and related frameworks in 2017. The issue opens with a very compelling article by George Sugai and colleagues, who discuss the need for “doubling down” our efforts to implement PBIS and other programs with precision and to emphasize behavioral science foundations within the context of current challenges in the national climate. The authors summarize the tenets of the highly successful and influential PBIS framework now being implemented in more than 23,000 U.S. schools ([www.pbis.org](http://www.pbis.org)) and make a cogent call for proactive leadership. Indeed, the significant base of knowledge and experience of PBIS represents a powerful and positive platform for both stabilizing programs and preparing for growth in the years to come. Two very prominent themes in the article by Sugai et al. are the emphasis on intervention fidelity and on proactive responses in prevention and intervention to address bullying, primary themes of the two other articles in the issue.

### From Good Intentions to Great Implementation

The second article in this issue is by Allison Bruhn, from the University of Iowa, and Shanna Hirsh, from Clemson University. They discuss the importance of treatment integrity, a synonym for implementation fidelity, and/or treatment fidelity for effective PBIS/MTSS efforts. All staff who work in schools, including educators, school psychologists, counselors, social workers, and others are charged with implementing evidence-based practices. These staff often receive inadequate support for these practices, however, and efforts to promote treatment integrity may not be purposeful or consistent. Building from their experience with the useful and pragmatic framework of the Treatment Fidelity Model for Implementation, the authors describe dimensions of treatment integrity, the importance of data-based decision making, and suggestions for overcoming challenges to optimal implementation. For PBIS/MTSS efforts to realize their potential for improving school-level and student-level outcomes, emphasis on treatment integrity is foundational, and Bruhn and Hirsh's article is an important resource for the field.

### Causes and Consequences of Social Exclusion and Peer Rejection Among Children and Adolescents

The issue concludes with an article by Kelly Lynn Mulvey, with graduate students Jiali Zheng and Corey Boswell, of the

#### REPORT ON

## Emotional & Behavioral Disorders in Youth™

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University of South Carolina. They discuss the causes and consequences of interpersonal and intergroup social exclusion among students. Children and adolescents frequently experience both interpersonal and intergroup exclusion or peer rejection, which can have serious and lasting consequences for children's development and functioning and success in SEBA domains. The authors suggest an approach for encouraging students who have been "excluders" or "observant bystanders" to adopt inclusive attitudes and welcoming behaviors toward other students who exhibit differences. The article offers a new lens through which to view social exclusion and bullying, suggesting important new directions for practice and research.

### Improving Programs and Services Amid Opportunities and Challenges

Most academic articles do not purposefully situate presented themes in relation to recent history and the current social, ecological, and political context, despite the importance of such an analysis (Cottrell & Kraam, 2005; Glied & Cuellar, 2003; McLeroy et al., 1988). George Sugai and colleagues provide such an analysis in their exceptional article and call for those involved in SBH, PBIS, and related fields to move from "rumination" to action amid opportunities and challenges to improve programs and services for children and youth in 2017. Building from the article

by Sugai and colleagues, Bruhn and Hirsh, and Mulvey and colleagues present ideas and action strategies for improving implementation/treatment integrity and assuring that innovative approaches reach all youth in need, with special consideration for those experiencing exclusion. In many ways, these three linked articles present a microcosm of critical themes playing out in our nation. We hope they are as helpful in engendering positive actions in research, policy, and practice in your communities as they are in South Carolina and the southeastern United States (see [www.schoolbehavioralhealth.org](http://www.schoolbehavioralhealth.org)).

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—Mark D. Weist

([weist@mailbox.sc.edu](mailto:weist@mailbox.sc.edu)) and

Robert Stevens

([Robertnstevens@comcast.net](mailto:Robertnstevens@comcast.net)) ■

### A Note From the Publisher

Mark D. Weist, Ph.D., is a professor in the Department of Psychology at the University of South Carolina. Prior to joining USC, he was on the faculty of the University of Maryland School of Medicine, where he helped to found and direct the Center for School Mental Health, one of two national centers providing leadership for the advancement of school mental health (SMH) policies and programs in the United States. Dr. Weist has published and presented widely in the SMH field and has edited or coedited nine books.

Robert Stevens, Ph.D., is coordinator of Stakeholder Engagement for Health Sciences South Carolina (HSSC), leadership team member of the South Carolina Association for Positive Behavior Support Network, and patient investigator for the Mid-South Clinical Data Research Network at Vanderbilt University.

Professor Weist will lead the School Behavioral Health Dissemination and Engagement Project within the School Mental Health Team (SMHT) of USC's Department of Psychology, with co-director Stevens providing leadership of the project through his role as leadership team member of the South Carolina Association for Positive Behavior Support Network. The Civic Research Institute is pleased to welcome Professors Weist and Stevens as coeditors of this third of four consecutive issues of *EBDY*.

### From the Editors

Work on this four-issue volume of the *Report on Emotional & Behavioral Disorders in Youth* (Winter, Spring, Summer, Fall 2017) is supported by a grant from the Patient-Centered Outcomes Research Institute (PCORI) through the Eugene Washington Conference Award for the School Behavioral Health Dissemination and Engagement Project (#EAIN 2874; 2016–2018). We also convey our appreciation to the South Carolina Department of Mental Health and to the South Carolina Department of Education for their support of the community of practice and conference, and for efforts to link together education and mental health priorities and strategies through well-executed SBH programs. Finally, thanks are extended to Josh Bradley, Allison Farrell, Lee Fletcher, Elaine Miller, and Ashley Quell of the University of South Carolina School Behavioral Health Team, and to the Civic Research Institute for the opportunity to publish these four consecutive issues of *EBDY*.



# National Climate Change: Doubling Down on Our Precision and Emphasis on Prevention and Behavioral Sciences

by George Sugai, Jennifer Freeman, Brandi Simonsen, Tamika La Salle, and Dean Fixsen\*

## National Climate Change

Communities, families, and schools are witnessing and experiencing the social and political effects of the culmination of a fierce and contentious U.S. presidential election campaign and the even greater impact of a significant change in the composition, organization, and functioning of the judicial, executive, and legislative branches of the U.S. government. In response, public reaction and activism have escalated in forms and intensities that have not been experienced in recent decades. Social media have become major outlets for individual and group voices. Informal and formal groups have increased their levels of advocacy, activism, and visibility.

Although we acknowledge and praise the rights of individuals and groups to exercise freedoms of speech, press, assembly, religion, and petition, we are troubled by some of the contentious, hostile, malicious,

hurtful, and derogatory forms in which these freedoms are being expressed. Recent headlines have highlighted the dangerous side effects of a divided nation, where hate is not only being modeled and reinforced on a national stage, but is also spilling into classrooms and schools (Southern Poverty Law Center, 2016a, 2016b). Reports of bullying incidents and hate crimes have sharply increased in schools (e.g., CBS News, November 13, 2016; PBS NewsHour, November 11, 2016; Wallace & LaMotte, November 30, 2016) and communities (Bailey, November 14, 2016) during and following this election season. The Southern Poverty Law Center (2016a) reported that 21% of the 861 post-election hate incidents occurred in K-12 schools, and numerous reports indicate an increase in demand for mental health support for teens and adults since the election (e.g., Market Watch, November 12, 2016, CBS Chicago, November 13, 2016, KNPR, December 9, 2016).

These conditions present educators with significant and immediate challenges in supporting students while facing their own feelings of stress, confusion, and lack of preparedness. Students are arriving at school anxious, upset, scared, stressed, or angry. Although some students successfully and productively move through their day, others display signs of withdrawal, anxiety, depression, or other mental health concerns. In addition, students may bring hurtful speech and actions into school, be victimized by hurtful acts, or be bystanders watching others experience hurtful conduct and often experiencing adverse reactions themselves.

In June of 2016, Sugai, Horner, and Lewis suggested that a two-prong prevention approach was needed to address the many significant challenges confronting educators in schools. They described the first, long-vision prong as an emphasis “on prevention that requires a systematic and deliberate implementation of daily proactive practices,” and the second, short-vision prong as “an emphasis on implementation of immediate and daily prevention

practices—that is, what do we do every day, all day, and across all school settings to reduce the likelihood of minor and major behavior incidents and increase the probability of displays of prosocial behavior.” For short- and long-term prevention practices to be effective, the authors suggested that equal, if not more, attention should be focused on the systems that maximize staff capacity to implement these practices with the greatest fidelity over the longest periods of time.

## Doubling Down Now With Prevention and Behavioral Science

Given these dramatic changes in our national, community, and school climates, we suggest that educators and school mental health professionals must not wait until students demonstrate signs of stress, trauma, and mental illness that are associated with incidents of discrimination, bullying, harassment, and exclusion. We should not assume that students and their families have or will develop the capacity to respond to and address these incidents and their effects. We must act *now* and *proactively* to address students’ social, mental, and behavioral needs; to bolster positive school climates so that learning can occur; and to firm up our relationships with students to ensure that they feel safe, appreciated, and respected.

Acting now is important and doable for several frequently promoted reasons. First, schools often serve as the de facto mental health support system for students. Providing all students with a safe, predictable, and positive environment is critical and often a prerequisite to effectively addressing many mental health concerns (Bazelon Center, 2006). Second, implementing basic positive and proactive practices works (Horner et al., 2015). When these key practices are implemented well, students’ social, emotional, behavioral, and academic outcomes improve. Finally, by implementing positive, proactive practices, schools can more effectively support students who may experience greater difficulties and require additional support (Forman et al., in press; Kutash et al., 2006; Walker et al., 2005).

*\*George Sugai, Ph.D., is a professor in the University of Connecticut’s Neag School of Education, a research scientist in its Center for Behavioral Education and Research (CBER), and codirector of the Center on Positive Behavioral Interventions and Supports. Jennifer Freeman, Ph.D., is an assistant professor in the Neag School of Education. Brandi Simonsen, Ph.D., is an associate professor in the Neag School of Education and codirector of CBER. Tamika La Salle, Ph.D., is an assistant professor in the Neag School of Education and a research scientist at CBER. Dean Fixsen, Ph.D., is a professor in the University of North Carolina’s Gillings School of Global Public Health. Professor Sugai can be reached by email at [george.sugai@uconn.edu](mailto:george.sugai@uconn.edu).*

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*Portions of this manuscript are based on and taken from a practitioner’s guide developed by the authors for the Office of Special Education Programs Center on Positive Behavioral Interventions and Supports. See <http://www.pbis.org/Common/Cms/files/pbisresources/Positive%20and%20Proactive%20Strategies%2031%20Jan%202017.docx>.*

Over the last three decades, the value, evidence, and features of prevention and behavioral sciences have been recommended as the first line of action for affecting the incidence and prevalence of problem behaviors and societal challenges (Biglan, 1995; Biglan et al., 2012; Mayer, 1995; Walker et al., 1996). In 2015, Biglan presented convincingly that we have well-documented practices grounded in behavioral science that can improve some of the most pressing challenges of our present-day society and culture. More importantly, he emphasized that these practices are only as good as our capacity to implement them within a *nurturing* prevention science approach.

In this article, we suggest that the challenges of the past and present are clear and that now is the time to double down on promoting practices that we know work and have the greatest likelihood of being implemented with fidelity over time in classrooms and schools. Specifically, although we acknowledge that a diverse range of effective practices and interventions exists, we propose that educators must select practices that can be done daily with high levels of fidelity and sustainability and that have the greatest likelihood of producing observable and educationally meaningful outcomes (Horner et al., in press; Sadler & Sugai, 2009). Thus, we present a set of principles that guide the selection and use of an explicit set of prevention and behavioral practices and systems for all classrooms and schools.

### **Starting With Effective and Efficient Implementation Capacity**

Given the wide array of evidence- and non-evidence-based choices, the selection and use of academic and behavioral support practices must be informed and justified. Recent emphasis has been on investing in comprehensive implementation frameworks (e.g., multitiered systems of support, response to intervention, Positive Behavioral Interventions and Supports [PBIS], integrated systems frameworks) that organize multiple practices and interventions and give us the means to improve decision making (Sugai et al., 2016). Across these systems, a number of shared principles guide practice selection and implementation efforts. Central to these systems is the establishment of a leadership team that is responsible for operationalizing these principles and administering practice use. This leadership team has a number of important characteristics.

First, a leadership team must have representation from the organization that is charged with practice selection and

implementation. Although variation exists across school size, level, and type, membership is represented generally by individuals who will be asked to implement a given practice, for example, grade-level teachers, non-teaching staff (e.g., paraprofessional, office, custodial), related specialists (e.g., nursing, special education, counseling, speech, school psychologists), and administrators. At the middle and high school levels, departmental representation (e.g., science, arts, counseling) may replace grade-level representation. Parental and student membership and voice are strongly recommended; however, given concerns related to confidentiality and

knowledge and fluency related to characteristics, implementation, and evaluation of effective behavioral practices and systems, especially as they relate to current behavioral issues, prevention, and behavioral sciences. The important interactive association of academic, behavioral, and mental health practices and outcomes should be explicitly targeted by the team and prioritized by the staff as a whole.

Finally, leadership team decision making, implementation management, and progress evaluation should be guided by principles that maximize durable intervention fidelity, maintain positive classroom and school

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## ***The goals are to align system structures, integrate system resources, and leverage system functions to maximize supports for effective teacher interactions with students.***

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privacy, ad hoc (as needed) involvement may be appropriate. Individual members should indicate their commitment to the indicated purpose and expected outcomes, to active participation, and to supporting the colleagues they represent.

Second, this leadership team must have the authority to make school-wide decisions and to develop and coordinate a three- to five-year implementation action plan. This authority may require a careful mapping of existing and upcoming initiatives and decisions regarding priority, alignment, and integration. Given the immediacy of the current national school climate change, behavioral prevention and intervention efforts should be among the top two to three school improvement targets if intervention fidelity and sustainability are to be maximized. Leadership team responsibilities include (1) revising and writing of policy and implementation procedures, (2) shaping professional development content and schedules, (3) establishing a regular and protected meeting schedule, (4) securing funding to cover implementation activities, and (5) scheduling regular opportunities to report and engage at faculty and staff meetings. District-level commitment and support (e.g., policy, expert personnel, procedures, funding) that are aligned with and enabling of school efforts are also critical to leadership team authority.

Third, the collective membership of the leadership team should have content

climate priority for all students and staff and family members, and boost student outcomes. The goals are to *align* system structures, *integrate* system resources, and *leverage* system functions to maximize supports for effective teacher interactions with students. A sample of these guidelines is included in Table 1.

### **An Explicit Set of Evidence-Based Prevention and Behavioral Practices**

Given the foundations of capacity development, leadership team, and guiding decision-making principles, the next priority is the selection and use of effective prevention and behavioral practices, strategies, and interventions that are experienced directly by students. Generally, for example, the Southern Poverty Law Center (2016b, p. 13) recommends that school administrators should (1) “set the tone . . . to affirm your school’s values, set expectations about inclusion and respect, and explain your vision for the school community,” (2) “take care of the wounded . . . to provide for the needs of specific students . . . some [of whom] are experiencing trauma,” (3) “double down on anti-bullying strategies . . . everyone can be an ally and upstander,” (4) “encourage courage . . . to speak up when they see or hear something that denigrates any member of the school community,” and (5) “be ready for a crisis . . . you will not have time to learn how to manage it: . . . be prepared.”

**Table 1: Maximizing Supports for Effective Teacher Interactions With Students**

Guiding Implementation Principles	Example Decision-Making Questions
1. Align and integrate academic and behavior supports.	<ul style="list-style-type: none"> <li>Do all staff and students understand and act based on the reciprocal relationship between academic and social behavior success?</li> <li>Are comparable decisions made for both academic and social behavior outcomes?</li> <li>Are implementation supports for academic and behavioral interventions used to promote and encourage the use of effective interventions by teachers and staff?</li> </ul>
2. Invest in prevention first.	<ul style="list-style-type: none"> <li>How do <i>all</i> staff members support <i>all</i> students in <i>all</i> settings to increase the likelihood of desired outcomes and reduce the risk for all students?</li> <li>If not occurring yet, how can we reduce the probability that it will happen?</li> <li>If just starting to occur, how can we reduce its impact (intensity, frequency, impact, duration)?</li> <li>If occurring, how can we prevent it from worsening (intensity, frequency, impact, duration)?</li> <li>If occurrences are chronic, what can we do differently that is more targeted and/or indicated?</li> </ul>
3. Use local data to understand and address pressing questions, needs, concerns, and challenges.	<ul style="list-style-type: none"> <li>What is happening?</li> <li>How often is it happening?</li> <li>Where is it happening?</li> <li>Who is involved?</li> <li>Why is it happening?</li> <li>What would we like to see happening instead?</li> <li>What are we doing now and how well?</li> </ul>
4. Screen regularly and monitor progress continuously.	<ul style="list-style-type: none"> <li>Do we have any students who present indications of possible risk and/or who display high-risk behaviors that are unresponsive to existing supports?</li> <li>Do we conduct classroom and school-wide behavior and mental health screening procedures at least monthly?</li> <li>Do we monitor student progress on (a) school-wide expectations weekly and (b) individual behavior expectations at least daily?</li> </ul>
5. Give priority to selection and use of empirically supported practices that are contextually appropriate.	<ul style="list-style-type: none"> <li>What quantitative and replicated research documents effectiveness of a practice?</li> <li>Under what conditions and context was practice documented?</li> <li>How strong is the alignment between the research outcomes and our needs?</li> <li>How similar/different are the implementation conditions of the research and our applied setting/context?</li> <li>How does this practice align, conflict, integrate, etc., with our current practices?</li> <li>How does this practice directly and efficiently address our current needs?</li> </ul>
6. Organize high fidelity use of practices and systems in a multitiered system of supports.	<ul style="list-style-type: none"> <li>Are all students explicitly taught (e.g., defined, modeled, practiced, reminded, reinforced) school-wide behavioral expectations in classroom and non-classroom settings?</li> <li>Are decision rules in place for timely identification of students who need more targeted and/or indicated behavior supports?</li> <li>Are school-wide, small-group, and individual behavior support practices sequenced and aligned?</li> </ul>
7. Consider culture and context in practice and implementation decisions.	<ul style="list-style-type: none"> <li>Has culture been broadly considered and explicitly defined (e.g., gender, religion, race, neighborhood, family, disability, LGBTQ, SES, education)?</li> <li>Has the district/school/faculty communicated a clear commitment to promoting and protecting diversity (e.g., gender, religion, race, neighborhood, family, disability, LGBTQ, SES, education)?</li> <li>Have individual and school-wide staff learning and cultural histories and their influence been reviewed and reconsidered?</li> <li>Have individual and group student learning and cultural histories and their influences been reviewed and reconsidered?</li> <li>Have strategies and perspectives been implemented that consider and improve the interaction of student and staff and family members?</li> </ul>
8. Embed professional development and use into the regular routines of schools and classrooms.	<ul style="list-style-type: none"> <li>Do we use one-time professional development events to establish agreement about need, solution, and implementation action plan?</li> <li>Do we develop action plan activities that embed development of implementation accuracy and fluency into existing scheduled opportunities (e.g., grade level/department meetings, all staff meetings, shared electronic communication systems)?</li> <li>Do we provide ongoing explicit training in key prevention and behavior support practices for all staff?</li> <li>Is coaching done to support teacher and staff use of academic and behavioral practices?</li> <li>Is fidelity of the use of interventions done regularly with the data used to improve supports for teachers and staff?</li> </ul>
9. Establish sustainable, fluent, and local behavioral expertise.	<ul style="list-style-type: none"> <li>Do we have formal systems (i.e., teams) at the school-wide level for maintaining high intervention fidelity of Tier 1 prevention practices for all students and staff across all school settings?</li> <li>Do we have formal specialized behavior support expertise for continuous use and monitoring of targeted group and indicated individual behavior supports?</li> <li>Do the district and/or region have formalized systems and expertise to support school level use of a full continuum of behavior support?</li> </ul>



More specifically, the focus is on achieving educationally important and measurable student outcomes, for example:

- Reductions in norm-violating behavior;
- Increases in student self-management behaviors;
- Decreases in teasing and harassment;
- Increases in reported positive classroom and school climates;
- Decreases in the use of reactive management practices; and
- Increases in attendance and academic engagement.

We emphasize the use of immediate and daily prevention practices—that is, what we do every day, all day, across all school settings to reduce the likelihood of minor and major behavior incidents and increase the probability of displays of prosocial behavior.

For example, every staff member during every lesson and for all students must:

- Set challenging and achievable academic and behavior goals;
- Model positive examples of the expected social skills and behaviors expected from students;
- Prompt/cue and recognize desired social behavior at higher rates than are used for negative or norm-violating behavior;
- Maximize every minute for successful academic and behavioral engagements; and
- Continuously and actively supervise all students across all settings at all times (Myers et al., in press; Scott, 2017; Simonsen & Myers, 2015).

On an hourly and daily basis, minor behavior incidents (e.g., noises, out of seat, off task) should be treated constructively, quickly, and quietly. Incidents of minor disruptive behavior represent teachable moments or opportunities to remind students of the desired behavior and to prompt and reinforce future opportunities. The process of handling minor behavior incidents should never sacrifice instructional time for any student, and if minor behaviors become chronic, the focus shifts toward a plan that rearranges conditions so that the opportunity to engage in problem behavior is reduced or eliminated. More information and specific examples of practices are available in the Office of Special Education Programs guide *Supporting and Responding to Behavior* (OSEP, 2015).

Every major behavior event (e.g., fighting, harassment, chronic or significantly disruptive non-compliance) should be treated as a “bad” habit that has worked

for the student in the past and is highly likely to continue to occur under specific situations (Duhigg, 2012). Because a bad habit, by definition, is chronic, well-learned, and efficient, solutions must be much more informed and targeted (O’Neill et al., 2015). That is, the intervention must be based on a specific understanding of the triggering and maintaining conditions and on the development of a specialized intervention that formally cues and rewards desired behavior and carefully eliminates competing cues and rewards for problem behavior. This plan must provide at least hourly implementation schedules (especially in the most likely problem behavior

and actions. Also, teach students specific problem-solving strategies for instances in which they experience or see disrespectful behavior. Create a school-wide “stop signal” for disrespect. Teach students to use that signal to walk away from disrespectful acts. Show students how to use that signal when standing with a peer who is experiencing disrespectful behavior, and help students identify how and when they should report disrespectful actions to an adult.

If simple instruction is not sufficient, adopt a structured social skills program. For example, at Bully Prevention (<http://www.pbis.org/school/>

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***The intervention must be based on a specific understanding of the triggering and maintaining conditions and on the development of a specialized intervention that formally cues and rewards desired behavior and carefully eliminates competing cues and rewards for problem behavior.***

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settings) by individuals who are better at doing the intervention than the student is at doing the problem behavior. Daily progress monitoring is required to enable immediate tweaking of the intervention to improve effectiveness and efficiency.

Thus, the short view focuses on what adults do now with every instructional and social engagement opportunity. To summarize, educators should invest in and use five empirically supported, high-impact practices (Center on PBIS, 2017, p. 2–3):

1. **Establish positively stated expectations** that explicitly communicate respect for *all* students and that value and embrace diversity among students as well as adults. Clearly describe how students and adults can display observable expectations in each classroom routine and school setting that contribute to a common language and a predictable, respectful, and safe experience for all.
2. **Explicitly and purposefully teach expectations** across all classroom routines and school settings. Specifically define, model, and practice each expectation, and use positive and negative examples so that students see the line between appropriate and inappropriate behavior

*bully-prevention*), a number of free, empirically supported curricula are available to supplement school-specific lessons. The Collaborative for Academic, Social, and Emotional Learning site ([www.casel.org](http://www.casel.org)) is a useful guide to other curricula. Consider explicitly teaching expectations in the context of the national dialogue through practice and mini-lessons on how to interact respectfully with others who support different political positions.

3. **Give specific praise for displays of appropriate behavior.** Actively supervise students to catch as many instances of appropriate behavior as possible. When disrespectful behavior occurs, provide a specific error correction to identify the mistake and to teach and practice the correct response. Give feedback so that praise exceeds corrections (e.g., 4 to 1 ratio).
4. **Use data to monitor implementation, and screen for students** who require more intensive support. Monitor how lessons are provided and how students respond to the behavior of their peers. Although published screening and progress monitoring tools are available,

start regularly examining existing data sources (e.g., office referrals, school nurse visits, academic failure, attendance) to identify students who may require more targeted or intensive supports. Look for students who display interpersonal challenges (e.g., teasing, intimidation, harassment) as well as personal challenges (e.g., withdrawal, anxiety, self-harm).

Utilize school climate data to examine experiences of groups of students who may be more personally affected by the national conversation, including students who identify as Muslim, Jewish, Latino, black, or LGBTQ; have disabilities, history of trauma, or mental health challenges; have recently immigrated

an immediate and explicit reinvestment and doubling down of their use. These steps will help ensure that all schools provide students with a nurturing, safe, positive, and predictable environment free from harassment, bullying, hate speech, and other negative behaviors currently being modeled and reinforced in the media and in communities across our country.

In a short period of time, our social and political landscape has been altered such that norms of civility, respect, permission, and responsibility have shifted dramatically. Some of these shifts are positive: engagement, voice, and participation have increased. However, at the same time, we are concerned by reports of the associated change in antisocial behaviors displayed by

approach increases the likelihood that significant events may occur, resulting in significant emotional and behavioral consequences and long-term negative climates and consequences.

Contemporary school and classroom challenges must be defined, verified, and discussed. However, emphasis must be shifted quickly from rumination to prevention. A multitiered system of prevention practices requires moment-to-moment, hour-to-hour, day-to-day, month-to-month, and year-to-year engagement. Practice selection and adoption are necessary but insufficient. Equal, if not more, attention must be directed toward systems or organizational supports (leadership, decision making, support continuum) that enable practice use to be effective, efficient, durable, and relevant. If intervention fidelity is high and sustained, preventing the development and occurrences of our contemporary challenges is thinkable and doable.

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***A multitiered system of prevention practices requires moment-to-moment, hour-to-hour, day-to-day, month-to-month, and year-to-year engagement.***

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to the United States or have family members who are immigrants; or who represent other diverse backgrounds. Diversity is a positive quality; embracing and valuing diversity requires a safe, respectful environment and a deliberate approach that supports *all* students, families, and staff members.

5. **Provide a differentiated continuum of positive support** for students that integrates and addresses academic, behavioral, social, and emotional needs and expectations within a multitiered systems of support framework, such as Positive Behavior Interventions and Supports (PBIS) or Response to Intervention (RtI). Work as teams within multitiered systems of support to identify and deliver appropriate practices for students who require targeted or intensive support. Use student responsiveness to intervention to move to more or less specialized supports.

### Concluding Comments

We acknowledge that few prevention and behavioral researchers and practitioners will be surprised by the practices, guiding principles, and systems we describe in this article. However, in the current climate, we strongly suggest that educators revisit and implement positive and proactive practices to support *all* students, and we encourage

children, youth, and adults and the cumulative negative effects on instructional and social climates of classrooms and schools.

Major societal shifts are sometimes followed by a period of wait-and-see and attempts to react to bursts in antisocial behavior by “getting tough” and putting in place zero tolerance policies and procedures. Although corrective actions may be necessary, we encourage educators in classrooms and schools in particular to not regress to punishment-based responses that contribute to negative school climates and adversely affect the academic and social behavior development of students. Instead, we emphatically advocate that educators must act now in preventive, deliberate, and actionable ways that students experience every moment of every school day and that promote safe, respectful, and trusting relationships of students with adults, adults with other adults, and students with other students. This immediate response is intended to prevent development and occurrences of disrespectful, irresponsible, discriminatory, and hurtful behavior and to reduce the intensity, frequency, duration, and impact of existing antisocial behavior. The long view is to invest in effective preventive practices and systems that sustain positive, respectful, caring, and effective classroom and school climates for all students. Limiting our focus to reactive management and a wait-and-see

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# From Good Intentions to Great Implementation

by Allison L. Bruhn and Shanna E. Hirsch\*

## Good Intentions

Artists, filmmakers, musicians, and authors have made famous the saying: “The road to hell is paved with good intentions.” Despite the hyperbole, this might also be true for teachers, support staff, school-employed mental health staff (e.g., psychologists, social workers, counselors), and clinicians from collaborating community agencies charged with implementing evidence-based practices and interventions. The beginning of the school year brings about an optimistic energy for adults and students alike, and school staff are eager and ready to implement new ideas with a new group of students. As the school year drags on and the energy fades, however,

## Treatment Integrity

“Treatment integrity,” a phrase that can be used interchangeably with “implementation fidelity,” is defined as implementing instruction or intervention as originally intended (Yeaton & Sechrest, 1981). For students with significant SEB issues, we cannot expect their problems to improve when an intervention is not implemented consistently and correctly. Although fidelity does not guarantee successful outcomes, it does give students an opportunity to benefit from intervention and increases the likelihood that accurate decisions about the intervention and student responses to it are made. Given the importance of treatment integrity for establishing evidence-based

of treatment integrity may be assessed quantitatively or qualitatively. Adherence is the dimension most commonly measured; it consists of assessing whether or not, or to what extent, program components have been delivered. Without adherence to the delivery of intervention components, assessing other dimensions such as exposure (e.g., dosage), quality (e.g., traits of the implementer such as enthusiasm and preparedness), participant responsiveness (e.g., the degree and quality of participation), and program differentiation (i.e., different from other interventions that may be in place) is likely unnecessary (Schulte et al., 2009).

Researchers and practitioners may use both indirect and direct methods to assess treatment integrity to find out if the intervention is being delivered as originally designed (Keller-Margulis, 2012). Indirect methods may include permanent products and self-report. A permanent product represents a tangible or concrete product resulting from a behavior performed by the student or staff. For instance, a teacher may implement a self-monitoring intervention with a student who is struggling with on-task behavior during whole group instruction. Every two minutes for 20 minutes (i.e., 10 intervals), the student writes “yes” or “no” on a form to indicate whether or not he or she is on task. The self-monitoring form can serve as a permanent record indicating that the student has (or has not) complied with the intervention. If all 10 intervals were completed by the student, that would provide evidence that the student was adhering to the intervention. If only a few intervals were completed and the student had the opportunity to complete them, that would indicate partial implementation and a lack of treatment integrity.

In terms of self-report, the instructor or interventionist may complete a checklist or rating scale noting the components he or she implemented. For example, a school counselor may conduct a social skills intervention group. As the lesson is being taught, or after the lesson, the counselor might answer a series of questions such as: Was the skill defined and taught to students using examples and nonexamples? Was the skill modeled? Were students given an opportunity to practice using the skill? Did students receive feedback during practice? Answers

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*As the school year drags on and the energy fades, teachers and school staff must balance a multitude of competing demands while striving to keep instruction and interventions sharp.*

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teachers and school staff must balance a multitude of competing demands while striving to keep instruction and interventions sharp. In the midst of the daily grind that is the K-12 school day, it is possible that what we think we are doing does not match what we are actually doing. This disconnect between intention and implementation indicates, in scientific terms, a lack of treatment integrity. For students with significant social, emotional, or behavioral (SEB) issues, it is critical that the evidence-based instruction and interventions they are entitled to receive are implemented with integrity so that they have the maximum opportunity to achieve the intended positive outcomes.

practices and making accurate decisions about students’ responses to an intervention (see Sugai et al., in this issue), this article seeks to promote understanding about treatment integrity and how it may be improved so that students have an increased chance of benefiting from intervention. Specifically, we first discuss dimensions and assessment of treatment integrity. Next, we describe why treatment integrity is important, particularly in the data-based decision-making process. Finally, we discuss factors affecting treatment integrity and provide recommendations for troubleshooting when treatment integrity is low, so that even when the beginning-of-the-year energy recedes, evidence-based instruction and intervention are still delivered with quality and accuracy as originally intended.

## Dimensions and Assessment of Treatment Integrity

As described by Dane and Schneider (1998), dimensions of treatment integrity include adherence, exposure, quality of delivery, participant responsiveness, and program differentiation. These dimensions

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\*Allison L. Bruhn, Ph.D., is an assistant professor of special education in the Department of Teaching and Learning at the University of Iowa. Shanna E. Hirsch, Ph.D., BCBA-D, is an assistant professor of special education in the Department of Education and Human Development at Clemson University. Professor Bruhn can be reached by email at [Allison-bruhn@uiowa.edu](mailto:Allison-bruhn@uiowa.edu).

to these questions, which are recommended practices for teaching social skills (Maag, 2006; Simonsen & Myers, 2015), indicate the degree to which the social skills intervention was implemented as perceived by the teacher.

Direct methods of assessing treatment integrity involve an outside observer watching and collecting data on implementation. In the case of the self-monitoring intervention described above, the outside observer could set a timer concurrent with the student's timer (i.e., every two minutes) and record if the student self-monitored at each interval. In the social skills intervention example, the outside observer could complete the same form as the counselor's self-report form. The observer and counselor could then compare forms to see if they agreed or not. Generally, a multi-method/multi-informant approach is recommended for assessing treatment integrity (Bruhn et al., 2015; Keller-Margulis, 2012; Roach & Elliott, 2008). This means that both indirect and direct methods are used, and that informants may include a variety of people with knowledge or experience with the intervention, such as teachers, behavior analysts, school psychologists, administrators, and the students themselves.

### Treatment Integrity and Data-Based Decision Making

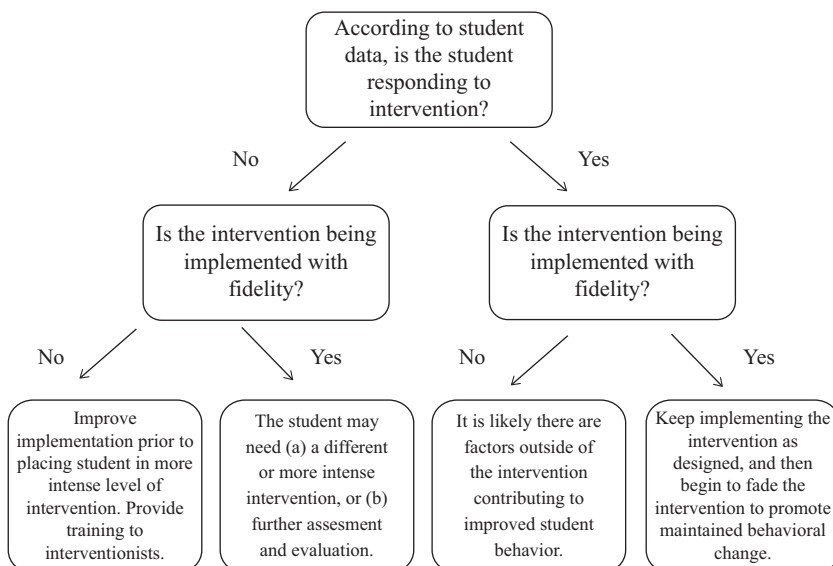
Assessing treatment integrity and understanding the factors that affect it are essential for several reasons, but perhaps the most significant reason is because it is impossible to know if an intervention is effective without knowing the degree to which it was implemented (Yeaton & Sechrest, 1981). If a student appears nonresponsive to an intervention, but it is discovered that treatment integrity was less than optimal, then it is plausible that she or he needs further intervention exposure to increase the likelihood of a positive response. If integrity was high, however, but the student did not demonstrate positive changes, then practitioners (e.g., teachers, mental health providers, school psychologists, counselors, social workers) can be confident that the intervention was likely ineffective for that student. For interventions that were delivered with integrity but were ineffective, practitioners may decide to adapt the intervention, discontinue the intervention and try something else, or refer the student for further assessment.

Understanding responsiveness and non-responsiveness is particularly pertinent to data-based decision making, in which

data are used to determine how resources are allocated, who receives what type of intervention, and whether targeted supports are warranted. Gage and McDaniel (2012) describe data-based decision making as a framework for teachers and school staff to determine whether or not a student responds to a specific intervention. Analyzing intervention data alongside treatment integrity data enhances the potential to inform instruction by measuring how implementation of an intervention affects student performance (Schulte et al., 2009). In practice, a combination of student outcome data and treatment integrity data can be used to determine how to proceed with helping a student (Bruhn et al., 2014). For example, in a study on the effects of a function-based intervention on stereotypical behavior, a teacher was to deliver specific praise every two minutes (Bruhn, Balint-Langel, et al., 2015). When integrity was low, the student's behavior did not improve. When integrity was high—that is, when the teacher was providing frequent, specific praise—stereotypical behavior decreased substantially. Because treatment integrity data were available, the researchers and teachers were able to analyze those data in conjunction with the student's behavioral data to determine that when intervention was implemented with integrity, the student responded positively. Had treatment integrity data not been available, the researchers might have incorrectly concluded that specific praise was ineffective.

Given the need for understanding the relation between student outcomes and treatment fidelity, we created the Treatment Fidelity Model for Intervention to help teachers and school staff interpret intervention results and determine next steps (see Figure 1). Using the Treatment Fidelity Model for Intervention, the first question to ask is: According to student data, is the student responding to intervention? The second question is: Is the intervention being implemented with fidelity? If the answers to these questions are: no, the student is not responding to the intervention and the intervention is not being implemented with fidelity, then the current intervention should be adjusted so that it is implemented with fidelity before placing a student in a different or more intense level of intervention. This enables practitioners to understand whether the intervention is or is not effective for a particular student. Conversely, if the intervention was implemented with fidelity but the student was not responsive, then the model indicates the student may need (1) a different or more intense intervention or (2) further assessment and evaluation. If the answers to both questions are yes, the intervention was being implemented with integrity and the student was responding positively to the intervention, the intervention should continue as designed, and then fading procedures that promote maintenance and generalization can begin when appropriate.

**Figure 1: Treatment Fidelity Model for Intervention**



Source: Reprinted with permission from Bruhn et al. (2014, p. 23).



These procedures will depend on the type of intervention. In Check-In/Check-Out (CICO), for example, students begin and end the day with a mentor who checks to see how they are doing, if they have their necessary materials, and who goes over the student's daily progress report (DPR; Hawken, 2006). The DPR is a form for teachers to provide frequent ratings of student behavior and feedback. Students set DPR goals for their behavior and often receive contingent reinforcement for meeting those goals. These components can be adjusted slowly over time to sustain behavioral change. Suggestions for promoting maintenance in CICO include gradually reducing teacher feedback (Campbell & Anderson, 2011), moving toward a more

discontinue the intervention, given that it is likely not the cause for student improvement but, rather, a result of other things going on in the student's life.

### **Factors Affecting Treatment Integrity**

Although assessment of treatment integrity may provide a quantitative measure of how an intervention is being implemented, the assessment may not take into account factors that can adversely affect treatment integrity. For example, function-based interventions, which are highly individualized interventions with multiple components (e.g., environmental adjustments, reinforcement contingencies) designed to address the underlying purpose for a student's behavior

for those interventionists who may lack experience, those who are implementing a complex intervention, or those whose students have significant problems. If initial training has not been sufficient and interventionists do not yet have adequate skills, then implementation may not be sufficient either, particularly without ongoing support (Bellg et al., 2004). Initial training may be used to introduce an intervention, practice implementation, and check for understanding, but it should always be followed by follow-up trainings or check-ins to monitor how the implementation is progressing and to make adjustments as needed.

Another factor that can affect treatment integrity is social validity, or buy-in (Hiemen et al., 2005). If the people charged with implementing an intervention believe the intervention will be effective and they view the procedures as feasible, they are more likely to implement with integrity (Gresham et al., 2000). Conversely, without buy-in, intervention quality will almost always be compromised. Assessing implementer buy-in on the front end may be beneficial. It may be that a teacher believes certain components of an intervention are too intrusive and disruptive to the flow of regular classroom instruction. If this is known and acknowledged on the front end, the teacher can work with others to (1) make adjustments to the problematic components so that they are more feasible to implement, (2) access additional implementation support, or (3) obtain additional training. Similarly, it may be beneficial to include those charged with implementing an intervention in the planning process prior to implementation.

A third possible way to increase buy-in is through reinforcement of implementation behaviors. If, for example, a teacher is implementing an intervention in the classroom, an administrator or other faculty may do a casual walk-through and provide specific praise to the teacher for implementation. Or, in PBIS programs that rely on tickets to reinforce students when they are displaying positive behavior, those tickets could also be used to reinforce teachers. A potential way of doing this could involve monthly drawings in which students' tickets are drawn for a prize and the teacher's name that appears on the students' ticket could also earn a reward. In this way, the teacher is being reinforced for implementing a core component of PBIS (e.g., acknowledging a student's positive behavior with a ticket).

Similar to social validity, contextual fit can affect the extent to which interventions

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***When designing interventions, involving those charged with implementing the intervention may increase contextual fit because the intervention can be designed to match the interventionist's knowledge, skills, and values.***

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variable schedule of reinforcement (Miller et al., 2014), and raising goals incrementally (McDaniel & Bruhn, 2016). In a study of CICO by McDaniel and Bruhn (2016), an initial DPR goal was set based on baseline DPR scores. Once the students obtained their DPR goal consistently throughout the week, the goal was raised about 10% above the mean DPR score of the current week for the following week. This systematic, incremental increase resulted in slow and sustained positive behavioral change. Other interventions may use different fading procedures. In self-monitoring interventions, for example, students may begin monitoring their on-task behavior every two minutes, then every five minutes, 10 minutes, and so on, until they are on-task consistently with very infrequent monitoring.

Finally, if the intervention is not being implemented with fidelity but the student demonstrates a positive response, it is likely there are factors beyond the intervention that are affecting the student's progress (e.g., changes in home life, relationships with others, maturation). Because fidelity is low, the positive response cannot be attributed to the intervention. In this case, practitioners could decide to improve fidelity or just to

(e.g., access attention, escape task), may be more difficult to implement than a simple intervention with only one or two components (Dusenbury et al., 2003)—that is, the complexity of the intervention may affect how well the intervention is implemented. This is why interventions should be designed to be practical and feasible.

Similarly, in school-wide Positive Behavior Interventions and Supports (PBIS), there are core components, such as clearly defined expectations, which have been taught, modeled, and practiced in every setting of the building; a system for acknowledging positive behaviors (e.g., praise, tickets); and systematic data collection and analysis. Given that there are multiple components that will be implemented by all the adults in the building, it is plausible that implementation across a school building could look very different—that is, high integrity in one classroom and low integrity in another. Whether the intervention is highly individualized or a general intervention delivered school-wide, when there are multiple components and personnel involved, training is especially critical.

Initial and ongoing training plays an important role for all staff, but particularly

are implemented successfully (Benazzi et al., 2006). Contextual fit refers to the extent to which an intervention's procedures fit with the environment as well as the interventionist's values, skills, resources, and administrative support (Benazzi et al., 2006). Measuring contextual fit during the initial implementation phase provides valuable information on the elements and skills needed to implement a plan. Interventions with high fit ratings are more likely to be implemented with integrity. Asking interventionists to complete a self-assessment during intervention development will provide information on whether an intervention is a good fit. Further, when designing interventions, involving those charged with implementing the intervention may increase contextual fit because the intervention can be designed to match the interventionist's knowledge, skills, and values. In addition, a team-based approach rather than an individual approach to intervention design may be the most effective because no one person has all of the information necessary to ensure contextual fit (Benazzi et al., 2006).

### Troubleshooting Practices

If data indicate that treatment integrity is less than optimal, and it is likely students could benefit from the assigned intervention given previous evidence of effectiveness, practitioners should commit to improving implementation. A plan for increasing treatment integrity includes:

1. Prioritizing areas for improvement;
2. Creating additional professional development opportunities;
3. Coaching faculty and staff; and
4. Self-monitoring implementation.

The following section provides an overview of these four troubleshooting practices.

It is important to note that all of these troubleshooting practices come with their own resource- and logistical-related challenges, which is why execution of such practices is dependent upon a school-site team that meets regularly and is dedicated to data-based decision making and professional development (Collier-Meek et al., 2013). The team, which should include a variety of personnel (e.g., teachers, school psychologists, administrators, social workers), will need to make time to gather and analyze assessment data, plan for training, and potentially seek out experts beyond those who are already in the school (e.g., district-level personnel, consultants, university personnel). Collectively, the team can

share the time, resource, and personnel load associated with these tasks by creating an action plan that delineates the responsibilities of each person and specifies when those responsibilities will be carried out.

### Prioritizing Areas for Improvement

To start, we recommend that practitioners review current implementation data to identify and prioritize improvement areas. For example, schools implementing a multi-tiered system of support such as school-wide PBIS, often use office discipline referral data to identify who is having difficulty, where and when behavior problems are occurring, and the possible motivation for behavior. These data may reveal a problematic time of day (e.g., morning transitions) or location (e.g., playground). This information may be combined with direct observation of treatment integrity during these

Another option is to gather information through surveys to help identify concerns and narrow down the target topic, time, or settings that need improvement. Identifying and focusing on a specific concern is important because schools have limited time and resources. A survey can be administered during a faculty meeting or shared electronically. Both allow for anonymity, which may result in more candid feedback because respondents will be free from fear of reprimand or administrators' evaluations. Further, collecting several data sources such as a survey and direct observation is beneficial for helping practitioners recognize a pattern. Using multiple sources also allows an issue to surface on one assessment that might not be apparent on another measure.

Returning to the previous example, a school implementing PBIS may administer

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## *Are teachers supposed to provide prompts for making transitions? Are teachers supposed to praise students on the playground when they observe them meeting or exceeding behavioral expectations?*

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problematic times and locations to provide a clearer picture of the concern. Depending on pre-established observation norms for the school, teachers may be notified ahead of time that a treatment integrity observation will be conducted. However, some have suggested a balance of prescheduled observations with random, unscheduled observations (Keller-Margulis, 2012). That is, whoever is being observed for implementation may be notified in advance for some treatment integrity assessments, and at other times, those assessments may occur without prenotification. Observers should be familiar with what delivering PBIS looks like: Are teachers supposed to provide prompts for making transitions? Are teachers supposed to praise students on the playground when they observe them meeting or exceeding behavioral expectations? If direct observations indicate that these key components of PBIS are not occurring during morning transitions and on the playground, then taken together with the office discipline referral data, the school could prioritize improving fidelity during these times and locations with the goal of reducing the number of students referred to the office.

treatment integrity protocols such as the School-wide Evaluation Tool (SET; Sugai et al., 2001), which requires an outside evaluator to conduct interviews with administrators, PBIS team members, teachers, and students, as well as to observe a variety of school settings and conduct a review of school materials and resources. Another tool is the Effective Behavior Support (EBS) Self-Assessment Survey (Sugai et al., 2003). Unlike the SET, the EBS Survey provides schools with information on faculty implementation and their views about which areas of the PBIS plan should be prioritized for improvement. Specifically, the EBS results indicate the degree to which faculty view PBIS components as being in place, partially in place, or not in place, and whether those components are high, medium, or low priorities for improvement. Conceivably, when a majority of faculty rate certain components as not in place and as having a high priority for improvement, then an action plan can be developed for moving forward with professional development in those high priority-low fidelity areas.

### Creating Additional Professional Development Opportunities

Typically, traditional professional development has not been aligned with actual practice (Ball & Cohen, 1999). Instead, it is often based on the professional development provider's knowledge rather than attendees' needs (Hill, 2007). The goal of gathering data prior to developing professional development activities is to recognize areas needing improvement. Moreover, the data allow an administrator or professional development provider to refine and prioritize the professional development topic(s). If more than one area is identified, professional development can be delivered in stages or in small-group sessions based on common needs. Customizing or differentiating professional development topics to meet the individual needs of teachers could be helpful,

participants review the document on their device (e.g., laptop, tablet) as part of the professional development session.

### Coaching Faculty and Staff

School-based instructional coaching is another method for increasing fidelity of specific instructional practices (Yoon et al., 2007; Youngs & Lane, 2014). During coaching, teachers work with an individual "coach" who is an expert or skilled peer to learn new practices while receiving performance feedback (Kretlow & Bartholomew, 2010). There are various coaching models including supervisory, side-by-side, and web-based virtual coaching.

The supervisory coaching model allows a coach to conduct an observation of the teacher following a general professional development training (Joyce & Showers,

classroom management practices (e.g., instructional strategies, teacher praise) and decreased reprimands (Rock et al., 2012). Given the demands on schools (e.g., paperwork, planning, supervising students), virtual coaching is a promising solution for supporting teacher implementation of skills and increasing treatment integrity (Rock et al., 2011, 2012).

### Self-Monitoring Implementation

Unfortunately, professional development and coaching may not, on their own, support long-lasting, accurate implementation of SEB interventions (Desimone 2009; Fixen et al., 2005; Klingner, 2004). To shift away from "train and hope" practices, practitioners must consider practices that build long-term teacher capacity to increase implementation (Desimone, 2009; Klingner, 2004). One such practice is self-monitoring, which involves an individual thinking about a specific skill or behavior and then recording the degree to which the skill or behavior was performed. Cooper and colleagues (2007) recommend the following seven-step self-monitoring plan to increase fidelity of implementation:

1. Identify a skill(s) to target as the focus of the intervention;
2. Identify a time and setting for the selected skill(s) to target;
3. Set a quantifiable goal;
4. Identify a strategy to prompt the use of a skill;
5. Record data of implementation;
6. Graph data to determine whether the goal was met; and
7. Reward oneself for meeting the goal (Cooper et al., 2007).

In practice, a teacher may want to increase the number of opportunities to respond (OTR) that she or he provides during math class. After identifying this skill to target during math, the teacher sets a goal of providing 15 OTRs during the 20 minutes of whole group instruction. To self-monitor this strategy, the teacher makes tally marks on a clipboard while simultaneously teaching each time an OTR is delivered. At the end of class, the teacher adds up the tally marks and graphs them on a sheet or paper or electronic form. If the goal of 15 OTRs was met, the teacher may decide to raise the goal for the next day and also to self-reinforce (e.g., buying a cup of Starbucks on the way home from school).

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***These plans should include specific or concrete steps that will be taken to improve implementation, especially for more complex or multicomponent interventions such as those that are function based.***

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especially if teachers are implementing some but not all components with fidelity. Additionally, as described by the Treatment Fidelity Workgroup of the National Institutes of Health, training sessions should include well-defined performance criteria indicating what must be done and to what level or degree (Bellg et al., 2004).

In addition to holding professional development sessions that include well-defined performance criteria to increase implementation fidelity (Bellg et al., 2004), we recommend providing faculty with written procedural plans. These plans should include specific or concrete steps that will be taken to improve implementation, especially for more complex or multicomponent interventions such as those that are function based (Dusenbury et al., 2003)—that is, "the more concrete the behaviors asked for in the professional development, the more likely teachers are to be high implementers" (Desimone & Stuckey, 2014, p. 476). This can be addressed by providing faculty with explicit, written procedures with corresponding treatment integrity checklists. Materials can be disseminated on paper or electronically. If choosing to share documents electronically, we recommend that

2002). After the observation, the coach provides performance feedback to the teacher. During the performance feedback session, a coach typically provides direct feedback on the quality of implementation, including the strengths displayed during the observation, areas for improvement, and strategies to improve implementation.

In the side-by-side coaching model, teachers may implement a new skill while the coach watches and then intervenes by modeling the skill and a rationale for correcting implementation (Kretlow & Bartholomew, 2010). The teacher is then given additional implementation opportunities and continues to receive immediate feedback "in-vivo."

Finally, web-based, virtual professional development coaching is an emerging practice that relies on technology to provide immediate, real-time feedback to teachers (Rock et al., 2011, 2012). Virtual coaching incorporates both immediate and delayed feedback through the use of a Bluetooth headset, Bluetooth adapter, or Webcam to view the classroom and communicate. Some research has shown that individuals who received virtual coaching support significantly increased their use of evidence-based



Self-monitoring checklists can be used to improve intervention implementation (e.g., Simonsen et al., 2014; Sutherland & Wehby, 2001) by pairing training with a follow-up self-monitoring plan. Self-monitoring also may serve as a prompt for implementation, which in turn may serve to improve implementation quality (Bruhn, Balint-Langel, et al., 2015). For example, if a teacher makes a goal to increase his/her rates of specific praise for a positive student behavior, the teacher can follow the previously described seven steps by keeping track of specific praise rates, continually monitor his/her progress, and adapting praise rate goals as necessary. This process can be used across a range of interventions, including foundational components of school-wide PBIS to highly individualized plans with individual students.

One challenge that teachers, school-employed mental health staff, and others encounter, is decreased fidelity during intervention maintenance. Researchers have used self-monitoring to help maintain high levels of implementation accuracy after didactic training on the Good Behavior Game (Oliver et al., 2015). Specifically, once implementation of the Good Behavior Game was stable and 100% of components were implemented with fidelity for five sessions, the researchers provided teachers with a self-monitoring checklist and discontinued performance feedback. The checklist contained components of the Good Behavior Game. The self-monitoring checklist provided a cost-effective and pragmatic tool to maintain teacher implementation after receiving high-quality professional development (Oliver et al., 2015).

Researchers also have used self-monitoring checklists to increase teachers' use of classroom management practices (e.g., behavior-specific praise; Simonsen et al., 2014). Following school-wide professional development on behavior-specific praise, Simonsen and colleagues (2014), tasked all teachers to monitor their behavior for a short period of time (e.g., one to two weeks). During this time period, the teachers selected a time of day (e.g., 10 to 15 minutes), method of recording (e.g., writing tally marks on paper, clicking a golf-counter), recorded their behavior, and reviewed their data. Results indicated that school-wide professional development with self-monitoring helped teachers increase and maintain implementation fidelity of behavior specific praise.

## Final Thoughts

Whether it is the exciting beginning, the monotonous middle, or the chaotic end of the school year, implementing evidence-based instruction and intervention as designed is imperative, particularly for those students with the most persistent and challenging social, emotional, or behavioral needs (Cook et al., 2016). When interventions that research has shown are effective when implemented with integrity *are actually implemented with integrity*, practitioners can be confident that a student's response to intervention is related directly to his/her experience of that intervention and not to other factors. Consequently, this allows for an accurate data-based decision-making

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***Whether it is the exciting beginning, the monotonous middle, or the chaotic end of the school year, implementing evidence-based instruction and intervention as designed is imperative, particularly for those students with the most persistent and challenging social, emotional, or behavioral needs.***

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process. As schools look to the future and focus on treatment integrity, they may consider the factors that can adversely affect implementation and the presented troubleshooting practices to improve implementation. In addition, having data-based decision-making teams in place who can carefully account for logistical, personnel, and resource-related problems for implementation may be invaluable (Collier-Meek et al., 2013). This will require teams that represent a variety of stakeholders (e.g., general and special educators, school psychologists, social workers, related service providers), have strong administrative support, meet regularly to monitor treatment integrity and student outcome data, and are committed to supporting implementation that leads to positive student outcomes (Collier-Meek et al., 2013).

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# Causes and Consequences of Social Exclusion and Peer Rejection Among Children and Adolescents

by Kelly Lynn Mulvey, Corey Boswell, and Jiali Zheng\*

## Social Exclusion and Peer Rejection

Social exclusion and peer rejection are pervasive phenomena in children's and adolescents' social interactions. Exclusion and rejection can occur for a myriad of reasons, and although exclusion may not always be intended to cause psychological harm, experiences of exclusion can have detrimental outcomes in terms of emotional and behavioral health (Buhs & Ladd, 2001; Juvonen et al., 2005; Killen et al., 2008; Killen & Rutland, 2011), academic difficulties (Buhs et al., 2006), a decrease in prosocial behavior (Coyne et al., 2011), and low self-esteem (Stanley & Arora, 1998; Verkuyten & Thijs, 2006). These experiences can be described as either interpersonal or intergroup (Abrams et al., 2005). Interpersonal exclusion involves rejection from individuals or the peer group because of individual differences, such as attractiveness (Leets & Sunwolf, 2005), or social deficits, such as temperamental characteristics, including being shy or withdrawn (Bierman, 2004; Rubin et al., 2006). Intergroup exclusion is marked by rejection by individuals or the peer group because of bias or prejudice regarding the victim's group membership, including characteristics such as ethnicity, socioeconomic status, nationality, native language group, gender, culture, or religion (Killen et al., 2013; Killen & Rutland, 2011). Interpersonal and intergroup exclusion may have different causes, but frequently the outcomes are the same for victims of both types of exclusion.

*\*Kelly Lynn Mulvey, Ph.D., is an assistant professor in the Department of Educational Studies at the University of South Carolina. Her research interests include moral development, social cognition, gender, aggression, and peer group dynamics. Jiali Zheng is a doctoral candidate at the University of South Carolina. Her main research interests are language development, peer group dynamics, motivation to learn, and social and emotional development. Corey Boswell is a doctoral candidate in educational psychology and research at the University of South Carolina. Among his many research interests are the mechanisms influencing adult learners in applied settings, the stability of giftedness, the cognitive neuroscience of emotion, and poverty's impact on developing brains. Kelly Lynn Mulvey can be reached by email at mulveykl@mailbox.sc.edu.*

## Are Rejection and Social Exclusion Bullying?

Many individuals assume that social exclusion and rejection are expected parts of growing up and do not constitute bullying or aggression. This is an important consideration because not all instances of rejection or exclusion are bullying or even unwarranted (Mulvey et al., 2010). For instance, excluding a child from the basketball team because she has trouble dribbling and passing the ball may be perfectly acceptable, but excluding her from the basketball team because she is shy or because she is Muslim would not. Thus, it is important to first consider the reasons for exclusion in evaluating whether the rejection or exclusion is, in fact, bullying. For instance, even young children think about social exclusion

exclusion, including both interpersonal and intergroup manifestations. Although some instances of social exclusion or peer rejection may not technically constitute bullying, excluding behavior frequently causes psychological harm and can have negative outcomes for emotional and behavioral health (Killen & Rutland, 2011). These negative outcomes, including internalizing symptoms such as depression and externalizing symptoms such as aggression, can result from a range of types of social exclusion and rejection, including both interpersonal and intergroup exclusion (Killen et al., 2013).

## Interpersonal Rejection

Children and adolescents may experience interpersonal rejection if they demonstrate shy, withdrawn, or anxious behavior

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*Although exclusion may not always be intended to cause psychological harm, experiences of exclusion can have detrimental outcomes in terms of emotional and behavioral health.*

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differently depending on the context. They might reference the importance of group functioning when discussing excluding an unskilled player from the team, but might reference psychological harm or prejudice when discussing excluding someone from the team because of their temperament or religion (Mulvey, 2016).

However, even social exclusion or rejection that causes psychological harm may not always constitute bullying. In order for aggressive behavior to be deemed bullying, the aggression needs to involve a power imbalance and to occur repeatedly (Espelage & Colbert, 2016). It is important to clarify that while, operationally, bullying must include these distinct dimensions, children often report peer victimization that does not meet these bullying criteria (Vaillancourt et al., 2008). Thus, researchers and practitioners should work carefully to understand how children describe and experience different types of peer rejection and social

or if they struggle with externalizing behavior such as aggression that may lead to a cycle of bullying followed by victimization (Killen et al., 2013; Rubin et al., 2006). Children who are shy, withdrawn, or anxious are often the victims of interpersonal rejection because their peers perceive these temperamental differences as social deficits that mark these children as nonthreatening and unlikely to retaliate (Olweus, 1993, 2001). Additionally, these children may struggle with social interactions and peer group processes, leading to rejection and exclusion (Rubin et al., 2006). Research demonstrates that children who are socially withdrawn and who do experience peer rejection and exclusion are likely to become more socially withdrawn over time (Oh et al., 2008). Thus, exclusionary behavior can reinforce shy and withdrawn personality traits that are already present.

Similarly, children and adolescents who exhibit high levels of externalizing behaviors



that include aggression, hyperactivity, or disruption (Liu, 2004) are often the victims of social exclusion. These children, who are rejected because of their own aggressive behavior, are often called bully-victims and show distinct trajectories of negative outcomes (Pouwels et al., 2016; Salmivalli & Peets, 2009; Yang & Salmivalli, 2015). For instance, children who are rejected because of externalizing behaviors are more likely to continue to exhibit externalizing symptomatology at increasing rates over time (Broidy et al., 2003; Ladd, 2006; Laird et al., 2001). Moreover, bully-victims are more likely to perceive the neutral or ambiguous actions of others as bullying, suggesting that they may struggle with social information processing (Pouwels et al., 2016). Individuals

desire to maintain homogenous social groups and can result in exclusion or rejection of those who do not share your group membership from your activities or group (Killen & Rutland, 2011; Levy & Killen, 2008; Rutland & Killen, 2015). Thus, children are, at times, rejected from peer groups because of their gender, ethnic, national, religious, language, or school identity.

Similar to interpersonal exclusion or rejection, intergroup exclusion can lead to negative outcomes in terms of internalizing and externalizing behaviors (Killen & Cooley, 2014; Rutland & Killen, 2015). However, intergroup rejection or bullying is often rooted in bias and discrimination, and research demonstrates that the likelihood of negative outcomes for bias-based

bullying. Many of these approaches have targeted rejection and exclusion as well. These approaches often focus on interpersonal rejection and exclusion and take a social-deficits approach whereby interventions target improving the social skills of victims or children at risk for rejection and exclusion, with the goal of helping them to improve their social competence (Bierman, 2004; Rubin et al., 2006). This approach assumes that children who experience interpersonal rejection are behaving in ways that invite their own rejection and that improving their social skills will reduce the victimization (Hodges et al., 1999). Although some studies of the effectiveness of social skills training have noted positive outcomes, a systematic review documented mixed results or no positive outcomes for almost half of the studies examining social skills training (Moote et al., 1999). Moreover, researchers have called for approaches that move beyond an exclusive focus on social skills training and that instead attend more carefully to the peer group context, such as peer norms and social dominance hierarchies that encourage rejection and exclusion (Mikami et al., 2010).

**Social Skills Training and Intergroup Exclusion.** Moving away from social skills training is particularly important, given that these types of approaches are especially unlikely to be helpful when the exclusion is based on group membership and not social deficits (Killen et al., 2013; Rutland & Killen, 2015). In instances of intergroup exclusion and rejection, however, the focus should be placed on the role of stereotypes, bias, and prejudice (Hitti et al., 2011; Killen & Cooley, 2014; Mulvey et al., 2010; Sunwolf & Leets, 2004). For instance, research demonstrates that children and adolescents do, at times, justify exclusion of their peers based on stereotypes about gender, ethnicity, language, or culture (Killen & Rutland, 2011). In instances of exclusion and rejection based on group membership, the focus should be not on providing social skills training for the victims, but, rather, on working to create inclusive environments where fair and equal treatment of others is the norm, where children are encouraged to take the perspective of others, and where prejudice and bias are not tolerated (Killen et al., 2013; Mulvey et al., 2013). Specifically, intergroup exclusion and rejection should be addressed through school-level support for positive intergroup contact, which is marked by equal status among groups, collaboration and cooperation, and the setting of common goals

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who do struggle with social information processing may exhibit hostile attribution bias, whereby they assume negative intent on the part of others, even in situations that are neutral (Dodge & Coie, 1987). There is evidence that exhibiting hostile attribution bias is related to heightened aggression in response to experiences of exclusion (DeWall et al., 2009). Thus, individuals can experience interpersonal rejection because of patterns of both internalizing and externalizing symptomatology, and these rejection experiences can heighten or reinforce the maladaptive behaviors that originally resulted in the exclusion and rejection (Ladd, 2006).

### **Intergroup Exclusion**

Although peer rejection and exclusion are often due to interpersonal reasons, both can also be the result of negative intergroup relations or of interactions with others who do not share one's group membership (Killen et al., 2013). Research demonstrates that children identify with groups through gender, ethnicity, or language early in life and that individuals exhibit a desire to enhance their group identity and positively promote their in-group (Bennett & Sani, 2008; Dunham et al., 2011; Tajfel & Turner, 1979). This can lead to a

bullying are higher than the odds of negative outcomes for general harassment, rejection, or exclusion (Russell et al., 2012). For example, youth who report bias-based discrimination such as exclusion and rejection also display higher incidences of substance use/abuse, risky behaviors, mental health concerns (such as depression), and negative school-related outcomes in terms of achievement and truancy (Russell et al., 2012). Research also indicates that adolescents who experience intergroup bullying that is intersectional (based on more than one category, such as discrimination because of race and weight) are more likely to engage in self-harm and suicidal ideation, and to experience higher rates of depressive symptoms than those who do not experience these forms of intergroup conflict (Garnett et al., 2014). Thus, intergroup exclusion or rejection can also be marked by serious, negative outcomes in terms of emotional and behavioral health for youth.

### **Responses and Interventions to Interpersonal and Intergroup Rejection and Exclusion**

School systems have taken different approaches to responding to and intervening in instances of peer victimization and

(Allport, 1954). Meta-analyses of research on intergroup contact demonstrate positive outcomes for children in terms of prejudice reduction and improvement in attitudes (Tropp & Prenovost, 2008).

**Bullying Prevention Programs.** Some research has indicated that bullying prevention programs implemented school-wide are effective in reducing bullying and victimization, including rejection and exclusion (Farrington & Ttofi, 2009). Program characteristics that may be particularly effective include sharing information with parents, increasing supervision during playground time, using both punitive and nonpunitive responses to bullying, and using technology such as videos and games to increase awareness of bullying (Farrington & Ttofi, 2009). More recent meta-analyses suggest that such interventions have very limited success in U.S. contexts, likely because current bullying interventions do not attend to the heterogeneous nature of most U.S. schools (Evans et al., 2014). Thus, research on bullying interventions and responses to rejection and exclusion in the United States and in other diverse settings should aim to harness the findings from research on intergroup contact and seek to create school environments that foster not only positive peer interactions (generally), but positive intergroup contact as well (Killen et al., 2013; Rutland & Killen, 2015; Tropp & Prenovost, 2008).

KiVa, a bullying intervention consistently identified as one of the most effective, takes a peer group and school-wide approach with attention to encouraging bystander responses involving defending and supporting victims of bullying, including rejection and exclusion (Yang & Salmivalli, 2015). The KiVa program teaches children how to engage in bystander intervention through role-playing and video game simulations (Salmivalli et al., 2011). Results from the KiVa program indicate that fostering bystander behaviors reduces bullying in school environments (Salmivalli et al., 2011). Although KiVa was initially developed and implemented in Finland, the model is being tested in new settings, with promising results observed in Italy (Nocentini & Menesini, 2016) and the United Kingdom (Hutchings & Clarkson, 2015). Although the settings where KiVa has currently documented evidence for success are still largely homogenous, testing is underway in more heterogeneous settings, such as in the United States.

**Bystander Intervention and Intergroup Contacts.** Moving forward, schools

should look to programs both that promote bystander intervention and that encourage positive intergroup contacts to create optimal environments for reduced peer rejection and social exclusion based on interpersonal factors and intergroup dimensions. Additionally, research has examined the importance of true bystanders who are not part of one's peer group. Future interventions should aim to encourage children and adolescents to challenge rejection and exclusion perpetuated by their own peer group, because they may be more influential in regulating the behavioral norms of their close friends than of their classmates. Research does find that peer group exclusion is stressful not only for those being excluded, but also for adolescents who

cross-group friendships. One school-wide climate-focused intervention, Creating a Peaceful School Learning Environment (CAPSLE), encourages greater awareness of others' feelings and mental states (Fonagy et al., 2009). Research shows that implementing the use of CAPSLE was associated with lower rates of victimization and aggression and increases in empathy for others (Fonagy et al., 2009). Research also suggests that school and peer group norms play a powerful role in establishing inclusive, welcoming school environments for children and adolescents (Hitti & Killen, 2015; McGuire et al., 2015; Thijs & Verkuyten, 2014; Tropp et al., 2014, 2016).

One way in which school and peer group norms can be shaped is through positive

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*Although youth may assume their friends will judge challenges to their peer group norms negatively, individually both children and adolescents demonstrate high levels of support for peers who speak out to encourage their group to act in inclusive, equitable, and nonprejudicial ways.*

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witness the exclusion of others (Sunwolf & Leets, 2004). Studies also demonstrate that children and adolescents do want to encourage fair treatment of others by their peer group (Mulvey & Killen, 2015, 2016; Mulvey et al., 2016), that they feel regret when they do not intervene (Sunwolf & Leets, 2003), and that they can influence their peers to act in nonprejudicial ways (Paluck, 2011).

**A Positive School Climate.** Interventions should focus on nurturing a positive school climate (Dessel, 2010) in which peers from different groups have equal status, work together cooperatively, and share common goals (Allport, 1954). Creating such a positive environment is important because research shows that schools where students perceive high rates of bullying and teasing also have higher dropout rates (Cornell et al., 2013). School climate can serve as a protective factor against bullying, rejection, and exclusion, including in diverse school settings where bullying is often directed at minority group students (Connell et al., 2015). Part of creating positive school climates involves shifting school norms toward inclusivity and acceptance of

bystander behaviors (Frey et al., 2015; Malti et al., 2015; Palmer et al., 2015), and there is evidence that schools can help foster climates where bystander behavior is encouraged and supported (Salmivalli et al., 2011; Yang & Salmivalli, 2015). However, there is also evidence that youth may be hesitant to engage in bystander intervention because of concerns about the social and peer repercussions of standing up for others (Mulvey & Killen, 2016; Mulvey et al., 2016). These concerns may be unwarranted, however, because although youth may assume their friends will judge challenges to their peer group norms negatively, individually both children and adolescents demonstrate high levels of support for peers who speak out to encourage their group to act in inclusive, equitable, and nonprejudicial ways (Mulvey et al., 2014, 2016; Mulvey & Killen, 2015, 2016).

## Conclusion

Intervention efforts should aim to foster inclusive school environments by encouraging bystander behaviors and by reinforcing school and peer group norms that promote inclusivity. Children struggle with social decisions and are faced with challenging

tasks of navigating ever-changing peer groups with a wide range of different norms (Mulvey et al., 2013). School personnel, parents, and group leaders can help ensure that the school climate more broadly is supportive and inclusive and that it encourages positive intergroup contact and acceptance of peers with a range of temperamental differences.

School mental health professionals should consider whether the causes of the rejection experience are interpersonal or intergroup when responding to situations involving social exclusion. Children and adolescents frequently struggle with both interpersonal and intergroup rejection and exclusion. Although these exclusionary

exclusion and rejection by seeking multifaceted intervention efforts that target school climate, school norms, intergroup attitudes, and peer norms, and that encourage active, assertive bystanders.

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### ***Nurses, physicians' assistants, doctors, mental health counselors, and health-care professionals should ensure that their care includes attention to issues related to psychological and behavioral health.***

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experiences may not always constitute bullying, they frequently do result in psychological harm and can lead to serious consequences for children's behavioral and emotional health and well-being (Killen et al., 2013).

Nurses, physicians' assistants, doctors, mental health counselors, and health-care professionals should ensure that their care includes attention to issues related to psychological and behavioral health. This is especially important because rejection, exclusion, and bullying can lead to mental health issues for victims, aggressors, and even those who observe these types of aggression (Espelage & Colbert, 2016).

Practitioners, even those outside of the school environment, can play an important role in addressing the negative consequences of these types of experiences for youth. School personnel may not always be aware of the rejection and exclusion experiences faced by students in their care (Nansel et al., 2001; Waasdorp et al., 2011). This indicates the importance of having teachers, counselors, school psychologists, and administrators talk directly with students about the harmful nature of these behaviors, both to encourage students to speak up if they are experiencing rejection and exclusion, and also to serve as engaged bystanders who create inclusive spaces for their peers. Schools should look to mitigate

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# From the Literature: What's Hot . . . What's Not

by Michelle Charlin\*

## *Treating Depression*

### **The Youth-Mental Health Engagement Network: An Exploratory Pilot Study of a Smartphone and Computer-Based Personal Health Record for Youth Experiencing Depressive Symptoms**

Forchuk, C., Reiss, J., Eichstedt, J., Singh, D., Collins, K., Rudnick, A., Walsh, J., Ethridge, P., Kutcher, S., and Fisman, S. *International Journal of Mental Health* 45(3), 205–222, 2016

Although the American and Canadian health care systems are very different, this Canadian study provides information that American care providers and researchers may find useful. The Internet-based

from psychiatric nurses to a marriage and family therapist and 41 of their patients between the ages of 16 and 21 participated in the study. Most of the young people suffered with mood disorders and anxiety. Care providers were issued tablets; patients were given smartphones because most of them already use the devices. Six themes were identified through focus groups. The severity of the illness and the intensity of treatment influenced how often the LSR was accessed. Patients used the LSR most often for tracking their symptoms.

Usage increased patients' self-awareness and autonomy, sometimes helping them realize that sleep or eating patterns affected their moods. Changes in the therapeutic relationship were related to boundaries and communication. Because both

## *Positive Attending*

### **Teacher-Provided Positive Attending to Improve Student Behavior**

Perle, J.G. *TEACHING Exceptional Children* 48(5): 250–257, 2016

Positive attending promotes the use of praise that includes a specific description of a desired behavior. Instead of telling a student that he has done a good job, his teacher might say: "I'm so proud of you for listening." Although using positive attending can decrease disruptions in the classroom and can positively affect the entire class, few teachers have received training in how to use this skill. Perle provides a table listing sample targets and ways to begin the praise. Praise should be "specific, immediate, consistent, frequent, and preventative." It should be clear to the child what she/he has done correctly. Teachers should collaborate with paraprofessionals, administrators, and lunchroom staff so that everyone can work with students on increasing appropriate behaviors. Everyone's words should be genuine. Appreciation should be given as quickly as possible after an action is observed so that students can form a link between a behavior and its reinforcement. Those who are often most in need of praise are sometimes the ones who receive it the least. If youth are behaving properly without any form of prompting, it is extremely important to praise them in the moment. Repeated, positive reinforcement may be particularly helpful for children with ADHD and emotional and behavioral disorders because they may not always realize they are being addressed. Only a few seconds are needed to speak words of kindness and/or give a high-five, and making the effort can prevent many problems. It is better if praise is centered on performance rather than the person (person-centered). It is better to say: "Nice work on solving those equations!" than "You're a natural mathematician," because a child's self-worth could become lowered in later years when he needs tutoring to solve geometric proofs.

Active ignoring pairs well with positive attending. If an undesirable behavior harms nothing or no one and is a cry for attention or an object rather than proof of a need to "escape a situation," the behavior can be ignored. As soon as the child begins to

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*Because both parties could view or edit records around the clock, professionals could send messages of praise and alert patients on when to implement crisis plans.*

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Lawson SMART record (LSR) allows the contents of electronic personal health records (ePHRs) to be accessed and updated by patients and medical professionals. The Mental Health Engagement Network (MHEN) project found that when adults with mental illness used LSR to monitor moods, keep track of appointments, and correspond with mental health care workers, they were less likely to be hospitalized or arrested. Because depression affects so many youth and they are not being assisted as early as they could be in ways they are able or willing to use, the researchers of the Youth-Mental Health Engagement Network (YMHEN) wondered what might encourage or discourage young people from using the ePHR, how usage might affect their typical care, and how the ePHR could be improved for their use. Nine professionals ranging

parties could view or edit records around the clock, professionals could send messages of praise and alert patients on when to implement crisis plans. Scheduled visits became more focused because providers had often reviewed patient information in advance. Dialectical behavior therapy (DBT) and cognitive behavioral therapy (CBT) treatment requirements integrate easily with LSR usage. Patients almost always had their phones with them and could easily do their daily homework assignments such as DBT diary cards. Suggestions for personalization and simplification showed that a solution created for adults should not be modified by, for example, merely adding a depression scale for their age group. Participants wanted to add pictures, play games to achieve their treatment goals, hide or move sections not relevant to their care, and expedite the login process. The LSR was well received by youth and could be adapted to better suit the population. Although the researchers did not measure treatment efficacy, health professionals advised "increased patient compliance" over paper-based systems.

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\*Michelle Charlin has a B.A. in English from Emory University and an M.L.I.S. from the University of South Carolina. She can be reached by email at [mcharlin@progressivetel.com](mailto:mcharlin@progressivetel.com).

behave, the move toward better behavior should be praised. For example, a teenager who stops muttering for a moment after being told that she cannot use a pencil instead of a pen for an assignment might be told: "I'm really impressed that you are accepting 'no.'" The behavior could become worse before it gets better (extinction burst) when the child realizes that a previously successful strategy no longer works.

A note of caution is that some students may feel they are being punished if they openly receive praise. Methods of improving one's use of positive attending include setting goals, role-playing with fellow teachers, monitoring usage with a handheld clicker, having others or vibrating cellphone timers provide prompts, and placing visual reminders in the classroom.

### ***Early Intervention for Behavioral Problems***

#### **Early Intervention for Children With Behavior Problems in Summer Settings: Results From a Pilot Evaluation in Head Start Preschools**

Hart, K.C., Graziano, P.A., Kent, K.M., Kuriyan, A., Garcia, A., Rodriguez, M., and Pelham, W.E., Jr+.

*Journal of Early Intervention*  
38(2): 92–117, 2016

If preschool-aged children who exhibit emotional problems or externalizing behavior problems (EBDs) such as screaming, threatening, and being physically aggressive do not receive help, they will have even greater problems in elementary school. If they do not receive intervention until later, it will be more costly than when they were younger. Poor children with notable behavioral difficulties are at risk of not receiving enough treatment; those who are also from minority families are at greater risk; and children from minority families whose primary language is not English are most at risk. Head Start programs will not be enough to prepare most children with EBDs for kindergarten. There are many programs of benefit to preschoolers, but these are held during the school year. During the summer, even an average student will lose academic skills. This study investigates two interventions: a high-intensity (HI), four-week Kindergarten Summer Readiness Classroom (KSRC) involving weekly parent workshops and a low-intensity (LI) program of only parent

workshops. Fifty children, 39 boys and 11 girls, who attended Head Start programs in a large, urban city in Florida were vetted. None of the children had pervasive developmental disorders. Their main reason for referral to the program was externalizing behavior problems, including forms of ADHD, oppositional problems, and/or conduct problems.

Children were randomly assigned to the two groups. Families, preschool teachers, and kindergarten teachers involved in assessments held before the program, nine weeks after kindergarten began, and nine months after the program received gift cards. Families brought their children to one of two KSRC sites and were given \$2 toward transportation costs for each day of attendance. Classrooms were staffed by a

A week after the start of kindergarten, parents were asked to attend four more workshops at the same site as the KSRC camp. Booster sessions were offered from October to May, and parents were asked to attend seven meetings with their child's teacher and a school consultant. After the school year began, both sessions and parent-teacher meetings were not as well attended as hoped. Parents of children in the LI group could attend the same parental meetings during the summer (on different days from the HI parents) and school year, but were not invited to school consultation meetings. For the HI group, all parents reported behavioral improvements in their children, and 91% reported academic improvements. At the start of kindergarten, children in the HI group had better relationships with their

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***For the HI group, all parents reported behavioral improvements in their children, and 91% reported academic improvements.***

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lead teacher who was a clinical psychology graduate student and by four aides who were undergraduates or first-year graduate students. Staff training was provided. Students could arrive as early as 7:30 a.m. and could stay for aftercare as late as 5:30 a.m. on the days when parental training was being held. Children were fed breakfast, lunch, and snacks. The two main areas of focus of the 140 hours of intervention were academic preparedness and social-emotional and behavioral preparedness.

Positive attending was used, as were tokens that could be given or taken away depending on behavior. A daily report card (DRC) was sent home for weeks two to four. Based on staff instruction during daily meetings, parents provided "daily DRC-contingent rewards at home" and returned the report card each morning signed and with a notation of what type of reward had been given. Instruction was given to individuals, small groups, and the whole group. Parents of children in the HI group could attend four weekly hour-and-a-half workshops held at the end of the day. The sessions, taught by graduate students in clinical psychology, included topics such as parental empowerment, parent-child relationships, home learning, and problem solving. Translators were available for those who spoke Spanish and Creole.

teachers than the LI students had. However, the LI students were doing just as well by the end of the school year. Findings suggest that for the best results, children as well as parents should be involved in interventions.

### ***Diet, ADHD, and ASD***

#### **Omega-3 and Omega-6 Polyunsaturated Fatty Acid Levels and Correlations With Symptoms in Children With Attention Deficit Hyperactivity Disorder, Autistic Spectrum Disorder and Typically Developing Controls**

Parletta N., Niyonsenga T., and Duff J.  
*PLOS One*  
11(5): e0156432, 2016

Attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) may be influenced by diet and bacteria in the gut. This study examined the levels of polyunsaturated fatty acids (PUFAs) in children with ADHD and ASD and compared them to controls. PUFAs are not made by the body; their sources are food and nutritional supplements. Standard Western diets now include far more omega-6 (n-6) polyunsaturated fatty acids than omega-3 (n-3) PUFAs. More omega-6 PUFAs than omega-3s may cause inflammation, increase

the risk of blood clots, and raise blood pressure. This has implications for mental illness, which has inflammation and reduced cerebral blood flow as part of its pathology. Five milliliters of venous blood were taken from 565 Australian children who were between three and 17 years old. Compared to the controls, those with ADHD and ASD had lower levels of the n-3 PUFAs EPA and DHA and the n-6 PUFA AA (arachidonic acid). The AA/EPA ratio was higher than for controls, and the n-3/n-6 ratio was lower. Omega-3 supplementation has been reported to help children with ADHD symptoms. DHA seems to provide even better outcomes than EPA, but studies could be done on the effectiveness of a combination of the two omega-3s. It is possible that issues with PUFA metabolism contribute

social and biological, that may contribute to CD development.

This study focuses on the neurobiological component of CD development. Abnormalities in the connective white matter in the brain have been found in individuals with CD. Twenty-seven of the 48 males aged 12 to 19 who participated in this study had CD. Twenty-one controls were of the same age and lived in the same areas as those with CD. The areas were described as “deprived and inner city.” All of the boys were right-handed, and English was their first language. None of the boys took medications. Except for CD, ADHD, and anger management issues, they had no other mental diagnoses. The controls had much higher IQs, but this was taken into account.

may be dimensionally related to behavior problems in some youngsters.”

### ***Implementing TWA+PLANS***

#### **Using Self-Regulated Strategy Development to Help High School Students With EBD Summarize Informational Text in Social Studies**

Ennis, R.P.

*Education and Treatment of Children*  
39(4): 545–568, 2016

To prepare students for employers’ and colleges’ expectations with regard to written communication skills, schools are now teaching writing in classes that have traditionally not been expected to emphasize it. Students with emotional and behavioral disorders (EBDs) often have difficulties reading, and this affects their writing abilities. Self-regulated strategy development (SRSD) is an evidence-based writing intervention that has proven to be of benefit to students with EBDs.

This study is the second to focus on the use of the SRSD mnemonic TWA+PLANS and/or informational writing with this population. The mnemonic reminds students to **Think** before reading, think **While** reading, think **After** reading, **Pick** goals, **List** ways to meet goals, **And** make **Notes**, and **Sequence** notes. Ennis sought to discover whether TWA-PLANS could be put into effect with fidelity with high school social studies students who have EBDs and live in a therapeutic residential facility. Two to three times a week, three students left their social studies classes for one-on-one instruction in a different classroom with a researcher who had taught SRSD before but not with this mnemonic or for summarizing informational text. Six lessons that gradually introduced the writing process were presented. One student needed to repeat lessons. Before and after the intervention, students’ writing was evaluated on summary elements, summary quality, and the total number of words written. Each of the students “had a significant change in level for all writing variables.” The author does not mention if the study participants were envied or bullied by other residents for what could be viewed as special treatment or if the study participants benefited academically and socially from spending time with a visitor they would not otherwise have met. Ennis recommends that ways be found for teachers to implement TWA+PLANS in groups or in the classroom.

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### ***Minors who lie, steal, destroy property, and hurt others repeatedly during a six- to 12-month period are likely suffering from conduct disorder (CD).***

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to neurodevelopmental disorders. PUFA metabolism could be affected by gut microbiota. A referenced study found that taking the probiotic bifidobacterium breve along with n-3 PUFA alpha-lipoic acid (ALA) raised DHA levels in the brain.

### ***White Matter and CD***

#### **A Whole-Brain Investigation of White Matter Microstructure in Adolescents With Conduct Disorder**

Sarkar, S., Dell’Acqua, F., Froudust Walsh, S., Blackwood, N., Scott, S., Craig, M.C., Deeley, Q., and Murphy, D.G.M.

*PLOS One*

11(6): e0155475, 2016

Minors who lie, steal, destroy property, and hurt others repeatedly during a six- to 12-month period are likely suffering from conduct disorder (CD). In the United Kingdom, it requires 10 times as much money to raise the worst affected of these youth than to raise non-sufferers. Those with CD often display mood disorders, antisocial personality disorder (ASPD), and difficulties with drug and alcohol abuse when fully grown. Money spent on prevention in early life may reduce the cost of interventions in later life. To learn how CD may be prevented, studies have been done of the several factors, both

Parents and participants completed two questionnaires, the Strengths and Difficulties Questionnaire (SDQ) and the Antisocial Process Screening Device (APSD). The boys were interviewed using the CD and oppositional defiant disorder (ODD) subsections of the Kiddie Schedule for Affective Disorders and Schizophrenia—Present and Lifetime version (K-SADS-PL). Each time ODD was discovered, it was in tandem with CD. Those who had scored 20 or greater on the APSD questionnaire that they or their parents had completed were also interviewed using the Psychopathology Checklist Youth Version (PCL-YV). Those who scored 20 or greater were deemed to have psychopathic traits. DT-MRI images of each boy were collected and analyzed. Fractional anisotropy (FA) is “an index that quantifies directional differences in the diffusion of water molecules inside tissues” as well as being a measure of microstructural integrity. In seven areas of the brain, the CD group had “significantly greater FA than controls in WM regions corresponding predominantly to the fronto-cellular circuit.” The boys with CD also had “increased FA in the corticospinal tract,” which may play a role in how emotions are processed. Those with CD may not respond normally to fearful and threatening circumstances. It is possible that “variation in WM microstructure



*Immune Response and OCD***Microglial Dysregulation in OCD, Tourette Syndrome, and PANDAS**

Frick, L. and Pittenger, C.  
*Journal of Immunology Research*  
 2016: 1–8, 2016

In the past few years, scientific knowledge has increased about microglia, “the brain’s resident immune cells,” microglial dysregulation, and the role dysregulation plays in obsessive-compulsive disorder (OCD), Tourette syndrome, and pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS), but there is still much to learn. Much of what is known and conjectured is based on post-mortem examinations of adult human brains and studies of genetically altered mice. However, positron emission tomography (PET) scans are beginning to be done on children. The nervous system and the immune system work together to fight infection, and sometimes, responses to infection are out of proportion to what is needed. Children with PANDAS may temporarily develop symptoms of OCD and Tourette syndrome, but PANDAS (also known as PANS) may be “etiologically distinct from non-PANDAS Tourette syndrome.” OCD and Tourette syndrome are often comorbid, have childhood onset, and co-occur with changes to the striatum, which is an area of the brain associated with movement, motivation, and the reward system. The authors suggest that additional studies be done to determine if the release of too much glutamate by microglia during immune responses leads to OCD. Another microglial abnormality is the expression of too little of the fractal-kine chemokine receptor CX3CR1; mice deficient in this protein display behaviors similar to those of people who have autism spectrum disorders. CX3CR1 deficiencies may be involved with abnormal synaptic pruning. HdC-KO mice, those that do not properly biosynthesize histamine, may have CX3CR1 deficits. Research could be done to determine if individuals with a rare form of Tourette syndrome linked to HdC deficiency have CX3CR1 deficiencies and if they are affected by abnormal synaptic pruning. Such research could lead to new therapeutic options.

*Introducing CW-FIT***Student and Teacher Outcomes of the Class-Wide Function-Related Intervention Team Efficacy Trial**

Wills, H., Kamps, D., Fleming, K., and Hansen, B.  
*Exceptional Children*  
 83(1): 58–76, 2016

Children in this study’s intervention group enjoyed being taught in a classroom in which fellow students were more on-task, there were fewer disruptions, teachers praised more than they reprimanded, and there were rewards for good behavior. Students and teachers learned better ways of interacting through implementation of Class-Wide

need arose. Tier 1 of CW-FIT is the group contingency intervention. Its components are “teaching classroom rules and skills, using a group contingency with differential reinforcement of appropriate behaviors through class teams and points, and minimizing attention to inappropriate behavior (planned ignoring).” At the beginning of sessions, a daily goal was announced and a timer was set to beep at some unknowable point every two to five minutes. When the timer beeped, team charts were updated. When classes ended, rewards were distributed. Tier 1 activities prevented or lessened behavioral problems for most children.

Students whose on-task and disruptive behaviors did not meet expectations received Tier 2 self-management interventions.

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***In 10- to 15-minute sessions, three primary skills were introduced and practiced in sequence: getting the teacher’s attention, following directions, and ignoring inappropriate behavior.***

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Function-Related Intervention Teams (CW-FIT). Over a four-year period, 313 students in kindergarten through sixth grade in 159 classrooms in 17 schools were assigned to the control or study group. Students in both groups were at risk for emotional and behavioral disorders (EBDs). Coaches with education and social work training taught the teachers and provided them with feedback on fidelity every two weeks. Teachers chose to introduce CW-FIT during subjects in which students were the most unruly and disengaged; math and reading were the most commonly selected. Before instruction, teachers and students collaborated to produce reinforcement/reward menus that included dance time, math games, stickers, and pencils. In 10- to 15-minute sessions, three primary skills were introduced and practiced in sequence: getting the teacher’s attention, following directions, and ignoring inappropriate behavior. Posters reinforcing each skill were placed in strategic areas. Throughout the 18 weeks of program use, the posters were reviewed to pre-correct skills at the beginning of lessons and as the

Thirty-five of these students received booster sessions in small groups with the aforementioned coaches and peer role models. During Tier 1 intervention classes, a mini-chart featuring their team’s goal was placed on their desks. When the timers beeped, teachers would record team scores and verbally prompt self-managers to evaluate themselves on the mini-charts. Instead of mini-charts, seven Tier 2 students received help cards because they needed help completing work and were often off-task when topics were more difficult. Tier 2 interventions resulted in significant improvements. For example, the frequencies of disruptive behaviors for help card users changed from 19.2 at baseline to 9.7 during CW-FIT to 6.1 during CW-FIT plus help cards. In subsequent questionnaires, 45% of teachers stated that they had used the intervention during the school year following their participation in the study. One of the most heartening aspects of the study is that the authors went back to the teachers who had been in the control group and provided them with CW-FIT training. ■

**Calendar of Events, July 2017 – October 2017****July**

- 6-11 American School Counselor Association.** Denver, CO. Sponsor: ASCA. Website: <http://www.ascaconferences.org/>
- 9-11 National Principals Conference.** Philadelphia, PA. Sponsor: NAESP and NASSP. Website: <http://www.principalsconference.org/>
- 16-19 Youth Leadership Summit.** San Francisco, CA. Sponsor: National Council for Community and Education Partnerships. Website: <http://www.edpartnerships.org/youth-leadership-summit-yls>
- 17-20 Summer Institute on Youth Mentoring.** Portland, OR. Sponsor: Portland State University. Website: <https://www.pdx.edu/youth-mentoring/>

**October**

- 19-21 22nd Annual Conference on Advancing School Mental Health: Promoting School Mental Health and Positive School Climate.** Washington, DC. Sponsor: Center for School Mental Health. Website: <http://csmh.umaryland.edu/Conferences/>
- 22-25 National Dropout Prevention Conference: A New Vision for Dropout Prevention.** Palm Springs, CA. Sponsor: National Dropout Prevention Network. Website: <http://dropoutprevention.org/conferences/2017-national-dropout-prevention-network-conference/>
- 27-29 ASCD Conference on Educational Leadership.** Orlando, FL. Sponsor: ASCD. Website: <http://www.ascd.org/conference-on-educational-leadership.aspx>



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