4G– Selecting Evidence-based Practices in Support of Mental and Behavioral Health for Students

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- **Topic:** Mental Health/Social-Emotional-Behavioral Well-Being
- **Keywords:** Implementation, Interconnected Systems Framework, Trauma

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Learning Objectives

1. Identify key criteria for evaluating evidence-based practices
2. Align practices within a MTSS framework
3. Identify strategies to ensure implementation fidelity across tiers
4. Identify strategies to make data-driven decisions to enhance sustainability and impact

Dispelling the Myths

Evidence-based medicine is NOT	Evidence-based education is NOT
Old-hat and is something everyone is doing.	Something all teachers are doing.
Conducted only by researchers in 'ivory-towers.	Just conducted in university education departments but also takes place in schools and multi-academy trusts.
Cookbook or recipe-led practice.	Attempting to replace teaching craft and skill with a check-list of pre-determined approaches.
Restricted to randomized trials and meta analyses.	Just about EEF sponsored randomized trials but requires individual teachers to reflect on how to improve their practice in their own particular school or college.
A method for reducing the cost of health-care.	About reducing the cost of education by making all teachers more effective but will require significant investment in teacher CPD in order to increase basic research literacy.

What does "Evidence-Based" mean?

Generally, evidence derived from clinically relevant research on psychological practices should be based on systematic reviews, reasonable effect sizes, statistical and clinical significance, and a body of supporting evidence.

(APA Policy Statement on Evidence Based Practice in Psychology,2005)

How Is Evidence Based Treatment Applied?

"Evidence-based practice in psychology is the integration of the best available research with clinical expertise in the context of client characteristics, culture, and preferences"

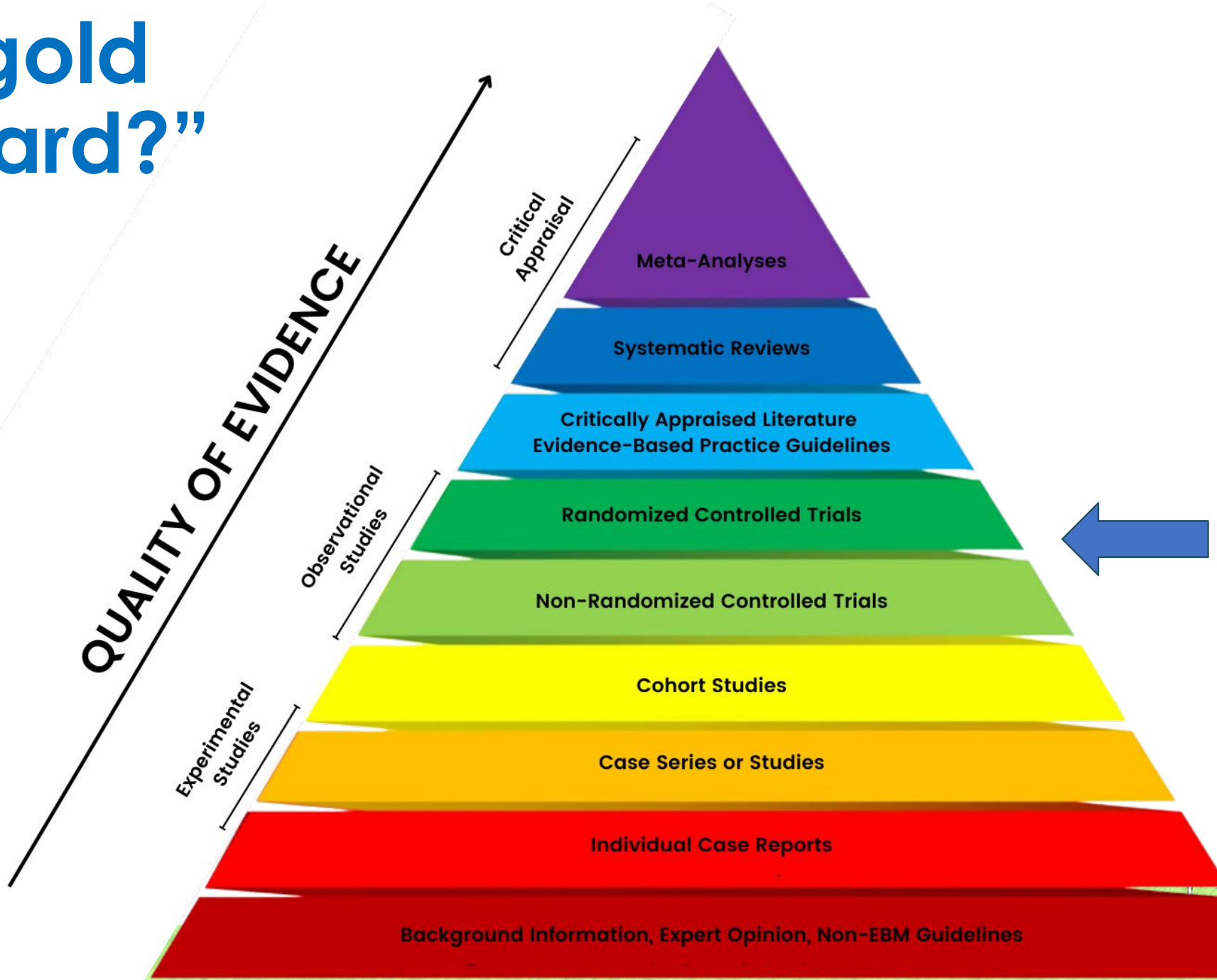
(American Psychological Association, 2005)

Why is Evidence-Based Care Important?

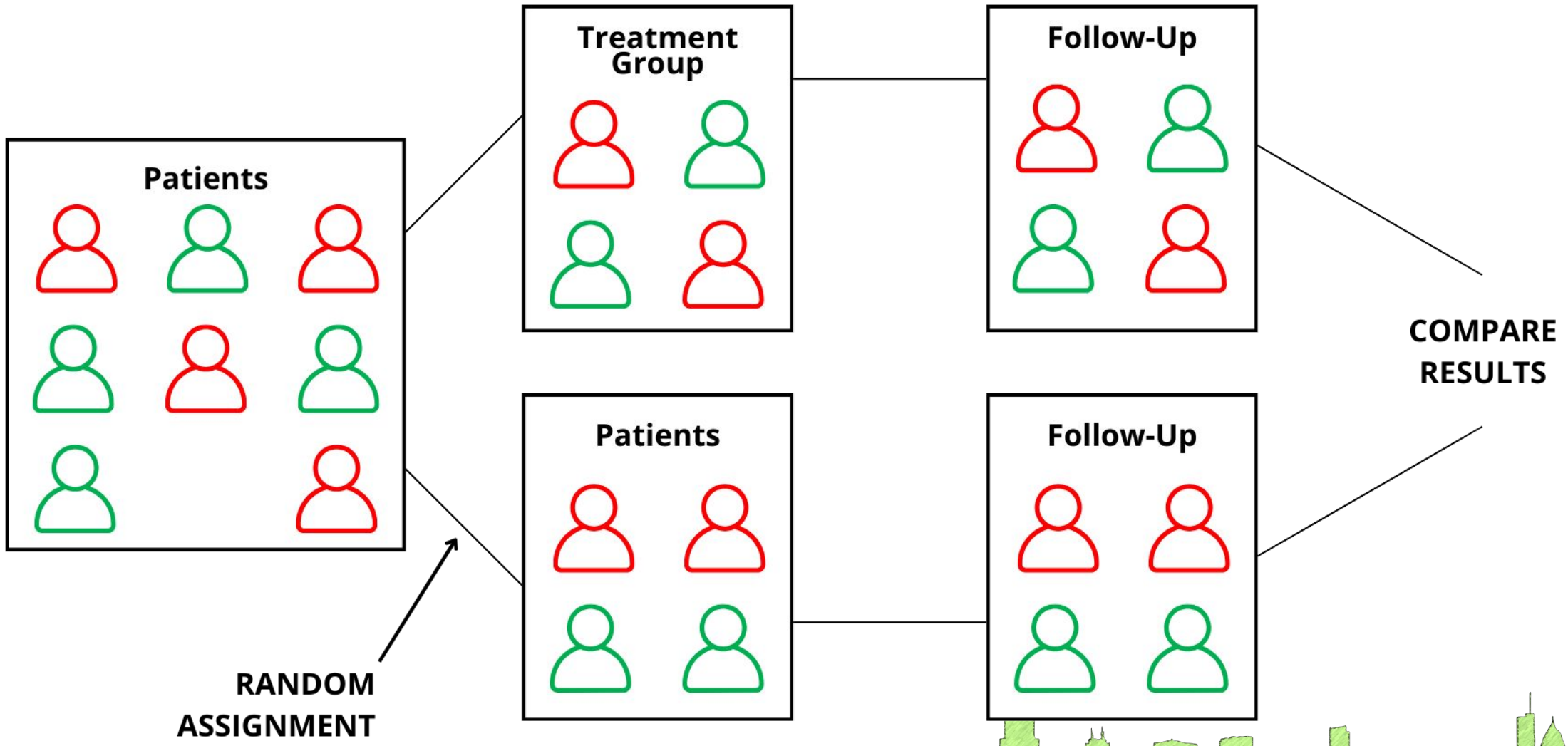
"Evidence-based practice has an important role in facilitating our professional accountability… As part of providing a professional service, **it is our responsibility, whenever possible, to ensure that our practice is informed by the best available evidence**

(Hoffman et al., 2017).

The "gold standard?"



What does a "RANDOMIZED CONTROLLED TREATMENT" Study look like?



Ok, if evidence-based practices work, what gets in the way of doing them?

Answer: It's complicated

LACK OF APPROPRIATE EDUCATION-FOCUSED RESEARCH

Lots of studies

↓

But **few** using **rigorous research design**

↓

Little high quality evidence to guide practice

(Hayward & Phillips, 2009; Nelson, Leffler, & Hansen, 2009).

RELEVANCE TO THE WORK, AND DIFFICULTY WITH IMPLEMENTATION

How's this supposed to work in my classroom?

BIAS

"This doesn't match my current approach."

"I'm not willing to put the time in without some incentive."

"I'll only do this if I'm not happy with what I'm currently doing."

"I already have my current approach and I'll only adopt this if it already confirms what I'm doing."

What works to get past the impediments?

- Create **professional development cohorts** to provide a chance to try and review new approaches
- **Engage teachers in research thinking.**
- **Build a professional reading culture** for your school, district, or system. This might include subscribing to practitioner or academic journals, as well as access to research-based practitioner books or academic books.
- **Engage with academics and universities.** This can be through professional learning or school-university partnerships in order to bridge the gap between those doing educational research, and those seeking to understand and enact it in practice.

(Netoliky, 2018)

https://www.cambridge.org/insight/blog/how-schools-can-engage-with-research-and-evidence

Why do even the most EFFECTIVE innovations sometimes fail?

COMMON PITFALLS

1. **Siloed**/ Fragmented/ "One-Off…" **Adoptions and Implementation**
2. We stop at Visuals, Theory, or Manuals
3. Lack of **SHARED** Purpose, Outcomes, and Supports
4. No Plan for **SUSTAINABILITY**
5. Weak two-way **COMMUNICATION**

BEHAVIORAL HEALTH AUDIT FINDINGS

Office of the Washington State Auditor
Pat McCarthy

The state's approach to student behavioral health is **FRAGMENTED AND LACKS SUFFICIENT RESOURCES**

Behavioral health supports and services available to students **DEPEND ON WHAT SCHOOLS ARE ABLE TO PROVIDE AT THE LOCAL LEVEL**

McCarthy, P., Frank, S., Cortines, C., Fleming, T., Cato, C., Clark, B., Patino, N., Cooper, K. (2021). K-12 Student Behavioral Health in Washington: Opportunities to improve access to needed supports and services. Office of the Washington State Auditor.

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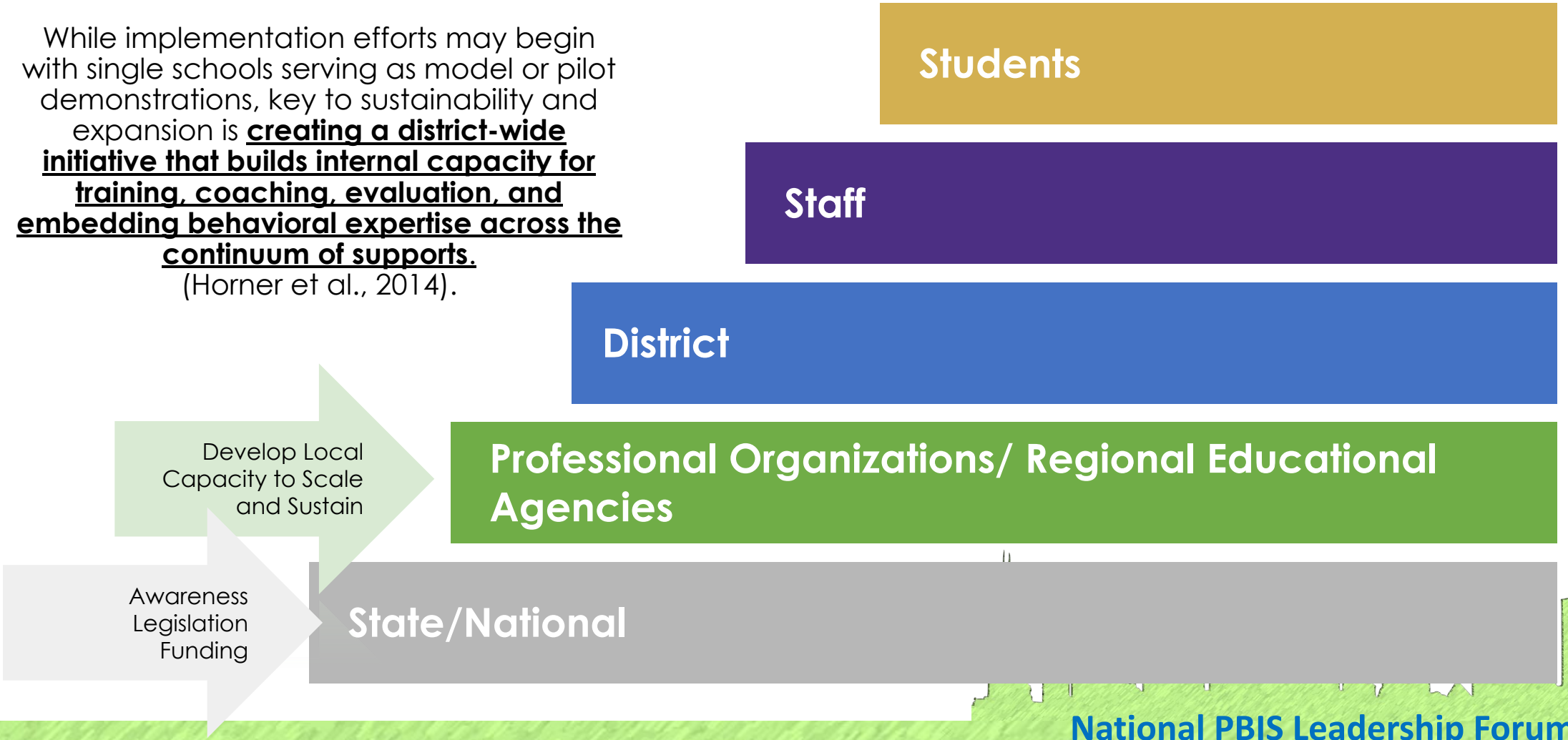
IMPLEMENTATION CASCADE

While implementation efforts may begin with single schools serving as model or pilot demonstrations, key to sustainability and expansion is **creating a district-wide initiative that builds internal capacity for training, coaching, evaluation, and embedding behavioral expertise across the continuum of supports.** (Horner et al., 2014).



ROLE OF THE STATE | LEGISLATION

RCW.28A.150.230 | District School Directors' Responsibilities
RCW 28A.320.230 | Instructional Materials Committee
WAC 392-190-055 | Textbooks and instructional materials Scope Elimination of bias
RCW.28A.345.130 | Model Policy and Procedure for Instructional Materials Diverse and Inclusive Curricula
RCW 28A. 415.445 | Bi-annual Required Training with Funding Sources

ROLE OF THE PROFESSIONAL ORGANIZATIONS | RESOURCES & TRAINING

WASHINGTON

Policy: 2020
Section: 2000 - Instruction

Course Design, Selection, and Adoption of Instructional Materials

The board recognizes its responsibility for improving and growing the schools' educational programs. To this end, course designs will be evaluated, adapted, and developed on a continuing basis. Instructional materials shall be selected to ensure alignment with state learning standards and enable all students to master foundational skills and knowledge to achieve college and career readiness.

I. Definitions
For the purpose of policy and procedure 2020, the following definitions will apply:

A. **Course Design** is the process that includes identifying and sequencing essential content to support students' skill development towards state learning standards. Course design involves providing teachers with appropriate instructional materials, professional development, and support systems as they implement the course.

B. **Instructional Materials** are materials designed for students and their teachers as learning resources to help students acquire facts and skills, develop cognitive processes, and meet state learning standards. Instructional materials may be printed or digital and may include textbooks, technology-based materials, other educational media, and assessments. They may carry different licensing types, from open to all rights reserved. For the purposes of this policy, there are five categories of instructional materials:

Core Instructional Materials are the primary instructional resources for a given course. They are district-approved and provided to all students to help meet learning standards and provide instruction toward course requirements.

Alternative Core Materials are the primary instructional materials for a given course used with a subset of students. These materials are intended to replace approved core materials and may be used for specialized course offerings or flexible learning environments.

Intervention Materials are designed to support strategic or intensive intervention for students at risk of not meeting established learning standards. Intervention materials are used with students to accelerate progress toward particular learning goals based on systematic assessment, decision making, and progress monitoring.

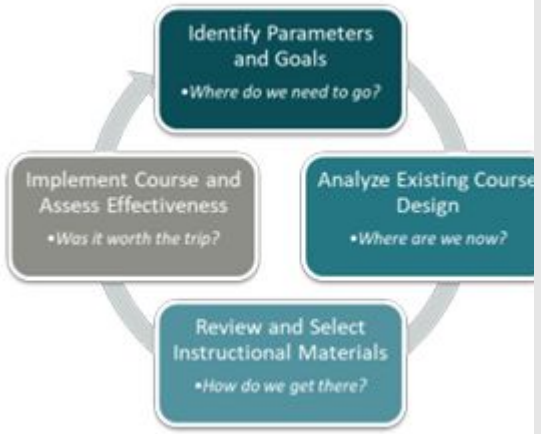
Supplemental Instructional Materials are used in conjunction with the core instructional materials of a course that are not expressly required by the school or district and are instead selected at a teacher's discretion. These items extend and support instruction. They include, but are not limited to, books, periodicals, visual aids, video, sound recordings, computer software, and other digital content.

Temporary Supplemental Materials are those items used in conjunction with the core instructional materials of a course that are of interest or value for a short period and are chosen within district established guidelines. They are not intended to supplant the adopted curriculum nor be used on a regular instructional basis. Examples might include timely

Course Design and Instructional Materials Selection and Adoption

District Toolkit

2024



Washington Office of Superintendent of PUBLIC INSTRUCTION

Washington Office of Superintendent of PUBLIC INSTRUCTION

WASHINGTON MODEL RESOURCE:
Screening for Biased Content in Instructional Materials

TABLE OF CONTENTS

Important Note:

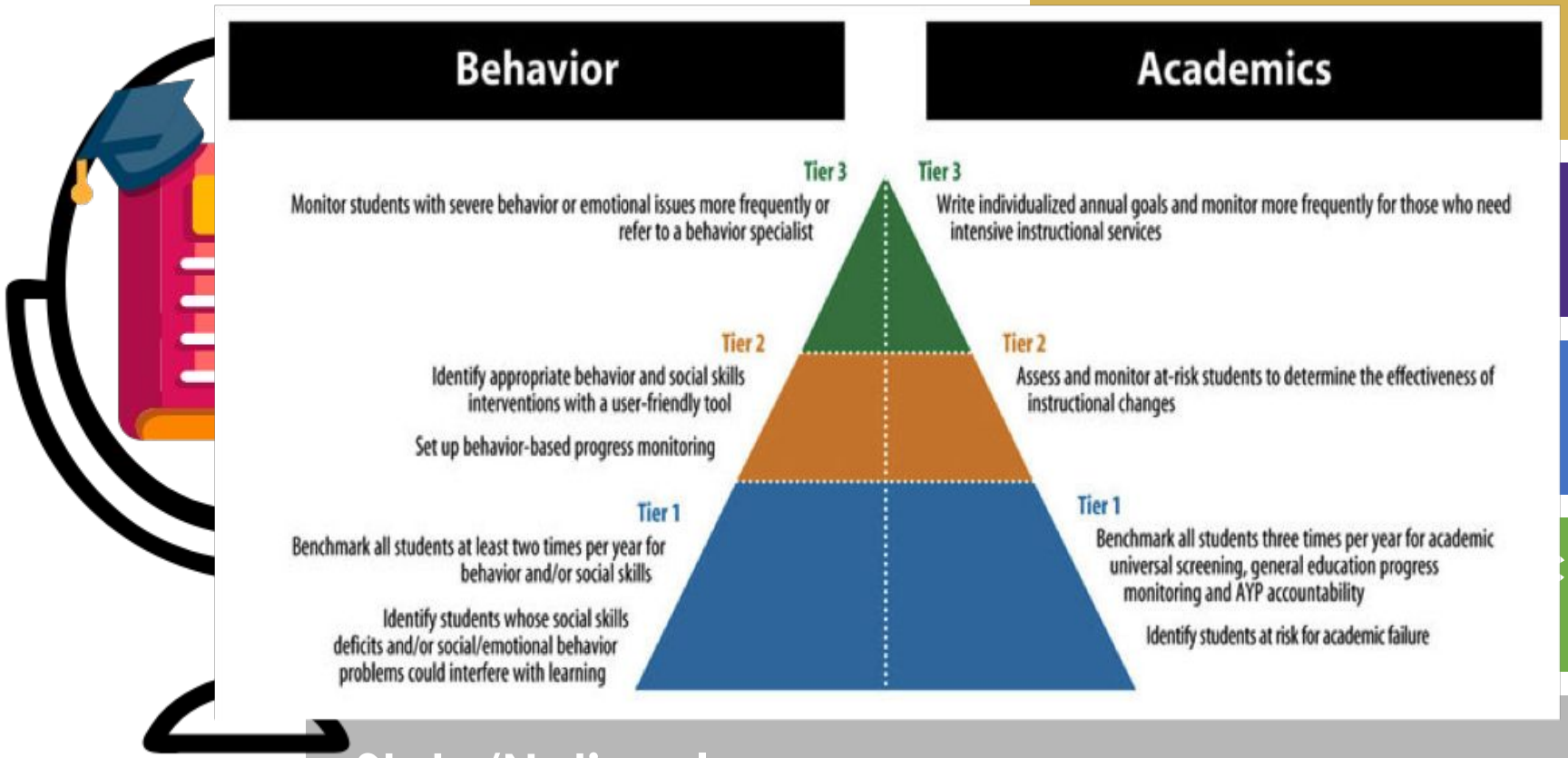
This is version 1.0 of the updated Washington Models for the Evaluation of Bias Content in Instructional Materials (2009). To create this refreshed document, we drew upon a wide variety of existing resources, collaborators throughout OSPI departments, and expert district and educational service district partners. See Reference section for details.

OSPI is releasing this model tool for screening for biased content to Washington districts in the hope that it will provide suggestions and examples for this required part of the instructional materials selection and adoption process. We greatly value your feedback about the tool. Below is a link to a survey to provide your input, questions, and suggestions:

Screening for Biased Content – Tool Feedback

Based on your responses, we will plan on making any revisions to the document in the summer of 2021.

ACADEMICS V. BEHAVIORAL



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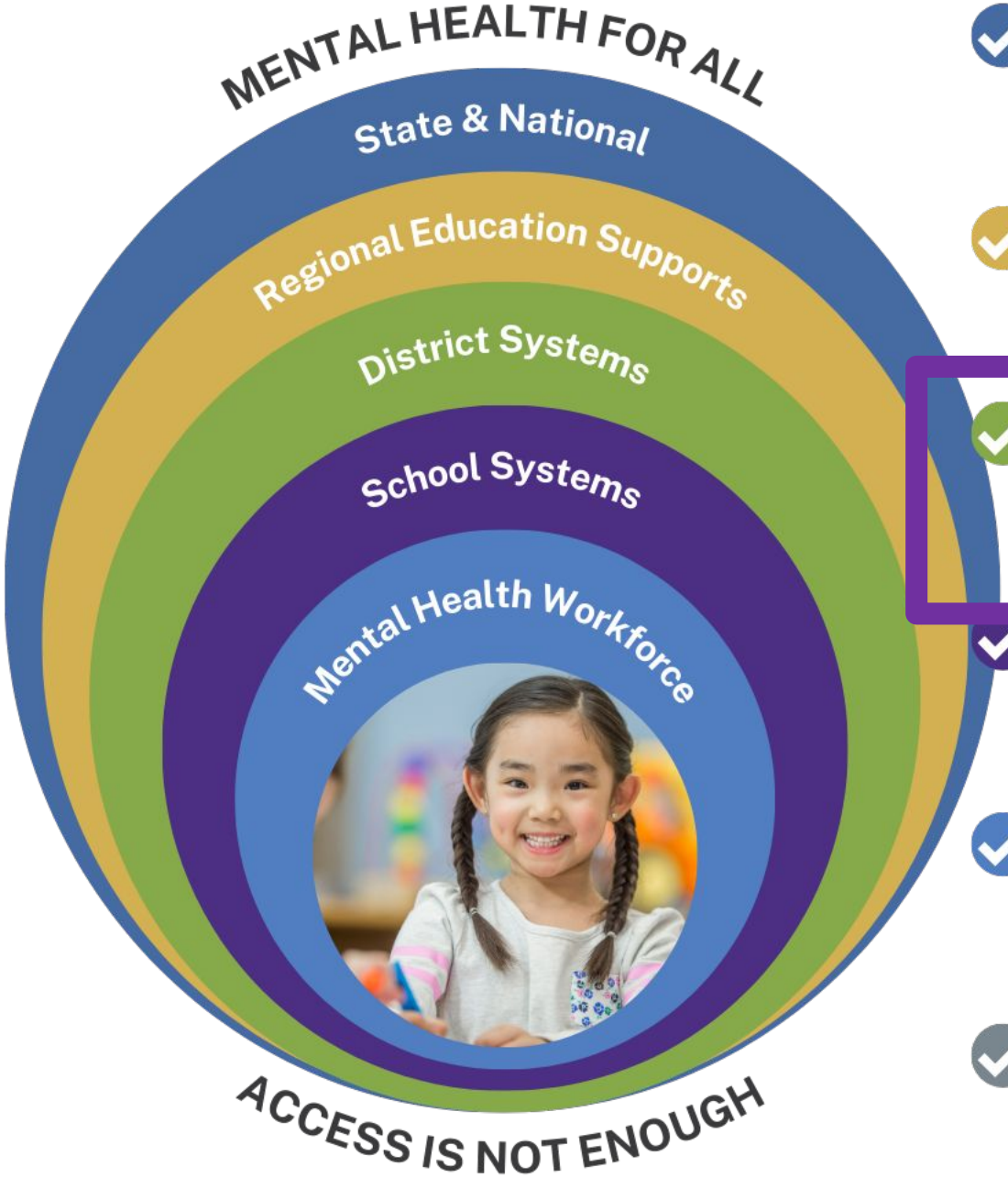
State/National



State & National

Build awareness, capacity, and policies that fund and support what works

- Funding
- Policy
- Visibility
- Research Knowledge

Regional

Develop local capacity to scale and sustain implementation

- Training
- Coaching
- Expanded Data Systems to Promote Equity

District Systems

Build district teams that fund and lead comprehensive school mental health

- Integrated Teams
- Collaborative Selection & implementation of A Continuum of Effective Interventions

School Systems

Select and Lead Implementation of Evidence-Based Practices

- Single-System of Delivery
- Family/Youth/ Community Partnerships
- Data-Informed Supports

Mental Health Workforce

Pre/In-service training and support for teachers, school counselors, school psychologists, social workers, and nurses, etc.

- Expanding Roles of Clinicians
- Supports Across the Tiers
- All Roles Working Together

Children & Youth

Assure that school communities (staff, families, community MH providers) provide effective interventions across every tier of support.

- Early Detection
- Evidence-Based Supports & Interventions
- Social Emotional Learning
- Suicide Prevention

CRITICAL FEATURES

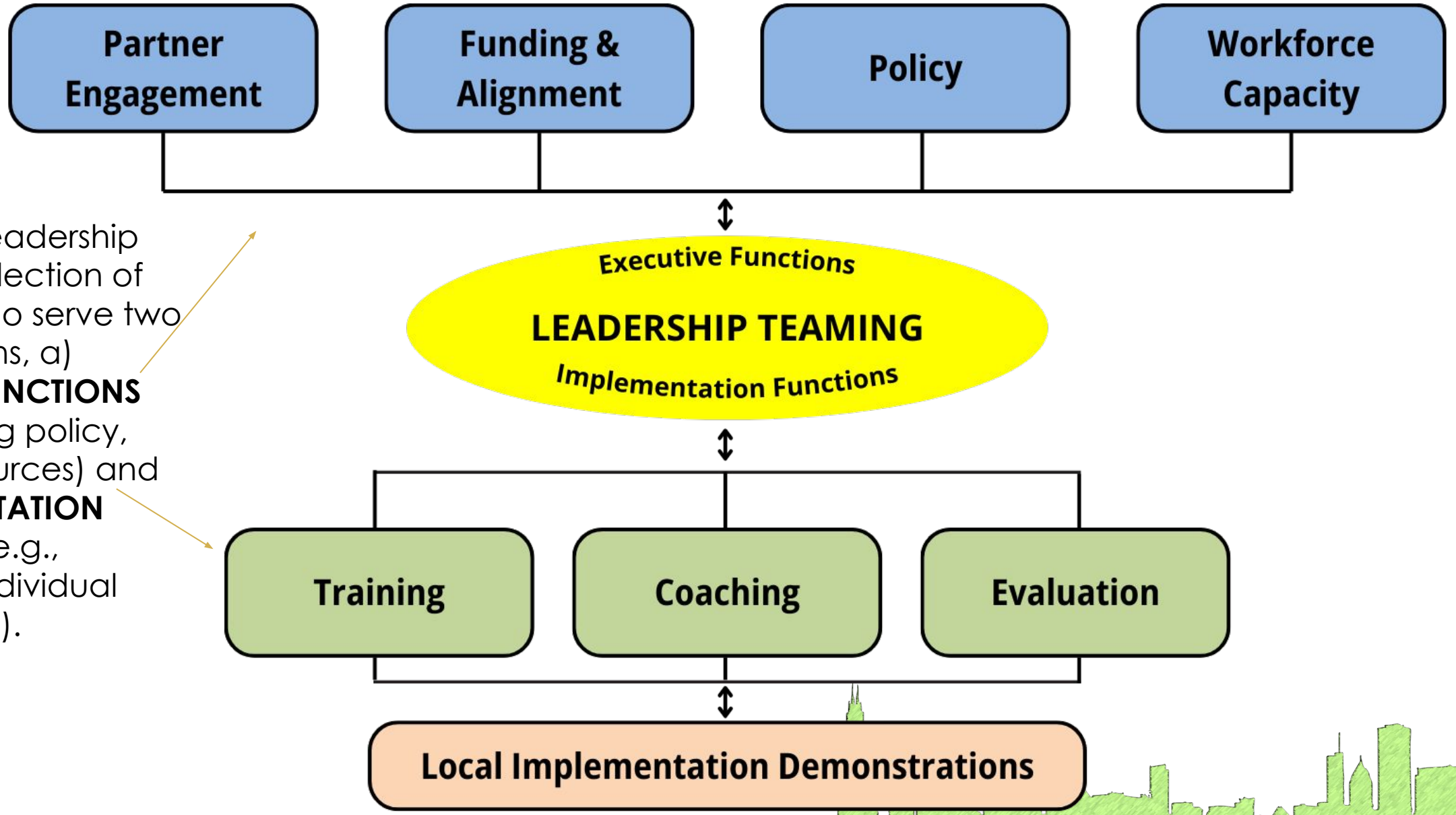
EFFECTIVE TEAMS co-design efforts with youth, family and community members

DATA-BASED DECISION MAKING that include school data and community data

FORMAL PROCESS for the selection and implementation of **EVIDENCE-BASED PRACTICES ACROSS A CONTINUUM OF SUPPORTS**

Rigorous **PROGRESS-MONITORING** for both fidelity and effectiveness of all interventions regardless of who delivers

Ongoing **COACHING** for systems and practices



The District Leadership Team is a collection of personnel who serve two main functions, a) **EXECUTIVE FUNCTIONS** (e.g., creating policy, aligning resources) and b) **IMPLEMENTATION FUNCTIONS** (e.g., supporting individual school teams).

ROLES AND RESPONSIBILITIES

DISTRICT LEADERSHIP TEAM

- ➔ Selects innovations
- ➔ Establishes routines and procedures
- ➔ Determines roles and responsibilities
- ➔ Ensures appropriate skilled staffing
- ➔ Provide professional learning
- ➔ Supports implementation in buildings with additional coaching and technical assistance
- ➔ Aligns data, systems, and practices

SCHOOL LEADERSHIP TEAM

- ➔ Communicates with school community
- ➔ Supports building staff
- ➔ Customizes procedures and routines
- ➔ Coordinates data based-decision making
- ➔ Implementing interventions
- ➔ Progress monitoring

The District Standardizes.

The Buildings Contextualize.

EXPANDING TEAMS

- ➔ Which voices with social-emotional-behavioral health expertise within school system could ben
- ➔ Which voices of mental health, juvenile ju service agency partners could benefit th
- ➔ In what ways are we ensuring that multip voices (i.e.: staff, MH agencies, parents/f etc.) will stay at the table
- ➔ through the development of systems and implementation?

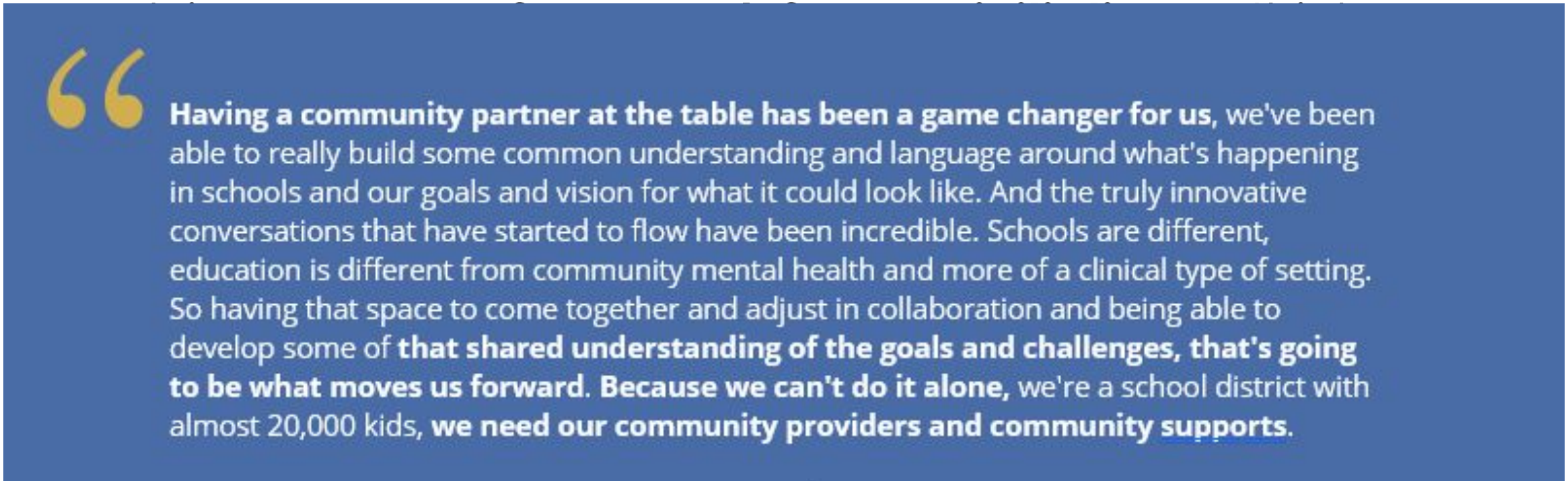
EXPANDING TEAMS

Roles and Responsibilities		
Role	**Overall Description**	**Example Tasks**
School District Superintendent or Designee(s)	Provide overall authority and leadership to the project and direct reports. When possible and appropriate, reallocate resources, address any policy or funding needs, share information with the school board and community to promote visibility and buy-in for the project. This may include the State level Department of Education.	• Provide and promote mission within education systems • Secure funding for priorities within education systems • Direct policy changes within education systems
Mental Health/Child-Family Serving/Community Agency Agency Executive Director(s) or Designee(s)	Provide overall support and leadership to the project and direct reports. When possible and appropriate, reallocate resources, address any policy or funding needs, share information with community stakeholders to promote visibility and buy-in for the project. This may include the State level Department of Human Services.	• Provide and promote mission within community systems • Secure funding for priorities within community systems (e.g., participation in teams) • Direct policy changes within community systems (e.g., change in process for selecting programs or interventions)
Family Member	Provide voice and perspective for families within the district and community. Advocate and promote this process with other families to encourage buy-in and participation.	• Promote mission with opportunities with other families • Ask questions about the work that create understanding and clarity for all families • Provide feedback and input from a family lens in discussions • Engage in tasks for installation and implementation • Be a liaison to connect DCLT and other families

EXPANDING TEAMS

Role	Overall Description	Example Tasks
District Coach to support the ISF	Co-facilitate leadership of the team, responsible for action plan, note taking, keeping implementation moving with established timelines, etc. In addition, will have responsibility with district level PBIS coach for overall fidelity of continuum of interventions	• Collaborate with a team of coaches from community partners • Co-coordinate and lead action planning and activities of ISF installation and implementation • Co-facilitate DCLT meetings • Co-direct evaluation plan for DCLT • Monitor and support school staff implementation of continuum of interventions defined by DCLT • Design and provide training and coaching to school teams and district staff
Mental Health/Child-Family Serving Agency/Community Agency Coach to support the ISF	Co-facilitate leadership of the team, responsible for action plan, note taking, keeping implementation moving with established timelines, etc. In addition, the supervisor will have responsibility within the Agency for overall fidelity of implementation of continuum of interventions.	• Collaborate with a team of coaches from district and other community partners • Co-coordinate and lead action planning and activities of ISF installation and implementation • Co-facilitate DCLT meetings • Co-direct evaluation plan for DCLT • Monitor and support community staff implementation of continuum of interventions defined by DCLT • Design and provide training and coaching to community staff and clinicians
Building Principal or Designee from ISF Schools	Responsible for sharing information from building with the district-community leadership team and vice versa. Responsible for overall implementation across tiers within his/her building. Will advocate and promote this process with students, families, and staff.	• Promote mission with staff, families, and students • Create welcoming space for community partners to facilitate continuum of interventions • Secure resources (e.g., reallocation of staff responsibilities, time for students to receive intervention) to support implementation of a continuum of interventions defined by DCLT

"I'd say one of the biggest strengths that I see out of the ISF



- - District Community Leadership Team Member

Role of Community Partners

"As a Community Partner it has been extremely useful to be a part of the DCLT and learn how school systems function. Systems, in general, are often complex, confusing and only understood to those who function within them. Having an equal seat at the table allows for an open dialog about how each system (behavioral health and education) can work together. This partnership then lends itself to how we can impact our shared end goal of supporting the overall wellbeing of the child. The opportunity to work together and build a system that will function effectively for each and every child is paramount for communities, families and youth."

Andrea Peyton, MSW, CMHS
Program Director, Lutheran Community Services Northwest

STUDENT & FAMILY VOICE

- **2 YEAR** Process
- **SHARED LEARNING**–External Facilitation
- Over 50 participants
- Family/ Community Prioritization
- 1 Year Field Testing (Student/Staff/Family Voice)

PASCO SCHOOL DISTRICT

DECISION MAKING

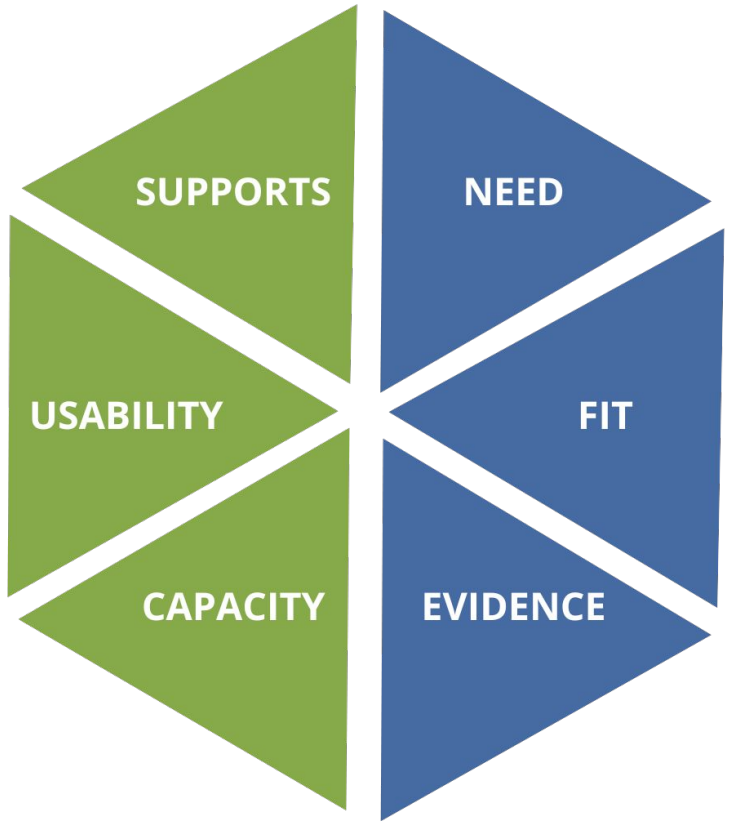
PROFESSIONAL JUDGEMENT

EVIDENCE-BASED DECISION-MAKING

THE HEXAGON TOOL

Scaffolds the decision-making process for **evaluating the fit and feasibility of evidence-based programs or practices** within your **specific context** during the **exploration** phase**.**

- It's more than a tool/resource!
- It's a **continuous improvement process** intended to regularly **evaluate new and existing programs, communicate, and foster stakeholder engagement.**



FORMAL SELECTION PROCESSES

- What state/local policies/resources currently exist?
- What does your organization use for academics?
- What other high-quality/reputable exist?

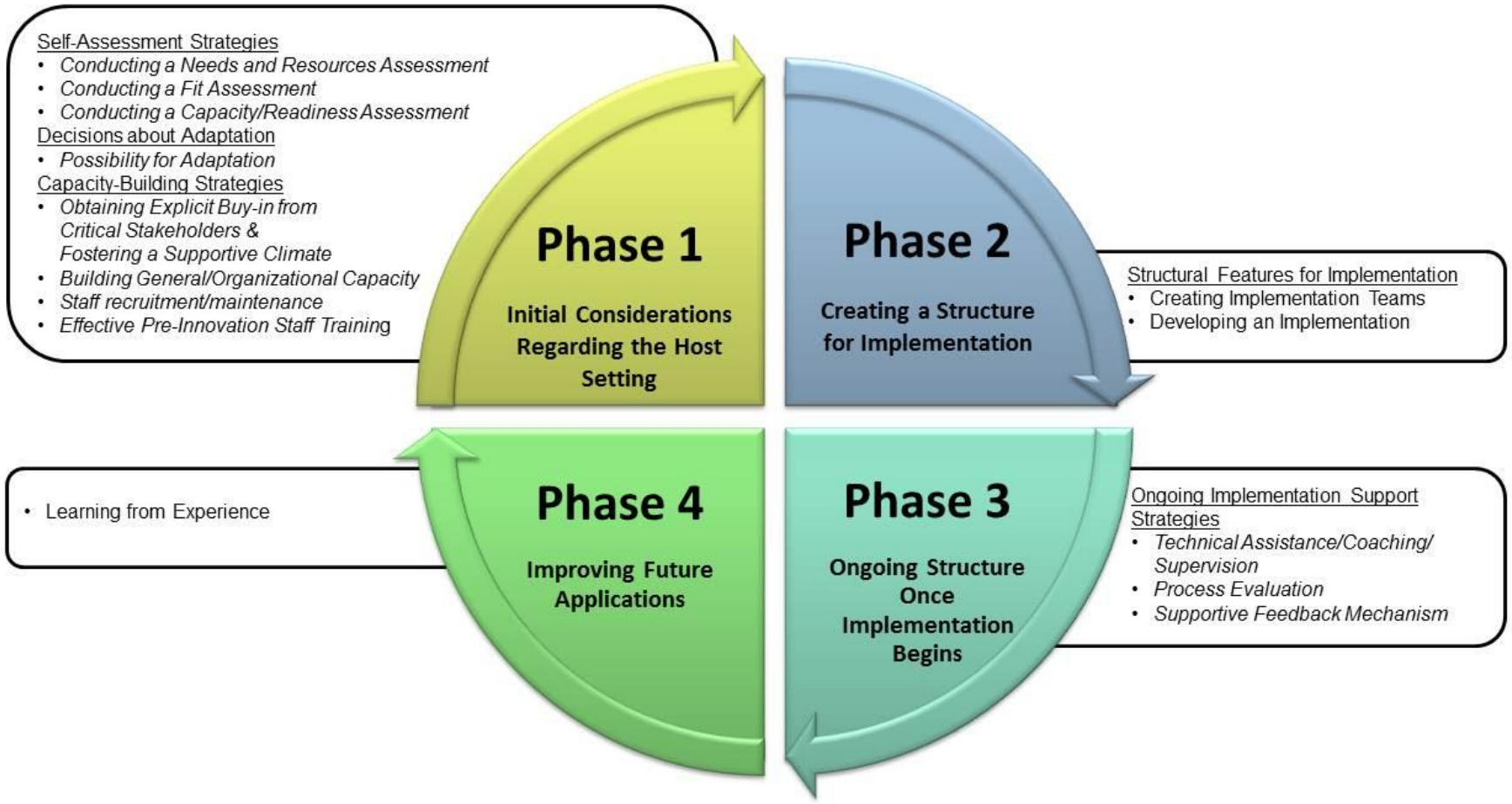
CONSUMER GUIDE TO SELECTING EVIDENCED BASED MENTAL HEALTH SERVICES WITHIN A SWPBS MODEL

ITEM	STATUS	NOTES
Assessment		
1. An assessment has been conducted to determine the need, risk and intensity of the services. These may include the following depending on the presenting problem and the level of risk student presents with: ☐ Strengths assessment. i.e.; Strengths and Difficulties Questionnaire (Goodman, 1997) ☐ Functional behavioral assessment ☐ Social skills assessment i.e.; (SSIS, SRS) ☐ Mental health functioning rating scales i.e.; Self-Report Youth Inventories ☐ Risk assessment ☐ Diagnostic assessment	Select Current Status	
2. Results of the assessment indicate the strengths and skill deficits of the student	Select Current Status	
3. Assessment results are reviewed at the appropriate continuum of behavior support team (universal, tier II, tier III) ☐ to determine the appropriate school based intervention and/or ☐ referral, in conjunction with the school team, to a more qualified mental health professional if needed to assess	Select Current Status	

PASCO SCHOOL DISTRICT

EXEMPLAR TAKEAWAYS

- ➔ Identify barriers early and invite/address them early!
- ➔ Spend time on relationships
- ➔ Invest in learning
- ➔ Leverage the policies, resources, and practices we use with academic interventions
- ➔ OVER communicate–early and often
- ➔ Create frequent feedback loops and ensure it is representative of the entire community
- ➔ Participate rather than lead
- ➔ Go slow to go far



QUALITY IMPLEMENTATION FRAMEWORK – Abe Wandersman

Plan

Figure 2
The Interactive Systems Framework for Dissemination and Implementation 2.0

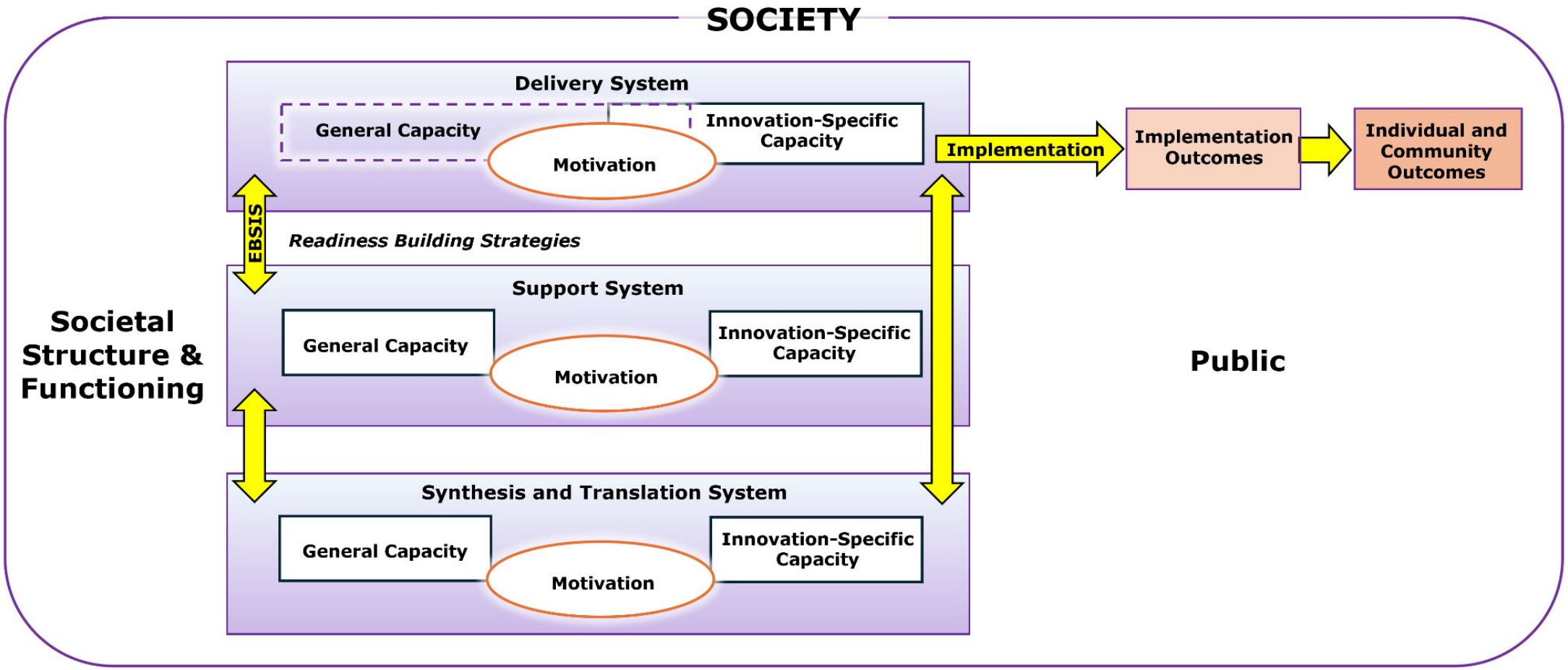


Table 3
GTO Accountability Questions and Supporting Literature Base

GTO STEPS	ACCOUNTABILITY QUESTIONS	RELEVANT LITERATURES
Step 1: Needs and Resources Assessment	What are the underlying needs and conditions that must be addressed?	Needs/Resource assessment
Step 2: Goals	What are the goals, target population, and objectives? (i.e., desired outcomes)?	Goal setting
Step 3: Best Practices	What science (evidence) based models and best practice can be used in reaching the goals?	Consult literature on science-based and best-practice programs
Step 4: Fit	What actions need to be taken so the selected practices "fits" the community context?	Feedback on comprehensiveness and fit of program
Step 5: Capacities	What organizational capacities are needed to implement the practices?	Assessment of organizational capacities
Step 6: Planning	What is the plan?	Planning
Step 7: Implementation/ Process Evaluation	Is the practice being implemented with quality?	Process evaluation
Step 8: Outcome Evaluation	How well is the practice working?	Outcome and impact evaluation
Step 9: Continuous Quality Improvement	How will continuous quality improvement strategies be included?	Total quality management; continuous quality improvement
Step 10: Sustainability	If the practice is successful, how will it be sustained?	Sustainability and institutionalization

Example: Addressing Trauma Across Tiers

- Supporting Students Exposed to Trauma
- Cognitive Behavioral Intervention for Trauma in Schools
- Trauma-Focused Cognitive Behavioral Therapy

Supporting Students Exposed to Trauma (SSET)

- SSET is an intervention program for students in 5th grade and above who have been exposed to trauma and have symptoms of PTSD; adapted from CBITS
- Delivered by school staff- including teachers and counselors without clinical training (with support from a local clinician); designed to help schools and school systems that do not have access to school-based clinicians
- Consists of 10 student-group meetings with periodical progress updates for parents and out of session assignments and activities for students
- Students learn skills surrounding regulation, relaxation, problem solving, and processing trauma related memories and grief

(National Child Traumatic Stress Network, 2017)

Supporting Students Exposed to Trauma (SSET)

(National Child Traumatic Stress Network, 2017)

Supporting Students Exposed to Trauma (SSET)

- Training can be live (in person or virtual) or online, though live trainings are considered the gold-standard
- More information and intervention materials can be found through the Center for Safe and Resilient Schools and Workplaces website, found here
- Learn more about SSET from the National Child Traumatic Stress Network's (NCTSN) Fact Sheet

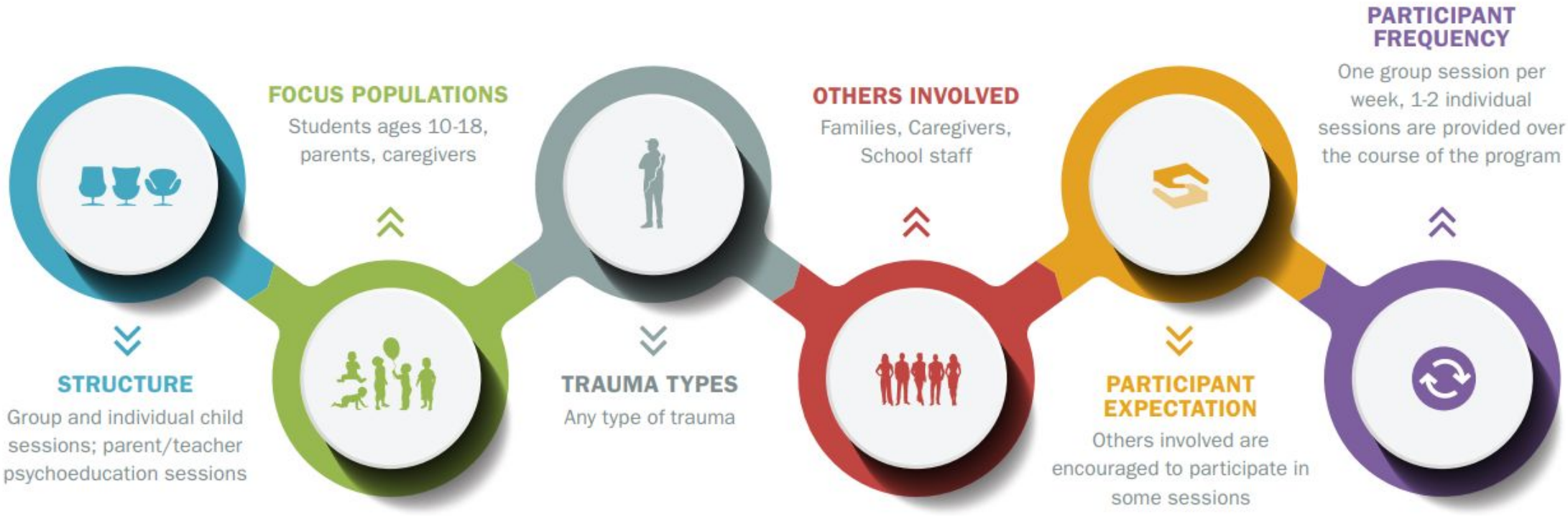
(National Child Traumatic Stress Network, 2017)

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

CBITS: a school-based group intervention used to target the effects and symptoms of trauma (i.e. PTSD, depression, anxiety, behavioral problems) in students ages 10-18 (Langley et al., 2010; The National Child Traumatic Stress Network, 2024).

- **Successful implementation** results in improved social and academic functioning, improved grades and attendance, increased peer and parent support, and increased coping skills (Center for Safe & Resilient Workplaces, 2025).
- **CBT techniques and skills**: affect regulation, relaxation, challenging maladaptive thoughts and problem-solving, cognitive restructuring, and traumatic memoy and grief processing through psychoeducation and experiential learning (The National Child Traumatic Stress Network, 2024)

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)



(National Child Traumatic Stress Network, 2017)

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

- Students develop and reinforce social-emotional processing skills through 10, in-school group sessions, 1-2 individual meetings, 2 parent education sessions, and 1 teacher education session over the course of 10 weeks (Langley et al., 2010).
  - Interventions also target parents and caregivers
- CBITS Training Menu
- Learn more about CBITS from the National Child Traumatic Stress Network's (NCTSN) Fact Sheet

Trauma-Focused CBT (TF-CBT)

- Integrates theories and techniques of several therapeutic interventions to address and improve the symptoms of post-traumatic stress in youth
- Originally developed to address needs of children who experienced sexual abuse, but has been used and studied over the past 15 years for many other populations of traumatized youth
- Evaluated and refined over the past 30 years; 25 RCTs have been conducted in the U.S., Europe, and Africa comparing TF-CBT to other active treatment conditions (all documenting superiority of the treatment)

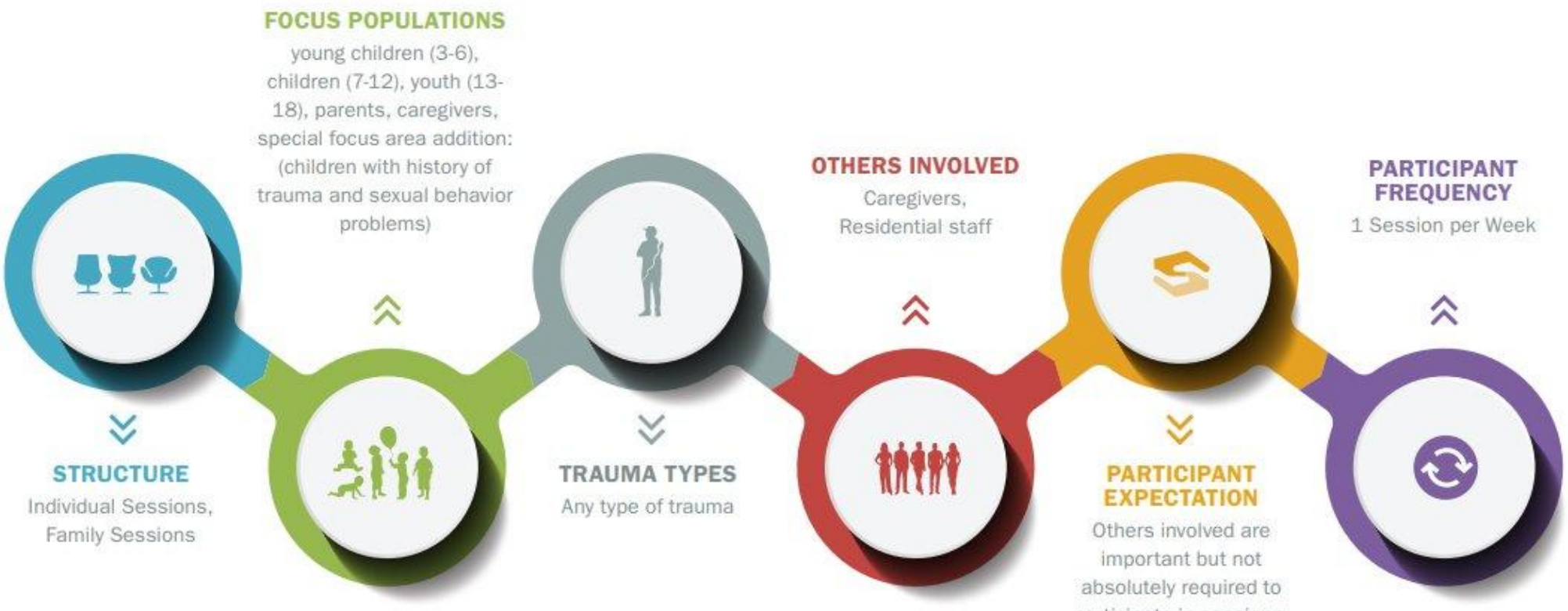
(National Child Traumatic Stress Network, 2017; National Therapist Certification Program, 2025)

Trauma-Focused CBT (TF-CBT)

- Structured, short-term intervention that can last anywhere from 8-25 sessions
- Core features include psychoeducation, coping skills, gradual exposure, cognitive processing, and caregiver involvement
- Highly effective ad improving youth PTSD symptoms; also effectively addresses affective (e.g., depressive, anxiety), cognitive, and behavioral problems, and improves the participating parent or caregiver's personal distress about a child's traumatic experience, effective parenting skills, and supportive interactions with the child

(National Child Traumatic Stress Network, 2017; National Therapist Certification Program, 2025)

Trauma-Focused CBT (TF-CBT)



(National Child Traumatic Stress Network, 2017; National Therapist Certification Program, 2025)

TF-CBT – Access to Materials

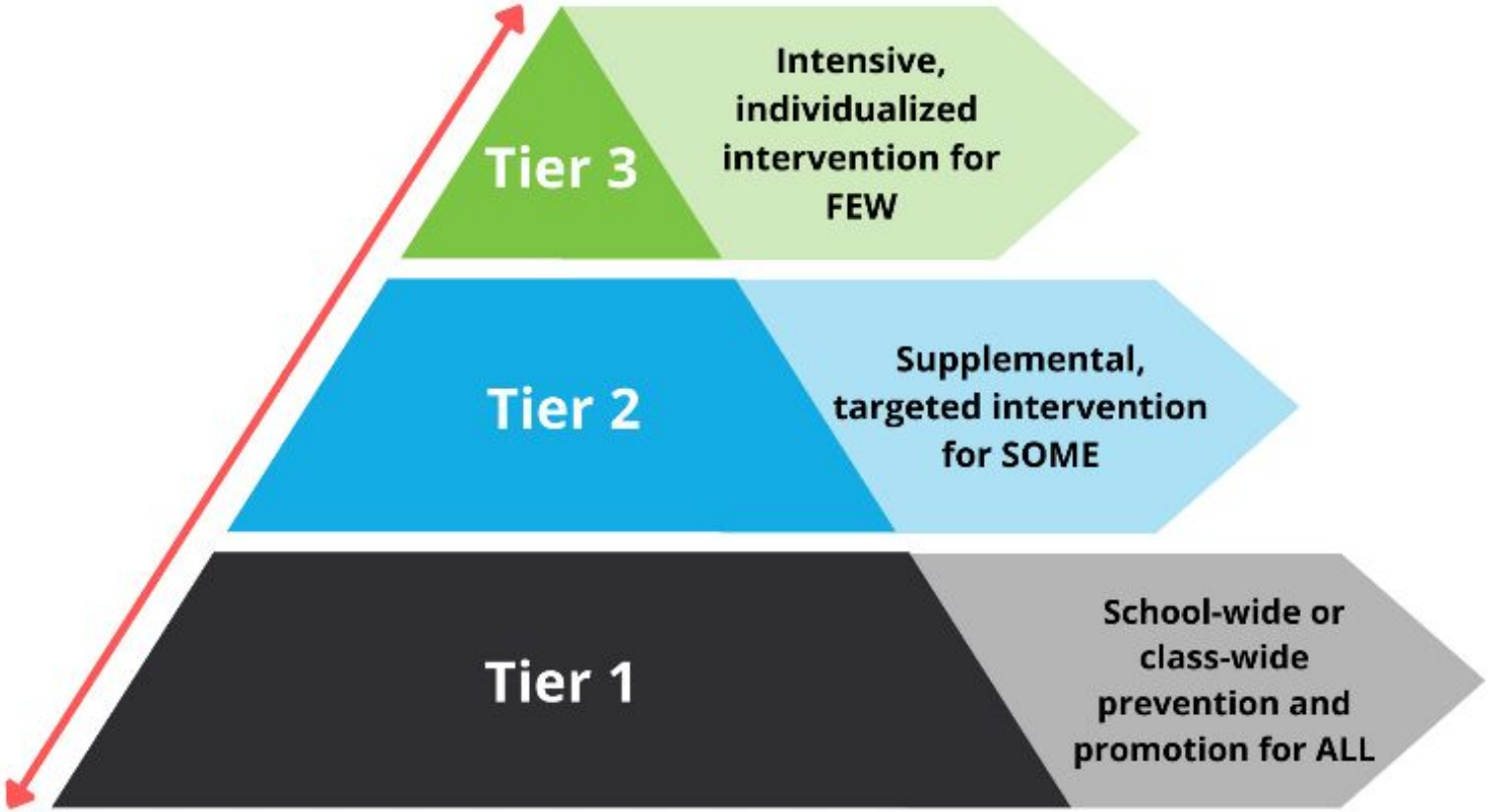
SAMHSA has recognized TF-CBT as a Model Program due to the extensive outcome data from RCTs that support its effectiveness in improving a variety of problems. Training is available at:

- MUSC – TF-CBT Web 2.0
- TF-CBT National Therapist Certification Program

Learn more about TF-CBT from the National Child Traumatic Stress Network's (NCTSN) TF-CBT Fact Sheet

(National Child Traumatic Stress Network, 2017; National Therapist Certification Program, 2025)

ALIGNING PROGRAMS: SUPPORTS ARE ADDITIVE



- Students receiving Tier 2 and Tier 3 support ***also*** continue receiving Tier 1 support
- Aligning practices means more **streamlined** supports for students

WHY ALIGN?

- Ensures resources are responsive to student needs
- Maximizes efficiency for staff, school, and district
- Reduces "initiative overload" and duplication of effort
- Promotes consistency and coherence across system

APPROACHES TO ALIGNMENT

1

Single-Practice Scaling

- Select EBPs you can implement across tiers
- Focus on intensity
- e.g., Second Step at Tier 1 and "double dose" in small group setting at Tier 2

2

Core-Plus Model

- Consistent core practices across tiers
- Focus on layering
- e.g., Tier 1 PBIS, Check-in/Check-out at Tier 2, Behavior Intervention Plan at Tier 3

3

Nested Practices

- Coherent framework and language
- Focus on complementarity
- e.g., select practices with common theoretical foundations (CBT, SEL, trauma-informed care)

CONSIDERATIONS FOR ALIGNMENT

Cross-Disciplinary Collaboration

- Teams should include:
  - Individuals involved in intervention delivery across tiers (at minimum)
  - School-based and community providers (ideally)
- Ensures EBPs complement instead of compete

CONSIDERATIONS FOR ALIGNMENT

Integrated Data Systems

- Include relevant social-emotional, behavioral, academic, and community data
- Metrics to consider:
  - Student outcomes (screening results, discipline referrals, teacher nominations, etc.)
  - Service utilization (number/percent accessing Tier 1, 2, and 3 supports)
  - Staffing (interventionists available in each building)
  - Resources (interventions, programs, etc. available)
- Decision rules

2-STEP PROCESS

Step 1: Assess Needs and Resources

1. Know what the student body/community needs/wants
2. Know what is available
3. Compare needs to resources
    - To what extent do resources reflect needs?
    - Determine what to continue, discontinue, invest in

2-STEP PROCESS

Step 2: Select Practices

1. Match the practice to the **problem**
   - If 40% of students display self-regulation difficulties, does Tier 1 address self-regulation?
   - Consider the *why* beneath the problem (e.g., can't do vs. won't do)
2. Match (or adapt) the practice to the **context**
   - Is the intervention feasible to implement? Are staff available? Is training needed/accessible? Are space and materials available? Affordable? Does it align with school/district priorities?

STATES SUPPORTING ALIGNMENT

- Training, coaching and guidance materials – defining alignment, applying the logic, synthesizing data, mapping resources, selecting practices
- Prioritizing/Tailoring support
  - Identifying haphazard implementation, resource constraints
- Templates/examples of tiered EBP menus
- Models of alignment in different settings/contexts
- Data dashboards integrating key metrics (student outcomes, service utilization, staffing, resources, etc.)

TIERED RESOURCE MAP

	Tier 1	Tier 2	Tier 3
Academic			
Externalizing Behavior			
Social-emotional and mental health			

TIERED RESOURCE MAP

	Tier 1	Tier 2	Tier 3
Teaming			
Practices			
Systems			
Data			

QUESTIONS

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