Focused Feedback – Behavior Support Plans

Cognitive Behavioral Therapy

- Internalizing Disorders

- Externalizing Disorders

Yellow Group Team Leaders

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Cognitive Behavior Therapy

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Best Predictor of Treatment Outcomes

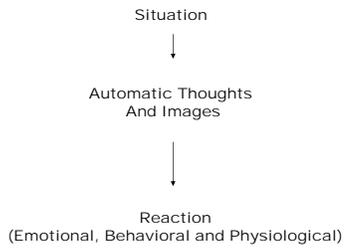## **Meaningful therapeutic relationship**

- Build rapport
- Develop client's commitment to therapy
- Express genuine interest and concern
- Be empathic and validate frustrations

<div align="right">Messer & Wampold, 2002; Norcross, 2002</div>
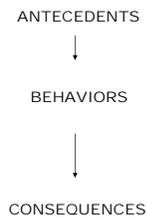

Key Things to Consider

- TIME itself is part of the intervention

- Rome wasn't built overnight

- CBT WORKS, so trust it

- Flexibility within integrity

- JUST DO IT!

The General Cognitive Model

Situation

↓

**Automatic Thoughts
And Images**

↓

**Reaction
(Emotional, Behavioral and Physiological)**

The General Behavioral Model

ANTECEDENTS

↓

BEHAVIORS

↓

CONSEQUENCES

Cognitive + Behavior Therapy = CBT

- Cognitive therapy is a form of therapy that assumes that faulty thought patterns cause emotional responses and maladaptive behavior; thus, changing thoughts will result in changed behavior.
- Behavior therapy is a therapeutic approach that treats emotional and behavioral disorders as maladaptive learned responses that can be replaced by healthier ones with appropriate training and reinforcement.

Cognitive-behavioral therapy (CBT)
integrates features of behavior therapy into the traditional cognitive restructuring approach.

Definition of CBT

- Focused form of psychotherapy based on a model suggesting that psychological disorders involve dysfunctional thinking and poor problem-solving and coping skills

- The way an individual feels and behaves in influenced by the way s/he processes and perceives her/his experiences

The Cognitive Triad

- **Negative view of the self** (e.g., I'm unlovable, ineffective, nothing I do is right)

- **Negative view of the future** (e.g., nothing will work out, the future looks bleak)

- **Negative view of the world** (e.g., world is hostile, others are out to get me)

Beck, 1978

CBT for Two Classes of Mental Health Problems

Disruptive Behaviors		Anxiety	
• Aggression • Poor self control • Impulsivity	• Guiding self statements ("Stop, Think Act") • Positive self statements ("You can solve this problem") • Problem-solving skills • Accurate interpretation of social events • Relaxation training (controlled breathing, meditation, progressive muscle relaxation) • Thick reinforcement for using skills	• Nighttime fears • School refusal • Separation anxiety • Generalized anxiety • Specific phobias • Social phobia • Obsessive Compulsive Disorder	• Recognition of faulty cognitions ("I can't go in that elevator"; "Everyone will laugh at me when I give my talk") • Positive self statements ("I can handle this"; "I know that's just my anxiety telling me lies") • Relaxation training • Modeling, role playing, reinforcement for using CBT skills • Exposure to a hierarchy of anxiety-producing situations

An Example of a CBT Curriculum Coping Cat Program to Address Anxious and Depressive Symptoms

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Somatic Management Techniques

- **Somatic management techniques -** because the body is conditioned to respond in a heightened state of avoidance or escape (fight or flight) to external stimuli that is *perceived* as threatening or fearful, children are taught relaxation techniques to calm this response.
  - Deep breathing, positive self-talk, cognitive distraction technique

Cognitive Restructuring

- **Cognitive restructuring -** The child or adolescent learns new ways to deal with feared situations by investigating, uncovering and challenging anxiety-provoking thoughts. The following techniques are incorporated into this component: identification of automatic thoughts (AT), gathering evidence to dispute negative AT's and keeping a diary to monitor daily thoughts.

Problem-Solving

Problem solving - A child is taught to identify real life problems, then to list and evaluate possible solutions to overcome the problem, assess the (dis)advantages of each solution, and select the best action for resolving the problem.
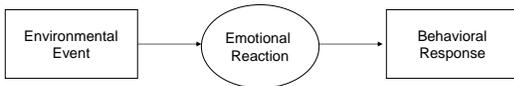
Exposure

- **Exposure** - Involves gradual and systematic exposure to a feared situation. It can take the form of **guided imagery** (the therapist guides the child through step-by-step visual imagery of confronting the feared situation); **symbolism** (the use of pictures or props); simulation (role-playing a feared situation); or **in vivo** (contact with the real situation).
  - **Graduated exposure** - For instance, a child that is afraid of dogs. He can become used to dogs through a series of graduated exposure to a dog. He may first be confronted by using pictures of dogs in friendly situations (symbolism) and later encouraged to stand near a dog, next to a dog and then to touch a dog (in vivo).
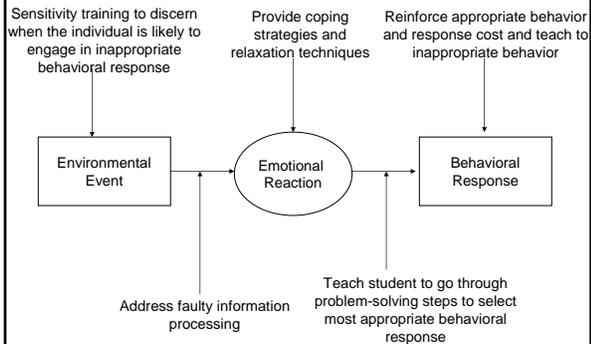
An Example of a CBT Curriculum Coping Power Program to Address Externalizing Behaviors

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**COGNITIVE-BEHAVIOR THERAPY
MODEL OF TREATMENT**

Environmental Event → Emotional Reaction → Behavioral Response

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COGNITIVE-BEHAVIOR THERAPY MODEL OF TREATMENT

Sensitivity training to discern when the individual is likely to engage in inappropriate behavioral response

Provide coping strategies and relaxation techniques

Reinforce appropriate behavior and response cost and teach to inappropriate behavior

Environmental Event → Emotional Reaction → Behavioral Response

Address faulty information processing

Teach student to go through problem-solving steps to select most appropriate behavioral response

Child Component

The Coping Power Child Component consists of 34 structured cognitive-behavioral group sessions and periodic individual sessions designed to positively affect the child's:

- Ability to set short and long term goals
- Organization and study skills
- Anger management skills
- Social skills
- Problem-solving skills
- Ability to resist peer pressure
- Entry into positive peer groups

IMPORTANT: WHETHER YOU WILL EMPHASIZE INDIVIDUAL OR SMALL GROUP SESSIONS WILL DEPEND ON THE STUDENTS YOU ARE WORKING WITH.

Parent Component

The Coping Power Parent Component consists of 16 group sessions and periodic individual contacts aimed at developing and reinforcing parents' use of:

- Praise and positive attention
- Clear rules and expectations
- Promotion of child study skills
- Appropriate discipline practices
- Parental stress management
- Family communication and problem-solving
- Reinforcement of problem-solving skills the children the learn in Coping Power

IT IS RECOMMENDED THAT COUNSELORS ATTEMPT TO MEET WITH PARENTS OF TIER III KIDS ONCE A MONTH TO GO OVER SOME OF THESE SKILLS.

COORDINATION OF PLANS: BEHAVIOR SUPPORT, ACCOMMODATION, AND MENTAL HEALTH TREATMENT
by Diana Browning Wright

I. BEHAVIOR SUPPORT PLANS: When do we need them?

- ♦ **IDEA/504**—Use when "Behavior Impedes Learning" of the Student or Peers.
- ♦ **IDEA/504**—Use in discipline situations, after an Functional Behavioral Assessment; e.g., for suspension past 10 cumulative days in a school year, involuntary transfer or manifestation determination states behavior is a manifestion of the disability (i.e., direct, substantial relationship to the disability OR IEP non-implementation of a component led to the misbehavior.
- ♦ **IDEA**—Use in discipline situations, after the student has been removed to an interim alternative educational setting (IAES) for 45 school days for drugs, weapons or extreme dangerousness, use to designate services that "ensure behavior doesn't recur,"
- ♦ **NO Disability**—It is best practice for a school team to develop a BSP to address any behavior support need when lesser interventions have not been successful in removing behavioral barriers to educational success (e.g., when environmental changes, daily report cards, counseling, behavior contracts, individualized reinforcement schedules, etc. have not been effective.)

Considerations in Developing Behavior Support Plans:

Some data is always required to develop a BSP, but extensive data collection is typically unnecessary when team members know the student and the environment well. Data collection about the frequency, intensity and duration of the problem behavior must increase when the behavior is not yet understood enough to hypothesize the function, or understand the relationship of the behavior to environment and outcomes requires more analysis.

Is an asessment plan required?
1. Student has an IEP or 504 Plan
   - **Unnecessary –** If the plan is developed "based on a review of existing data" during an IEP team meeting, no assessment plan is needed.
   - **Necessary –** If new data must be collected to inform interventions (specific student observation and data collection, testing, analysis to determine effect of identified or not yet identified disability or diagnoses on the behavior, etc.)
2. Student does not have a disability
   - **Unnecessary –** If no disability is suspected, no assessment plan is necessary, but involve the family and student in the development of plan, which will typically be developed in a site-based team effort because less intensive interventions have not proven successful.
   - **Necessary –** If disability is suspect and new data is to be collected (testing, analysis to determine disability, etc.) an assessment plan is necessary.

Best Practices for Behavior Support Plan:

Assure the plan always addresses <u>both</u> prongs, the student/environment match and the reason (function) of the behavior in sufficient detail as to be implementable by team members:

- Specify environmental/instructional changes to reduce the student's need to exhibit the behavior and what immediate and immediate past (setting events) will 'predict' or 'trigger' the behavior.
- Teach, elicit, and reinforce a functionally equivalent replacement behavior (FERB) when strategies to support general positive behaviors do not suffice.
- Specify parties responsible for implementing each component with enough clarity so that outside readers reviewing the plan can determine responsibilities.
- Specify coordination with other plans and two way communication between all stakeholders.
- Specify reactive strategies to use if the problem behavior occurs again so that all implementers prompt the FERB, manage the problem safely, debrief calmly and apply any identified consequences with skill.

Behavior Support Plans For Whom?

Students who have behaviors impeding their learning or that of others benefit from BSPs.

- **If student has an IEP**—Under, "special considerations" every IEP team must determine if behavior impedes learning, and if so, specify positive behavior approaches, among other strategies. If lesser general positive supports are ineffective, the BSP is the next step.
- **If student has a 504 plan**—The BSP becomes a part of the service plan to ameliorate adverse effects of the condition on a major life activity (learning). Accommodation plans are the primary component of 504, but if not effective, BSP is the next step.
- **If student receives only general education services**—The school can elect to provide for any student a behavior plan when lesser interventions have not been successful through the regular on-site support team.
- **If disability is suspect, but not yet determined**—If a disability related to this behavior is questioned, the BSP is the intervention of choice to determine the student's response to the intervention (RtI) prior to assessing for disability. This is the function of the on-site team, with participation from personnel able to develop a competent plan and oversee implementation and student response.

II.   ACCOMMODATION PLANS: When do we need them?

Accommodation Plans For Whom?

- **IDEA/504**—A student with an identified disability whose IEP team (or 504 team) determines accommodations (not substantially altered standards), and/or modifications (substantially altered standards) are needed to afford equal opportunity to access curriculum in the least restrictive environment requires an accommodation plan as part of their IEP or 504 plan.

- **No Disability Identified**—
  1. The school team determines, or the teacher independently decides, to differentiate instruction, providing accommodations, for ANY of the learner's characteristics. Because there is no disability identified, these adaptations must not substantially alter standards. All students are entitled to differentiation, and differentiation and accommodation are substantially the same.
  2. A student study team often specifies, designs and monitors student response to interventions prior to consideration for special education evaluation. The accommodation plan addresses any characteristic requiring special consideration: temperament, mood swings, ad/hd, slow processing, weak recall of facts, anxiety, etc. If effective, the student does not need special education (i.e., specialized instruction due to the unique nature of the disability).

Best Practices for Accommodation Plans:

- Plans should be team developed when the teacher needs assistance matching 1. instructional strategies, 2. student characteristics or disability and 3. curricula and tasks to meet state standards.
- Be sure all providers know an IEP or 504 plan is a legally binding document, and any accommodation plan from this process is therefore legally binding. Providers can propose alternatives through the IEP or 504 team process.
- Be sure the accommodation plan details specifically what must be done and how to grade or evaluate learning outcomes with accommodations/differentiation in place.
- Communicate with teachers and providers about the rationale for accommodations and differentiation. Accommodations and differentiation enhances learning outcomes, leads to effective instruction for that student and effective measurement of content mastery. Without their use, learning outcomes will be reduced, and often reflect, the continued measurement of the effects of disability or learner characteristic on performance rather than actual learning that occurred.(e.g., asking a student with poor written language skills to describe what he learned in a lesson may yield different outcomes when compared to asking what he learned in a one on one interview with an adult with verbal prompts).

Differences Between Behavior Plans and Accommodation Plans:

- **Behavior Support Plans** are designed to address environmental changes and teaching of replacement behaviors to eliminate the student's use of an inappropriate **form** of behavior to get needs met. (All students are entitled communicate needs: getting or rejecting something. It is the form of the behavior we are addressing, in addition to providing supports to enhance learning outcomes. (I.e., A student with ad/hd and a 504 plan may engage in purposeful misbehavior and need a behavior plan to teach alternative protest (reject) behaviors.)
- **Accommodation Plans**: address changes in instructional content, form, delivery, measurement, performance criteria, etc. to enhance learning outcomes. (I.e., The same student may need an accommodation plan to address self-regulation, impulsivity, etc.)

III.   MENTAL HEALTH TREATMENT PLANS and COUNSELING SERVICES

- ♦ **Both Mental Health Treatment (MHT) plans and Counseling Services** are implemented by licensed providers (For example, clinical psychologists, social workers, school psychologists, counselors with educational certification.) MHT plans are to address mental health status, and underlying feelings and thoughts that may be affecting emotional well-being and concomitant behavior patterns and learning outcomes. Counseling services address underlying feelings and thoughts, and may include specific social skills deficits. Both approaches will sometimes measure change in behavior in both therapy or counseling sessions and real world environments as a result of interventions.
- ♦ **Mental Health Treatment plans** are based on assessment with signed informed consent for assessment and treatment, conducted by a licensed provider, with services often provided in a variety of settings, before, during and after school, to achieve goals.
- ♦ **Counseling Services** primarily occur during the school day and are provided based on identified needs, but do not require formal assessment. Consent for service is required.
- ♦ **Mental Health Treatment plans and Counseling Services** may include case management, including school/physician information exchange. They may also parent training, and therapies: group, cognitive behavior individual therapy, and other therapies depending on the developmental and psychological functioning of the student such as art, music, and play therapies.
- ♦ **LAW:** Mental Health Services provided at school district expense are a "Related Service to benefit from the student's special education" and require an IEP team determination that the service is necessary. They require treatment goals on the IEP as for all services.
- ♦ **LAW:** Counseling Services can be considered mental health services if the counselor is licensed to perform the needed function. If so, the above provisions apply. All students with and without IEPs can receive counseling, however, without being considered, "Related Service". Counseling Services are typically short term in nature, to address specific psychosocial stressors (e.g., divorce, bullying, social skills deficits, etc.) and vary in nature and depth from site to site. They do not require formal goals or monitoring.

Similarities between Behavior Plans and Mental Health/Behavioral Health Treatment Plans:

- Both address patterns of behavior and long standing difficulties that lesser interventions have not eliminated.
- Both require coordination between plans and providers with on-going two way communication between all stakeholders.

Behavior Support Plans		Mental Health Treatment Plans
BSPs are based on analysis of antecedent and consequences in the immediate and immediate past to identify 'predictors' or 'triggers' for the behavior and the "function" the behavior serves for the student.	vs.	MHTs are based on analysis of emotional status, psycho-social stressors both past and current, DSM-IV diagnoses; These are the longer range 'predictors' or 'triggers,' often internalized and removed in time from current settings.
BSPs primarily target what the student and adults <u>do</u>. They focus directly on the "do" of all behavior change efforts: "think, feel, do." Belief: Change the environment and the student will change what s/he does, and thinking and feeling will subsequently change.	vs.	MHTs primarily target how the student "thinks and feels," addressing cognitive distortions and resolution of intrapsychic conflicts. Belief: Change how the student thinks and feels and s/he will subsequently change what s/he does.
BSPs strive to change the form of the unacceptable behavior, change the environment to remove the student's need to use the behavior. (This can include reflection, helping student think about the effects of his/her behavior.)	vs.	MHTs change how the student feels and thinks in order to change actions; manage medication; assist family with dynamics; coordinate interventions in interagency collaboration when significant disorder or dysfunction is present.
BSPs address specific educational settings to eliminate behaviors impeding learning.	vs.	MHTs address behaviors interfering with emotional/mental well-being in any environment when necessary, including home, school, community, school supported workplace.
BSPs specifically state what school personnel should do to support the student at school and how to communicate with all implementers and stakeholders.	vs.	MHTs state goals for the student related to the nature of the problem. They do not always state how school personnel should support the student in the classroom.
BSPs have a broad definition of who requires a plan—any time behavior problems have not responded to lesser interventions.	vs.	MHTs have a narrower definition of who requires treatment if the district is funding service.
BSPs have built in ongoing communication between service providers at school without permission for communication within the school setting. Specification for other exchanges is built into plan approval.	vs.	Informed consent for exchange of information is necessary. Often extensive confidentiality rules between agencies are present. Under emergency safety situations, a "duty to warn" overrides components of confidentiality.

Method of Coordinating All Plans: What if a student has multiple plans?

Action Planning for all three plans is necessary. When multiple plans exist, a case manager will be necessary to coordinate exchanges of information, monitor implementation fidelity and assure outcomes are being attained.

Clarity in Writing Plans is necessary. By examining all the charts above, a team can determine what needs to be developed, by whom, using which approach. In general, consider the three common causes of behavior concern and respond with the appropriate plan:

- If temperament, characteristics, disability, and processing features interfere with learning, use an "accommodation or differentiated instruction plan" approach to remove barriers to educational success.

- If past trauma, or significant psychosocial stressors removed from the school environment are impacting student behavior, consider either "counseling services" or "mental health treatment plans."

- When specific behaviors are achieving a specific outcome for the student, and lesser school wide, class wide or individual positive supports have not yet been effective, develop a behavior support plan.

Measure student progress on all three plans through measurable goals with on-going progress monitoring. Report to parents "at least as often as is reported for student without disabilities" if the student has an IEP or 504 plan, but consider increasing communication if the situation warrants more frequent data reporting. If the student has neither an IEP or 504 plan, use the regular report card or other school/home communication to report outcomes of interventions.

Develop three written form types to facilitate precise planning. Teach staff how to implement quality interventions for all three plans. See: www.pent.ca.gov for forms and teaching tools.

Develop a "memorandum of understanding" between agencies when interagency collaboration is in effect (e.g., Systems of Care) to facilitate information sharing.