

# PUBLICATION SERIES

Office of Mental Health and Substance Abuse Services

## A MENTAL HEALTH PRACTITIONER'S GUIDE TO POSITIVE BEHAVIOR SUPPORT FOR CHILDREN WITH DISABILITIES AND PROBLEM BEHAVIOR AT SCHOOL

By Timothy P. Knoster, Ed.D.

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## PUBLICATION SERIES

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## **A Mental Health Practitioner's Guide to Positive Behavior Support for Children with Disabilities and Problem Behavior at School**

by

**Timothy P. Knoster, Ed.D.**

### **Introduction**

One of the greatest challenges faced by schools is in providing effective services and programs to children with disabilities who exhibit problem behavior. This challenge can become further complex in relation to the integration of medically necessary mental health services with individualized educational programs (IEPs).

On June 4, 1997, amendments to the Individuals with Disabilities Education Act (IDEA) became law (P.L. 105-17). These amendments introduced several new concepts, two of which are particularly important to the education of students with disabilities who exhibit problem behavior. Section 614(d)(3)(B)(I) of P.L. 105-17 states that "in the case of a child whose behavior impedes his or her learning or that of others, the child's IEP team must consider, when appropriate, strategies, including positive behavioral intervention strategies and supports, to address that behavior." Section 615(k)(1)(B)(i) of the law states, "If the local educational agency did not conduct a functional behavioral assessment and implement a behavioral intervention plan for such child before the behavior that resulted in the suspension described in subparagraph (A), the agency shall convene an IEP meeting to develop an assessment plan to address that behavior." In addition, "If the child already has a behavioral intervention plan, the IEP Team shall review the plan and modify it, as necessary, to address the behavior" (Section 615(k)(1)(B)(ii)).

Positive Behavior Support (PBS) and Functional Behavioral Assessment (FBA) are not new concepts or practices. However, in the context of IDEA, they represent an important effort to improve the quality

of behavioral interventions and support. As schools collaborate with the mental health community in order to organize to meet these requirements and meet the behavioral needs of children with disabilities, attention must be given to the definitions, features, and uses of PBS and FBA (Sugai et. al., 2000). The purpose of this paper is to provide mental health practitioners with useful information that defines FBA and PBS, describes critical features of FBA and PBS, and provides guidance concerning the coordination and/or integration of mental health services within the context of student IEPs.

### **Background and Definitions**

Traditional approaches to "manage" problem behavior are often ineffective, primarily for two reasons (Bambara and Knoster, 1998). First, the common application of behavior management has paid little attention to understanding (a) who the child is, (b) what the social contexts for the behaviors are, and (c) what the function or purpose of the problem behavior is. Second, traditional management procedures have predominantly placed greatest emphasis on using unpleasant consequences to suppress or control behavior, rather than teaching and reinforcing the use of socially acceptable alternative skills.

An alternative approach referred to as *positive behavior support or positive approaches* has emerged in response to the shortcomings of traditional behavior management procedures. Positive behavior support is a values-driven approach to solving problems that educators in partnership with mental health practitioners can use

effectively across a variety of settings. It involves the assessment and reengineering of environments so children with problem behaviors experience reductions in their problem behaviors and increase social, personal, and vocational quality in their lives.

This approach represents the application of behavior analysis and systems change perspectives within the context of child-centered values to the intensely social problems created by problem behavior (Research and Rehabilitation Center on Positive Behavior Support, 2000). It is an approach that blends values about the rights of children and adolescents with disabilities with a practical science about how learning and behavior change occur. Positive behavior support incorporates recent trends in research and practice that emphasize designing positive and effective interventions that are based on a comprehensive assessment of the factors affecting a child's behavior (Horner et al., 1990). Simply stated, PBS is a collaborative, assessment-based process to develop effective, individualized interventions and supports for children (as well as adults) with challenging behavior. Support plans focus on proactive and educative approaches.

### **Underlying Assumptions**

Positive behavior support is guided by four fundamental assumptions about challenging behavior and effective intervention. These underlying assumptions are consistent with, and/or supportive to, Pennsylvania CASSP Principles (OMHSAS, 1995).

First, problem behaviors are context related...that is, they are usually triggered and maintained by something in the child's environment. Environmental influences may be discrete events external or internal to the child, such as being presented with a difficult task, being told what to do, or having a bad cold. Environmental influences may also be broad and consist of an interplay of multiple factors such as the child's

routines, quality of his/her social relationships, experiences with negative events, and lack of opportunity to participate in personally rewarding activities.

Second, problem behaviors serve a function for the child. Although socially unacceptable, children often engage in problem behaviors because they serve a useful purpose. For example, a child may engage in problem behavior to escape or avoid unpleasant situations such as failure in front of peers, or to gain access to desired activities, objects, or social interactions.

Third, effective interventions and support are based on a thorough understanding of the child, his or her social contexts, and the function of the problem behavior. Current research suggests that the most effective interventions are assessment based and directly linked to known environmental influences and to the function of the problem behavior (Carr, et al, 1999). Once the function of the problem behavior is understood, the goal is to teach socially acceptable alternatives. Once environmental influences are understood, the goal is to (a) modify these factors to minimize stressors for the individual, (b) prevent problem behaviors from occurring, and (c) encourage the child's long-term use of alternative skills.

Fourth, effective interventions and support are grounded in child-centered values that respect the dignity, preferences, and goals of each child. More than a technology to reduce problem behavior, PBS is grounded in child-centered values that treat all children, regardless of their level of ability or the nature of their problem behavior (e.g., mental illness), with the same respect and dignity we hold for ourselves. This means that interventions must not stigmatize the child and must be acceptable for same-age peers without disabilities in typical settings.

Child-centered values also require us to honor personal preferences and goals; and to work toward

outcomes that are not just important to teachers, mental health practitioners, and parents, but are also meaningful to the child.

### **Key Features**

Positive behavior support has three key features. These features include: functional (behavioral) assessment, comprehensive intervention and supports, and lifestyle enhancement (Horner & Carr, 1997; Koegel, Koegel, & Dunlap, 1996).

#### ***Functional Behavioral Assessment.***

The cornerstone of PBS is the use of functional (behavioral) assessment. Functional assessment is a process for identifying the events that trigger and maintain problem behavior (Demchjak & Bossert, 1996; Foster, Johnson & Dunlap, 1993; Rep & Horner, 1999).

The purpose of FBA is to gather both broad and specific contextual information (e.g., environmental factors that influence behavior) in an effort to discover the reasons for problem behavior in order to improve the effectiveness, relevance, and efficiency of behavior support plans (Carr et. al., 1999; Foster-Johnson & Dunlap, 1993; O'Neill et. al, 1997; Sugai, Horner & Sprague, 1999). By the end of the initial assessment process, child centered teams develop hypothesis statements that (a) summarize assessment results, (b) offer explanations for individualized behavior support plans.

#### **Gathering Broad Information**

The first step in the assessment process is to gather broad information about the child's skills and abilities, preferences and interests, general health status and quality of life. This information is vital not only to increase understanding as to why the child engages in problem behavior, but also to guide the development of effective interventions and support that are uniquely tailored to the child's preferences, needs, and life circumstances. Table 1

highlights what to assess and where to gather relevant broad information.

**Table 1**

<p style="text-align: center;"><b>Gather Broad Information</b></p> <p style="text-align: center;"><i>Access What Areas?</i></p> <p><b>Student strengths and skill limitations</b> <b>Daily routines and activities</b> <b>Student and family preferences and goals</b> <b>Physical health concerns</b> <b>Mental health concerns</b> <b>Quality of life:</b></p> <ul style="list-style-type: none"><li>• <b>Relationships</b></li><li>• <b>Happiness</b></li><li>• <b>Choice and control</b></li><li>• <b>Access to preferred events</b></li><li>• <b>School and community inclusion</b></li></ul> <p style="text-align: center;"><i>Gather Information Where?</i></p> <p><b>Team discussions</b> <b>Interviews</b> <b>Review of records</b> <b>Rating scales</b> <b>Specific skills assessments</b></p> <p style="text-align: right;">(Bambara and Knoster, 1998)</p>
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When gathering broad information, consider how you can build upon the child's current strengths in each area assessed. Conversely, consider how negative influences or the absence of positive factors may be contributing to the child's problem behavior. For example, when assessing daily routines, preferences, and goals, determine what the child enjoys and consider whether typical routines provide sufficient opportunities to pursue interests and participate in preferred activities. Conversely, consider whether the child's day is filled with events that are disliked, problematic, or unduly stressful. When exploring health concerns, consider whether problem behaviors are related to the child's physical health (e.g., cold, menstrual

cramps, chronic anemia), routines and patterns (e.g., poor dietary or sleep habits), or mental health issues (e.g., depression, anxiety). As should be standard practice, interagency IEP teams supporting a child/adolescent with emotional and/or behavioral difficulties should identify interventions and supports that will address mental health concerns directly (e.g., seek medical assistance) and indirectly (e.g., lessen demands on days when the child is not feeling well).

Finally, it is important to gather information about the child's lifestyle by asking a series of questions. For example: What is the quality of the child's relationship with peers and family members? Is the child happy and content? Does he or she have opportunities for choice and control within typical routines? Does the child have reasonable access to preferred activities? Is he or she included in typical school and community activities? Answers to such questions provide not only important clues for understanding what factors appear to be contributing to problem behavior, but also help to identify relevant goals with the child and his or her family within the context of the IEP team.

A range of information gathering tools and processes may be used by interagency teams at the broad assessment stage. They include: team discussions; interviews with the child, teachers and therapists, and family members; a review of the child's records; rating scales; classroom observation; and specific skills assessments (e.g., communication, social skills, reading).

### Gathering Specific Information

The child's IEP team gathers operational information in the second stage of the FBA that will (a) pinpoint the conditions that are regularly associated with the problem behavior, and (b) identify the function or purpose of the child's behavior (Tilly, et al, 1998). Table 2 lists four important questions to be answered and a few

common approaches to gathering relevant specific information.

**Table 2**

## **Gather Specific Information**

### *Questions to Answer*

- 1. When is the child most likely to engage in problem behavior?**
- 2. What specific events appear to be contributing to the problem behavior?**
- 3. What function(s) does the problem behavior serve for the child? What might the child be communicating?**
- 4. When is the child less likely to engage in problem behavior?**

### *Approaches for Gathering Specific Information:*

- ♦ **Informant Methods:**
  - **Individual interviews**
  - **Team discussion or interviews**
  - **Rating scales or surveys**
- ♦ **Direct observations:**
  - **Scatter plots**
  - **ABC analyses**

(Bambara, Knoster, 1995; 1999)

A variety of approaches can be used to answer the questions posed in Table 2. Typically, the IEP team should build on the broad information gathering techniques previously described (e.g., interviews and discussions) by directly observing the child across priority situations and settings. Directly observing the child in his or her typical routines is extremely important as this can aid the interagency team in the design of practical interventions and support for use across school, home, and community settings.

### Generating Hypothesis Statements

Once the initial assessment process is completed and predictable patterns emerge that explain when and why the child engages in problem behavior, the

team is ready to develop hypothesis statements. Interventions developed without assessment-based hypotheses are less likely to be successful as they typically ignore important factors contributing to the problem behavior (Carr, 1994; Horner, 1994; O'Neill et. al., 1997; Repp, 1994; Sugai, Lewis, Palmer, & Hagan, 1998). More important, they ignore the reason for the problem behavior from the child's perspective (i.e., function). As such, IEP teams are encouraged to develop two types of hypotheses to guide intervention efforts: a specific hypothesis and a global hypothesis (Pennsylvania Department of Education Guidelines on Effective Behavior Support, 1995).

A specific hypothesis pulls together the specific information gathered during the assessment process.

Specific hypotheses explain why a problem behavior occurs by (a) describing fast and slow triggers (antecedent and setting events) regularly associated with the problem behavior, and (b) identifying its possible function. Specific hypotheses consist of three component statements:

- When this happens: (a description of specific antecedent and setting events associated with the problem behavior),
- The child does this: (description of the problem behaviors),
- In order to: (a description of the possible function of the problem behavior).

Table 3 illustrates one example of a specific hypothesis for a particular teenage boy.

**Table 3**

<b>Specific Hypothesis for Larry</b>	
<b><i>When this happens:</i></b>	<b>Larry is in a period of time (cycle) where his energy level is unusually high, he has limited opportunities to interact with others for more than twenty minutes, and he is in need/wants to interact with staff or peers.</b>
<b><i>Larry does this:</i></b>	<b>Talks constantly and makes inappropriate physical contact with peers/staff or engages in disrobing.</b>
<b><i>In order to:</i></b>	<b>To gain the undivided attention of preferred people.</b>

A specific hypothesis, such as Larry's, should drive the short-term intervention components of an individualized plan of support. It provides precise information on what fast or slow triggers could be modified to minimize or prevent problem behavior. A specific hypothesis provides useful information to teach alternative skills by also identifying the possible function of the problem behavior (e.g., to gain attention in Larry's example).

Specific hypotheses are essential for designing effective support plans, but they alone cannot provide a comprehensive understanding of the complexity of conditions that might be adversely influencing behavior (this is particularly true for a child diagnosed as mentally ill). It is, therefore, highly recommended that IEP teams also develop a global hypothesis summarizing the relevant, broad information gathered during the first stage of the functional assessment process (Pennsylvania Department of Education, Guidelines on Effective

Behavior Support, 1995). A global hypothesis addresses broad influences related to a child's skills, health, preferences, daily routines, and overall quality of life. In effect, a global hypothesis provides a contextual explanation (i.e., big picture) for why the events identified in the specific hypothesis are problematic for the child. A global hypothesis (summary statement) for Larry is illustrated in Table 4.

**Table 4**

Larry is a 15-year-old who expresses a great interest in social relationships with peers his own age. He enjoys animals, drawing, and playing video games (particularly Nintendo). Larry has been contending with a neurological biochemical disability causing him to have uncontrollable changes in his energy level, distractibility, and unusually high needs for stimulation, and (at times) thought disturbances. He has limited experience/success in terms of family/living stability with a history of multiple changes in living arrangements and psychiatric hospital placements. He has been a victim of physical and sexual abuse in the past. Larry has been prescribed various dosages and types of medication in the past ten years (e.g., Phenobarbital, Mellaril, Haldol, Thorazine) and diagnosed in various ways (e.g., ADD, MR, PDD, SED, LD). Larry's history and current status seriously impedes his ability to focus his attention at school coupled with his perception of school being a negative experience. While he is verbal, Larry does not appear to have the social skills to gain attention or avoid/modify unpleasant situations in socially acceptable ways.

Global hypotheses drive the long-term prevention components of an individualized support plan. They help to keep the team focused on

expanding the child's skills, facilitating meaningful outcomes, and improving the child's quality of life.

### ***Comprehensive Intervention and Supports***

Effective support plans consist of multiple interventions and support strategies. This is sometimes referred to as a multi-component plan, which is a technical way of saying that the team is going to do a number of different things within a close time proximity in an agreed upon manner. This includes preventative, teaching, and reactive types of activities. Comprehensive support plans are comprised of 1) antecedent and setting event modifications, 2) the teaching of alternative skills, 3) consequence strategies, and 4) lifestyle interventions. Each of these four component areas works in concert with one another to contribute to meaningful outcomes that can be durable over time.

Once hypotheses have been developed, a structured process should be used to identify and select supportive strategies and interventions (Knoster, 1998). In particular, interagency teams should in light of their hypotheses:

- brainstorm possible interventions,
- seek clarification on particular items that emerge through brainstorming,
- discuss the appropriateness of those interventions on the list in terms of
  - relationship to the hypotheses and
  - feasibility of use within typical routines and settings,
- select priority interventions in light of this discussion
- identify the types of supports team members will need in order to implement the selected interventions, and
- document the selected interventions and supports for staff in the child's support plan.

This decision-making process should be used across the four component areas previously described (i.e., antecedent and setting event modifications, teaching alternative skills, consequence strategies, and lifestyle interventions).

Table 5 presents examples of interventions and supports that have been successfully implemented by various interagency IEP teams in different settings. In reviewing these examples, it is important to remember that the identification and selection of particular strategies for any given child

should be based on hypotheses generated as a result of an FBA for that particular child as previously described.

**Table 5**

<b><u>Examples of Supportive Interventions</u></b>	
<b><u>Antecedent/Setting Event Modifications</u></b>	
<b><i>Remove Problem Events</i></b>	<ul style="list-style-type: none"> <li>• Avoid giving difficult tasks for independent performance.</li> <li>• Avoid bringing child to large crowds.</li> <li>• Avoid exposing child to long delays.</li> </ul>
<b><i>Modify a problem event</i></b>	<ul style="list-style-type: none"> <li>• Reduce the number of requests.</li> <li>• Modify instruction at school to decrease errors.</li> <li>• Change voice intonation.</li> <li>• Modify schedule.</li> <li>• Use suggestive rather than directive language (e.g., "What should you do now?").</li> <li>• Treat the physical illness.</li> </ul>
<b><i>Interspersing Events</i></b>	<ul style="list-style-type: none"> <li>• Mix difficult word problems with easy ones.</li> <li>• Mix mastered tasks with acquisition tasks for independent performance.</li> <li>• Schedule non-preferred activities (e.g., cleaning) among preferred activities (e.g., leisure).</li> <li>• Precede directive for non-preferred activities (e.g., "Brush your teeth") with easily followed directives (e.g., "Open the cabinet, choose your favorite toothpaste").</li> </ul>
<b><i>Add Events That Promote Desired Behaviors</i></b>	<ul style="list-style-type: none"> <li>• Include child preferences in activities</li> <li>• Use cooperative strategies to encourage participation.</li> <li>• Schedule preferred activities in daily routines; involve child in planning to increase predictability.</li> <li>• Provide a rich variety of activities from which to choose.</li> <li>• Provide increased opportunities for social interactions before problems arise.</li> <li>• Transport the child to scheduled counseling sessions.</li> <li>• Provide opportunities for daily exercise.</li> <li>• Monitor impact of medication.</li> <li>• Promote a healthy diet.</li> </ul>
<b><i>Block or Neutralize Negative Events</i></b>	<ul style="list-style-type: none"> <li>• Allow the child to take frequent breaks during difficult activities.</li> <li>• Reduce academic demands at school when the child appears agitated or upset.</li> <li>• Provide opportunities for rest when the child is tired or ill.</li> <li>• Provide time alone or time to regroup after a negative experience.</li> </ul>

**Examples of Supportive Interventions**

**Teaching Alternative Skills**

<b><i>Teach Replacement Skills</i></b>	<ul style="list-style-type: none"> <li>• Teach the child to communicate, “I need help,” to replace problem behavior during difficult situations.</li> <li>• Teach the child to initiate social interactions (e.g., “play with me”) to replace teasing peer.</li> <li>• Teach the child to play a video game, to replace biting fingernails during “down” times.</li> </ul>
<b><i>Teach General Skills</i></b>	<ul style="list-style-type: none"> <li>• Teach organizational skills to prevent the child from becoming frustrated when faced with multiple tasks at school.</li> <li>• Expand social play skills so that the child has more success with peers.</li> <li>• Teach the child to self-initiate activities using a picture schedule to prevent boredom.</li> </ul>
<b><i>Teach Coping and Tolerance</i></b>	<ul style="list-style-type: none"> <li>• Use desensitization techniques to teach the child to cope with medical examinations.</li> <li>• Teach the child to relax during stressful events.</li> <li>• Teach the child to control angry outbursts.</li> <li>• Teach self-monitoring of mood.</li> </ul>

**Examples of Supportive Interventions**

**Consequence Strategies**

<b><i>Reinforce Use of Alternative Skills</i></b> <i>Replacement Skills</i>  <i>General or Coping and Tolerance Skills</i>	<ul style="list-style-type: none"> <li>• Respond to use of replacement skill (e.g., all requests for a “break”) immediately and consistently.</li> <li>• Use praise and age appropriate rewards for solving word problem.</li> <li>• Have the child self-record instances of controlling anger.</li> </ul>
<b><i>Reduce Consequences for Problem Behavior</i></b>	<ul style="list-style-type: none"> <li>• Redirect the child to another activity or prompt her to use an alternative skill.</li> <li>• Provide corrective feedback (e.g., “No, don't hurt John”).</li> <li>• Implement age-appropriate negative consequences (e.g., loss of privileges, time-out, restitution).</li> </ul>
<b><i>Crisis Management</i></b>	<ul style="list-style-type: none"> <li>• At first signs of crisis, engage the child in a calming activity.</li> <li>• Clear others from the area; make area safer.</li> <li>• Use gentle physical guidance and protection to prevent injury.</li> </ul>

<b><u>Examples of Supportive Interventions</u></b>	
<b><u>Lifestyle Intervention</u></b>	
<b><i>Quality of Life Adaptations</i></b>	<ul style="list-style-type: none"><li>• Help the child maintain friendships by inviting peers to play and share in common interests.</li><li>• Use peer networks to introduce the child into play groups.</li><li>• Incorporate opportunities for daily choice making across routines.</li><li>• Develop an action plan that will move the child from a segregated, to an inclusionary, school setting.</li><li>• Sample prospective jobs; help the adolescent to procure his choice.</li><li>• Help the child to participate in after-school activities choice.</li></ul>
<b><i>Maintenance Strategies</i></b>	<ul style="list-style-type: none"><li>• Teach teachers and staff across settings how to make specific accommodations.</li><li>• Teach peers to understand the child's communication system.</li><li>• Use picture schedules to make daily routines predictable and understandable for the child.</li><li>• Help the child practice new skills in different settings.</li><li>• Help the child set and monitor goals.</li></ul>

While using hypotheses as a common point of reference from which to select interventions will increase the likelihood of success, it is unlikely that any one intervention will be sufficient by itself for children with complex mental health needs. This is why multiple interventions (i.e., multi-component plans) are typically required by interagency teams supporting children with challenging behavior.

Preventative strategies (such as adults stating clear expectations, modifying seating arrangements in the classroom, or adapting the pace of interaction) can have a powerful and fast effect on a child's behavior. However, it is unlikely that any given teacher, therapist, and/or parent will be in a position to completely engineer the entire day for any particular child. Additionally, even if this were possible, it would not be desirable as the child is not being taught new skills to enable him/her to function independently. Therefore, it is necessary to combine the use of preventative strategies with teaching alternative skills.

Alternative skill instruction can be classified into teaching 1) replacement skills, 2) general skills, and 3) coping and tolerance skills (Dunlap & Kern, 1996; O'Neill & Reichle, 1993; Bambara & Knoster, 1995; 1999). Replacement skills operate as a one-for-one substitute for the child that will serve the exact same function as the problem behavior (e.g., asking for help as opposed to yelling and screaming when frustrated to get help). General skills are broad skills that constructively alter problem situations and help to prevent the need for problem behavior (e.g., organizational skills to prevent the child at school from becoming frustrated when faced with multiple assignments). Coping and tolerance skills are things that the child learns to do when he or she is faced with difficult situations (e.g., relaxation techniques such as deep breathing and/or visual imagery exercises to use during stressful situations).

It is necessary for child-centered teams to employ consequence interventions in concert with

antecedent/setting event modifications and the teaching of alternative skills. In example, a child's teacher or therapist may use consequence strategies to 1) reinforce the acquisition and use of alternative skills, and 2) reduce the effectiveness of problem behavior should it continue to occur. The goal of consequence strategies (feedback) is to teach the child that his/her use of alternative skills is a better way (i.e., more acceptable and more efficient) of bringing about desired results than the problem behavior. In addition, consequence interventions also help to de-escalate crisis situations and protect the child and his/her family, staff, and property from harm. In developing crisis management plans, the team should 1) carefully define what constitutes a crisis, 2) describe intervention procedures and who will be involved, 3) identify resources needed to implement the plan (such as calling another adult for help), and 4) agree on procedures for documenting and reporting use of the crisis management plan. Crisis management plans should be developed to address the escalation, eruption, and de-escalation phases of crisis and should not be used as the sole approach to addressing a child's problem behavior.

Finally, lifestyle interventions and support should be designed and implemented by the child's team in conjunction with the other previously described approaches. Lifestyle refers to the typical

ebb and flow of daily life across routines and settings. Lifestyle interventions and support contribute to long-term prevention of problem behavior through general improvement in the child's quality of life (e.g., friends, access to events or activities of interest, personal choice and power over age appropriate life decisions). Lifestyle interventions and support are important in that 1) a child's dissatisfaction with their circumstances may likely contribute to problem behavior, 2) children are more likely to learn new social skills in contexts that are enjoyable and desired, and 3) they allow for ongoing, long term support for the child as he/she grows and develops.

In total, individualized plans of support are uniquely tailored to each child's needs, preferences, and shared long-range goals (Hansen, 1999). Effective support plans take into consideration the perspective of the child and his/her family, and the feasibility (i.e., doability) of interventions in the plan. This is accomplished by involving the child (where appropriate), along with his/her family, and staff members in designing interventions and support to best insure a good fit across settings and routines. Table 6 provides a simple self-check for IEP teams designing individualized support plans for children with chronic mental health needs.

**Table 6**

<b>Self-Check for Designing Support Plans at School for Children with Chronic Mental Health Needs</b> (Adapted from Bambara and Knoster, 1998)		
<b><i>Antecedent and Setting-Event Modifications</i></b>		
Does the plan include antecedent and setting-event modifications to prevent problem behavior from occurring?	Y	N
Does the plan include modifications to make desired behaviors more likely?	Y	N
Are mental health treatment components designed and delivered in concert with educational interventions?	Y	N
<b><i>Teaching Alternative Skills</i></b>		
Did your team consider all three approaches to alternative-skill training (e.g., replacement skills, general skills, coping and tolerance skills)?	Y	N
Do replacement skills serve the same function as the problem behavior?	Y	N
Do general skills help the child prevent problem situations from occurring?	Y	N
If the plan targets multiple alternative skills, are the ones that produce the most immediate effect for the child taught first?	Y	N
Are the selected alternative skills to be taught consistent with the child's mental health treatment plan?	Y	N
<b><i>Consequence Interventions</i></b>		
Does the plan include consequence strategies for (a) strengthening alternative skills, (b) reducing the pay-off for problem behavior, and (c) crisis management if necessary?	Y	N
Do consequences for alternative skills produce outcomes that are more effective or efficient than the problem behavior.	Y	N
Are desired outcomes for the problem behavior reduced or eliminated?	Y	N
Does the crisis management plan address three phases of a crisis: (a) escalation, (b) Eruption, and (c) de-escalation?	Y	N
Are strategies selected consistent with therapeutic goals in the child's mental health treatment plan?	Y	N
<b><i>Lifestyle Interventions</i></b>		
Does the plan include supports that will improve the child's quality of life?	Y	N
Does the plan include long-term adaptations that will (a) help the child maintain new skills, and (b) prevent problem behaviors from occurring?	Y	N
Has the child and his/her family been provided the opportunity to participate in selecting interventions at a level they choose?	Y	N
<b><i>Overall</i></b>		
Are the intervention strategies logically linked to the hypotheses?	Y	N
Does the plan reflect individual and family preferences?	Y	N
Are all intervention strategies (a) age-appropriate, and (b) acceptable for other child without disabilities?	Y	N
Can the plan be carried out in everyday settings without stigmatizing the child?	Y	N
Have you identified supports that team members need to implement the plan?	Y	N
Has the team identified how they will measure and report the child's (a) acquisition and use of alternative skills, (b) reduction in problem behavior, and (c) improvement in quality of life?	Y	N

Effective support focuses not only on reducing behavior problems, but also on enhancing a child's overall quality of life (Meyer & Evans, 1993). Meaningful outcomes include lifestyle improvements such as participation in community life, gaining and maintaining satisfying relationships, expressing personal preferences and making choices, and developing personal competencies. Such improvements in quality of life are facilitated by establishing a positive long-range vision with the child and his/her family (e.g., through a wrap around approach) and mobilizing natural supports through effective teamwork (Kincaid, 1996).

Constructive behavior change still serves as the primary measure of effectiveness. However, it is important to realize there may be times when a child's behavior does not immediately change, but his/her environment is positively altered by the support activities of the student's team. In other words, occasionally a child's behavior may remain the same, but the adults in the child's world have learned to more effectively and efficiently deescalate crisis situations (e.g., a child may still experience manic episodes, but his/her family, therapist, and teachers have learned how to safely de-escalate crisis situations). In a further example, the support team may be able to assist parents in community integration activities with their child despite the fact that the child's behavior may be less than ideal.

Table 7 summarizes both "what" and "how" to collect important information to evaluate the impact of intervention with a child who presents problem behavior. Deciding what information to collect and measure will be guided by the specific goals in the child's individualized plan (e.g., IEP and mental health treatment plan), with the most obvious being (a) the increase in use of socially acceptable alternative skills (e.g., replacement skills, general skills, and coping and tolerance skills) and (b) reduction in problem behavior. Teams may wish to

monitor these outcomes over time and across different situations (e.g., in different classrooms, in the community, at home). Teams may also want to measure broader results such as those that emerge through lifestyle interventions (Mayer & Janney, 1989; Risley, 1996; Turnbull & Turnbull, 1996; Janney & Snell, 2000). This may include assessing positive side effects of support (e.g., improved grades or increased participation in community events); measuring improvements in health and well being (e.g., decreases in need for psychotropic medications, fewer physical injuries); measuring child, family, and staff satisfaction; and measuring increases in positive family interactions.

**Table 7**

## **Measuring Progress**

### ***What Information to Collect***

- Increases in use of socially acceptable alternative skills
- Reductions in occurrence of problem behavior
- Positive side effects (e.g., improved grades, increased attention, peer acceptance)
- Improvements in quality of life (e.g., increased participation in typical activities, increased choice/decision making, inclusion)
- Improvements in consumer satisfaction (e.g., child, family, staff, and others)
- Improvements in health or well being

### ***How to Collect Information***

- Interviews (e.g., teachers and therapist, child, parents, service providers)
- Informal and anecdotal reports (e.g., communication logs with parents, teacher progress notes)
- Rating scales (e.g., child affect, social scales, opportunities for choice)
- Natural documents (e.g., report cards, incident reports, medical records, placement records)
- Direct observation (e.g., frequency counts, measures of duration, observation logs)

Adapted from Meyer and Janney (1989)

In addition to determining what to collect and how to collect it, the team will need to identify who will take the lead in gathering information. This is particularly important for interagency teams. In particular, an interagency team supporting a child with chronic mental health needs should answer the following questions:

1. Who will collect what pieces of information and in which settings?
2. Who will be responsible to summarize and display the information?
3. When and how often will information be collected?
4. Who will meet, when, and how often to review and discuss the displayed information for decision making?

While reaching agreement on what type of information to collect and how to collect it is important, understanding how to make educational and therapeutic decisions using this information is critical for long-term success. Based on the information you collect, the team will need to determine whether you will need to reevaluate components of the plan, strengthen support strategies, or expand the plan beyond its current scope (Bambara and Knoster, 1998).

When the support plan is effective, the child and his/her team will realize increases in new skills, reductions in problem behavior, and progress toward broader lifestyle improvements. When this happens, the team should ask, "What's next?" Do these gains justify maintaining the status quo, or should the support plan be expanded to enhance further growth?

If progress is not evident, the team should ask, "Why not?" It may be that the hypotheses are inaccurate or that the plan does not adequately address the influences or function of the child's behavior. It could be that the plan has been implemented inappropriately, or that other events have hindered positive outcomes (e.g., poor coordination of school and mental health services and programs). Lack of progress should trigger a re-assignment of the support plan and not necessarily promote movement toward more intrusive and/or more restrictive interventions.

Making decisions about the effectiveness of a support plan requires thoughtful consideration. Keep in mind that modifications will be likely as the child's needs and circumstances change over time.

## **Summary**

Positive behavior support is an important approach to identifying and organizing effective school practices, especially for children who present significant problem behavior (Sugai, et. al., 2000). Collaborating as a team is the best way to design and implement effective interventions and supports, as well as to measure progress and make modifications to individualized support plans for children who present problem behavior. Parental consent to share information and to employ an interagency collaborative approach, obviously, serves as a logical starting point. Reaching consensus on meaningful outcomes with the child and his or her family is essential to the process. Listening and respecting the child's and family's perspectives, in tandem with defining how information is to be collected and used in selecting and implementing interventions and support, will best ensure the realization of expected outcomes.

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## References

- Bambara, L.M., & Knoster, T.P. (1998). Designing positive behavior support plans. *Innovations* (No. 13). Washington, DC: American Association on Mental Retardation.
- Bambara, L.M., & Knoster, T.P. (1995). *Guidelines: Effective behavioral support*. Harrisburg: Pennsylvania Department of Education, Bureau of Special Education.
- Carr, E.G. (1994). Emerging themes in the functional analysis of problem behavior. *Journal of Applied Behavior Analysis*, 27, 393-400.
- Carr, E.G., et al. (1999). *Positive behavior support for people with developmental disabilities: A research synthesis* (American Association on Mental Retardation Monograph Series). Washington, DC: American Association on Mental Retardation.
- CASSP Core Principles. (1995). Harrisburg, PA: CASSP Advisory Committee of the Pennsylvania Office of Mental Health and Substance Abuse Services.
- Demchak, M.A., & Bossert, K.W. (1996). Assessing problem behaviors. *Innovations* (no. 4). Washington, DC: American Association on Mental Retardation.
- Dunlap, G., & Kern. (1996). Modifying instructional activities to promote desirable behavior: A conceptual and practical framework. *School Psychology Quarterly*, 11, 297-312.
- Foster-Johnson, L., & Dunlap, G. (1993). Using functional assessment to develop effective, individualized interventions for challenging behaviors. *Teaching Exceptional Children*, 25, 450.
- Hansen, M. (1996). Writing effective treatment plans: The Pennsylvania CASSP model. A CASSP Technical Assistance Paper. Harrisburg, PA: PA CASSP Training and Technical Assistance Institute.
- Hansen, M., et al. (1999). Child, family and community core competencies. Harrisburg, PA: PA CASSP Training and Technical Assistance Institute.
- Horner, R.H. (1994). Functional assessment: Contributions and future directions, *Journal of Applied Behavior Analysis*, 27 401-404.
- Horner, R.H., & Carr, E.G. (1997). Behavioral support for students with severe disabilities: Functional assessment and comprehensive intervention. *The Journal of Special Education*, 31, 84-104.
- Horner, R.H., Dunlap, G., Koegel, R.L., Carr, E.G., Sailor, W., Anderson, J.A., Albin, R.W., & O'Neill, R.E., (1990). Toward a technology of "non-aversive" behavioral support. *Journal of the Association for Persons with Severe Handicaps*, 15, 125-132.
- Individuals with Disabilities Education Act of 1990, 20 U.S.C. § 1400 *et seq.*

Janney, R., & Snell, M.E. (2000). Behavioral Support. Baltimore: Paul H. Brookes.

Kincaid, D. (1996). Person-centered planning. In L.K. Koegel, R.L. Koegel, & G. Dunlap (Eds.), *Positive behavioral support: Including people with difficult behavior in the community* (pp. 439-466). Baltimore: Paul H. Brookes Publishing Co.

Knoster, T. Creating effective behavior support plans. Tri-State Consortium on Positive Behavior Support. Newsletter. Fall 1998.

Koegel, L.K., Koegel, R.L., & Dunlap, G. (1996). *Positive behavioral support: Including people with difficult behavior in the community*. Baltimore: Brookes.

Meyer, L.H., & Janney, R.E. (1989). User-friendly measures of meaningful outcomes: Evaluating behavioral interventions. *Journal of The Association for Persons With Severe Handicaps*, 14, 263-270.

Meyer, L.H., & Evans I.M. (1993). Science and practice in behavioral intervention: Meaningful outcomes, research validity, and usable knowledge. *Journal of the Association for Persons with Severe Handicaps*, 18, 224-234.

O'Neill, R.E., et al. (1997). *Functional assessment and program development for problem behavior: A practical handbook*. Pacific Grove, CA: Brooks/Cole.

O'Neill, R., & Reichle, J. (1993). Addressing socially motivated challenging behaviors by establishing communicative alternatives: Basics of a general case approach. In J. Reichle & D.P. Wachter (Eds.), *Communication and language intervention series: Vol. 3. Communicative alternatives to challenging behavior: Integrative functional assessment and intervention strategies* (pp. 205-235). Baltimore: Paul H. Brookes Publishing Co.

Repp, A. (1994). Comments on functional analysis procedures for school based behavior problems. *Journal of Applied Behavior Analysis*, 27, 208-412.

Repp, A. & Horner, R.H. (Eds.). (1999). *Functional analysis of problem behavior: From effective assessment to effective support*. Belmont, CA: Wadsworth.

Risley, T. (1996). Get a life: Positive behavioral intervention for challenging behavior through life arrangement and life coaching. In L.K. Koegel, R.L. Koegel, & G. Dunlap (Eds.), *Positive behavioral support: Including people with difficult behavior in the community* (pp. 403-424). Baltimore: Brookes.

Sugai, G., et al. (2000). Applying positive behavior support and functional behavioral assessment in schools. *Journal of the Positive Behavior Interventions*, 2, 3, 131-143.

Sugai, G., Horner, R.H., & Sprague, J. (1999). Functional assessment-based behavior support planning: Research-to-practice-to-research. *Behavioral Disorders*, 24, 223-227.

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Turnbull, A.P., & Turnbull, H.R. (1996). Group action planning as a strategy for providing comprehensive family support. In L.K. Koegel, R.L. Koegel, & G. Dunlap (Eds.), *Positive behavioral support: Including people with difficult behavior in the community*(pp. 99-114). Baltimore: Brookes.